United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center
October 24, 2011-October 28, 2011

Date of Report: January 15, 2012
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Introduction

Background

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

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

In order to conduct reviews of each of the areas of the Settlement Agreement 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.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

Methodology

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

(a) **Onsite review** – During the week of the 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. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

(c) **Observations** – While 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, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.

(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the facility.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the 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:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

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. The Facility made available to the Monitoring Team and number 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 greatly appreciates all this assistance from staff throughout the Facility. The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Judy Miller, and the staff who assisted her to keep up with all our requests, particularly Gloria Henrichsen, Tracy Stafford, Susan Steamer, David Savage, and Vivian Mahan. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations.

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 the Facility 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.

Given the number of issues identified during the baseline review, it was expected that the change processes would take time. During this review, it was clear that the staff at the Facility had taken a number of steps to address identified issues and to comply with the Settlement Agreement. In a number of areas, progress had been made. In other areas, the foundation had been laid for change. In some areas, concerted efforts need to be made over the next six months to make the necessary improvements. The following report provides brief highlights of areas in which the Facility is doing well or had made significant improvements and other areas in which improvements are needed.

General Comments

RSSLC had made significant progress toward compliance in several sections of the Settlement Agreement but less in others. It was clear to the Monitoring Team that the Facility was continuing to make efforts to improve services and supports.

Population. Population of the Facility at the beginning of the compliance visit was 376 individuals.

Facility Self-Assessment. The Self-Assessment and Plan of Improvement could be revised to be more effective at both assessing and reporting status and at doing and documenting effective planning to meet the requirements of the Settlement

Agreement. For the most part, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide details as to the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit (and, in some Sections, prior to the last visit). The information provided for the various provisions did not always relate to the Settlement Agreement requirements for the specific provisions. There were few examples of analyzed and summarized data contained in the self-assessment data that indicated how those activities were moving the Facility toward compliance within the respective provisions. There was no clear sequential framework or timelines established to identify how they expected to reach compliance. The POI should describe, in addition to the self-rating of compliance:

- The activities the Facility engaged in to conduct the self-assessment of the provision. This might include sampling, observations, implementation of their self-assessment tools, etc.
- How the Facility used the findings from these activities to determine substantial compliance or noncompliance.

Separately in each Section of the POI, the Facility also provided a list of action steps to be done. Some of these steps build on each other and were presented in an appropriate order. Others were simply additional tasks to be done. It would be helpful if the Facility were to plan actions to accomplish specific goals and requirements, and present them in a way that shows an organized approach that can be tracked. These, along with measures of outcome, could provide the framework for reports of status. The Facility should consider how it might use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

Specific Findings
Following are summaries of specific findings for each Section of the Settlement Agreement.

<u>Restraints</u>
RSSLC had taken a number of steps to improve processes and policies. The Facility achieved substantial compliance with Provision C.2 of the Settlement Agreement and had made progress on several others. Crisis intervention restraint use at RSSLC had remained relatively stable since the last review period.

- Positive Practices and Improvements Made
  - RSSLC restraint policies had been revised to be consistent with State policy.
  - In order to improve the usefulness of data in noting trends that may identify practices that appear to need special attention or focused intervention by clinical staff, some data were not trended over a rolling three-month period. While the Facility should be commended for initiating these changes in presentation of trend data, the Trend Analysis Report needs continued improvement to track detailed data elements over time, at least for the equivalent time period for which the summary data are tracked.
  - Documentation of restraint use had improved dramatically from that observed at the last review.

- Improvements Needed
    - The Monitoring Team was unable to confirm that staff serving as restraint monitors are adequately trained in the application and assessment of restraint.
    - The Monitoring Team could not determine on an individualized basis, whether restraints used were prohibited by medical orders.
    - Medical staff had not consistently established monitoring protocols for chemical and medical restraint specific to each episode of restraint. Nursing staff had not consistently monitored individuals in chemical or medical restraint correctly largely due to the absence of doctor-ordered specific monitoring protocols.
    - Nursing staff had not consistently been monitoring individuals in restraint post-release in accordance with policy.

<u>Abuse, Neglect and Incident Management</u>
The Facility continued to make progress in addressing issues of abuse, neglect, and incident management. Several of the provisions and components of provisions have met substantial compliance.

- Positive Practices and Improvements Made
    - The Facility had undertaken a policy review which resulted in several policies merging into two key policies. This represents a significant improvement in that these policies are now, for the most part, aligned with DADS policies and include provisions that, if carried out effectively and consistently, should lead to substantial compliance with all provisions of Section D of the SA.
    - 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.
    - The Facility had a sufficient number of trained investigators to ensure an investigator is onsite 24 hours a day seven days a week.
    - Investigations were completed using a standard format, and, for the most part, were conducted in a timely fashion.
    - Training for staff on abuse and incident reporting was in place, and all staff was current in that training.
    - Employee and volunteer background checks were completed timely.
    - 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.
- Improvements Needed
    - Many incidents were not reported within one hour to DFPS as required by policy.
    - Most investigations of non-serious discovered injuries reviewed by the Monitoring Team were insufficient in scope and depth to ensure all instances of abuse and neglect are discovered and reported.
    - There continues to be a problem with timely response from DFPS in initiating investigations.

Quality Assurance

The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of a sound QA system. Quality Assurance procedures were in place for many Sections and requirements of the Settlement Agreement. A data system was in place that consolidated and reported data from monitoring and auditing. The QA process had not yet developed to use data routinely to develop action plans. Corrective action plans were developed primarily to address specific problems found through monitoring and auditing; development of a broader corrective and strategic action process using information from a variety of sources was limited.

- Positive Practices and Improvements Made
  - QA systems are in place for many sections of the SA.
  - The development of a data system that was consolidating data from monitoring and program auditing and producing compliance reports was impressive. The process for inter-rater reliability checks, and generally improving the accuracy of monitoring data was encouraging and seemed to be working particularly well.

- Improvements Needed
  - The trend analysis reports required by DADS were deficient with respect to the inclusion of a sufficient period of trend data.
  - The QA process at the Facility had not as yet developed an organized process to use monitoring data to routinely and consistently develop Corrective Action Plans (CAPs).

Integrated Protections, Services, Treatments and Supports

The Facility continued to implement the "Supporting Visions" PSP process, but this was still meeting with limited success. Quality of staff participation had improved, but the processes and assessments did not yet reliably identify the individual's strengths, preferences and needs.

- Positive Practices and Improvements Made
  - The Facility had received training in the revised Personal Focus Assessment in September 2011, a process that appeared to be improved in terms of person-centeredness.
  - The Monitoring Team commends the Facility for devoting considerable resources to training for QDDPs.
  - RSSLC had developed a cross-disciplinary PSP/PST Committee to address issues with PSP meetings and initiate resolutions with various disciplines, a step the Monitoring Team commends.
  - The data system in use at the RSSLC to record QA monitoring activity and data, and array data for analysis, related to Provision F was much improved from that observed at the last monitoring review. The development of a data system that was consolidating data from monitoring and program auditing and producing compliance reports was impressive.

- Improvements Needed
    - The Facility also reported all of its QDDPs had been certified in the Q-Construction facilitation skills, but competence in these skills was not always evident to the Monitoring Team.
    - No meaningful preparation was provided to ensure the PFA and/or PSP processes were conducted in a manner that facilitated real participation by the individuals.
    - PST members sometimes came to planning meetings without a basic knowledge or awareness of an individual's current status or needs
    - PSTs often failed to conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
    - 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.
    - PSP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner, but was encouraged to find the Facility had developed an additional committee on Community Exposure that holds promise for improvement in this area.

<u>Integrated Clinical Services</u>

Improvement continued to occur in integrated discussion among clinicians at some planning meetings, and there were indications of work being done to increase integrated planning. However, there continued to be examples in which planning and discussions were not integrated. The Facility remained in substantial compliance with Provision G.2.

- Positive Practices and Improvements Made
    - The weekly integrated clinical meeting had evolved and included the QDDP. This meeting reviewed one individual per week; it would be important for the process to be replicated at the PST level so that integrated clinical planning would occur for all individuals.
    - The Facility has a format for responding to and identifying care plans arising from consultations. With one exception, Facility clinicians reviewed and documented decisions about recommendations from consultations.
    - There was documented evidence in records of individuals with skin integrity issues that the Wound Care Nurse collaborated with other relevant disciplines to provide integrated care.

- Improvements Needed
    - There were also several examples throughout the report in which clinicians did not participate adequately in planning for individuals.

- Health Maintenance Plans (HMPs) and Acute Care Plans (ACPs) did not contain integration with other relevant disciplines.
- Speech therapists were not actively participating in the development of the PSP as evidenced by lack of documented discussion or presence at the annual PSP.

Minimum Common Elements of Clinical Care

Although no provisions are yet in compliance, the Facility had made extensive efforts to develop clinical indicators and standards of practice for chronic conditions.

- Positive Practices and Improvements Made
  - The Facility had begun to identify clinical indicators of chronic conditions. Policy I.31 Chronic Clinical Indicators had been implemented. This policy established a process by which chronic disease topics would be researched and standards of care recommended.
  - The Facility had established a pilot QA project to track diabetes. A database had been populated, and graphs of some indicators were available.
  - Nurse Educators had implemented the State's mandated Clinical Indicators for Health Status Change Class and had trained all of the 619 incumbent staff. They had begun teaching this class at New Employee Orientation.
- Improvements Needed
  - Adequacy and timeliness of assessments remained problematic. Assessments were not always done when there were changes in health status, and both routine assessments and assessments for chronic conditions were not consistently comprehensive.
  - The Facility did not have a plan or procedure in place to ensure or monitor that treatments and interventions were implemented timely.
  - Diagnoses were generally in current DSM or ICD format, but there was not always documentation of clinical rationale or follow-up diagnostics.

At-Risk Individuals

Although statewide procedures for risk assessment had been implemented, identification of risk levels and of means to address risks was still in need of significant improvement.

- Positive Practices and Improvements Made
  - The statewide risk assessment procedure, with guidelines for rating risk, had been initiated.
  - At one PSP planning meeting observed by the Monitoring Team to assess adequacy of the risk assessment process, there was open discussion among PST members including presentation and discussion of clinical data and clinical

discussion among appropriate team members in decisions regarding risk. The team provided adequate justification of designated risk levels.

- Improvements Needed
  - Data from monitoring of the risk assessment process done by the QA Department differed significantly from data reported by other staff.
  - Risk assessments were not routinely conducted within five working days of risk identification or a change in circumstances.
  - Assessments were not sufficiently comprehensive to enable interdisciplinary discussion of risk.
  - Although the discussion about risk at the observed PSP meeting involved interdisciplinary discussion and determination of risk levels, there was little discussion addressing how risk impacted potential alternative placement, or affected the daily life of the individual.

Psychiatric Care and Services

The Facility was in process of hiring a psychiatrist in order to improve caseloads; until that position is filled, the Facility did not have sufficient resources to provide the services required by the SA. The Lead Psychiatrist actively participated in the interdisciplinary process.

- Positive Practices and Improvements Made
  - All psychiatrists were board certified.
  - Reiss Screens were administered to all individuals who required them.
  - Behavioral data were considered in decisions regarding pharmacological treatments.
  - Monthly reviews were conducted in the psychiatric clinics for all individuals who were treated with psychiatric polypharmacy, and evidence was presented which showed decreases in polypharmacy rates across the campus.
  - Informed consents were developed and signed by the treating psychiatrist.

- Improvements Needed
  - Some individuals did not yet have a psychiatric evaluation.
  - The Monitoring Team continued to find cases where different diagnoses were cited in the various sections of an individual's clinical record, where individuals had unresolved "not otherwise specified" (NOS) or "rule out" (r/o) diagnoses, and where cited diagnoses were not linked to specific behavioral characteristics of proposed disorders.
  - There were no medication plans in place, and in psychiatric clinics, known as PBMCs, medications were not linked to specific behavioral characteristics of proposed disorders.
  - Medical and Dental Support Plans were in place for many individuals, but there was no program in place to review the technical adequacy of newly developed support plans, and there was no system in place to monitor existing support plans to determine whether they were effective.

- New evaluations had improved but the evaluations did not provide the justifications needed to substantiate the diagnoses that were made.
- Although behavioral data were considered in decisions, a process was not in place to provide integrated behavioral care through combined assessment and case formulation.
- Although individuals received required screens for medication side effects, not all screens were signed by the prescribing physician, and it is possible that not all individuals who were rated as having dyskinesia had the diagnosis added to their Active Problem Lists.
- The Monitoring Team could not confirm that informed consent was in place for all psychoactive medications.

Psychological services

Progress was delayed due to vacancy in the position of Director of Behavior Service. A new director has begun to address many of the improvements needed, but there had not been sufficient time for the planned improvements to be implemented or to demonstrate complete implementation and effect. Despite this challenge, the Facility did provide evidence of modest progress in a few areas.

- Positive Practices and Improvements Made
  - The staff and resources necessary to provide intellectual and adaptive assessment were obtained, although this was recent and had not yet resulted in completion of assessments.
  - The Facility had a PBSP in place for each individual identified as requiring behavior intervention.

- Improvements Needed
  - Progress toward credentialing staff as BCBAs had stagnated.
  - Although new data collection forms had been implemented, these forms were not yet consistently used, even in the most recent PBSPs. The graphical presentation of behavior data and the use of those data in formulating treatment plans continued to reflect weaknesses noted during previous site visits.
  - The structural and functional assessments, although more often including widely accepted instruments such as the FAST and MAS, continued to lack comprehensive use of behavior-analytic principles. As a result, it was not possible to demonstrate that PBSPs were evidence-based and likely to provide adequate supports and teaching.
  - A variety of counseling strategies were utilized for the 13 individuals involved in non-PBSP psychological services, but that such strategies lacked formalization and did not adhere to evidence-based or empirical practices. Although a template for non-PBSP treatment plans had been developed since the previous site visit, the Facility had not implemented the template.
  - Due to pervasive weaknesses in the assessment process, it was likely that only limited understanding of the individual's treatment targets was gained and only minimal support for intervention strategies was provided.

- Documentation of the consent and approval process reflected that the consent process at times was not well organized, failed to incorporate a review of the latest information regarding the individual, and was not completed in a timely manner.

Medical Care

The Facility continued to take actions to improve medical services and had implemented many new processes. Although it had made advancement toward compliance, the Facility's activities have not enhanced the overall practice of medicine at the Facility.

- Positive Practices and Improvements Made
  - The Facility conducts weekly interdisciplinary meetings for select cases.
  - The Facility developed and implemented standard orders for acute and chronic conditions, and developed a quarterly review process to address chronic medical conditions
  - The Facility reported participating in the DADS Central Office External Medical Provider Audits on three separate occasions.
  - The Facility reported developing a database for the management of diabetes mellitus, which was assessed by the Monitoring Team and determined to an excellent mechanism to assist in the management of diabetes mellitus.
  - In general, the Monitoring Team noted marked improvement with the Facility's mortality review process, and is complimentary of its committee structure and function. Additional emphasis on Root Cause Analysis and physician recommendations would be advantageous to the process.

- Improvements Needed
  - The medical audit process does not yet provide clinical performance review.
  - The Facility did not have a comprehensive Medical Quality Assurance process in place.
  - The Facility must continue to work with DADS Central Office to implement practice protocols that will help ensure acceptable standardized care.

Nursing Care

The Nursing Department continued to demonstrate a high degree of enthusiasm and commitment to moving toward compliance with all provisions of the Settlement Agreement. The Nursing Department had essentially remained stable since the last compliance review. Several staffing realignments were made to improve nursing services.

- Positive Practices and Improvements Made
  - Nursing Care Monitoring Tools continued to be completed. The rolling months' data were becoming more complete and accurate. The data now analyzed should be useful in developing corrective action plans. The Nursing

Department and the Quality Assurance Nurses formed a Nursing POI Committee to review the monitoring data to reconcile disparities between the monitoring tool completed by the nursing staff and those completed by the Quality Assurance Nurses.
    - The Facility had continued to make improvements in the Emergency Response System. The Facility had adopted and implemented the revised Emergency Response Policy, 044.2 and had begun training the required staff on the policy. Mock Medical Emergency Drills were completed according to schedule. Corrective action was taken when necessary for staff who failed to perform satisfactorily. Additional emergency equipment was purchased and issued for all areas needing such equipment.
    - There was evidence that all core State and Facility nursing policies, procedures, and processes, had been finalized. The Nurse Educators maintained an excellent tracking database and were able to validate that 97% to 100% of the nursing staff had been trained in the core policies, procedures, and processes.
    - The Facility had recently implemented the State's Medication Variance Policy, which should assist in continuing to improve all aspects of medical administration practices.
    - The Facility had a comprehensive Medication Error Database to track, analyze and trend medication errors using a root cause analysis approach.
- Improvements Needed
    - Management of acute changes in status had improved since the last compliance review but there remained opportunities for continued improvement for all aspects of managing and documenting care according to the Acute Illness and Injury Protocols.
    - Although great strides had been made to improve the quality of the nursing assessments, the nursing summaries need continued improvement to critically analyze clinical data derived from the assessments, for each identified nursing problem/diagnosis, to accurately reflect whether individuals' health status was improving, maintaining, or regressing.
    - Health care plans continued to lack adequate individualization to meet individuals' specific problems. Plans did not demonstrate an integration with other disciplines to meet the total needs of individuals.
    - Due to the low number of medication errors reported there was a concern that errors were under reported by all disciplines responsible for medication administration practices.
    - The Medication Variance and Pharmacy and Therapeutic Committee should better utilize the data derived from the database to identify causative/contributing factors for the medication errors.

<u>Pharmacy Services and Safe Medication Practices</u>
Several provisions of this Section were found in substantial compliance and continued to make progress overall.

- Positive Practices and Improvements Made

- Quarterly Drug Regimen Reviews were of high quality. Clinical pharmacists and physicians collaborated well on this process.
- The Facility adequately collected and presented data to physicians, Pharmacy &Therapeutics Committee (P&TC), and at Psychiatric Medication and Behavior Management Clinics, on the use of STAT medications, benzodiazapines, anticholinergics, and on risk factors for metabolic syndrome.
- The Facility ensured meaningful and consistent DUEs and used standardized guidelines to conduct DUEs.

- Improvements Needed
  - There were significant issues with prescribers appropriately completing MOSES and DISCUSS assessments, and these assessments were not obtained more frequently when clinically indicated.
  - The Facility needs to perform more in depth analysis of medication variances, ensure follow-up to remedial actions, enhance physician collaboration, and improve reporting practice of medication variances.

<u>Physical and Nutritional Management</u>

Overall, while some improvement have been noted, primarily with the PNMT due to the addition of a PNM nurse, RSSLC still needs to make substantial improvements in order to in mitigate the risks associated with physical and nutritional supports.

- Positive Practices and Improvements Made
  - A Physical and Nutritional Management Team (PNMT) had been formed and focused on clinical issues and assessment and served as a resource to the PST.
  - An Aspiration Pneumonia/enteral Nutrition evaluation was developed.
- Improvements Needed
  - Lacking from the PNMT was review and analysis of the PNM system and whether interventions recommended were having a positive impact on the individuals living at RSSLC. There was still no evidence that data were collected and the team was reviewing these data to better identify system issues or respond to recurrent issues on a regular basis.
  - A new risk process that is intended to more accurately identify individuals at risk had been developed and implemented; however, lack of use of clinical judgment and critical thinking when the PSTs had to move beyond the guidelines often resulted in inaccurate assignment of risk.
  - Individuals were not provided with comprehensive assessments in response to changes in status or as part of an annual assessment due to often referring to outdated tests and external assessments. Additionally; supports regarding the areas of oral care, head of bed assessment, bathing positioning, and medication administration were missing from the assessment process and were not comprehensively included in the PNMP.
  - Staff was observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual.

- **T**here was not a formal monitoring process in place and the monitoring that occurred did not address all the areas covered by the monitoring form. The monitoring process did not include all components of a thorough monitoring system.
- While PNMPs were reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at a high risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response).
- The Aspiration Pneumonia/enteral Nutrition evaluation was not consistently completed as indicated by the policy.

<u>Physical and Occupational Therapy</u>
The Facility was trying to fill Physical Therapy (PT) positions in order to provide an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.

- Positive Practices and Improvements Made
  - Assessments were completed in accordance to the schedule set forth by RSSLC.
  - Assessments/screenings were completed within 30 days of admission for those individuals who were newly admitted.
  - All individuals had received an OT/PT assessment that indicated whether or not the individual required OT/PT supports and services. This high percentage was consistent with the previous compliance.
  - Central Office had revised the OT/PT assessment to include more of a focus on how deficits were affecting functioning and what supports would be needed to move the individual forward by increasing independence and overall abilities.
- Improvements Needed
  - Assessments were not being consistently completed in response to a change in status.
  - Assessments were not comprehensive as they lacked objective measurements and detailed information that allowed for comparative annual analysis.
  - Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Additionally, therapy services were not consistently integrated into the PSP.
  - 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.
  - There was a lack of problem solving and identification of issues that contributed to decline. Updates focused primarily on observations and did not include objective testing to clearly identify the cause of decline or clearly identify the functional outcome of the decline and the pathway in which increased independence or return to previous status would be accomplished.

Dental Services

The Dental program was making significant progress in addressing some requirements but needed to ensure all individuals receive needed services timely and move forward on implementation of new programs that are just in process of implementation.

- Positive Practices and Improvements Made
  - RSSLC had an excellent process to provide emergency dental services.
  - The Facility had processes in place to closely monitor people following oral sedation and intravenous sedation (TIVA).

- Improvements Needed
  - The Facility had developed an excellent process to enhance oral hygiene at the living area but needs to implement it fully, including implementation of suction toothbrushing.
  - The Facility must mitigate its high rate of missed dental appointments, and must consider increasing available TIVA days for individuals who could benefit from additional dental care under anesthesia.
  - The Facility had a limited number of programs to reduce need for sedation and restraint, including desensitization programs, and must address this issue with greater focus.
  - Dental health care issues were not consistently included in the context of the PST process, although the Dental Office provided an excellent dental summary that the PST can use to understand the individual's dental and oral health care needs..

Communication

RSSLC only had two SLPs on campus. The priority for one of the SLPs was to focus on dysphagia; therefore, the communication caseload for the entire campus belonged to one therapist. The ratio of therapist to client was 1:188, which was too large a caseload for the therapists to actively participate in all facets of care. Due to the lack of staff availability, progress in these areas continued to shown very slow improvement. Implementation of devices and mentoring of staff related to these devices were not occurring with enough frequency to improve the overall level of care as it related to communication expansion.

- Positive Practices and Improvements Made
  - The majority of assessments identified whether the individual required direct or indirect therapy.
- Improvements Needed

- Individuals identified as having decreased communication had not consistently been provided with the needed assessments, and assessments that were provided were not consistently comprehensive in identifying methods to expand communicative functioning.
- Programs in place to assist some individuals were not being consistently implemented.
- Alternative and Augmentative Communication (AAC) devices were not consistently portable, functional, or available in a variety of settings. The Facility had a list of shared devices but did not have a monitoring process that tracked the presence, working condition, and effectiveness of the AAC equipment.

Habilitation, Training, Education, and Skill Acquisition Programs

The Facility had invested time and effort by the Facility toward improving services for individuals living at RSSLC. Documentation reflected a good faith effort on the part of the Facility to progress toward compliance with the Settlement Agreement. Nevertheless, delivery of services was inconsistent, with some examples of outstanding provision of active treatment and implementation of skill acquisition programs, and other examples in which there was a lack of both.

- Positive Practices and Improvements Made
  - In the new classrooms in the Neches building, all staff were observed to implement formal training programs with skill and consistency. At the Nueces residence, staff during the evening meal were engaging and supportive of all individuals during the evening meal.
  - The Facility had increased the use of task analysis to 77% of all skill acquisition programs.
  - Staff in residential areas failed to respond when individuals engaged in stereotypic and potentially harmful behavior, and failed to provide leisure materials or engage individuals.
  - Although the number of individuals employed had decreased since the last compliance visit, three individuals had been provided employment in the community, which demonstrated progress toward community-based training.
- Improvements Needed
  - Despite the expanded use of task analysis in developing skill acquisition programs, documentation did not reflect that improved assessment lead to improvements in the skill acquisition plans.
  - No data from training in community settings was provided.

Serving Persons in the Most Integrated Setting

Although the Transition Coordinator and Post-Move Monitor demonstrated a strong commitment to facilitating the ability of individuals to move to an appropriate integrated setting in a manner that promoted safety and good adjustment. Significant deficits in the Facility's assessment processes continued to hamper these efforts to develop and implement adequate transition planning.

- Positive Practices and Improvements Made

- The Facility had continued to focus significant attention on community transitions, and had 27 active referrals at the time of this site visit.
- The Transition Coordinator had implemented a tracking system for several CLDP and transition-related benchmarks, including the 45-day assessments, trial visits and timeliness of PMM visits.
- The Monitoring Team also commends the creativity of some of the newer approaches taken by the Facility toward promoting education and awareness of community living options, including the usual provider fair held during the visit in which provider agencies rotated through all residential units and met with PSTs to describe their services, answer questions, and learn about the needs of the population at each unit.
- Staff had accompanied individuals to visit friends and ex-roommates who had moved to the community from RSSLC. This was a particularly commendable practice, as it not only promoted the maintenance of relationships, but also presented community living in a context that would be more meaningful to individuals.
- The Monitoring Team found that the PMM Checklists were generally being completed in a timely manner. There was also considerable progress noted in the process used to complete the PMM Checklists. In many instances, the Post-Move Monitor had taken actions and maintained a comprehensive record that documented careful follow-up and loop closure.
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- Improvements Needed
  - RSSLC had recently developed or revised a significant number of policies related to transition; however, the Monitoring Team found many instances in which the requirements of the statewide and local policies were not yet being implemented as required.
  - There were many instances in which the PST failed to identify in each individual's PSP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles.
  - There were some instances in which supports were not adequately documented in the PMM Checklists reviewed, and during the PMM visit observed, the Monitoring Team found it necessary to prompt the Post-Move Monitor to observe for the presence of certain supports, as well as to act with immediacy regarding a situation with potential for harm to the individual.

<u>Consent</u>

The Facility was still awaiting guidance from DADS, which continues to work on development of statewide policies and procedures and recently provided drafts. When these are done, the Facility plans to implement significant changes in compliance with those policies and procedures.

- Positive Practices and Improvements Made
    - The Facility maintained a prioritized list of individuals with guardianship status, with the prioritization criteria remaining the same as in the previous visits. The list was currently undergoing a thorough review.
    - The Human Rights Officer had continued 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.
    - The Facility continued to provide substantial supports for self advocacy, but is encouraged to engage the members in a more formal and purposeful decision-making curriculum as a next step in promoting their ability to effectively participate in making important decisions about their lives.
    -
- Improvements Needed
    - The PSTs did not currently adequately assess decision-making capacities nor develop appropriate action plans to address deficits. PSTs did not use 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. Pending statewide policies on Guardianship, Advocacy and Affirming and Protecting Rights, at least in the draft forms made available for review, addressed the assessment and prioritization processes.
    - While awaiting development of statewide policies, little organized effort had been undertaken by the Facility to recruit guardians.

<u>Recordkeeping and General Plan Implementation</u>
Overall, the Facility had made significant progress in meeting the requirements of this Section. The Facility maintained a Unified Record consisting of an Active Record, Master Record, and an individual section in a Group Notebook. However, the Facility also had a number of other books in which documents were kept. Some of these documents could be considered part of a Unified Record, and the Facility needs to identify all components of the Unified Record so they can ensure consistency across components of the records and can include all components in the required random audits.

- Positive Practices and Improvements Made
    - The Facility had a process to address errors in documentation through corrective actions arising from audits, both for specific deficiencies in individual records and systemic actions intended to improve documentation.
    - The Monitoring Team commends the Facility for developing a system to monitor the documentation done by new employees after on-the-job training.
    - Corrective actions were checked by the URCs for completion; a database had been initiated that may help identify continuing errors that may indicate a need for systemic changes.
    - In addition to the audits of the Unified Record, the Facility had established a tracking system to determine whether discipline assessments were posted to the share drive 10 days before annual PSP planning meetings. This system

will permit tracking of whether assessments are posted in time to permit PST members to review them for information needed for integrated planning.
    - At the time of the last compliance visit, each records clerk audited one Active Record per month from her own unit, but there was now a rotation established so each records clerk audits a different unit each month.

- Improvements Needed
    - There were still numerous errors and deficiencies in documentation, although there had been improvement.
    - Although the Facility had implemented a robust audit system, it was unclear whether all components of the Unified Record were included in the audits.

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) 10/10/11 2. RSSLC Section C Presentation Book 3. DADS Policy #001: Use of Restraint 8/31/09 4. DADS Policy #015: Dental Services 8/17/10 5. RSSLC Policy J.1: Use of Restraint 10/19/11 6. RSSLC Policy J.8 Documenting Significant Behavior Incidents 11/29/10 7. PMAB Training Curriculum 8. Facility training materials for restraint monitors 9. Restraint Reduction Team Meeting minutes for 9/21/11 and 10/11/11 10. Restraint documentation for non-medical restraints: Individuals #630 (9/15/11 - 2x), #713 (5/29/11 and 6/24/11 - 2x), #448 (9/2/11 - 2x), #757 (8/18/11 at 1:23pm), #235 (8/27/11 - 3x), #68 (9/12, 13, and 14/11), #110 (7/5/11), #52 (9/6/11), and #113 (8/12/11) 11. Restraint documentation for medical restraints: The sample of 19 medical restraints: Individuals #180, #17, #10, #508, #155, #426, #465, #16, #470, #119, #148, #551, #124, #751, #296, #719, #694, #212, and #388 12. Restraint documentation for protective mechanical restraints: Individuals #351 and #429 13. For Individuals ##235, #267, #325, #448, #630, #713 and #757, the individual's PSP and addenda, PBSP and PBSP progress notes, restraint documentation, and psychological evaluation and updates 14. State report "Percent of All Employees Completing Courses of Training Program" 9/30/11 15. Restraint related monitoring/QA forms and reports 16. List of individuals for whom restraint is prohibited (undated) 17. List of individuals with mechanical restraints for protective reasons (undated) 18. List of individuals with a Safety Plan 9/22/11 19. List of individuals injured during restraint 5/1/11 to 9/21/11 20. Restraint log 5/1/11 to 10/25/11 21. Dental Oral Sedation Log 9/28/11 22. Dental TIVA Log 9/28/11 23. Medical and Dental Support Plans and implementation documentation for Individuals #708, #223, #538, #318, #160, #598, #530, #598, #2, and #662 24. Facility Restraint Trend Analysis for period ending 9/30/11 25. QA Department Trend Analysis Report 8/31/11 26. Incident Management Team minutes for 7/6/11, 7/13/11, 7/20/11, 7/27/11, 8/3/11, 8/10/11, 8/17/11, 8/24/11, 8/31/11, 9/7/11, 9/14/11, 9/21/11, and 10/24/11 27. List of staff approved as Restraint Monitors (undated-document request II.26) 28. Restraint Monitors training transcripts (18)

	29. Direct Care Professional (DCP) training transcript (25) 30. Incident Management Team minutes for 7/6/11, 7/13/11, 7/20/11, 7/27/11, 8/3/11, 8/10/11, 8/17/11, 8/24/11, 8/31/11, 9/7/11, 9/14/11, 9/21/11, and 10/24/11 **People Interviewed:** 1. Bobby Buckner, Director of Behavioral Services 2. Pat Newell, Psychology Assistant 3. Joan Poenitzsch, Director of Quality Assurance 4. Billie DeJean, Psychologist 5. Reuben Muhammad, Incident Management Coordinator **Meetings Attended/Observations:** 1. Incident Management Team Meeting (IMRT) 10/24/11 **2.** Sabine Unit Morning Meeting 10/27/11 **3.** Quality Assurance/Quality Improvement (QA/QI) Council 10/25/11 4. Administrative Review Team 10/26/11 5. Restraint Reduction Committee 10/26/11
	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 determined that the RSSLC is in substantial compliance with Provision C.2. This provision requires that restraints be terminated as soon as the individual is no longer a danger to him/herself or others. The POI reported that restraint policies had been revised to be consistent with State policy and these changes were implemented on 6/14/11. This was the Facility's second attempt at reworking its restraint policies to align with State policy and the requirements of the Settlement Agreement (SA). These most recent revisions have accomplished this. The POI did not use data in its self-assessment of compliance with the SA. Data that could be used for this purpose, at least for some sections of this provision, were available. Both the Behavioral Services Department and the QA Department regularly audit various components of restraint use. The Facility had a process to compare audit results from the QA Auditor with audit results from the Behavioral Services Department. While this process had been in place for several months, its continued maturation should lead to the use of data as one measure of compliance in future SA monitoring reviews.
	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 determined that the RSSLC is in substantial compliance with Provision C.2. This provision requires that restraints be terminated be terminated as soon as the individual is no longer a danger to him/herself or others. Since the last review the RSSLC restraint policies had been revised to be consistent with State policy and these changes were implemented on 6/14/11. This was the Facility's second attempt at reworking its restraint policies to align with State policy and the requirements of the Settlement Agreement (SA). These

	most recent revisions have accomplished this. The most observable change in practice had been the use of State required forms to document restraint use. Crisis intervention restraint use at RSSLC had remained relatively stable since the last review period. The RSSLC Trend Report indicates the use of crisis intervention restraint 96 times in the five months since the last review (May, 2011 through September, 2011). In the five months prior to the last review (December 2010 through April, 2011) restraint was used 90 times. Restraint use by month is quite variable, ranging from a low of 9 in February, 2011 to a high of 30 in April, 2011. Presentation of some trend data had improved. Some data were now trended over a rolling three month period. This was initiated since the last Monitoring Team review by the RSSLC in order to improve the usefulness of data in noting trends that may identify practices that appear to need special attention or focused intervention by clinical staff. While the Facility should be commended for initiating these changes in presentation of trend data, the Trend Analysis Report needs continued improvement to track detailed data elements over time, at least for the equivalent time period for which the summary data are tracked. The documentation of restraint use had improved dramatically from that observed at the last review. This was most likely attributable to the change in practice that resulted in use of DADS forms, additional staff training, and an auditing process within the Facility. Improved documentation resulted in a finding of substantial compliance for provision C.2. The Monitoring Team was unable to confirm that staff serving as restraint monitors are adequately trained in the application and assessment of restraint. Only four of the 15 (27%) restraint monitors in the sample used by the Monitoring Team completed all required training courses. Those that did not cannot be considered adequately trained to perform the duties of a restraint monitor with respect to SA requirements. The Monitoring Team could not determine on an individualized basis, whether restraints used were prohibited by medical orders. One instance was identified where restraint was used in clear contradiction to a physician's order. The facility practices needed to ensure a substantive clinical and administrative review of each restraint episode were not well defined and need to be better organized. The administrative processes associated with the use of medical restraint remain problematic. Medical staff had not consistently established monitoring protocols for chemical and medical restraint specific to each episode of restraint. Nursing staff had not consistently monitored individuals in chemical or medical restraint correctly largely due to the absence of doctor-ordered specific monitoring protocols. Additionally, nursing staff had not consistently been monitoring individuals in restraint post-release in accordance with policy.

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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 Facility's POI did not offer a rationale for its self-assessment rating. RSSLC did not consistently administer restraint in accordance with applicable, written policies, procedures, and plans governing restraint use. This was especially prevalent in the use of medical restraint. The Facility reported that restraint policies had been revised to be consistent with State policy and these changes were implemented on 6/14/11. This was the Facility's second attempt at reworking its restraint policies to align with State policy and the requirements of the Settlement Agreement (SA). These most recent revisions have accomplished this. The most observable change in practice has been the use of State required forms to document restraint use. An additional element of the revision of Policy J.1 was to incorporate all requirements of restraint administration into one policy. Prior to these revisions, the RSSLC had seven separate policies that addressed aspects of restraint administration. This made it difficult for staff to locate relevant policy requirements and ensure that adherence to one of the policies did not conflict with adherence to one of the other policies, as noted in previous compliance reports from the Monitoring Team. Incorporating all requirements into one policy makes it easier now to locate requirements. Crisis intervention restraint use at RSSLC remained relatively stable since the last review period. The RSSLC Trend Report indicated the use of crisis intervention restraint 96 times in the five months since the last review (May, 2011 through September, 2011). In the five months prior to the last review (December 2010 through April, 2011) restraint was used 90 times. Restraint use by month was quite variable, ranging from a low of 9 in February, 2011 to a high of 30 in April, 2011. The monthly trend analysis completed by the Facility identified most variances and identified specific causes when they could be determined, for example medication changes that had occurred with specific individuals. The FY11 Trend Analysis Reports showed the quarterly use of restraint ranging from 41 to 73, with an average of 17.5 per month. These data were for the 12 month period beginning in September, 2010 and ending in August, 2011. The number of restraints reported for September, 2011 was 17 which was consistent with the average over the last 12 months. The Facility provided the Monitoring Team with two reports both labeled Restraint Trend Analysis Report. One report was the standard report prepared by all SSLCs for DADS and the other was a report prepared by the Quality Assurance (QA) Department reporting compliance monitoring/audit results. The DADS report included data elements	Noncompliance

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		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. At RSSLC some of these data were trended over a rolling three month period. This was initiated after the last Monitoring Team review in order to improve the usefulness of data in noting trends that may identify practices that appear to need special attention or focused intervention by clinical staff. While the Facility should be commended for initiating this trend data, the Trend Analysis Report needs to longitudinally track more data and more detailed data elements over time. A review of the "restraints by hour" data, which was reported for the current month only, can demonstrate why this is important. The August 31, 2011 trend report showed restraint use peaking at what is typically referred to as "transition times"-- right after breakfast (waiting to go to day/work programs), right after lunch (waiting for programming to resume), and the period between day/work programming ending in the afternoon and dinner (waiting for dinner). The September 30, 2011 trend report did not show these same peaks, with the time of day of restraint use more evenly distributed throughout the day. These data (as an example) should be trended over an extended period of time in order for the Facility to have a clearer picture that may lead to change in practices that would be intended to lead to positive outcomes. Using the data referenced above, if the Facility reacted to the August data they may have addressed an issue that the August data suggested was prevalent and in reviewing September data may have addressed an entirely different issue. Analyzing data over a longer period of time would increase the likelihood that root cause issues associated with restraint use could be identified and addressed. A similar scenario could be hypothesized for data reporting the location where restraint occurred. As a general guideline, the Monitoring Team believes that any data routinely collected for the current report month should be trended for at least a 12 month period. In reviewing the September 30, 2011 Trend Report, it was reported that for the previous rolling three months eight of the 20 restraints (51%) were horizontal (i.e. individual taken down to the floor) restraints. In the hierarchy of physical restraints horizontal side-lying restraint is the most restrictive technique allowed by policy. The high percentage use of horizontal restraint may serve as an indication that effective active treatment and behavioral treatment planning and implementation may not be occurring for the individuals involved in these restraints or that less intensive forms of restraint were not always considered or were not effective. Behavioral practices at the RSSLC are discussed in detail in Section K of this report. Deficient practices are presented in Section K that affect the use of restraint at the RSSLC. Additionally, active treatment practices are discussed in detail in Section S of this report. Deficient practices are presented in Section S that 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.	

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		The second report labeled Restraints Trend Analysis Report presented data gathered from monitoring reports administered by both the QA Department and the Behavioral Services Department. This report also contained information regarding inter-rater reliability and displayed data by each question on the monitoring tool. This was a very informative and useful report especially with respect to Facility self-assessment of SA compliance. It should probably be renamed so that it does not get confused with the similarly named report required by DADS. RSSLC Policy J.1: Use of Restraint also addressed requirements associated with medical restraint. Documentation review and interviews by the Monitoring Team suggest that staff involved in the use of medical restraint, primarily medical and nursing staff, did not implement restraint policy 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 19 restraint episodes for which the Facility was asked to produce documentation. The Monitoring Team assembled two 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. These samples were: • Non-medical restraints: Individuals #630 (9/15/11 - 2x), #713 (5/29/11 and 6/24/11 - 2x), #448 (9/2/11 - 2x), #757 (8/18/11 at 1:23pm), #235 (8/27/11 - 3x), #68 (9/12, 13, and 14/11), #110 (7/5/11), #52 (9/6/11), and #113 (8/12/11). This sample of 17 restraints represented 20% of non-medical restraint episodes since the last review. This sample included four of the ten restraints listed as "emergency chemical," eight restraints from the four most frequently restrained individuals, seven restraints of individuals with Safety Plans, three of the four restraints listed as "emergency mechanical," and two individuals who had been restrained only once but for whom horizontal side-lying restraint was required. This sample will be referred to as Sample C.1 in this report. • Medical Restraints: Individuals #180, #17, #10, #508, #155, #426, #465, #16, #470, #119, #148, #551, #124, #751, #296, #719, #694, #212, and #388. This sample of 19 restraints represented 15% of medical restraint episodes since the last review. This sample included three instances where restraint was used for a medical procedure and 16 instances where medical restraint was used for a dental procedure. Of these 16, 10 were instances of oral pre-treatment sedation and six were instances of TIVA. This sample will be referred to as Sample C.2 in this report.	

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		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 it felt would demonstrate compliance with Section C 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 use of prone restraint was identified or the subject of any discussion in meeting minutes. <u>Other Restraint Requirements</u> Based on document review, the Facility policy states 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. For Sample C.1 (non-medical restraints) the following are the results of this review: • Thirteen of 17 records (76%) included documentation showing that the Individual posed an immediate and serious threat to self or others. The Face-to-Face Assessment and Debriefing (FFAD) section 3.1 asks "person's behavior an immediate and serious risk of harm to self or others?" Four FFADs reported the answer to this question as "no." This was the case with Individual # 52 and three restraints of Individual #68. All four were noted on the Restraint Checklist (RC), and the log provided to the Monitoring Team, as emergency chemical restraint. The documentation for each of these four restraints was confusing. For Individual #52 the reason for restraint was reported on the RC as "behavior exhibited" and "medical/dental". There was also a notation "allow medical procedure to be done." The three restraints for Individual #68 were noted to be chemical restraint that occurred at exactly the same time on three consecutive days in mid-September. Some of the documentation seemed to indicate that this may not have been an actual chemical restraint but rather the re-initiation of a psychoactive medication that had	

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		been discontinued six weeks earlier. Apparently because the Facility Human Rights Committee (HRC) had not approved the re-initiation of the medication the Facility classified its use as emergency chemical restraint. Because the Facility chose to categorize the use of medication in this instance as chemical restraint the Monitoring Team evaluated documentation accordingly. In the 13 instances where the FFAD reported "yes" to the question "person's behavior an immediate and serious risk of harm to self or others?" this response was corroborated by narrative information on the Restraint Checklist (RC). Finally, in reviewing the QA Department Trend Analysis Report (5/1/11 to 8/31/11) it was noted that the Facility self-identified one instance where restraint occurred and there was insufficient evidence that the individual posed an immediate and serious risk of harm to self or others. • In three of 17 records (18%), there was documentation showing that the restraint monitor could not validate that restraint use was done for the appropriate reason (not for the convenience of staff or as punishment). This documentation is contained in the section 3.4 of the FFAD. All three restraints for Individual #68 were so noted. • There were other instances where documentation on the RC and FFAD raised questions as to if restraint occurred for the appropriate reason. Restraint use for three of the individuals (representing seven restraint episodes) in the sample of individuals who had Safety Plans did not document that Safety Plans were followed. None of the seven RC's reported that Safety Plans were implemented prior to restraint use, nor were there any notations in restraint documentation to suggest that Safety Plan implementation would have been inappropriate because of the specific crisis circumstances faced by staff. This was the case for Individuals # 448, #630, and #713. Failure to implement Safety Plans (which are always part of a Positive Behavior Support Plan) may indicate that restraint occurred before absolutely necessary, raising the question if restraint was used as an alternative to clinically directed behavior program implementation, i.e. for the convenience of staff. Two of these seven FFADs reported Safety Plan implementation (Item 4.5 on the FFAD) but without corroborating data on the RC. The Monitoring Team is unable to consider the data presented on the FFAD as more valid than data presented on the RC. In two restraint episodes both the RC and the FFAD reported the Safety Plan was not implemented. Failure to implement a Safety Plan, without further documentation in restraint files, leaves open the question as to if restraint was used for the convenience of staff. 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. • Additionally, Individual #448 had documented restraint restrictions due to a significant medical condition. Any restraint other than a physical hand hold was	

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		explicitly prohibited in his medical orders and SP. This individual was placed in horizontal restraint contrary to these orders on 9/2/11 at 11:57am. A physician's order, dated 9/2/11, but without a time noted, states "may use personal hand hold restraint from 11:40 to 11:45pm and horizontal restraint from 11:57pm to 12:10pm for elopement and aggression to self." This note was signed by a Nurse Practitioner. The times recorded in this note corresponded precisely to times noted on the RC. Apparently this order was written after the prohibited restraint had occurred, and after Individual #448 had been exposed to whatever risk previous physician orders were intended to mitigate. Finally, in reviewing the QA Department Trend Analysis Report (5/1/11 to 8/31/11) it was noted that the Facility self-identified one instance were restraint occurred and there was insufficient evidence to rule out that restraint did not occur for staff convenience. • In 11 (65%) of the 17 records there was documentation to suggest restraint may have been used prior to implementing a graduated range of less restrictive measures. Individuals #630 (2x), #448 (2x), and #713 (3x) had Positive Behavior Support Plans (PBSP) and Safety Plans (SP). The Restraint Checklist for each of these seven restraints reported that the individual's Safety Plan was not implemented prior to the use of restraint. In two instances the RC reported the PBSP was implemented (implying the Safety Plan may have been implemented since Safety Plans are incorporated in to PBSPs); however, the lack of a required entry for Safety Plan implementation on the RC s leaves the question open to conjecture. 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 in these instances may not have occurred prior to the use of restraint. • Restraint documentation for Individuals #52 and # 68 did not contain any information addressing pre-restraint interventions. As noted earlier, these restraints may have been misclassified as chemical restraint. Finally, in reviewing the QA Department Trend Analysis Report (5/1/11 to 8/31/11) it was noted that the Facility auditing of restraint records did not detect any instances where restraint was used prior to implementing a graduated range of less restrictive measures, although the Monitoring Team did find several examples. • 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 #235 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	

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		prompts and redirection, removal of dangerous objects, trading out staff, moving furniture, and changing the environment. Fifteen of 17 (88%) records contained information validating Personal Support Team (PST) review of the restraint episode. Documentation provided to the Monitoring Team for two restraints of Individual #630 did not include PST review. Thirteen of 17 (76%) records contained information validating IMRT Morning Meeting review of the restraint episode. Documentation provided for the restraint of Individuals #52 and #68 (3x) did not include IMRT minutes to validate review of the restraint. Protective mechanical restraints were in use for 12 individuals living at the RSSLC. Two were selected for the sample for this review. The use of mittens for Individual #16 was in place because of the individual's persistent self-injurious behavior (SIB). The use of a jumpsuit for Individual #351 was in place because of the individual's persistent PICA behavior. RSSLC policy requires that the use of a mechanical restraint in a Safety Plan includes a plan to systematically decrease and eliminate the need for the protective restraint device. 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. The following are the results of this review: • Both individuals had a Safety Plan as required by policy. • The Facility plan had been effective in fading the use of protective restraint for Individual #16. This is well documented in Personal Support Team Addendums (PSPAs). Documentation provided to the Monitoring Team reported that in early 2008, Individual #16 required a restraint jacket and helmet with a full face shield to promote healing and prevent further self-inflicted injuries. The PST engaged in a series of steps since then to gradually adjust the type of protective restraint used with Individual #16, each step representing less restrictive devices and techniques. As of September, 2011 hand mittens were the only protective restraint in use on a non-contingent basis. Individual #16's Safety Plan calls for the mittens to be removed for five minutes every 55 minutes. Documentation presented to the Monitoring Team included, for each 24 hour period, three Restraint Checklists and an FFAD. The three RCs corresponded to the three work shifts of direct care professionals. In reviewing documentation for October 14, 2011, as an example, there were 124 event code entries for the 24 hour period. Most are related to circulation checks and there are entries that reflect the five minute release requirements. Code H would be the appropriate code for this purpose and as an example on first shift on October 14th code H is noted at appropriate intervals. The PST for Individual #16 had effectively	

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		carried out the policy requirement of implementing a systematic plan to reduce and eventually eliminate the need for protective mechanical restraint. • Protective mechanical restraints (jumpsuit) were in place for Individual #351 because of PICA behavior. The Safety Plan for Individual #351includes a description of 19 activities as part of a fading plan. At the core of the fading plan is to allow Individual #351 to wear regular clothing once a day and to work with the Individual with the hope that the attempts at ingesting non-edible items decreases to three or fewer within a 60 day period. Data included in the documentation presented to the Monitoring Team confirms the Safety Plan had been successful in preventing ingestion of non-edible items but had not been successful in decreasing attempts at ingestion. Documentation presented to the Monitoring Team included, for each 24 hour period, two Restraint Checklists and an FFAD. The two RCs corresponded to the morning and afternoon work shifts of direct care professionals. Presumably, Individual #351 was not in restraint at any point during the night shift. In reviewing documentation for September 25, 2011 there were 60 event code entries for the 16 hour period. Most are related to circulation checks and toileting release. 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.2 (medical restraint). The following are the results of this review: • None (0%) of the 19 medical restraints reviewed contained documentation that a physician had specified a monitoring schedule or the type of monitoring that should occur and that was individualized. Documentation typically referenced "sedation protocol", or notations such as "medical monitoring x 24hrs." Post op orders for TIVA were also not individualized. When the physician orders were translated by a nurse to a Medical Monitoring Form the nurse would typically use discretion in providing more specific information for others, primarily direct care staff to follow. This is not sufficient to comply with the SA requirement that a physician specify a monitoring schedule and the type of monitoring. The lack of individualization is of concern. The use of a very broad statement such as "sedation protocol" (what this protocol entailed was not shared with the Monitoring Team) is of concern as well. It was not clear what specifically is included under the rubric "sedation protocol" at the RSSLC. • Most monitoring was documented on the Medical Monitoring Form (12/7/10). This form, for each instance of medical restraint, was initiated by a nurse and provided instruction to Direct Care Professionals as to what is to be monitored at what frequency. This form also noted which specific home staff had been in-serviced with respect to the monitoring related to the specific individual and the medical restraint. Staff logs are maintained to document that the required monitoring occurred.	

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		• It appears to the Monitoring Team that nurses, not physicians, were directing the type and frequency of monitoring medical restraint. The failure to consistently administer restraint in accordance with applicable, written policies, procedures, and plans governing restraint use, especially medical restraint, must be corrected in order to achieve compliance with this provision of the SA. Additional information regarding the use of medical restraint can be found in Section J.4 of this report.	
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 does not concur and finds this provision to be in substantial compliance. The Facility's POI did not offer a rationale for its self-assessment rating. The appropriate restraint release code on the RC to indicate that an individual was released immediately because they were no longer a danger to themselves or others is "P". Section 2.6 of the FFAD provides similar documentation. Seventeen nonmedical restraints were included in Sample C.1. Four were noted as chemical restraint. The other 14 restraint episodes all provided appropriate documentation related to restraint release. Finally, in reviewing the QA Department Trend Analysis Report (5/1/11 to 8/31/11) it was noted that Facility audits of 124 restraint episodes all indicated that restraints were terminated as soon as the individual is no longer a danger to him/herself or others.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require	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 Facility's POI did not offer a rationale for its self-assessment rating. Examples of issues with policy implementation were presented in section C.1 and will not be repeated in this section. The policy issues described in C.1 are sufficient in scope to preclude a determination of substantial compliance with this provision of the SA. <u>Training Requirements</u> 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	Noncompliance

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	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.	2. Approved verbal and redirection techniques 3. Approved restraint techniques 4. Adequate supervision of any individual in restraint The RSSLC restraint policy did not 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 second name of a direct care professional 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 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.3, to determine the following: For training class RES0105 Restraint: Prevention and Rules for Use at MR Facilities all 25 (100%) 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. For training class PMA0320 – PMAB Basic all 25 (100%) had completed the training within the last 12 months. For training class PMA0400 – PMAB Restraint all 25 (100%) had completed the training within the last 12 months. For training class PMA0700 – PMAB Prevention all 25 (100%) had completed the training within the last 12 months. For training class PBS0100 – Positive Behavior Support all 25 (100%) 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. 98% RES0105 Restraint: Prevention and Rules for Use at MR Facilities	

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		2. 91% RES0110 Applying Restraint Devices 3. 98% PMA0320 – PMAB Basic 4. 98% PMA0400- PMAB Restraint 5. 98% PMA0700 –PMAB Prevention 6. 97% PBS0100 – Positive Behavior Support The compliance rates derived from the sample conducted by the Monitoring Team are in all cases higher 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. With the exception of class RES0110, data related to staff training are sufficient to demonstrate substantial compliance with the training component of this provision. The examples of issues with policy implementation presented in Provision C.1 (which are not reiterated in this section) are sufficient in scope to preclude a determination of substantial compliance with this provision of the SA.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	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 Facility's POI did not offer a rationale for its self-assessment rating. 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 17 non-medical restraints (Sample C.1, in 16 (94%) there was evidence documenting that restraint was used as a crisis intervention. On the restraint checklist for Individual #52 the RC labeled the restraint as medical. From the documentation provided the Monitoring Team was unable to determine if this restraint was medical or crisis intervention. There was a physicians' order in advance that would indicate the possibility that this was a medical restraint; however, documentation focused on behavior that indicated imminent risk of harm, and a debriefing was held (which is not required for medical restraint) that stated this was the least restrictive procedure to manage the behavior, stated that a restraint monitor was notified after the chemical was administered (which is not required for medical restraints), and indicated sedation for a medical procedure was not previously approved by the Human Rights Committee. There was no current order for medical restraint. It was included on the log of chemical restraints provided by the Facility. The Facility needs to ensure accurate determination and documentation of whether a restraint is for medical or crisis intervention purposes. The Monitoring Team was provided, in the documents requested prior to the visit, with a	Noncompliance

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		list of individuals for whom restraint was prohibited; only Individual #448 was listed. In comparing this list with the log of restraints, the Monitoring Team identified that this person with restraint restrictions was restrained. Individual #448 was placed in horizontal side-lying restraint even though this Individual's Safety Plan and medical documentation explicitly prohibited use of restraint other than a personal hold of the Individual's hands. This individual was placed in horizontal restraint contrary to these orders on 9/2/11 at 11:57am. A physician's order, dated 9/2/11, but without a time noted, states "may use personal hand hold restraint from 11:40 to 11:45pm and horizontal restraint from 11:57pm to 12:10pm for elopement and aggression to self." This note was signed by a Nurse Practitioner. The times recorded in this note corresponded precisely to times noted on the RC. Apparently, this order was written after the prohibited restraint had occurred, and after Individual #448 had been exposed to whatever risk previous physician orders were intended to mitigate. Other documentation provided by the Facility relevant to the 17 non-medical (crisis intervention) restraint records (Samples C.1) reviewed did not contain information about whether a physician had provided a medical order stating whether there were restrictions on restraint for the individual, or if the ISP identified limitations on the type of restraint that could be used. Therefore, the Monitoring Team could not determine, on an individualized basis, whether any other restraints used were prohibited by medical orders. Documentation in the files prepared by the RSSLC does not allow the Monitoring Team to adequately determine if physicians and the PSP regularly assess whether restraint should be limited or prohibited prior to implementation for each individual who is restrained. It is essential that the PST and staff providing supports and services have all information needed to make decisions about restraint use. The Monitoring Team recommends that the Facility maintain a complete and accurate Do Not Restrain list that includes any restrictions or limitations placed on the use or type of restraint by the physician and PSP. The Facility should also have and document a process to verify the list is current, complete, and accurate. Physician orders for crisis intervention restraint that is not part of a Safety Plan are required by State policy. The RC for Sample C.1 noted the date and time a physician was contacted for a physician order. Documentation presented to the Monitoring Team confirmed a physician order in each instance. Finally, in reviewing the QA Department Trend Analysis Report (5/1/11 to 8/31/11) it was noted that Facility audits reported four instances of restraint use not supported with a physician order. It was a positive finding that the Facility audited for this issue and reported variances. Medical and dental support plans had been developed for many individuals; however, documentation of implementation led the Monitoring Team to conclude implementation did not always occur as planned. For example:	

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		• Individual #708 had a medical support plan that was put in place on 5/20/11. Training was to occur weekly. Documentation provided to the Monitoring Team reports the training did not begin until June 20th. • Individual #296 had a dental support plan that was put in place with her PSP on 6/3/11. Documentation provided to the Monitoring Team reports the training did not begin until August 13, 2011. • Individual #719 had a dental support plan that was put in place in May 2011. No data sheets were provided, leading the Monitoring Team to conclude the plan had not been implemented. • Individual #538 had a dental support calling for program implementation two times daily. Data provided to the Monitoring Team reflected inconsistent implementation. RSSLC needs to improve its policies, practices, and procedures in order to demonstrate that if medical restraints are required for routine medical or dental care for an individual, the PSP for that individual includes treatments or strategies to minimize or eliminate the need for restraint and that they are implemented according to the plan. Additional information regarding medical restraint is provided in Section J.4 of this report.	
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	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 Facility's POI did not offer a rationale for its self-assessment rating. Review of Facility training documentation showed that there were adequate training curricula on the application and assessment of restraint and that the training was competency based. The Facility provided a list of 92 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 in RSSLC policy 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	Noncompliance

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	physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	8. RIG0100 Rights of Consumers 9. PBS0100 Positive Behavior Support 10. Facility developed FFAD training The training records of 18 of the 92 (20%) staff designated as restraint monitors were selected for review. Beginning with the fourth name, every fifth name on the list of restraint monitors was selected for this sample. The results of this review is: 1. ABU0100 Abuse and Neglect – 18 of 18 (100%) had completed this training within the last 12 months. 2. PMA0320 PMAB Basic - 17 of 18 (94%) had completed this training within the last 12 months. 3. PMA0400 PMAB4: Restraint – 9 of 18 (50%) had completed this training within the last 12 months. 4. PMA0700 PMAB7: Prevention - 16 of 18 (89%) had completed this training within the last 12 months. 5. CPR0100 – 17 of 18 (89%) had completed this training. 6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities - 14 of 18 (78%) had completed this training within the last 12 months. 7. RES0110 Applying Restraint Devices- six of 18 (33%) had completed this training within the last 12 months. 8. RIG0100 Rights of Consumers -17 of 18 (94%) had completed this training within the last 12 months. 9. PBS0100 Positive Behavior Support-16 of 18 (89%) had completed this training within the last 12 months. 10. Facility developed FFAD training – 18 of 18 (100%) completed this training. The Monitoring Team was unable to confirm that staff serving as restraint monitors are adequately trained in the application and assessment of restraint. Only four of the 15 (27%) restraint monitors in the sample completed all required training courses. Those that did not cannot be considered adequately trained to perform the duties of a restraint monitor with respect to SA requirements. None of the 17 non-medical restraint records in the sample had an alternative physician-ordered monitoring schedule. The Facility reported in its response to the Monitoring Team's document request that it had no individuals for whom an alternative monitoring schedule had been approved. 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 17 restraint records for restraints that occurred at the Facility	

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		(Sample C.1), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 13 (76%) of the instance of restraint. Listed below are the Individuals and date of each restraint where this did not occur: o Individual #713: 5/29/11 at 8:30 p.m. The nurse did not monitor until 10:40 p.m. o Individual #448: 9/2/11 at 11:40 a.m. and 11:57 a.m. The nurse did not monitor every 30 minutes. o Individual #235: 8/27/11 at 3:15 p.m. The nurse did not monitor until 4:00 p.m. ▪ Monitored and documented vital signs in 10 (59%) and documented attempts to monitor vital signs for three additional individuals. Records that did not contain documentation of this included: o Individual #713: 5/29/11 at 8:30 p.m. The nurse did not monitor vital signs until 10:40 p.m. o Individual #448: 9/2/11 at 11:40 a.m. and 11:57 a.m. The nurse did not monitor vital signs every 30 minutes. o Individual #235: 8/27/11 at 2:20 p.m. The nurse took vital signs at 2:30 p.m. but did not take vital signs again when the individual was released at 2:50 p.m. o Individual #68: Received chemical restraints on 9/12, 9/13, and 9/14/11. There were no Physician Order's for monitoring. According to RSSLC's Behavior Restraint Policy, J.01, D.4., "Physician order for chemical restraint shall include that evaluation by a licensed healthcare professional occurs every fifteen minutes for two hours following medication administration." Individual #68's vital signs were not consistently monitored every 15 minutes on 9/12/11 but were monitored for two hours. On 9/14/11 vital signs were monitored every 30 minutes as opposed to the required 15 minutes but were monitored for two hours. On 9/13/11 vital signs were monitored every 15 minutes for two hours. o Although Individual #757's vital signs were not assessed according to policy, the documentation indicated that the nurse made reasonable effort to take the vital signs but Individual #757 refused to allow vital signs to be taken. o Although Individual #113's blood pressure and pulse were not taken, the documentation indicated that he nurse made reasonable effort to take Individual #113's blood pressure and pulse. It was positive to find that the nurse was able to assess Individual #113's respirations. o Additionally, Individual #713: 6/24/11 at 12:20 p.m. and 12:35 p.m. The nurse attempted to take blood pressure and pulse but Individual	

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		#713 refused. The nurse assessed respirations. ▪ Monitored and documented mental status in 12 (71%). Records that did not contain documentation of this included: o Individual #448: 9/2/11 at 11:40 a.m. and 11:57 a.m. The nurse did not monitor Individual #448's mental status every 30 minutes. o Individual #235: 8/27/11 at 2:20 p.m. The nurse did not assess mental status again when released at 2:50 p.m. o Individual #68: Received chemical restraint on 9/12, 13, and 14/11. There were no Physician Order's for monitoring. According to RSSLC's Behavior Restraint Policy, J.01, D.4., "Physician order for chemical restraint shall include that evaluation by a licensed healthcare professional occurs every fifteen minutes for two hours following medication administration." Individual #68's mental status was not consistently monitored every 15 minutes on 9/12/11 but was monitored for two hours. On 9/14/11 mental status was monitored every 30 minutes as opposed to the required 15 minutes but was monitored for two hours. On 9/13/11 mental status was monitored every 15 minutes for two hours. Based on documentation provided by the Facility, three restraints had occurred off the grounds of the Facility in the last six months. All three were reviewed. A licensed health care professional: ▪ Conducted monitoring within 30 minutes of the individual's return to the Facility. o Three of the three incidents (100%) were monitored by a licensed health care professional upon return to the Facility. ▪ Monitored and documented vital signs in none (0%). Records that did not contain documentation of this included: o Individual #713: 6/24/11 at 12:20 a.m. and 12:35 a.m. refused to allow the nurse to take blood pressure and pulse. The nurse assessed respirations. o Individual #113: 8/12/11 refused to allow the nurse to take blood pressure and pulse. The nurse assessed respirations. ▪ Monitored and documented mental status in three (100%). ▪ In one (33%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects was not documented. Sample C.2 was selected from the list of individuals who had medical restraint since the last review. It represented 15% of the individuals for whom medical restraint was used. For these individuals documentation provided by the Facility was reviewed. In no case	

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		(100%) did the physician specify the schedule of monitoring required with sufficient clarity; and, in no case (100%) did the physician specify the type of monitoring required with sufficient clarity. Refer to Provision C.1 for details. Nevertheless, as reported in Provision J.4, medical monitoring for safety was guided by nursing sedation protocol and was documented on the Medical Monitoring Form. This involved medical monitoring every 30 minutes for 24 hours. The orders did not specify whether vital were included in the monitoring, and this was done per nursing discretion. The protocol was followed uneventfully in the 10 cases that were reviewed.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	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 Facility's POI did not offer a rationale for its self-assessment rating. A sample (Sample C.1) of 17 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: 1. In 17 (100%), continuous one-to-one supervision was documented. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 94%. 2. In 17 (100%), the date and time restraint was begun was documented. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. 3. In 17 (100%), the location of the restraint was documented. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. 4. In 17 (100%), information about what happened before, including the change in the behavior that led to the use of restraint, was documented. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. 5. In 10 (59%), the interventions taken by staff prior to the use of restraint were documented and were adequate for post restraint review. The Restraint Checklists for individuals with Safety Plans did not indicate that interventions in the Safety Plan were attempted. The 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. The Facility should reassess the degree of scrutiny it applies to its monitoring/auditing to ensure results are accurate and are more closely aligned with the findings of the Monitoring Team 6. In 17 (100%), the specific reasons for the use of the restraint were documented. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. 7. In 17 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint were indicated on the restraint checklist. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. 8. In 17 (100%), the names of staff involved in the restraint episode were indicated on the restraint checklist. Nine (53%) of the restraints in the sample included	Noncompliance

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		use of the horizontal side-lying technique. In all nine at least two staff were listed as applying the restraint. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. 9. The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint, including: o In all 17 (100%) observations were documented frequently and at release. The longest restraint was 15 minutes. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. o In all 17 (100%), the specific behaviors of the individual that required continuing restraint were noted. The 8/31/11 QA Department Trend Analysis reported a compliance rate of 95%. o Because of the short duration of all 17 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. The 8/31/11 QA Department Trend Analysis reported a compliance rate of 71% from its 133 audits of restraint documentation. o In 17 (100%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. o In 17 (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. Additionally, the 8/31/11 QA Department Trend Analysis reported a compliance rate of 100%. o In 15 of 17(88%), 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 #713 (5/29) and #757. The 8/31/11 QA Department Trend Analysis reported a compliance rate of 98%. The Facility is to be commended for making significant improvements since the last review in documenting restraint episodes correctly and for the most part accurately, and for using the correct form required by DADS policy. The Monitoring Team reviewed restraint documentation to determine if those staff monitoring restraint were on the list provided of approved restraint monitors. For one restraint (Individual #110) a restraint monitor was not notified of the restraint and a FFAD was not completed until the next day. For three of the remaining 16 (19%) restraints in the sample the person noted as the restraint monitor was not on the approved list provided to the Monitoring Team. This was the case for Individuals #52, and #713 (6/24 2x).	

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		Restraint monitors were not always present within the required 15 minutes. This was the case with two (12%) of the 17 restraints in the sample for Individuals #757 (8/18) and #448 (9/2). The 8/31/11 QA Department Trend Analysis reported a compliance rate of 82%. <u>Medical Restraint</u> The Monitoring Team asked for all documentation associated with the medical restraints 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 of policy requirements in 13 of 13 cases of oral pre-treatment sedation (100%) or the six cases of use of TIVA. 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 13 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 (refer to Provision J.4 regarding documentation of monitoring following dental pre-treatment sedation) it should also be recorded on the Restraint Checklist as the policy required. 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. The RSSLC made significant improvement in its documentation of non-medical restraint. Continued administrative oversight should lead to compliance with this provision with respect to the use of non-medical restraint. The RSSLC needs to significantly improve its administrative procedures relative to medical restraint in order to achieve compliance with this provision.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three	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 Facility's POI did not offer a rationale for its self-assessment rating.	Noncompliance

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	times in any rolling thirty day period, the individual's treatment team shall:	According to Facility documentation, during the six-month period prior to the on-site review, a total of seven individuals were placed in restraint more than three times in any rolling thirty-day period. A sample of seven of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met. The sample included Individuals #235, #267, #325, #448, #630, #713 and #757. The following documents were reviewed • PSPs, • PSP addenda, • PBSPs, • PBSP progress notes, • Restraint documentation • Psychological Evaluations and Updates The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. For one of the individuals/instances reviewed (14%), the individuals' teams met to discuss the restraints.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For none of the individuals/instances reviewed (0%), individuals' teams reviewed the individual's adaptive skills. The following are examples of where teams failed to do this adequately: • For none of the individuals sampled was there a current adaptive assessment that could be reviewed for restraint related issues. For one of the individuals/instances reviewed (14%), the individuals' team reviewed the biological, medical and psychosocial factors. The following is an example of the individual for whom this was done appropriately: • For Individual #235, the PSP materials reflected comprehensive discussion of potential medical conditions related to restraint use. The PST identified a urinary tract infection that was the potential reason for self-injurious behavior. For this individual, self-injury was the reason restraint had been implemented. Other than Individual #235, documentation for the sampled individuals did not reflect a review of adaptive skills and biological, medical, psychosocial factors related to applications of restraint.	Noncompliance
	(b) review possibly contributing	For one of the individuals/instances reviewed (14%), individuals' teams reviewed the	Noncompliance

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	environmental conditions;	possibly contributing environmental conditions. The following is an example of an individual for whom this was done appropriately: • Individual #235 had a structural and functional assessment completed near the time of the restraint applications (July 2011). This assessment was reviewed following the applications of restraint. The following are examples of where teams failed to do this adequately: • Other than Individual #235, documentation for the sampled individuals did not reflect a review of structural and functional assessments related to applications of restraint. Only three individuals (#325, #713 and #757) had a structural and functional assessment completed during the six months prior to the site visit.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For one of the individuals/instances reviewed (14%), individuals' teams reviewed and/or performed structural assessments of the behavior provoking restraints. The following is an example of an individual for whom this was done appropriately: • Individual #235 had a structural and functional assessment completed near the time of the restraint applications (July 2011). This assessment was reviewed following the applications of restraint. The following are examples of where teams failed to do this adequately: • Other than Individual #235, documentation for the sampled individuals did not reflect a review of structural and functional assessments related to applications of restraint. Only three individuals (#325, #713 and #757) had a structural and functional assessment completed during the six months prior to the site visit.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	RSSLC used a combined structural and functional assessment to assess the relationship between the environment and undesired behavior. For one of the individuals/instances reviewed (14%), individuals' teams reviewed and/or performed structural assessments of the behavior provoking restraints. The following is an example of an individual for whom this was done appropriately: • Individual #235 had a structural and functional assessment completed near the time of the restraint applications (July 2011). This assessment was reviewed following the applications of restraint. The following are examples of where teams failed to do this adequately: • Other than Individual #235, documentation for the sampled individuals did not reflect a review of structural and functional assessments related to applications of restraint. Only three individuals (#325, #713 and #757) had a structural and functional assessment completed during the six months prior to the site visit.	Noncompliance

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	(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 seven of the individuals reviewed (100%), the individual had a PBSP. Of the seven individuals in the sample who had PBSPs, only the PBSP for Individual #235 reflected adequate compliance with expectations, as indicated below. • One (14%) was based on the individual's strengths; • One (14%) specified the objectively defined behavior to be treated that led to the use of the restraint; • One (14%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and • One (14%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The following is an example of an individual for whom an adequate PBSP was in place: • Individual #235 had a current structural and functional assessment that reflected adequate assessment practices. . The following are examples of individuals who had inadequate PBSPs: • Other than Individual #235, documentation for the sampled individuals did not reflect a review of structural and functional assessments related to applications of restraint. Only three individuals (#325, #713 and #757) had a structural and functional assessment completed during the six months prior to the site visit. There was no evidence to tie changes in restraint use or behavior trends to anything done by the Facility in relation to restraint. Other than Individual #235, restraint use was rarely if ever mentioned in PST/PSP materials. Four of the seven individuals/instances sampled (57%) had an active Safety Plan. The Safety Plans of these four individuals 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.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant	For none of the individuals reviewed (0%), the individual's behavioral data and/or treatment integrity checks showed that the PBSP was implemented with a high level of treatment integrity. Documentation provided by the Facility did not reflect that treatment integrity or reliability assessments had been conducted in relation to the individuals	Noncompliance

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	treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	included in the sample.	
	(g) as necessary, assess and revise the PBSP.	In one of the records reviewed (14%), 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: • The PBSP for Individual #235 was reviewed by the PST following the incidents involving restraint application. The PBSP was not revised following this review, but the PST did identify medical conditions that could have contributed to the behavior resulting in restraint. Documentation did not reflect follow-up on these medical conditions. The following are examples of where teams failed to do this adequately: • Other than Individual #235, documentation for the sampled individuals did not reflect a review of the PBSP in relation to the applications of restraint. • One of the PBSPs (Individual #713) included in the sample was revised near the time of restraint application, but revision was due to the annual PSP: documentation did not reflect the inclusion of restraint use in the PBSP development process. • There was no documentation to indicate any of the remaining PBSPs was revised due to the use of restraint or in the time shortly following the use of restraint.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	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 Facility's POI did not offer a rationale for its self-assessment rating. RSSLC policy for the review of crisis intervention restraints requires that: 1. "Within 24 hours of the individual's release from restraint that is not authorized by a Safety Plan, the QMRP or EOD 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 EOD 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	Noncompliance

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		day of the restraint. The review will be summarized in a PSP addendum. 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 PSP addendum for emergency restraint review and 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 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 had been prepared by the time of the meeting. This sometimes consisted of only verbal reports from staff. When documents were available the review appeared to consist primarily of making sure key information had been recorded on the Restraint Checklist and a simple description of the restraint episode was reported. The Unit Morning Meeting observed by the Monitoring Team consisted of a brief review to ensure certain data was available to be recorded on the RC. There was some discussion of the circumstances of the restraint and of conditions that if modified might prevent the future use of restraint. This level of discussion was an improvement from that observed during the previous review; however, if the RSSLC considers the review done at the Unit Meetings to represent the restraint review called for in the SA, substantial improvement in the scope and depth of review will need to occur. 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 Facility policy referenced above.) There was little to indicate that the language in 2.b in the Facility policy referenced above is addressed with sufficient clinical orientation such that the PST can explore and consider alternative treatment plans. This remains a serious barrier to achieving compliance with the SA. Facility staff sometimes refer to the IMRT as the restraint review body but there was little evidence that IMRT review consisted of more than a review of factual events. Review that occurred at IMRT was often based on anecdotal information and the account of events presented by the Unit Director or staff from the Behavioral Services Department. When questioned about this process, administrative staff indicated that the substantive review of restraint use usually occurs at the Unit Meeting but as noted above this does not seem to be the case.	

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		The facility practices needed to ensure a substantive clinical and administrative review of each restraint episode needs to be better organized. 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 Support Team may better understand circumstances and develop strategies to address issues impacting restraint use. Other SSLCs have developed processes to do this. The RSSLC may wish to review these with DADS and develop a similar process in order to ensure restraint use is receiving the level of clinical review necessary to "ascertain the circumstances" as required by the SA.	

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

1. Consistently administer restraint in accordance with applicable, written policies, procedures, and plans governing restraint use, with a special focus on administrative processes related to medical restraint. (Provisions C1 & C.3)
2. Implement a process to ensure restraint restrictions designated by the physician or PST are adequately documented and communicated to staff working with individuals who have such restrictions. (Provision C.4)
3. Implement a process to ensure that if medical restraints are required for routine medical or dental care for an individual, the PSP for that individual includes treatments or strategies to minimize or eliminate the need for restraint and that they are implemented according to the plan. 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. (Provision C.4)
4. Improve the organization of facility practices designed to ensure a substantive clinical and administrative review of each restraint episode occurs. 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. (Provision C.8)
5. The Trend Analysis Report needs to track additional data elements over time, at least for the equivalent time period the summary data are tracked. (Provision C.1)
6. 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. (Provision C.4)

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. Use compliance monitoring/audit 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) 10/10/11 2. RSSLC Section D Presentation Book 3. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 5/11/11 4. DADS Policy 02.3 Incident Management 1/31/11 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 8/10/11 9. RSSLC Policy C.01 Incident Management 8/1/11 10. RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 5/11/11 11. RSSLC Policy D.8 Completing/Routing Client Injury Report 3/10/11 12. RSSLC Policy E.10 Participating in Unit Morning Meeting 3/10/11 13. RSSLC Policy E.17 Completing Incident Information Reports 2/28/11 14. Unusual incidents log 5/1/11 to 9/1/11 15. Log of serious injuries 5/1/11 to 9/12/11 16. Log of serious incidents 5/1/11 to 10/21/11 17. Log of witnessed Injuries 5/1/11 to 10/21/11 18. Log of discovered Injuries 5/1/11 to 10/21/11 19. Log of peer to peer injuries 10/1/10 to 9/30/11 20. CMS 2567's for survey dates 5/25/11 and 6/16/11 21. Incident management meeting minutes for 7/6/11, 7/13/11, 7/20/11, 7/27/11, 8/3/11, 8/10/11, 8/17/11, 8/24/11, 8/31/11, 9/7/11, 9/14/11, 9/21/11, and 10/24/11 22. Individual training records for RSSLC investigators 23. Individual training records for DFPS investigators 24. Documentation of volunteer background checks 25. Documentation of employee background checks 26. RSSLC Criminal Background Checks report 9/1/11 27. Training curriculum for Abuse, Neglect, and Exploitation 28. Acknowledgement of Reporting signed forms for 25 randomly selected employees 29. Log of Department of Family Protective Services (DFPS) cases 5/1/11 to 10/21/11 30. DFPS investigation reports and related documentation for cases 40002387, 40069827, 40214642, 40220367, 40222484, 40223658, 40226321, 40231959, 40233564, 402362295, 58980967, and 40247759 (sample D.1) 31. DFPS investigation reports 40278235, 39706247, 39707428, , 40241085, 40226321, 40206745, 40013427, 39953787, 39311831, 40276236, and 40294909

	32. Office of Inspector General (OIG) investigation reports 07356-11 and 07066-11 33. DFPS/OIG/RSSLC coordination meeting minutes 8/17/11 34. FY11 OIG case log (undated) 35. Document prepared by RSSLC with regard to the audit process to detect under reporting of injuries 36. Materials used to educate individuals, LARs, and family members on Abuse, Neglect, and Exploitation 37. DADS report MHMR0102 Percent of All Employees Completing Course of Training 9/30/11 38. Incident Information Report (E.17) for Individuals #16, #424, #596, #436, and #783 (sample D.3) 39. RSSLC investigations of serious injuries UIRs 11-184, 11-196, 11-241, and 11-256 (sample D.2) 40. Unusual Incident Reports (UIRs) 11-182, 11-246, 11-209, 11-210, 11-247, 11-236, 11-227, 11-221, and 12-030 41. List of employees/dates placed in No Direct Contact status (undated) 42. Administrative Review Team for Client Injury Reports (CIRs) and E.17s minutes for 8/17/11, 9/1/11, 9/7/11, 9/9/11, and 9/14/11 43. Staff Training Records (25 randomly selected employees) 44. State report "Percent of All Employees Completing Courses of Training Program." 9/30/11 45. Self-Advocate meeting minutes 5/4/11, 5/8/11, 6/8/11, 6/22/11, 8/3/11, 8/17/11, 9/7/11, and 9/21/11 46. Employee roster 9/20/11 47. RSSLC Trend Reports 9/30/11 **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. John Kimble, OIG Investigator 6. Robin Eversole, Volunteer Coordinator **Meetings attended/Observations:** 1. Incident Management Team Meeting (IMRT) 10/24/11 **2.** Sabine Unit Morning Meeting 10/27/11 **3.** Quality Assurance/Quality Improvement (QA/QI) Council 10/25/11 4. Administrative Review Team 10/26/11 1.
	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 concurred with RSSLC that it is in substantial compliance with Provision D.1 and Provision D.5. Provision D.1 primarily addresses policy requirements associated with abuse and neglect reporting and zero tolerance. Provision D.5 addresses required background checks of employees and volunteers. For Provision D.2 RSSLC reported it was in substantial compliance with two of nine components. The Monitoring Team determined RSSLC was in substantial compliance with six of nine components. Provision D.2 addresses primarily policy implementation.

	For Provision D.4 RSSLC reported it was not yet in compliance and the Monitoring Team agreed with this self-assessment. This provision addresses primarily tracking and trending data related to incident management. In the POI, the RSSLC did not provide any methodology related to its self-assessment process. In all but one instance the self-assessment rating was identical to the rating given by the Monitoring Team in the last review, even though in this review the Monitoring Team determined substantial compliance in six areas self-assessed as noncompliant. The Monitoring Team would expect the RSSLC to develop self-assessment methodologies that would yield results more closely aligned with the review findings of the Monitoring Team.
	Summary of Monitor's Assessment: Since the last review the Facility had undertaken a policy review which resulted in several policies merging into two key policies: Policy C.01 Incident Management (revision date 8/1/11) and Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (revision date 5/11/11). This represents a significant improvement in that these policies are now, for the most part, aligned with DADS policies and include provisions that, if carried out effectively and consistently, should lead to substantial compliance with all provisions of Section D of the SA. 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. The Facility had a sufficient number of trained investigators to ensure an investigator is onsite 24 hours a day seven days a week. The video surveillance program remains an important administrative tool in detecting abuse and neglect, and in the conduct of investigations. Facility policies were not implemented consistently. For example, in the sample of 10 DFPS cases selected for review, five noted the time of the alleged incident. In four (80%) the incident was not reported to DFPS within one hour. In two of four (50%) investigations of serious injuries selected for review the incidents were not reported immediately (within one hour) to the Facility Director/designee. The review of investigations of discovered injuries, including non-serious injuries, is an important process to ensure all instances of possible abuse and neglect are discovered and reported. Most investigations of non-serious discovered injuries reviewed by the Monitoring Team were insufficient in scope and depth to make such a determination. The Monitoring Team did not find any instances of lack of cooperation between the Facility, DFPS, OIG or local law enforcement in its review.

	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 the content of supervisory review. Training for staff on abuse and incident reporting was in place, and all staff was current in that training. All allegations of physical abuse received a law enforcement referral. There continues to be a problem with timely response from DFPS in initiating investigations. Initial investigatory activity exceeded the 24 hour requirement in seven (70%) of 10 cases reviewed by the Monitoring Team, sometimes by days. In every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status. Employee and volunteer background checks were completed timely. 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.

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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 concurs. The Facility's POI did not offer a rationale for its self-assessment rating. Since the last review the Facility had undertaken a policy review which resulted in several policies merging into two key policies: policy C.01 Incident Management (revision date 8/1/11) and policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (revision date 5/11/11). This represents a significant improvement in that these policies are now, for the most part, aligned with DADS policies and include provisions that, if carried out effectively and consistently, should lead to substantial compliance with all provisions of Section D of the SA. 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. RSSLC Policy C.02: Protection from Harm - Abuse, Neglect, Exploitation, required that staff 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).	Substantial Compliance

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		The Facility had a sufficient number of trained investigators to ensure an investigator is onsite 24 hours a day seven days a week. The video surveillance program remains an important administrative tool in detecting abuse and neglect, and in the conduct of investigations. 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 Facility policy demonstrated commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect. The Facility had practices in place to achieve this; therefore, this provision is found in substantial compliance. Nevertheless, issues were identified in this review that demonstrates concerns related to the effectiveness of some aspects of these policies and practices. For example, as noted in the findings for Provision D.2.a, examples of delay in reporting are inconsistent with a general understanding of the Facility's commitment to not tolerate abuse and neglect.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:	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) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility	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's POI did not offer a rationale for its self-assessment rating. RSSLC Policy C.01 Incident Management (revision date 8/1/11) and Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (revision date 5/11/11) were intended to address this provision of the SA. These policies included most reporting requirements necessary to comply with this component of the SA. The policy needs to ensure clarity of language that directs staff to report serious injuries immediately, within one hour, to the Facility Director/designee. The Facility used a standardized reporting system.	Noncompliance

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	Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	Facility policies were not implemented consistently. For example, in the sample of 10 DFPS cases selected for review, five noted the time of the alleged incident. In four (80%) the incident was not reported to DFPS within one hour. This was the case for: • DFPS Case 40214642: time of alleged incident was 10:00 am. Reported to DFPS at 3:51am the next day. This was a case of confirmed abuse. • DFPS Case 40220367: time of alleged incident was 11:15 pm. Reported to DFPS at 2:19 pm the next day. This was a case of alleged abuse with an inconclusive finding. • DFPS Case 40222484: time of alleged incident was 8:00 pm. Reported to DFPS at 7:54 am the next day. This was a case of unconfirmed neglect. • DFPS Case 40233564: time of alleged incident was 7:30 pm. Reported to DFPS at 9:27 am the next day. This was a case of confirmed neglect. In one of four (25%) investigations of serious injuries selected for review the incident was not reported immediately (within one hour) to the Facility Director/designee. This was the case for UIR 11-196. The Monitoring Team requested informational data related to abuse, neglect, and exploitation for the six month period of 4/1/11 to 9/30/11. This is displayed below. Total Number of Abuse Allegations 31 Substantiated 7 Inconclusive 1 Administrative Referral 3 Unsubstantiated 20 Total Number of Neglect Allegations 46 Substantiated 7 Inconclusive 6 Administrative Referral 13 Unsubstantiated 20 Total Number of Exploitation Allegations 0 The number of serious incidents (other than abuse, neglect, exploitation, and serious injury) from 5/1/2011 to 10/21/11 totaled 21 and included: Deaths – 3 Choking Incidents– 3 Sexual Incidents – 2 Suicide Threats – 6	

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		Unauthorized Departures – 7 Two samples of investigations were selected for review. These included: • Sample D.1 included a sample of ten DFPS investigations of abuse, neglect, and/or exploitation between 5/1/11 and 10/21/11. This sample included the following DFPS investigation reports 40002387, 40069827, 40214642, 40220367, 40222484, 40223658, 40233564, 40236295, 40241085, and 40247759. • Sample D.2 included a sample of four Facility investigations between 5/1/11 and 10/21/11. Sample D.2 consists of four serious discovered injuries: UIRs 11-184, 11-196, 11-241, and 11-256. In reviewing Sample D.1 (DFPS case reports) four of five (80%) DFPS cases where a time of the incident was identified 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 40214642, 40220367, 40222484, and 40233564. In reviewing Sample D.2 (facility investigations) two of four (50%) investigations were not reported immediately (within one hour) to the Facility Director/designee. Those that were not reported within one hour included UIRs 184 and 196. An additional element of properly reporting allegations of abuse and neglect is the investigation of non-serious discovered injuries. These investigations are conducted to determine, among other things, whether abuse and neglect can be ruled out as a cause, or a contributing factor, of the injury. The Monitoring Team reviewed the Incident Information Report (E.17) and a companion document "Investigative Review of Incident" form for five discovered injuries: Individuals #16 (6/13/11), #424 (8/31/11), #596 (9/3/11), #436 (6/13/11), and #783 (9/19/11). Important information was not recorded on the documents reviewed. For example, four of five (80%) did not have an entry noted in response to "Is there suspicion of abuse/neglect?" Two of five (40%) did not have an entry noted in response to "Who was responsible for the Individual at the time of discovery of the incident?" The person conducting the initial investigation is required to note his or her name on the E.17. This was missing on three (60%) of five forms reviewed. The Facility had an Administrative Review Team (ART) to review all Client Injury Reports (CIRs) and Incident Information Reports (E.17s). This group meets at least once a week. The ART membership is primarily upper level management. It is of concern that the five documents reviewed by the Monitoring Team (which had presumably undergone ART review) were incomplete and missing important data, especially with respect to ruling out abuse or neglect as a contributing factor, or cause, of the discovered injury. Discovered injuries per Policy E.17 are to be reported to the Home	

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		or Area Supervisor, or Campus Coordinator in off hours. The Monitoring Team did not identify any place on the Incident Information Report to document this notification occurred. The review of investigations of discovered injuries, including non-serious injuries, is an important process to ensure all instances of possible abuse and neglect are discovered and reported. Through the course of reviewing investigations the Monitoring Team noted that the video surveillance cameras have been helpful in ascertaining the facts associated with many 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 achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. The Facility's POI did not offer a rationale for its self-assessment rating. Based on a review of 10 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. Based on a review of the 10 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, residential areas received increased supervisory monitoring, and emotional assessments of victim trauma were conducted by psychology staff. In no case was an alleged perpetrator removed from no direct contact status prior to an investigation being completed, including administrative review of the investigation findings. The Monitoring Team has determined that this component of this provision is in substantial compliance with the SA.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	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 rationale offered in the POI was that only 98% of staff was current in training. The Monitoring Team confirmed a higher rate of compliance. Consequently, the Monitoring Team finds this component to be in substantial compliance. The RSSLC reported it had initiated a new process for annual retraining of staff which called for retraining to occur at an 11 month interval. The expected outcome of this process was that even if some staff were tardy in completing annual refreshers they had	Substantial Compliance

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		a one month window and still could meet the SA requirement of "at least yearly." DADS and Facility policy require that successful completion of class ABU0100 Abuse and Neglect, and class UNU0100 Unusual Incidents occur annually. The Monitoring Team has determined this is sufficient to demonstrate compliance with this provision of 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. With respect to the requirement that training is competency-based, the material reviewed included provisions for trainees to demonstrate their understanding of actions and conditions which may constitute 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. Review of 25 staff records (Sample C.2), showed that all 25 (100%) had completed competency-based training on abuse and neglect and unusual incidents prior to working directly with individuals and within the last 12 months. Additionally, the Monitoring Team reviewed the DADS report MHMR0102 Percent of All Employees Completing Course of Training (9/30/11) which reported a 99% compliance rate for staff completion within the last 12 months of ABU0100 and UNU0100. Only 10 of 1319 staff were not current with ABU0100 and only 12 of 1319 staff were not current with UNU0100. The Monitoring Team has determined that this component of this provision is in substantial compliance with the SA.	
	(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	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 Facility's POI did not offer any rationale for this self-assessment. The Monitoring Team does not concur with the Facility's self-assessment and finds this component to be in substantial compliance. The Facility did not consistently use the acknowledgement form 1020 required by State policy until June, 2011 to demonstrate compliance with this component of the SA. Prior to this, an RSSLC form entitled "Acknowledgement of RSSLC Employee Responsibility for Reporting Abuse/Neglect/Exploitation Incidents" (dated 12/15/09) was 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 some 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 is pleased	Substantial Compliance

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	any mandatory reporter's failure to report abuse or neglect.	the Facility was now uniformly using the form required by DADS. Copies were requested of the forms for staff hired during the two full months prior to the on-site review. Based on a review of the forms provided to the Monitoring Team, all (100%) recently hired staff had signed the DADS required acknowledgement form 1020. A sample of 25 staff (Sample C.2) was randomly selected to determine if annual acknowledgements had been signed. Twenty-three had current signed 1020 acknowledgement statements and three had the RSSLC form. Because the RSSLC form is roughly equivalent to the DADS 1020, and the Facility has implemented the use of the DADS form consistently since June, 2010, the Monitoring Team has determined this element of this component is in substantial compliance. The Facility reported three instances since the last review where a mandatory reporter failed to report abuse or neglect. These were identified in UIRs 11-182 and 11-246. Appropriate personnel action was taken in each case, resulting in two staff receiving 10 day suspensions and one staff being terminated. The Monitoring Team has determined this component of this provision is in substantial compliance with the SA.	
	(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. The Facility's POI did not offer a rationale for its self-assessment rating. Materials were provided to LARs prior to each individual's PSP meeting including the Recognizing Abuse and Neglect brochure, a rights booklet, and an invitation to join the Family and Friends organization. Each individual's PSP meeting presents an opportunity to reinforce with the individual and his/her family/LAR other activity undertaken at the Facility with respect to abuse/neglect reporting, and to reinforce to each individual their right to feel safe while living at the Facility. 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 discussion of abuse, neglect or other reportable incidents. A review by the Monitoring Team of the minutes of self-advocacy group meetings, and observation of the meeting held the week of the review, demonstrated agenda items and discussion at every meeting that addressed abuse, neglect, exploitation, or rights material.	Noncompliance

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		At least some family members, and some individuals, understand how to report allegations of abuse and neglect. Since the last review two allegations of neglect had been reported by family members, and one allegation of neglect and one allegation of abuse had been reported by an individuals living at the RSSLC. These included UIRs 11-197, 11-209, 11-224, and 12-015. The Monitoring Team believes the Facility needs to be more assertive in educating individuals and family members in order to achieve compliance with this component of the SA. Discussion at PSP meetings would be one way to accomplish this.	
	(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 not achieved substantial compliance with this component of this provision of the Settlement Agreement. The Facility's POI reported two instances where after hours monitoring discovered missing posters. The Monitoring Team does not concur with this self-assessment and finds this component to be in substantial compliance. A review was completed of the postings the Facility used. The Facility used 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 included prominent display of the 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 confirmed that the postings of individuals' rights were generally present and in areas to which individuals regularly had access. 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 inconsistent in application. The process described to the Monitoring Team required that each unit social worker conduct an inspection once a week. Since the last review the rate of compliance for each social worker, documenting that the weekly monitoring occurred, ranged from 19% to 62%. This measured whether or not the social worker engaged in the monitoring activity at the defined frequency. The frequency of monitoring should be consistent with the expectations described to the Monitoring Team. The report generated from this activity reflects "posters checked" rather than more definitive information as to if they were displayed where called for, were in good repair, and if they needed to be (and were) replaced. The Facility should improve its monitoring system to ensure it remains in compliance with this component of the SA.	Substantial Compliance

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	(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 not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Facility's POI did not offer a rationale for its self-assessment rating. The Monitoring Team does not concur with the Facility's self-assessment and finds substantial compliance. Based on a review of ten allegation investigations completed by DFPS (Sample D.1), DFPS had made appropriate law enforcement referral in all five allegations of physical abuse and one allegation of neglect. The Monitoring Team did not identify issues in the remaining four investigations in Sample D.1 that would suggest that law enforcement referral would have been appropriate. Based on a review of nine investigations completed by the Facility (Samples D.2 and D.3), 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. The Monitoring Team has determined that this component of this provision is in substantial compliance with the SA.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	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 Facility's POI reported no reports of retaliation had been received. 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. The Monitoring Team interviewed an OIG investigator who happened to be at the Facility conducting an investigation. The investigator was asked if he had discovered in any investigation activity any instances of actual or perceived retaliation against reporters. He indicated he had not, although occasionally staff indicated they were "kind of worried" about retaliation but did not report anything specific. Based on a review of investigation records (Samples D.1, D.2, and D.3), there were no concerns noted related to potential retaliation.	Substantial Compliance

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		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 did not have such a list because there were no incidents of perceived or actual retaliation reported. The Monitoring Team has determined that this component of this provision is in substantial compliance with the SA.	
	(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. The Facility's POI reported that a new process went into effect on 10/1/11. This process required that a facility investigator review one individual record per quarter. This review consisted of reviewing observation notes and integrated progress notes to determine that all significant injuries had been reported. During the last 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 POI submitted prior to the last review reported 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 stated 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." The Monitoring Team confirmed that this process remained in place. The additional process described above, along with continuation of the process described in the last review, remains insufficient to demonstrate compliance with this component of the SA. An under-reporting audit process should also consist of reviews of all potentially relevant information, including nursing notes, to determine if any information in any documents should have generated an incident report and did not. Finally, the Monitoring Team is reiterating an observation made in the last report: 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 produce a periodic written report summarizing the process and audit results.	Noncompliance
D3	Commencing within six months of	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved	

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	the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:	substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs.	
	(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 does not concur and finds compliance. The Facility's POI did not offer a rationale for its self-assessment rating. The RSSLC policy C.01 Incident Management included specific operational descriptions providing for the conduct of investigations. DFPS has similar descriptions and related training. Policy E.17, which addresses non-serious discovered injuries, provided direction on how to properly complete the E.17 document. It did not provide direction on how to conduct an investigation. The E.17 is essentially a document that collects information. A companion document "Investigative Review of Incident" is completed by a facility investigator and contains directions for analysis, conclusions, and development of probable cause if appropriate. The Monitoring Team review of facility policy found it described the conduct of investigations and required that investigators be qualified. The policy specifies that Facility Investigators (and any other staff authorized to conduct investigations) successfully complete Comprehensive Investigator Training (CIT0100), Conducting Serious Incident Investigations (INV0100), and a class in Root Cause Analysis. The policy required that investigators have training in working with people with developmental disabilities, including persons with mental retardation. This was accomplished through successful completion of People with MR (MEN0300). The Monitoring Team believes this training, if completed as described, should be adequate for the conduct of investigations at RSSLC. Finally, the Facility policy required that investigators be outside of the direct line of supervision of alleged perpetrators. The Monitoring Team reviewed current material used by DFPS in training its	Substantial Compliance

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		investigators. The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 4. Time and Stress Management In reviewing the materials associated with these modules, and in consideration that DFPS case investigations reviewed by the Monitoring Team were generally thorough and comprehensive and case reports were generally well written, the Monitoring Team is of the opinion that this training is competency-based and 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." Completion of this class would demonstrate additional training in working with people with developmental disabilities. RSSLC requires facility investigators to have completed the following classes: 1. ABU0100 Abuse and Neglect 2. UNU0100 Unusual Incidents 3. CIT0100 Comprehensive Investigator Training - although this class is no longer offered by Labor Relations Alternatives (LRA). Per interview with the IMC the LRA course noted below has been deemed as the appropriate alternative. 4. MEN0300 People with Mental Retardation 5. LRA training Fundamentals of Investigations and Conducting Serious	

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		Investigations (INV0100) 6. Training in Root Cause Analysis. DFPS had nine investigators assigned to work RSSLC cases. The training records for these investigators were reviewed. All nine completed the requirements for investigations training RSSLC had seven staff designated as investigators. The training records for these staff were reviewed. All seven had completed the requirements for investigations training. None of the staff designated as facility investigators had supervisory responsibilities that extend beyond the IMC Department; therefore, they are unlikely to be in the direct line of supervision of anyone subject to investigation. The Monitoring Team has determined that the RSSLC was in substantial compliance with this component of the SA.	
	(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 Facility's POI did not offer a rationale for its self-assessment rating. The Monitoring Team did not find any instances of lack of cooperation in its review of the ten DFPS investigations in Sample D.1. Additionally, the Facility produced several very good examples of cooperation with law enforcement. These were noted in UIRs 11-224, 11-231, 12-013, and 12-016. 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 8/17/11. The Monitoring Team interviewed an OIG investigator who happened to be at the Facility conducting an investigation. OIG was very complimentary of RSSLC administrative staff in the degree of cooperation received and the professionalism demonstrated by the IMC and his staff. The Monitoring Team has determined that this component of this provision is in substantial compliance with the SA.	Substantial Compliance
	(c) Ensure that investigations are	In its Plan of Improvement (POI) the RSSLC reported that it had achieved substantial	Substantial

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	coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	compliance with this component of this provision of the Settlement Agreement. The Monitoring Team concurs. The Facility's POI did not offer a rationale for its self-assessment rating. 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 10 of 10 (100%) investigation records from DFPS (Sample D.1) no evidence of interference by one agency or the other was identified. Of the four investigation records from the Facility (Samples D.2.), one serious injury had been referred to a law enforcement agency (and DFPS). The other three were serious injuries, where there was no suspicion of abuse or neglect, and therefore would not be appropriate for reporting to DFPS or law enforcement. The Monitoring Team has determined that this component of this provision is in substantial compliance with the SA.	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. The Facility's POI did not offer a rationale for its self-assessment rating. 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	Substantial Compliance

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		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. Additionally, since the last review the Facility had established a portable evidence kit to be used by investigators. Materials were kept in a rolling suitcase and included everything potentially needed to collect and process evidence, including a camera, plastic gloves, evidence bags, marking pens, a ruler, and more. At the last compliance visit, the Monitoring Team recommended 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. At that time, 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. To ensure that the record, which could serve as evidence during a review of the death, remained secure, the revised policy now states, "Upon notification of the death of an individual served, Incident Management staff secures all volumes of the individual's Active Record in the Incident management Department for a period of 10 calendar days. The record may be checked out from the Incident Management Department in order to complete required reports but must be returned to the Incident Management Department by the end of the shift of the staff member who checked it out." This was an important revision, and the Monitoring Team appreciates that the Facility implemented a thoughtful and appropriate response. The Monitoring Team also interviewed an OIG investigator who happened to be at the Facility conducting an investigation. He was asked if he had any issues with protection of evidence (when applicable). He reported he did not. The Monitoring Team has determined that this component of this provision is in substantial compliance with the SA.	
	(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	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's POI did not offer a rationale for its self-assessment rating. Data review and analysis should be available for the Facility to assess compliance for the POI. The Monitoring Team reviewed a document titled "Commencement of DFPS Investigation." Facility staff reported the procedures outlined in this document went into effect 8/1/11. The Monitoring Team expected substantive investigatory activity to commence within 24 hours of an incident being reported. These new procedures did not require DFPS presence at the Facility with 24 hours of an incident being reported nor did	Noncompliance

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	a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	they describe substantive investigatory activity that may be sufficient to demonstrate compliance with this component of the SA. The new procedures required that DFPS obtain enough information from the Facility to enable DFPS to "develop an initial plan for the investigation" within 24 hours. The new procedures also required DFPS to instruct the Facility to "protect evidence." Evidence associated with allegations would typically include testimonial evidence from witnesses and the alleged perpetrators. Often, this is the primary evidence used in DFPS investigations and used to reach investigation conclusions. For the Facility to protect this evidence, in the absence of timely interviews, extraordinary measures would need to be taken by the Facility. This could include in some cases the need to isolate staff witnesses from one another in order to prevent contamination of testimonial evidence until at least witness interviews have occurred (which is the primary reason that DFPS should begin interviewing staff as soon after the reported incident as possible). DFPS case reports should document the specific actions that the Facility was directed to take, and that DFPS verified were taken, to protect evidence (including the integrity of testimonial evidence provided by witnesses, potential witnesses, and alleged perpetrators). 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 selected and 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 ten DFPS investigations in the sample: Five of ten (50%) 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 documentation provided regarding any substantive investigatory tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following are examples for which commencement of the investigation did not occur within the first 24 hours or sooner: • Investigation 40002387 was reported to DFPS at 9:02 am on 6/30/11. The initial face-to-face interview with the alleged victim did not occur until 7/1/11 at 1:30 pm. The first staff interview did not occur until 7/6/11. 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. • Investigation 40236295 was reported to DFPS at 12:18 pm on 8/13/11. The initial face-to-face interview with the alleged victim was attempted on 8/16/11	

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		but the individual was at the dentist. The first interview with any RSSLC staff did not occur until 8/18/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. This was a case of unconfirmed physical abuse. • Investigation 40222484 was reported to DFPS at 7:54 am on 8/2/11. The initial face-to-face interview with the non-verbal alleged victim did not occur until 8/3/11 at 11:52 am. The first staff interview did not occur until 8/5/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. This was a case of unconfirmed neglect. • Investigation 40220367 was reported to DFPS at 2:19 pm on 7/30/11. The initial face-to-face interview with the alleged victim did not occur until 8/1/11 at 11:20 pm (note: this may have been a typographical error and meant to be "am"). The first staff interview occurred at 2:00 pm the same day. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. This was a case of an inconclusive finding of an allegation of physical abuse. • Investigation 40214642 was reported to DFPS at 3:51 am on 7/26/11. The initial face-to-face interviews did not occur until 7/29/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. This was a case of confirmed verbal abuse. The Facility places alleged perpetrators (AP) in non-direct care status immediately after an allegation and ensures they are closely supervised while on shift. When an AP is off duty the potential for contamination of testimonial evidence increases and can affect the integrity of an investigation. All ten investigations (100%) were completed within 10 calendar days of the incident. All ten (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In all ten (100%) if DFPS had concerns and recommendations for corrective action they were noted in the report. In each case 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:	

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		Three of four (75%) 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. UIR11-256 did not report any information in section 7 that would confirm if, and when, a facility investigator commenced the investigation. Two of four (25%) 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 11-256 (no IMC approval date noted on the UIR), and 11-196 (no IMC approval date noted on the UIR). All four (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. All four (100%) included recommendations for corrective action. To achieve compliance with this component of the SA, substantive investigatory activity must begin with 24 hours of a report of an incident. This investigatory activity would often occur at the Facility and include interviews with witnesses, but it must include clear documentation of initiation of substantive investigatory tasks, including tasks that serve to protect testimonial evidence from contamination.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person	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's POI did not offer a rationale for its self-assessment rating. 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;	Noncompliance

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	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.	• 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. Facility investigations (UIRs) did not always clearly document the names of all persons interviewed during the investigation and include for each person interviewed, an accurate summary of topics discussed or a summary of questions posed, and a summary of material statements made. 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 ten of ten (100%) investigations reviewed , 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 10 (100%), each serious incident or allegations of wrongdoing; o In 10 (100%), the name(s) of all witnesses; o In 10 (100%), the name(s) of all alleged victims and perpetrators; o In 10 (100%), the names of all persons interviewed during the investigation; o In 10 (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 10 (100%), all documents reviewed during the investigation; o In 10 (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 10 (100%), the investigator's findings; and o In 10(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 all four investigations reviewed (100%), the contents of the investigation	

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		report were insufficient to provide a clear basis for its conclusion. This is due to issues described below relative to identification and interview of potential witnesses. • The report utilized a standardized format that set forth explicitly and separately: o In four (100%), each serious incident or allegations of wrongdoing. o In none (0%), the name(s) of all witnesses. Section 5 of the UIR records the names of "staff on duty at the location or suspected location of the incident." This does not necessarily include all witnesses, for example, another individual, a visiting family member, a dietary worker delivering food, or a nurse or administrator making rounds are all potential witnesses. Additionally, the instructions that accompany the UIR state "do not routinely list all staff on the shift/home if they do not have relevant knowledge or investigative value." It is unlikely a determination as to whether a staff person "has relevant knowledge or investigative value" can occur without at least obtaining a witness statement, or making a clear determination as to why a witness statement was not taken, for example, a staff person is listed on a duty roster but was off campus with a group of Individuals at an activity, or, was away from the home attending a training class. In each of the four investigations no staff statements were taken as part of the investigation. The Monitoring Team cannot determine whether all four investigations of serious injuries identified the names of all witnesses. o In four (100%), the name(s) of all alleged victims and perpetrators. o In one (25%), the names of all persons interviewed during the investigation. UIR 11-241 did not provide specific information in this regard, UIR 11-256 only indicated that the investigator "interviewed staff and individuals on the home", and UIR 11-196 reported a series of events but did not indicate the source (e.g. interviews) of the information. 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 four (100%), all documents reviewed during the investigation. o In two (50%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. Section 8 of the UIR would typically be used to record information related to previous incidents. No information was provided in UIR 11- 189 and 11-196. o In four (100%), the investigator's findings. o In four (100%), the investigator's reasons for his/her conclusions. The Facility needs to establish work processes that establish the method by which all	

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		potential witnesses are identified, how a determination is made as to which witnesses are to be interviewed, and how interviews are conducted and documented in the UIR. Improvements in the facility investigation process, and accurate documentation related to facility investigations, are the primary obstacle to achieving compliance with this component of the SA.	
	(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 does not concur. As described in D.3.f facility investigation reports (the UIR) do not always reflect a thorough and complete investigation. The Facility's POI reported that a QA review of final investigation reports is in place at RSSLC. This review was not achieving the intended results. 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 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: • All ten (100%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. • All ten (100%) case files reviewed contained 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. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • In all four investigation files reviewed there was evidence that the supervisor had conducted a review of the investigation report. • There was no evidence that the review had resulted in changes being made to correct deficiencies in the report as reported in D.3.f. Improvements in the facility investigation process, and accurate documentation related to facility investigations, are needed to achieve compliance with this component of the SA. The Facility must review each report and other relevant documentation to ensure that: 1) the investigation is complete and meets all requirement of the SA; and 2) the report is accurate, complete and coherent and that any further inquiries or deficiencies (necessary to address requirements of the SA) are addressed promptly.	Noncompliance

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	(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 concurs. The Facility's POI reported that a QA review of final investigation reports is in place at RSSLC. RSSLC used the IMRT process to review the DFPS reports already reviewed by the IMC. This process is intended to ensure senior management of the Facility is involved in the review of each case. RSSLC used a form "DFPS Investigation Cover Sheet Allegation and Final Report", dated 3/22/11, to document 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 all 10 (100%) cases.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	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's POI reported that a tracking system related to this component of the SA was initiated on 9/21/11. Follow-up actions, persons responsible, and target dates, relative to DFPS and Facility investigations are noted in the UIR. Until the new tracking system is fully operational the Facility did not have an organized system to track implementation of planned actions. With respect to programmatic actions referenced in the SA the Facility needs to track the outcome of planned action(s) to ensure these action(s) corrected a situation and/or prevented recurrence. For example, if a recommendation is "follow-up psychological assessment will be conducted" the tracking system should include more information than just the assessment did or didn't happen. At some point a determination needs to be made if the follow-up action(s) resulted in a positive outcome for the individual that "corrected the situation and/or prevented recurrence." The Monitoring Team would expect that as the Facility's QA system evolves it will include processes to demonstrate compliance with this component of the SA. The Facility was able to effectively demonstrate that employee disciplinary action had occurred as planned with respect to investigation findings. Case files reviewed by the Monitoring Team included copies of all relevant disciplinary action taken in response to investigation findings. Documentation was also provided validating employee disciplinary action taken for each confirmed finding by DFPS since the last review. The Monitoring Team looks forward to reviewing the effectiveness of the recently implemented tracking system at the next review.	Noncompliance

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	(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 not yet achieved substantial compliance with this component of this provision of the Settlement Agreement. The Monitoring Team does not concur and finds this component to be in substantial compliance. The Facility's POI did not offer any rationale for its self-assessment rating. 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.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	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 Facility's POI reported attendance at State Office training on a new database for unusual incidents. The presentation of data in the RSSLC Allegations Trend Report (9/30/11) was not sufficient to identify trends. Most data were reported for the current month only. Data trended over time was extremely limited. The Trend Report also did not provide for longitudinal presentation of trend data by subcategories, such as allegations by home or shift. Additionally, the graphs on page nine, which report DFPS case disposition, did not delineate disposition by type of case. This is important because the outcome of investigations, trended over time, should be a key indicator as to the effectiveness of abuse and neglect training and the effectiveness of prevention strategies employed by the Facility. With respect to DFPS case dispositions, it is important to have data that can indicate whether the number and percentage of cases, by type, and by disposition, are increasing or decreasing over time. Some of these observations were made by the Monitoring Team at the last review. While some effort had been made to improve tracking and trending data, much more is needed. More detailed trend data is necessary to facilitate effective analysis that can lead to improved practice and better outcomes for individuals. From the data in the Trend Reports the Monitoring Team was able to make the following observations: The number of DFPS abuse allegation cases had decreased significantly since the last review, from 34 to 17, a 50% decrease. The number of DFPS neglect allegation cases had increased significantly since the last review, from 26 to 35, a 35% increase. Neither trend	Noncompliance

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		was noted in the narrative section of the Trend Report indicating the Facility had probably not engaged in (or documented) reflective and substantive discussion on this topic. Similarly, the number of serious injuries had increased significantly, from 9 to 19 without this trend acknowledged or discussed in the narrative section of the Trend Report. The RSSLC has had a Quality Assurance/Quality Improvement Council in place for several months. The Monitoring Team observed a meeting of this group during the review. A report is prepared for presentation at the meeting that includes quantitative monitoring data on several provisions of the SA, including Section D. This work is organized so each provision of the SA is reviewed quarterly by the QA/QA Council. The discussion observed at the meeting was noticeably more substantive than what was observed at the last review. As this QA/QI process matures it will be important that it identify systemic issues that need a Corrective Action Plan process initiated and that the QA/QI Council monitors the implementation of these plans.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm	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 concurs. The Facility's POI did not offer any rationale for its self-assessment rating. 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.	Substantial Compliance

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	to individuals at the Facility.	Background checks were conducted on new employees prior to orientation. Annual background checks were completed for all employees. Once 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. The Monitoring Team has determined that this provision is in substantial compliance with the SA.	

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

1. The Facility's Trend Analysis Report needs to be expanded to track additional data elements longitudinally. (Provision D.4)
2. The Facility needs to improve in consistent application of its policies related to the entire incident management process. (Provisions D.2.a, D.2.3, D.2.i, D.3.e, D.3.f, D.3.g, and D.3.i)
3. Improvement in timely reporting of incidents is needed. (Provision D.2.a)
4. Improvement in timely initiation of investigations is needed. (Provision D.3.e)
5. Improvement in review of non-serious discovered injuries is needed. (Provision D.2.a)
6. Additional steps to educate individuals and guardians regarding abuse/neglect identification and reporting need to be initiated. (Provision D.2.e)
7. The audit/monitoring process for ensuring compliance with the requirements associated with rights posters needs to be consistently implemented. (Provision D.2.f)
8. The audit process to determine under-reporting of injuries and other incidents needs improvement. (Provision D.2.i)
9. The Facility should ensure effective implementation of a recently initiated process for tracking recommendations resulting from reviews of investigation reports. (Provision D.3.i)
10. Ensure Facility investigations of serious incidents include all components necessary to demonstrate compliance with SectionD.3.f of the SA, including documenting the rationale for making a determination as to why certain witness statements were not taken. (Provision D.3.f)

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 10/10/11 2. DADS Policy 003-Quality Enhancement 11/13/09 3. RSSLC Section E Presentation Book 4. RSSLC Policy A.27 Quality Assurance/Quality Improvement Council draft 4/28/11 5. RSSLC Policy A.28 Quality Assurance Plan 10/11/11 6. RSSLC Quality Assurance Plan Draft (undated) 7. Restraint Trend Report 9/30/11 8. Unusual Incidents Trend Report 9/30/11 9. Allegations Trend Report 9/30/11 10. Injury Trend Report 9/30/11 11. QA Monitoring tools for each provision of the SA 12. QA/QI Council Meeting Minutes for 5/17/11, 6/14/11, 6/28/11, 7/12/11, 7/26/11, 8/16/11, 8/30/11, and 9/20/11 13. Restraint Reduction Team Meeting minutes for 9/21/11 and 10/4/11 **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 **Meetings attended/Observations:** 1. Incident Management Team Meeting (IMRT) 10/24/11 2. Sabine Unit Morning Meeting 10/27/11 3. Quality Assurance/Quality Improvement (QA/QI) Council 10/25/11 4. Administrative Review Team 10/26/11 5. Restraint Reduction Committee 10/26/11
	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 Facility's POI did not offer a rationale for its self-assessment rating. The Monitoring Team observed continued improvement in the development of the administrative processes associated with QA activity. The RSSLC was clearly moving its QA process in a direction that, with continued improvement, refinement, and consistent application, should lead to substantial compliance. The Facility reported improvements in the continued development and refinement of a data system to support the monitoring activities and produce reports that integrate the monitoring done (and data) at the department level with that done at the QA Department level. The Monitoring Team was able to review evidence of this process.

	Summary of Monitor's Assessment: The Monitoring Team was able to determine that QA systems are in place for many sections of the SA. The development of a data system that was consolidating data from monitoring and program auditing and producing compliance reports was impressive. The process for inter-rater reliability checks, and generally improving the accuracy of monitoring data was encouraging and seemed to be working particularly well. The data system in use at the RSSLC to record QA monitoring activity and data, and to array data for analysis, was much improved from that observed at the last monitoring review. The RSSLC is to be commended for the development and continued refinement of this data system. Data are tracked and trended using two primary systems. The first is the trend analysis reports required by DADS. This produced data related to restraint use, unusual incidents, allegations of abuse and neglect, and injuries. The second is a Facility implemented system using SA monitoring tools. The trend analysis reports required by DADS were deficient with respect to the inclusion of a sufficient period of trend data. The Facility reports, labeled Trend Analysis Report, presented data gathered from monitoring reports administered by both the QA Department and the Department being audited. This report also provided information regarding inter-rater reliability and displayed data by each question on the monitoring tool. This was an informative and useful report especially with respect to its potential use in future SA compliance self-assessment ratings reported in POIs. The QA process at the Facility had not as yet developed an organized process to use monitoring data to routinely and consistently develop Corrective Action Plans (CAPs). The Monitoring Team did not observe an organized and consistent methodology for the development and implementation of CAPs. The CAP system observed during this review was insufficiently organized to provide the Monitoring Team with assurance that CAPs were disseminated to all parties responsible for their implementation and reviewed to determine effectiveness. There are 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. A quality assurance and corrective action planning process should include two different sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. 2. Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, including: key indicators of the status and effectiveness of supports and services, including; tracking and trending data required

	by DADS; the results of monitoring/auditing referenced above regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. At the time of the review, the QA activity in place at RSSLC consisted of administrative steps directed at this first strategy. Activity directed at the second strategy was extremely limited and needs to expand. The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of a sound QA system.

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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. The Facility's POI did not offer a rationale for its self-assessment rating. DADS Policy 003- Quality Enhancement was reviewed and it was consistent with the requirements of the Settlement Agreement (SA). The RSSLC engaged in two primary sets of activity which can address this provision of the SA. First, the Facility produced the trend analysis reports required by DADS. This produced data related to restraint use, unusual incidents, allegations of abuse and neglect, and injuries. Second, the Facility had implemented SA monitoring tools and was producing data and reports relative to the results of this monitoring. The trend analysis reports required by DADS were deficient with respect to the inclusion of sufficient trend data. For example, 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 contained 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 included identification of type of allegation, staff involved and individuals involved, location of incident, date and time of incident, cause(s) of incident, and outcome of investigations. This provided a snapshot of the current month; however, these data were not trended over time. Additional information on this topic is presented in Section C.1 and D.4 of this report. The second set of reports, labeled Trend Analysis Report, presented data gathered from monitoring reports administered by both the QA Department and the Department being audited. This report also provided information regarding inter-rater reliability and	Noncompliance

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		displayed data by each question on the monitoring tool. This was an informative and useful report especially with respect to its potential use in the Facility's self-assessment of SA compliance. The report should probably be renamed so that it does not get confused with the similarly named report required by DADS. As reported to the Monitoring Team the analysis of data resulting from these reports is used primarily for brainstorming problem solving either at departmental meetings or at the QA/QI Council. The QA process at the Facility had not as yet developed an organized process to use these data to routinely and consistently develop Corrective Action Plans (CAPs) that address either the circumstances of each problematic sentinel event identified through monitoring, or, more importantly, for the identification of systemic issues requiring more substantive and focused remediation. A quality assurance and corrective action planning process should include two different sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. 2. Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, including: key indicators of the status and effectiveness of supports and services, including tracking and trending data required by DADS; the results of monitoring/auditing referenced above; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. At the time of the review, the QA activity in place at RSSLC consisted of administrative steps directed at this first strategy. Activity directed at the second strategy was extremely limited and needs to expand. The RSSLC QA Department had recently (10/11/11) approved its policy entitled A.28 Quality Assurance Plan. The language in the policy does not directly and specifically address each element of this section of the SA. Nevertheless the policy describes a set of comprehensive procedures that, when viewed in their entirety, would likely lead to compliance with this section of the SA. The Quality Assurance Plan policy has the stated purpose of establishing 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. It also requires that the RSSLC implement quality assurance processes consistent with current, generally accepted professional standards of care that detect problems with the provision of protections, services and supports, ensure appropriate corrective action is implemented, and result in improved services and supports. The plan calls for the Facility to engage in quality planning,	

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		monitoring and evaluation, data collection and analysis, data reliability assessments, and a corrective action planning (CAP) process. It also establishes eight Program Improvement Committees, and noted others would be established as QA activity identifies program improvement needs. Finally, the policy required that Program Improvement Reports be prepared for presentation to the QA/QI Council. At the last review it was reported that RSSLC Policy A.27 Quality Assurance/Quality Improvement Council was in draft form. This policy remains in draft form and has the stated purpose of reviewing and overseeing the facility's status in regard to: regulatory/life safety visits; annual peer audits; facility support performance and internal controls audits; and 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. In the last review the Monitoring Team noted that the QA/QI Council policy did not articulate a mission that focused on improving the quality of life for the individuals living at RSSLC. This concern had not been addressed in the policy and the draft policy remains largely procedurally oriented, focusing almost entirely on managerial oversight of various tasks described in the policy. The Facility also presented to the Monitoring Team an undated document labeled "RSSLC Quality Assurance Plan Draft." This was a matrix format and displayed 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. Curiously, this document, or the substance of its content, was not referenced in either RSSLC policy directed at QA. The data system in use at the RSSLC to record QA monitoring activity and data, and array data for analysis, was much improved from that observed at the last monitoring review. The RSSLC is to be commended for the development of this data system. At the time of review, the Facility was using 12 monitoring tools targeting Sections C, D, F, I, K, M, O, P, Q, R, S, and V of the SA. The Facility reported there were 176 different staff reviewers/monitors who entered data into the QA system. The majority of these were staff working in various departments who were auditing their own work, or the work of peers. They were referred to as "internal auditors" in RSSLC reports. The QA Departments had a set of staff that administered the same monitoring tools and were referred to as "external auditors" in RSSLC reports. Monitoring is scheduled to occur at the frequency described in the QA plan matrix described earlier. For each section of the	

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		SA that is part of this process a set of detailed reports were prepared by the QA Department. These reports were reviewed by the department responsible for the work activity associated with the SA section, the QA Department, and the QA/QI Council. Using Section V – Recordkeeping and General Plan Implementation as an example, these reports included: 1. For each record audited a tally of yes, no, N/A responses to each query on the monitoring tool. These data could be used to correct deficiencies in that specific record. 2. For a given report time period the overall "compliance score" (recorded as a percentage) for each record audited during the time period. 3. A tally of these data by query (each question on the monitoring tool) that resulted in the identification of areas above, and below 80% compliance. These data could be used to identify areas in need of systemic improvement. It was reported to the Monitoring Team that the Facility had not yet begun an organized and consistent process to use these data to identify systemic issues. 4. Data enumerated above were separately recorded for audits done by internal monitors (Records Clerks auditing sister units) and external monitors (QA staff). Comparisons of results were displayed in graph form by month. This could facilitate analysis of improvement or regression of inter-rater reliability over time. 5. Finally, the level of agreement between internal and external monitors, by question on the monitoring tool, and by month, was displayed. This could be used to determine if operational definitions of certain queries may be interpreted differently signaling a need to review each segment's methodology. It was reported that in some areas (e.g. Section C - restraint use) a process to achieve this had been initiated. The RSSLC had implemented some elements of the above process as early as November, 2009. RSSLC reported to the Monitoring Team that as of July, 2011 the system for the referenced 12 sections of the SA was fully operational and consistently administered for each section. Through observation and document review this was confirmed by the Monitoring Team. From its review the Monitoring Team was able to determine that QA systems were in place for many sections of the SA. The development of a data system that was consolidating data from monitoring and program auditing and producing compliance reports was impressive. The process for inter-rater reliability checks, and generally improving the accuracy of monitoring data was encouraging and seemed to be working particularly well when monitoring was addressing topics that would typically not need to reflect clinical judgment. The Monitoring Team looks forward to reviewing the continued refinement of these processes in its next review.	

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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. The Facility's POI did not offer a rationale for its self-assessment rating. Refer to Provision E.1 for a description of data collection and analysis processes in use at the RSSLC. Through interview, the QA Director reported the Facility had begun to generate corrective action plans responding to sentinel events most typically in response to issues identified in the daily IMRT meetings. The Monitoring Team did not observe an organized and consistent methodology for the development and implementation of these CAPs. 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. Some elements are in place, for example, the follow-up tracking done by the Incident Management Coordinator with respect to implementation of follow-up actions determined necessary after each review of investigation results. In many instances, 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 create a uniform system with common reports, common tracking, and common follow-up mechanisms for CAPs. The Facility also reported it had not as yet developed the capacity to establish and implement corrective action plans that address systemic problems identified through the quality assurance process. To meet this requirement of the SA the Facility must be able to demonstrate its QA process collects sufficient data from which comprehensive analysis can produce the identification of underlying systemic causes of problems that can only be successfully addressed through facility-wide, or department-wide, improvement initiatives. As described in provision E.1 the data system now in place at the RSSLC should be capable of producing reports that will be helpful in this regard. There are still 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/auditors who do not have specific subject matter expertise have adequate training and support from someone with specific subject matter expertise. As noted in Provision D.1, an inter-rater reliability process is in place at RSSLC and mechanisms are in place to improve inter-rater reliability using staff with subject matter expertise. The QA Department may want to consider a formal	Noncompliance

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		requirement that if inter-rater reliability is not within a specified acceptable range, a defined review process with those conducting the monitoring is to occur. 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. The Facility's POI did not offer a rationale for its self-assessment rating. The QA Director reported the Facility had begun to generate corrective action plans responding to sentinel and significant events most typically in response to issues identified in the daily incident management meetings. The Facility initiated CAPs for single instances of an identified problem, but was not yet addressing systemic issues. The Monitoring Team was unable to validate an organized and consistent methodology for the dissemination of CAPs to ensure all entities responsible for implementation were included. The Facility apparently relied on assignments made and reports during incident management meetings to accomplish this. Even if effective, this would not be sufficient to ensure compliance with this provision with respect to subject matters that are not within the scope of incident management meeting review. From this review the Monitoring Team is unable to validate that corrective action plans are disseminated to all entities responsible for their implementation. This is problematic because in many instances 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 create a uniform system with common reports, common tracking, and common follow-up mechanisms for CAPs. The Facility also reported it had not as yet developed the capacity to establish and implement corrective action plans that address systemic problems identified through the quality assurance process. Dissemination policies and procedures will need to be addressed once systemic CAPs become a regular outcome of the QA process. The CAP system observed during this review was insufficiently organized to provide the Monitoring Team with assurance that CAPs were disseminated to all parties responsible for their implementation. The process needs to define and identify "all parties" at the point a CAP is developed. The Monitoring Team was unable to find specific guidance in RSSLC policy's that would clarify this process. CAPs identify a "responsible person" but it is not clear if that is sufficient to validate that a CAP had been disseminated to "all parties" as required by the SA. Addressing this is policy would help in this regard.	Noncompliance
E4	Monitor and document corrective	In its Plan of Improvement (POI) the RSSLC reported that it had not yet achieved	Noncompliance

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	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.	substantial compliance with this provision of the Settlement Agreement. The Monitoring Team concurs. The Facility's POI did not offer a rationale for its self-assessment rating. The QA Director reported the Facility had begun to generate corrective action plans responding to sentinel events and that initiating the administrative activity necessary to achieve compliance with this provision was needed. The Monitoring Team did not observe an organized and consistent methodology for the development, implementation, and monitoring of CAPs. It was not apparent to the Monitoring Team, nor was sufficient evidence provided, 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. The Facility also reported it had not as yet developed the capacity to establish and implement corrective action plans that address systemic problems identified through the quality assurance process. The monitoring, and associated documentation, of CAP implementation will need to be addressed once systemic CAPs become a regular outcome of the QA process.	
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. The Facility's POI did not offer a rationale for its self-assessment rating. The QA Director reported the Facility had begun to generate corrective action plans responding to sentinel events and that initiating the administrative activity necessary to achieve compliance with this provision was needed. The Monitoring Team did not observe an organized and consistent methodology for the development, implementation, and monitoring of CAPs. It was not apparent to the Monitoring Team, nor was sufficient evidence provided, to demonstrate that there was a process to follow through from establishment of a corrective action (and modification if necessary), to documentation of completion of the action and to evaluation to ensure the action was effective. The Monitoring Team did not identify any process used regularly by the Facility to track the effectiveness of CAPs and determine whether they need to be revised. To achieve compliance with this provision, the Monitoring Team will need to provide evidence that effectiveness of CAPs is monitored, and that CAPs are revised as needed.	Noncompliance

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

1. Expand the data reported in Trend Reports to display more longitudinal data and to appropriately delineate subcategories, such as type of abuse (Provision E.1).
2. Develop a system of "weighting" data items on monitoring tools, where appropriate (Provision E.2).
3. Use data to proactively identify potential systemic issues requiring attention whether these improvements need to occur Facility-wide or be targeted to specific homes/shifts, day/vocational programs, and/or departments, as well as identify an array of (Provision E.1).
4. Develop a methodology to define and identify staff who should receive CAPs (Provision E.3).
5. Organize information related to CAPS in such a way data can be used to help identify systemic issues (Provision E.2).
6. Organize information related to CAPS so that effectiveness can be measured and CAPs can be modified as necessary (Provisions E.4 and E.5).

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. RSSLC Plan of Improvement (POI) dated 10/10/11 2. RSSLC Settlement Agreement Status Update, dated October 2011 3. Section F Presentation Book 4. RSSLC Policy G.02: Admission, dated 11/03/10 5. RSSLC Policy F.01: Scheduling Annual Personal Support Plan Meeting, dated 8/02/11 6. RSSLC Policy F.02: Scheduling Initial Planning Meeting, dated 11/18/10 7. RSSLC Policy F.03: Participating in Annual Planning Meeting, dated 9/2310 8. RSSLC Policy F.04: Personal Support Plan Process, dated 12/30/10 9. RSSLC Policy F.05: Completing Planning Meeting Documentation, dated 10/24/10 10. RSSLC Policy F.18: Participating in Personal Focus Assessment Meeting, dated 4/20/11 11. RSSLC Policy F.19: Active Treatment Program Training, dated 6/7/11 12. DADS Policy 004: Personal Focus Assessment, dated 09/01/11 13. Program Implementation Data Sheets for Individuals #51, #60, #70, #113, #156, #199, #363, #597, #640, #651, #694, #740, #746, and #747 14. Assessment Tracking by Discipline Log 15. Monitoring/Auditing Reports prepared by QA Department 5/1/11 to 10/19/11 16. Late Assessments by Unit and Discipline Report 5/1/11 to 10/19/11 17. PSP Assessment Tracking Log 5/1/11 to 10/23/11 18. Assessments available in shared drive for Individuals #386 and #584 19. PSP Attendance Tracking Log 5/1/11 to 9/12/11 20. Discipline PSP Attendance Report 5/1/11 to 10/23/11 21. PSP Monitoring Log 22. PSP Discipline's Assessments Tracking Worksheet for Individuals 23. Record Reviews for Individuals #51, #113, 124, #531, and #579 24. Personal Support Plans (PSPs) and Personal Focus Assessment (PFA) for Individuals #16, #58, #70, #160, #239, #440, #540, #632, #672, #680, #746, and #747 25. PSPAs for Individual #52 from two 5/2/11 meetings **People Interviewed**: 1. Joan Poenitzsch, Director of Quality Assurance 2. Carol Agu, QDDP Coordinator 3. QDDP and Social Worker for Individual #113 4. PST for Individual #51 5. Various DCPs **Meetings Attended/Observations:** 1. PSPs for Individuals #51, #60, #156 2. PFA for Individual #579

	3. CLDP for Individual #124 4. At Risk Team Meetings for Individuals #58 and #680
	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. With a few exceptions, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide many details as to the Facility's self-assessment processes, but rather listed actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may more fully use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. The POI described a number of actions the Facility had taken since the previous site visit, including the ongoing training of QDDPs in the Q-Construction facilitation skills and random monitoring, coaching and documentation reviews of PSP meetings by QA staff. These data were reported to be reviewed quarterly by the QA/QI Council for systemic issues. As noted above, this review should be used to provide data regarding progress and other outcome indicators that could be reported in the POI. Other activities reported included webinar training on the new Personal Focus Assessment (PFA) process; development of a tracking database to ensure timeliness of PSP assessments; the inclusion of QDDPs in weekly integrated medical reviews; and a new approach to competency-based training for staff responsible for program implementation. The Facility reported it had developed a PSP/PST Committee to address issues with PSP meetings and initiate resolutions with various disciplines. The Facility also reported some outcomes in its POI that the Monitoring Team could not validate, including competency certification of a substantial number of QDDPs in facilitation skills. RSSLC also reported PSTs had completed identification of barriers to individuals living in the most integrated setting and action plans to address the barriers were being implemented. Observations and record reviews during this site visit did not fully support either of these contentions.
	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 assessment which follows represents a compilation and synthesis of the interdisciplinary findings of the Monitoring Team. **Provision F1:** The Facility continued to implement the "Supporting Visions" PSP process, which was intended to reinforce the concept that planning is intended to support the individuals' vision for the future. The Facility had received training in the revised Personal Focus Assessment in September 2011, a process that appeared to be improved in terms of person-centeredness. The Facility also reported all of its QDDPs had been certified in the Q-Construction facilitation skills, but competence in these skills was not always evident to the Monitoring Team. Overall, the Facility continued to devote considerable resources to

	training for QDDPs, an effort the Monitoring Team commends. The new PSP format and process was still meeting with limited success specific to the requirements of this section of the SA. The Monitoring Team found the quality of participation had improved in some instances, but no meaningful preparation was provided to ensure the PFA and/or PSP processes were conducted in a manner that facilitated real participation by the individuals. PST members sometimes came to planning meetings without a basic knowledge or awareness of an individual's current status or needs. In addition, PSTs often failed to conduct comprehensive assessments of 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. **Provision F2:** The Monitoring Team found there were some examples of improved integration observed in planning meetings and record reviews. Overall, however, PSPs lacked many of the criteria specified in the SA for this Provision. The Monitoring Team found under Provision S that some 77% of the skill acquisition programs reviewed reflected some form of a task analysis. This was a step forward for the Facility; however, PSPs still 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. RSSLC had developed a cross-disciplinary PSP/PST Committee to address issues with PSP meetings and initiate resolutions with various disciplines, a step the Monitoring Team commends. It is recommended the work of this committee be closely coordinated with that of the QA/QI Council and responsive to the QA findings. The Monitoring Team also found PSP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner, but was encouraged to find the Facility had developed an additional committee on Community Exposure that holds promise for improvement in this area. RSSLC had initiated enhanced training and mentoring of staff in relation to the development and implementation of skill acquisition training programs. However, based upon the observations and document reviews completed as part of the current site visit, it was evident that RSSLC still needed to make significant improvements in preparing staff to provide meaningful and functional supports and to implement active treatment effectively. The data system in use at the RSSLC to record QA monitoring activity and data, and array data for analysis, related to Provision F was much improved from that observed at the last monitoring review. The development of a data system that was consolidating data from monitoring and program auditing and producing compliance reports was impressive. The Monitoring Team was unable to validate whether this QA process was yet identifying and remediating problems to ensure that the PSPs were developed and implemented consistent with the provisions of this section of the SA. This process was relatively new and needed time to mature. RSSLC had developed a cross-disciplinary PSP/PST Committee to address issues with PSP meetings and initiate resolutions with various disciplines, a step the Monitoring Team commends. It is recommended the work of this committee be closely coordinated with that of the QA/QI Council and

	responsive to the QA findings.

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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:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	This provision was found to be not in compliance. The Qualified Developmental Disabilities Professional (QDDP) was the one person assigned to each individual to facilitate the work of each PST. The Facility continued to devote considerable resources to training, monitoring and coaching for QDDPs, an effort the Monitoring Team commends, including completion of Q Construction facilitation training. The QDDPs had completed the Q Construction Facilitator training and each been certified by the Facility as competent to act in this capacity. In the PSPs observed during this monitoring visit, the Facilitators exhibited varying levels of competency. For example, the QDDPs for both Individuals #51 and #124 did not state what specific Action Plans would be included in the PSP during the PSP meeting, leaving open the possibility that important strategies might fall between the cracks and be left out of the plan. The assigned QDDP also remained responsible for monitoring and revising treatments, services, and supports. The Monitoring Team found the QDDP did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below under Provision F2. RSSLC reported it was continuing to provide monitoring, coaching and training to the QDDPs in this area. The Monitoring Team commends the initiative of the Facility towards ensuring effective PSP meetings and planning and looked forward to seeing the longer term results at the next site visit.	Noncompliance
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	This provision was found to be not in compliance. Data reported in the PSP Attendance Tracking log presented to the Monitoring Team for review was insufficiently organized to determine if each individual's PST met the requirements of this component of the SA. For example, the log had listed attendance by discipline for 80 PSP meetings. Facility staff who tried to assist the Monitoring Team in understanding these data, and how to interpret it, were unable to do so. It was unclear if disciplines listed for each individual were required to be at the PSP meeting. A related document, "Discipline PSP Attendance" purports to compare the list of disciplines identified at a Personal Focus Assessment meeting as needing to attend the PSP meeting with those that actually attended. RSSLC staff were also unable to clearly describe how to	Noncompliance

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	individual's preferences and needs.	interpret these data. As an example, the PSP Attendance Tracking Log reported 100% of the PSPs included a direct care staff in attendance. The Discipline PSP Attendance report indicated that direct care staff was present at 88% of PSP meetings. The Monitoring Team found the quality of participation had improved in some instances. In one impressive example, the Lead Psychiatrist played an integral part in the interdisciplinary team process and provided some important modeling for PST members as to how to make the process more truly person-centered. She was instrumental in probing with the individual what was really important to and for the individual and asked questions in a way that was clear and meaningful to the individual. For example, the QDDP stated the PFA had resulted in three primary goals: to get a passport, to own a bicycle and to live in the community. She then asked the individual if these were correct. The lead psychiatrist asked the individual more directly what were the three most important things and the individual replied spontaneously with three things: to "get out of here," to have a home of her own, and to be with family. The team then began to discuss the steps to be taken to obtain a passport. The lead psychiatrist stopped the team again to discuss with the individual why a passport was desired and what could be done with it. While the team did not ever really grasp this vision or act upon it, the Monitoring Team was pleased to see some team members who appeared to understand its importance. Similarly, the individual said one of the most important things she wanted was a bicycle. The team began to discuss how to obtain the bicycle as well as what the individual would need to work on to be allowed to have the bicycle. The lead psychiatrist stopped the team to not only ask the individual why the bike was important, but to divert the team from making one of the individual's three most important objectives contingent on being compliant with going to work. In other instances, participation by other team members was limited. For example, the Monitoring Team continued to find Habilitation Therapies were not actively participating in the development of the PSP as evidence by lack of documented discussion or presence at the annual PSP. For example, as described under Provision R.1, only two of 21 individuals had a Speech Therapist present at the annual PSP. Meaningful participation by individuals themselves also remained very limited. Individuals with intellectual disabilities benefit from repeated and ongoing experiential activities in this area, as with many others, as opposed to once or twice a year. 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. A newly revised PFA process, as described in DADS Policy 004: Personal Focus Assessment, dated 09/01/11, appeared to be a better design for developing an understanding of an	

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		individual's preferences, strengths and needs, but it was not robust enough to facilitate an individual's real understanding and participation. The Monitoring Team recommends that the Facility implement a 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 QDDPs 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 process and meeting, making them 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. The Facility reported it was planning to revise RSSLC Policy F.18: Participating in Personal Focus Assessment Meeting, dated 4/20/11, to reflect the updates contained in DADS Policy 004: Personal Focus Assessment, dated 09/01/11. It should consider incorporating additional requirements such as those described above when making the revisions.	
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.	This provision was found to be not in compliance. The Monitoring Team found a lack of rigor in the assessment processes at RSSLC. This is particularly troubling since careful assessments must lay the groundwork for all protections, supports and services to be provided. The Monitoring Team found this to be a pervasive issue that merits immediate attention on the part of the Facility. Assessments were often not completed on a timely basis. Assessments by various disciplines are to be completed and filed in the shared drive 10 days prior to a PSP meeting. This would enable all PST members to review all assessments and prepare for interdisciplinary and integrated discussion at the PSP meeting. In nine assessment areas the assessment was late at least one-third of the time including key areas such as health risk assessment (late 100% of the time), medical summary (late 49% of the time), and psychological evaluation (late 37% of the time). This was a continuing concern as even for individuals who had upcoming PSPs, as not all assessments had been posted as required. On 10/26/11, the Monitoring Team reviewed the available assessments with QDDPs for Individual #386 and Individual #584. For Individual #584, whose PSP was scheduled for 11/8/11, of 7 required, 6 (86%) had been	Noncompliance

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		posted. For Individual #386, whose PSP was scheduled for 11/7/11 of 10 required, eight (80%) had been posted. The Facility reported it was going to revise RSSLC Policy F.05: Completing Planning Meeting Documentation, dated 10/24/10, to require that PSP assessments be completed 30 days prior to the PSP instead of the currently-required 10 days in order to ensure there is adequate time to follow-up if the assessments are not posted in time. It was also noted the PFAs were not consistently completed on a timely basis. The Monitoring Team noted that the PFA was completed by the third quarterly meeting as required for only one of three PSP meetings observed during the monitoring visit. The purpose for completion of the PFA meeting by the third quarterly was to allow the PST members to complete their assessments and develop their recommendations in light of individual's identified preferences. For example, for Individual #51, the PFA was not available to PST members at the third quarterly or even by the time of the PSP meeting. This defeated the purpose of the PFA providing guidance to the PST members towards developing a person-centered assessment. Assessments were not consistently completed routinely and in response to significant changes in individuals' lives. Examples described in Provision O4 included: • As described in Provision M2, of the last five individuals who transferred to the community, only one formal Nursing Discharge Summary had been completed at the time of the compliance review. • As described in Provision L1, for Individual #290, it was noted that the Individual was to start treatment for H-pylori infection of the stomach, on 7/12/11. There was no follow-up to assess efficacy of the treatment. Because of a 25 pound weight loss during the past seven months, an order was written for a GI consultation and possible endoscopy, on July 21, 2011. At the time of this review, the GI consultation had not been processed, resulting in over a four month delay in treatment. • As described in Provision J6, not all individuals who lived at the Facility had psychiatric evaluations in place. In the POI the Facility reported that 31 individuals who received services had not yet been evaluated. In addition, review during the current tour for results of Reiss Screen evaluation found that there were 28 individuals who had Reiss screens that indicated they needed psychiatric evaluation, but these had not yet been done. Assessments were not routinely of sufficient quality to reliably identify the individual's strengths, preferences and needs. PST members did not always take personal responsibility for ensuring they were aware of information needed to complete an accurate and thorough assessment. This was true across a number of disciplines.	

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		Examples included: • For Individual #58, the PSP did not provide a consistent assessment of the individual's status. It stated the individual's "overall behavior has also improved and that the LOS would be discontinued due to improved behavior." This statement was attributed to the behavior analyst present at the meeting. In the same document, it noted the individual had regressed in all target behaviors over the past year, but did not indicate what the behaviors of concern were. The individual had also been hospitalized less than one month prior to the PSP date for a variety of psychiatric symptoms and behaviors that included aggression, but all of these circumstances were not considered together in an overall assessment of current needs. • As described in Provision M2, although the Nursing Department continued to show progress in completing the Annual and Quarterly Comprehensive Nursing Assessments, they continued to contain some incomplete and inaccurate assessment data. As described in Provision L1, there was demonstrated a systematic failure in assessing chronic medical conditions.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	This component was found to be not in compliance. Current assessment practices at RSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, a PSP that outlines the protections, services, and supports to be provided to the individual. As described in F1c, assessments required to develop an appropriate PSP meeting were frequently not done in time for PST members to review each other's assessments prior to the PSP meeting, nor were assessments completed with sufficient thoroughness. Even when the results of this flawed assessment process were used in the development of the PSP, the PSTs did not consistently use the available results appropriately to develop, implement, and revise the PSP as necessary. For example: : • For Individual #160, the most recent speech assessment was in 2008. According to the PSP, that assessment made recommendations for strategies to improve receptive and expressive language vocabularies. None of these specific recommendations were integrated into any of the individual's Action Plans.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	This provision was found to be not in compliance. 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) specifically objects. The PST as a whole and the members individually, serve as the state's qualified professionals for this purpose. It was noted that team members at RSSLC had recently been provided clarification and training as to	Noncompliance

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		their individual responsibilities to make a specific recommendation about the most integrated setting. The Monitoring Team attended three PSPs and one PFA and also reviewed five PSPs completed since the new process began in 10/10, as measures of how this new process may have affected the PSTs' implementation of this requirement of the SA. Findings included some signs of progress, including: • For Individual #740, the team did make an independent professional determination of the most integrated setting appropriate to the individual's needs, even though it was counter to LAR preference. • For Individual #16, the PST had substantial concerns about the individual's safety in a community living setting due to severe PICA behaviors. These concerns were well documented in the PSP, and the PST decided the individual's appropriate most integrated setting would be RSSLC as a result. The PST then developed a well thought out series of Action Plan strategies to explore whether an appropriate community living option could be found. Overall, however, the PSTs were not completing PSPs in compliance with this provision of the SA. The Monitoring Team found evidence of recommendations regarding most integrated setting in the professional assessments for zero of five recent PSPs (0%) provided in response to item V.3 in the Document Request. The Monitoring Team found evidence of recommendations regarding supports and services specific to community living in the professional assessments for zero of these five (0%) recent PSPs. It was not evident that all of the trained QDDPs were competent in the facilitation of this discussion of most integrated setting at the PSP meeting. PST members, including facilitators, continued to need additional training in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs. It is recommended the PSP/PST Committee develop strategies in this area.	
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:	While integration was still lacking in many respects as described below, the Facility had developed some approaches toward enhancing the integration of supports and services in the PSP. In addition to the ongoing Supporting Visions and Q-Construction training, the Facility had included QDDPs in weekly integrated medical reviews and developed a PSP/PST Committee to address issues with PSP meetings and initiate resolutions with various disciplines.	
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two		

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	years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	This provision was found to be not in compliance. PSTs did not consistently address in the PSP each individual's prioritized needs, provide an explanation for any need or barrier that is not addressed, identify the supports that are needed, nor encourage community participation. Examples included: • For Individual #51, the PST focused on preferences, but not on any real vision for the kind of life the individual wanted to lead. This resulted in Action Plans like obtaining a passport, but these did not address the real and stated desire to travel to Mexico. • As described in Provision C7, for seven PBSPs reviewed, only one plan (14%) could be said to be based on the individual's strengths. • For Individual #58, the PSP listed the preferences and interests identified in the PFA, but did not prioritize the preferences that were most important to the individual. In the Integrated Discussion section, the second item indicated the individual would be referred to a program having to do with animals due to the individual's "love of animals," but this preference had not been identified in the preferences and interests that came from the PFA. On the other hand, the PFA had identified a number preferences related to preferred activities, such as arts and crafts, shopping, outdoor activities, and interaction with peers and staff. None of these were addressed in the integrated discussion. • As described under Provision S3, the Facility provided a variety of information pertaining to community outings, including both raw data and narrative information pertaining to community training, including memos, PSPs, and lists of participants, but no training data were provided, making a full evaluation of this provision impossible. A Community Exposure Committee had recently been formed to begin to attempt to create meaning and purpose for community integration activities. This was a new endeavor, which was to be commended for its intent. The Monitoring Team recommends that the PSTs should take the primary responsibility for specifying the purposes for community activities, including, for example, how these activities support preferences and personal goals, training needs for functional skills, and increasing community awareness. The PSTs should develop an integrated approach, including not only purpose, but types of activities and minimum frequencies, to facilitate this learning. PSTs did not always appropriately focus on the strengths of individuals, as required in this provision of the SA. The Monitoring Team observed that PSTs were not always respectful of individuals in terms of how they described or interacted with them, and this	Noncompliance

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		translated into PSPs that were more often deficit rather than strength-based, It is recommended the Facility develop an initiative to foster and promote person-centered thinking and People First language as a partial antidote to this concern. Examples the Monitoring Team encountered during the site visit included: • In some instances, individuals were told during PSP and PFA meetings they are "targeted for" certain behaviors rather than having a respectful discussion about why the manifested behaviors might occur, how they might interfere with an individual's desired outcomes and/or how the team could support an environment that would reduce the likelihood the individual might need to resort to the behaviors in the first place. • For Individual #156, the PST documented the individual liked to tell others what to do and that the individual therefore "thought he was a staff." The PST was also observed during the individual's PSP meeting to reinforce behaviors that would likely expose the individual to ridicule. The individual was encouraged by the PST in his desire to be a policeman and to posture as though he were writing tickets. While the team encouraged this behavior in the beginning of the meeting, it later became disruptive and very difficult to redirect toward functional skills. • Individuals were provided reinforcement through "Behavior Trips" and "Behavior Stores." While the intent of reinforcing individuals for exhibiting adaptive behaviors and skills was appreciated, these references are both demeaning to individuals and harmful to others' perceptions of the individuals.	
	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;	This provision was found to be not in compliance. As described under Provision S1, there was a modest degree of improvement noted in the skill acquisition programs at RSSLC during the current site visit. It was noted that in 30 records reviewed to evaluate progress under Provision S, 77% of the skill acquisition programs reviewed reflected some form of a task analysis. This was a step forward for the Facility; however, 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, meet needs. The PSP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. For example, Individual #124 had a service objective that stated the individual would enhance recreation and leisure skills, by being provided with opportunity to participate in a variety of recreation and leisure activities. No specific activities were provided. This lack of specificity appeared to result in no actual implementation of any purposeful strategies toward achieving the objective. For 31 days in August 2011, there were entries documented on only 13 days. Eleven of the	Noncompliance

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		entries indicated the individual was watching television, while the other two entries noted the individual was at a group home. Additional examples may be found under Provision F1, Provision T1a and Provision T1b1. The Monitoring Team also found PSP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner, but was encouraged to find the Facility had developed an additional committee on Community Exposure that holds promise for improvement in this area.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	This provision was found to be not in compliance. As described in Provision J8, the Facility demonstrated progress toward integrated treatment in certain venues. These include the initiation of a weekly Integrated Clinical Meeting (ICM), which is a multidisciplinary meeting that includes medical services, psychiatry, behavioral services, nursing, pharmacy, habilitation, nutrition, dental, QDDPs, residential services and other services impacting the individual's health. The PSP still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual. Examples included: • As described in Provision M3, the HMPs and ACPs did not contain integration with other relevant disciplines. Only occasionally was there documentation in the plans to refer to the PNMP and PBSP. • As described in Provision L1, there was very poor integration of health care issues by the PST. • For Individual #540, the PSP was not a cohesive document that integrated assessment information. The integrated discussion and assessments sections indicated only the Rights Assessment, PFA, FSA, Living Options and Annual Risk Assessments were discussed during the PSP planning meeting. The individual had many more assessments included in the PSP packet. In the supports and services section, it appeared that sections of the assessments had been inserted through a cut and paste process without any integration. For example, according to the accompanying assessments, the individual had a diagnosis of cervical spondylosis with central stenosis and he was at a high risk for injury as a result. The OT/PT assessment update identified various assistive devices to be used for prevention of injury. The PSP did not provide an integrated synthesis of the potential risk and the strategies in a manner that would allow a reader to understand how they related. In one section under supports and services (Physical and Nutritional Management), the PSP bulleted that one focus was to reduce the risk of injuries due to falls with assistive equipment. The next section, Assistive Equipment, listed the equipment but did not indicate how any	Noncompliance

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		of it was intended to reduce the risk of injury. Several sections later, under Movement Techniques, the PSP stated there were to be no personal restraints due to cervical changes. It was not until the Medical summary several sections later that actual diagnosis and related risk of injury was stated, and that section did not reference the potential nature of the injury or the interventions needed to minimize the potential for occurrence. • For Individual #632, there was little integration evident in the PSP. The integrated discussion section itself consisted of nine sentences that jumped from a listing of items he might like to his trust fund balance to his weight. There was no indication of how this related to the preferences identified in the PFA nor how any of the information in the integrated discussion would be used to develop Action Plans. • For Individual #740, the integrated discussion was divided into eight separate discipline-specific sections that were not tied together in any way.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	This provision was found to be not in compliance. The methods for implementation were not always clear. Examples included: • For Individual #124, the program plan for increasing hand washing skills states "When instructor provides no more than 2 verbal prompts, (the individual) will put soap on hands and wash it off." The methodology stated the instructor should begin providing the level of assistance at step 3 of the Task Analysis, which was to put soap on hands, yet the initial request to the individual was "rub your hands together." • As described in Provision S1, for Individual #193, instructions stated that data collection was to be conducted "M-F"; it was unclear if this indicated Monday through Friday or Monday and Friday. The data reflected that neither interpretation had been fulfilled as data had been collected only 10 times during the month on various days of the week, with only one documented occurrence of the individual refusing to participate. • Many of the program plans reviewed did not identify the staff responsible for implementation, indication only that an "instructor" should follow the methodology.	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	This provision was found to be not in compliance. The PSP did not consistently 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. For example, for Individual #540, the PST identified the obstacles to community living were the LAR's reluctance for alternate placement and the individual's lack of understanding of community options. The PST did not develop any Action Plan regarding the LAR's reluctance. The Action Plan for enhancing community awareness	Noncompliance

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	community settings; and	included a number of strategies, but most did not have any clear functional relationship to enhancing community awareness. Besides a plan to attend quarterly group home tours, the other strategies included: • A money management objective to provide varying levels of physical assistance to make a purchase, but with no instruction as to how this would be used to enhance awareness or even support identified preferences or choice-making. The objective did not indicate that the program should be implemented in the community. • A Domestic Skills program to provide varying levels of physical assistance to remove objects from a table, but with no instruction as to how this would be used to enhance community awareness. • To provide the individual with opportunities to participate in a variety of recreation and leisure activities to enhance recreation and leisure skills, but with no specific instructions as to activities that could be explored in the community. • To continue to have opportunities to color pictures, to play table games, to socialize with direct care staff, to attend the on-campus workshop, to take van rides and excursions, and to look at magazines. None of these included any instruction as to how these activities could be structured to enhance community awareness.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	This provision was found to be not in compliance. The PSP did not consistently identify the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review. The Monitoring Team reviewed training objectives data sheets which would indicate that programs and data collection were not implemented consistently, nor did staff comprehend what they were supposed to do. For example: • For Individual #747, the data collection methodology for many of the training objectives was unclear and the data collection implemented inconsistently. For example, the Facility provided a data sheet for review, dated 6/22/11-7/21/11, for a training objective to have the individual respond when asked how work had been with no more than one verbal prompt. The frequency of data collection was indicated to be Monday through Friday for the 30 day period, but only 13 data collection opportunities were documented. Of the eleven that actually had data, the data were consistently recorded as fading Sequence A, in which the instructor gave no more than one verbal prompt. The correct responses were summarized as 5 out of 5, which appeared to bear no relation to the eleven correct responses recorded. • Individual #747 had an objective to maintain optimal health through walking to and from the workshop on weather friendly days to assist with achieving his	Noncompliance

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		desired weight range. A data sheet provided for review was dated 5/22/11 to 6/21/11. For only five of the 24 days recorded (21%) did staff record the individual walked to or from the workshop. The remaining days recorded some other activity that included watching tv, listening to music and playing table top games, none of which would have contributed significantly to weight loss. It was not clear why staff entered such data, as alternate activities were not included as an option for this objective. It was also not clear if this indicated the individual did not attend the workshop for many of these days or, if not, why the individual did not attend. • As described under Provision S1, a data collection form for Individual #44 included four sets of initials under Fading Sequence A and one set under Fading Sequence B, for a total of five data entries. The summary at the bottom of the form indicted success by the individual on three out of four trials. It was not evident whether the correct number of trials had been miscalculated or if the data collection process was unclear. • As described in Provision J3, in many cases, PBSPs did not provide the information that was necessary for the Monitoring Team to understand how and why the medications used were part of the overall treatment plan.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision was found to be not in compliance. There was a lack of coordination observed in the coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the PSP, as described throughout this Provision F.	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.	This provision was found to be not in compliance. PSPs generally appeared to be accessible to staff in the group notebooks and staff were aware of where to locate these. For example based on interviews with five DCPs, in seven of seven (100%) interviews with staff, they were able to identify the location of the PNMP and/or mealtime plan. Observations and review of program data indicated that, in terms of outcomes, however, the PSP did not appear to be comprehensible to the staff responsible for implementing it, as there were many instances in which staff could not describe supports contained in the PSP or did not implement them as called for in the PSP. In addition to data collection issues described in Provision F2a6 above, examples included: • In two of seven (28%) interviews with staff, staff could describe individual-specific PNMP strategies. • In one of seven (14%) interviews with staff, staff could describe the schedule for implementation of PNMP strategies.	Noncompliance

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		• In two of seven (28%) interviews with staff, staff stated they had received individual-specific training for PNMP strategies. • Staff did not understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. This lack of knowledge results in individuals being placed at an increased risk due to lack of staff understanding of the rationale for implementing strategies listed in the physical and nutritional management plans or dining plans. If staff are unaware of these, they may not observe for and report related health concerns or ensure their actions do not contribute to these risks.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	This provision was found to be not in compliance. The PST did not consistently ensure assessment of progress on a monthly basis, or more frequently as needed, or make revisions if there was a lack of expected progress. The Monitoring Team found that Quarterly Reviews were often not completed in a timely fashion nor in a way that provided for meaningful evaluation of progress or program revision. It appeared the Facility was aware of this problem as it had been addressed in Integrated Program Monitoring Meeting Minutes in August and September, 2011. Examples encountered by the Monitoring Team included: • For Individual #363, the Monitoring Team requested, among other items, the Quarterly Reviews for the past six months. When this material was reviewed off-site, it was found that the Facility had provided the Quarterly Reviews for the periods of 1/11-3/11 and 6/11-8/11. It is unknown whether a Quarterly Review for the intervening months was completed. The most recent Quarterly Review contained very little specific information regarding the individual's progress. Most entries were of a vague nature, such as "overall progress noted," "continue to monitor," or "continue." There was no meaningful evaluation of the individual's responses and no actions taken to revise any program. • Individual #51 had a PSP meeting during the monitoring site visit, during which she discussed her personal vision to live in the community in her own apartment. The PST noted there might be a barrier related to a court commitment and that action would need to be taken to determine if that were the case. The Monitoring Team reviewed the previous year's PSP and found that an Action Plan for the same issue had been included. The Quarterly Reviews for the year consistently indicated no progress, but no actions or plans to take actions to meet the need were documented.	Noncompliance
F2e	No later than 18 months from the	This provision was found to be not in compliance.	Noncompliance

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	Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	As described in Provision F1a, the Facility's QDDPs had completed the Q Construction training for PSP facilitation and continued a continued to receive monitoring and coaching from the QDDP Coordinator and QA staff. While the Facility had deemed all of its QDDPs to be competent in these facilitation skills, this was not validated by the observations and PSP reviews made for this site visit. The Facility had recently implemented a new approach toward ensuring competency-based training for staff responsible for program implementation. Under this approach, the QDDPs were responsible for training the Residential Coordinators on individuals' programs who, in turn, were to provide competency-based training to DCPs and other staff responsible for program implementation. It was reported this change was effective as of 10/6/11. The Monitoring Team looks forward to reviewing the outcomes of this new approach at the next site visit. It was encouraging that RSSLC had initiated enhanced training and mentoring of staff in relation to the development and implementation of skill acquisition training programs. However, based upon the observations and document reviews completed as part of the current site visit, it was evident that RSSLC still needed to make significant improvements in preparing staff to provide meaningful and functional supports and to implement active treatment effectively.	
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.	This provision was found to be not in compliance. PSP meetings did not always occur within 365 days of the previous review. In reviewing the tracking log provided by the Facility the Monitoring Team identified 13 individuals (3% of the population) whose PSP meeting did not occur within 365 days of the previous PSP meeting. For the most part PSPs were put into effect within 30 days of the Individual's PSP meeting. A review of program data sheets showed that most programs initiated at a PSP meeting were first implemented within 30 days. The Facility did not have a mechanism to track this other than the monitoring/auditing described in Section F.2.g. The log presented from the Monitoring Teams document request to validate program implementation was confusing and after reviewing it with RSSLC staff it could not be used to measure PSP completion dates or data which would confirm a date that the PSP was put into effect. For the three new admissions, the Monitoring Team found that two of three (67%) PSP documents were completed with the 30-day requirement, but zero of three (0%) had all	Noncompliance

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		required components. For example, only one of three (33%) had a speech or communication assessment completed. In addition, it was noted that the Health Risk Screening, which is considered an integral part of the PSP, was not completed until after the PSP meeting for any of the three new admissions. The QDDP Coordinator indicated it was the expectation the Risk Assessment would be completed during the PSP for new admissions, and it was not clear why that had not occurred in these instances.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	This provision was found to be not in compliance. The data system in use at the RSSLC to record QA monitoring activity and data, and array data for analysis, was much improved from that observed at the last monitoring review. Section F of the SA was included in this system. Monitoring/auditing is done by unit staff (in reports this is referred to as "internal audits") and by QA Department staff (in the reports this is referred to as "external audits). Each auditor uses the same tool, which asks questions related to each Section F requirement of the SA. The Monitoring Tool was developed by the Monitoring Team two years ago and had been adopted by the RSSLC with little change. Monitoring was scheduled to occur at the frequency described in the Facility QA plan. From the data collected through monitoring/auditing a set of detailed reports were prepared by the QA Department. These reports included: • For each Individual's record selected for audit a tally of yes, no, N/A responses to each query on the monitoring tool. • For a given report time period the overall "compliance score" (recorded as a percentage) for each record audited during the time period. • A tally of these data by query (each question on the monitoring tool) that resulted in the identification of areas above, and below 80% compliance. These data could be used to identify areas in need of systemic improvement. It was reported to the Monitoring Team that the Facility had not yet begun an organized and consistent process to use these data to identify systemic issues. Data enumerated above were separately recorded for audits done by internal monitors (primarily unit staff) and external monitors (QA staff). Comparisons of results were displayed in graph form by month. This could facilitate analysis of improvement or regression of inter-rater reliability over time. Finally, the level of agreement between internal and external monitors, by question on the monitoring tool, and by month, was displayed. This could be used to determine if operational definitions of certain queries may be interpreted differently signaling a need to review each segment's methodology. From its review the Monitoring Team was able to determine that a QA system was in	Noncompliance

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		place for this section of the SA. The development of a data system that was consolidating data from monitoring and program auditing and producing compliance reports was impressive. The process for inter-rater reliability checks, and generally improving the accuracy of monitoring data was encouraging and seemed to be working well. This process, particularly the data reports, was relatively new and needs time to mature. The Monitoring Team was unable to validate whether the QA process was yet identifying and remediating problems to ensure that the PSPs were developed and implemented consistent with the provisions of this section of the SA. RSSLC had developed a cross-disciplinary PSP/PST Committee to address issues with PSP meetings and initiate resolutions with various disciplines, a step the Monitoring Team commends. It is recommended the work of this committee be closely coordinated with that of the QA/QI Council and responsive to the QA findings. The Monitoring Team looks forward to reviewing the continued refinement of these processes in its next review.	

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

1. Implement a curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. (Provision F1b)
2. The PSP/PST Committee should develop strategies around additional training in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs. (Provision F1e)
3. PSTs should take the primary responsibility for specifying the purposes for community activities, including, for example, how these activities support preferences and personal goals, training needs for functional skills, and increasing community awareness. The PSTs should develop an integrated approach, including not only purpose, but types of activities and minimum frequencies, to facilitate this learning. (Provision F2a1)
4. The work of the PSP/PST committee should be closely coordinated with that of the QA/QI Council and responsive to the QA findings. (Provision F2g)

The following are offered as additional suggestions to the Facility:

1. Develop an initiative to foster and promote person-centered thinking and People First language in order to ensure PSPs build on the strengths of individuals. (Provision F2a1)

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) dated 10/10/11 2. RSSLC Status Update presentation dated October 2011 3. RSSLC Presentation Book for Section G 4. RSSLC Policy I.29 Integrated Clinical Meeting 9/7/11 5. Consultation reports for Individuals #119, #239, #267, #354, #358, #518, #525, #531, #558, #640, #701, and #757 6. Minutes of Integrated Meetings of 10/21/11 for Individual #353 and 10/26/11 for Individual #694; IPN and PSPA about meeting for Individual #694 7. PSP for Individuals #680 and #694 8. PSP, Integrated Risk Rating Form (9/21/11), PFA, Psychiatric Medication and Behavior Modification Clinic reports (7/19/11, 8/12/11, and 9/20/11), PBSP (undated) and PSP Progress Note (10/5/11) for Individual #58 9. Example of Integrated Progress Note (IPN) for Individual #134 10. RSSLC blank Consultation Report 11. Email of 10/19/11 from David Taylor, Acting Director of Habilitation Services, to Tran Quan, M.D., Director of Medical Services listing "Hab Therapy Serviceq" (sic) 12. PSPs, CLDPs, and other documents reviewed by the Monitoring Team **People Interviewed:** 1. Tran Quan,M.D., Medical Director **Meeting Attended/Observations:** 1. PSP Annual Planning Meeting for Individual #60 2. At Risk Team Meetings for Individuals #58 and #680 3. Integrated Weekly Meeting for Individual #694
	Facility Self-Assessment: The Facility reported noncompliance with Provision G.1 and substantial compliance with Provision G. 2. The Monitoring Team concurs. For Provision G.1, the actions since the last compliance visit described in the POI related to two initiatives—suction toothbrushing and the Integrated Weekly Meeting. There was no indication in the POI of other actions to provide integrated clinical services or of any assessment in place to evaluate whether clinical services are being provided in an integrated manner. In interview, the Medical Director reported several other committees that address both systemic and individual issues. For Provision G.2, the Facility did not provide any information on how the provision was assessed for compliance but did report several actions taken. The policy for on/off campus consultations was revised to incorporate the new procedure into the PSP process and the nursing and Primary Care Physicians (PCPs)

	were trained on the new procedure.
	Summary of Monitor's Assessment: Integrated discussion among clinicians continues to improve at the Facility. The weekly integrated clinical meeting had evolved and included the QDDP. This meeting reviewed one individual per week; it would be important for the process to be replicated at the PST level so that integrated clinical planning would occur for all individuals. There were other indications of integrated clinical services, ranging from multidisciplinary involvement in several committees that reviewed individual cases or addressed systemic issues such as wound care and restraint reduction. However, there were also several examples throughout the report in which clinicians did not participate adequately in planning for individuals. Therefore, the Monitoring Team found Provision G.1 in noncompliance. The Monitoring Team found Provision G.2 to be in substantial compliance. The Facility has a format for responding to and identifying care plans arising from consultations. With one exception, Facility clinicians reviewed and documented decisions about recommendations from consultations.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility reported not yet being in compliance with this provision; the Monitoring Team concurs. The Facility reported actions taken to increase integration; these actions focused on involvement in committees addressing integration for both individual case planning and systemic issues. These included: • The Weekly Integrated Meeting that focuses on one individual with complex issues that need to be addressed. The Facility developed a policy to guide this process that began in December 2010; the policy explains the responsibilities of each committee member in the discussion, how the meeting operates, how to integrate the discussion into the PSP process (the Facility had, since the last compliance visit, initiated attendance by the QDDP with key PST members; discussion gets captured in PSPA and action plans), and physicians dictate note into medical record as IPN. • Several disciplines participate in the Behavior Support Committee. • The Wound Care Committee/Skin Integrity Committee involves medical, nursing, nutrition, and habilitation staff. • The Medication Variance Committee involves several disciplines. • The Restraint Reduction Committee involves medical, psychiatry, behavioral, rights, nursing, administration, ombudsman, and community representation.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Other than the listing of the memberships of the committees, no information was provided to document formal actions to increase integrated discussion and planning or outcomes that show integration of interventions or changes in systems. However, the Monitoring Team identified examples of such integration. • As reported in Provision M.1, there was documented evidence in records of individuals with skin integrity issues that the Wound Care Nurse collaborated with other relevant disciplines to provide integrated care. • As reported In Provision Q.2, the dental office was currently working with the behavioral health department on collecting and assessing behavioral data on all individuals regarding oral hygiene and dental care. The Monitoring Team was also made aware that dental programs to minimize use of sedation and restraint, including desensitization, were being addressed by the newly hired director of Behavioral Services.. To facilitate the implementation of desensitization programs at the Facility, the Monitoring Team also noted that the dental office assisted with the implementation of desensitization programs by enabling individuals to participate at the dental office as part of their desensitization program. • Physical and Occupational therapists completed Annual physical therapy (PT) and occupational therapy (OT) assessments and updates collaboratively. However, there were also numerous areas in which integrated planning was not yet occurring. For example: • As reported in Provision M.1, the Health Maintenance Plans (HMPs) and Acute Care Plans (ACPs) did not contain integration with other relevant disciplines except for occasional documentation in the plans to refer to the PNMP and PBSP. • Habilitation Therapies were not actively participating in the development of the PSP as evidenced by lack of documented discussion or presence at the annual PSP. This was particularly true for Speech Therapists. As indicated in the next bullet, there were numerous areas in which Speech Therapists could have assisted other disciplines in planning interventions. • Although the Acting Director of Habilitation Services reported speech therapy collaborates with behavior services to develop communication strategies for individuals with behavior problems, the Monitoring Team did not find evidence that this was routine. As reported in Provisions R.1 and R.2, speech therapists were not involved in planning of positive behavior support plans (PBSPs)—although Provision J.8 provides an example in which this occurred--.and skill acquisition programs, nor with identification and treatment of cognitive disorders such as difficulty sequencing and/or memory issues that could be addressed. For persons receiving behavioral supports or interventions, the Facility did not have a process designed to identify who would benefit from AAC	

#	Provision	Assessment of Status	Compliance
		or speech assistance. The potential for the behavior to serve as communication was not consistently included as part of the behavioral assessment and Speech assessment process. The Monitoring Team reviewed RSSLC Policy I.29 Integrated Clinical Meeting, and several members of the Monitoring Team observed the Integrated Weekly Meeting held during the compliance visit. The policy stated that one individual is reviewed weekly, described how an individual is referred and selected, identified documentation to be done, and listed the departments to participate. Minutes of two meetings reviewed by the Monitoring Team showed that many disciplines, but not all listed in the policy, were present. Minutes of the meeting of 10/21/11 listed several participants and then stated "and all other members of the PST team." A general statement of that sort does not make clear who actually attended. The PST is defined to include the individual and LAR, if any. Furthermore, as speech therapists had not attended most PSP meetings, it was unclear whether a speech therapist was considered part of the PST for this individual. The minutes need to be specific about who participates in these meetings. Participation during the 10/26/11 meeting was active and included many of the staff in attendance. The discussion not only covered issues of concern about this individual but also led to discussion of a systemic issue related to a move this individual and others made to a different unit. Including this individual, five of six people who made this move lost weight. This was not noted by the participants in the meeting but was pointed out by the Monitoring Team; as a result, a plan was developed to review issues that could affect weight, such as increased activity level (something noted and reported in Section S as a positive finding) and differences in mealtime practices. The minutes, IPN, and PSPA noted assessment of active treatment/day programming and mealtime practices would be assigned to the QDDP. This process did bring together a number of disciplines to review the individual and to plan actions in an integrated way. It provides this opportunity for only one person per week. It is important for the process to be replicated at the PST level for people whose issues may not be as complex or who cannot be scheduled for the weekly meeting. A draft DADS statewide policy had also been available for a number of months. 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.	

#	Provision	Assessment of Status	Compliance
		To summarize, this provision is not in compliance. Steps have been taken to increase integrated planning. These processes need to spread throughout the planning of clinical services for all individuals served.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The Monitoring Team reviewed 24 consultations for 12 individuals to determine whether a Facility clinician reviewed the recommendations and documented adoption or referral to the PST. For 23 consultations (96%), there was documentation of review, usually by initial and date. For 22 of the 23 reviewed consultations (96%), there was evidence in the record (through IPN notes or physicians orders) of acceptance of the recommendations; for one of the 22 accepted recommendations, there was no evidence the PST addressed the recommendation or that the recommendation was implemented, although it had been accepted by the clinician. The Facility continued its procedure that required that consult and recommendation forms be given to the QDDP and Nurse Case Manager. The Facility had developed a standardized Consultation Form that identified whether the recommendation was approved, rejected, or other and included a place for Plan of Care. As the sample did not include any examples of recommendations that were rejected, the Monitoring Team could not determine what would happen in such a case. At the last compliance review, a rationale or alternative plan was provided for one rejected recommendation, and one was referred to the PST. The Monitoring Team finds the Facility is in Substantial Compliance with this provision. Nevertheless, the Monitoring Team recommends the Facility develop a process to ensure documentation of recommendations and care plans using the Consultation Form is completed and that the PST acts on those recommendations.	Substantial Compliance

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

1. Consider initiatives to replicate the integrated discussion process of the weekly meeting at the PST level for people whose issues may not be as complex or who cannot be scheduled for the weekly meeting, including clear documentation of actions to be taken and staff responsible. (Provision G1)
2. Provide training, review and mentoring, or another process to assist clinicians to develop integrated case formulations and treatment recommendations and to develop documentation that clearly demonstrates this integration in PSPs and the active record. (Provision G1)

The following are offered as additional suggestions to the Facility:

1. Develop a process to ensure there is documentation of review of all consultations and that the PST acts on those recommendations.

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) dated 10/10/11 2. RSSLC Status Update presentation dated October 2011 3. RSSLC Presentation Book for Section G 4. RSSLC Policy I.31 Chronic Clinical Indicators (10/12/11) 5. Copies of Power Point presentation on Observing and Reporting Clinical Indicators of Health Status Change 6. PSPs, CLDPs, and other documents reviewed by the Monitoring Team **People Interviewed:** 1. Tran Quan, M.D., Medical Director **Meeting Attended/Observations:** 1. PSP Annual Planning Meeting for Individual #60 2. At Risk Team Meetings for Individuals #58 and #680
	Facility Self-Assessment: The Facility reported it was not yet in compliance with any provision of this Section. The Monitoring Team concurs. The Facility did report several actions to meet requirements of this Section. Several actions were listed under several provisions. One set of actions showed a sequence of activities that built on each other; these involved the development of an acute clinical indicators policy, data form, monitoring, and inclusion in individuals' records; however, that has been inactivated pending State Office involvement. The Facility reported development of indicators of chronic conditions and of policy for a weekly clinical meeting. The Monitoring Team verified these had been done.
	Summary of Monitor's Assessment: The Monitoring Team found all provisions not yet in compliance. Nevertheless, the Facility had made extensive efforts to develop clinical indicators and standards of practice for chronic conditions. Adequacy and timeliness of assessments remained problematic. Assessments were not always done when there were changes in health status, and both routine assessments and assessments for chronic conditions were not consistently comprehensive. Assessments did not provide results that could adequately be used to develop, implement, and revise as necessary, a PSP that outlines the protections, services, and supports to be provided to the individual. In summary, there had not been significant improvement in the assessments, either in timeliness or comprehensiveness, but there had been a great deal of activity that may improve the use of clinical

	indicators to identify and establish treatment when there is a change in health status or a chronic condition. Furthermore, the Facility did not have a plan or procedure in place to ensure or monitor that treatments and interventions were implemented timely. Diagnoses were generally in current DSM or ICD format, but there was not always documentation of clinical rationale or follow-up diagnostics. The development and use of clinical indicators of efficacy of treatments and interventions had resulted in improvements in some areas but was still too recent to show routine implementation or effects on health status. The Facility had begun to identify clinical indicators of chronic conditions. Policy I.31 Chronic Clinical Indicators had been implemented. This policy established a process by which chronic disease topics would be researched and standards of care recommended. The Facility had established a pilot QA project to track diabetes. A database had been populated, and graphs of some indicators were available. As this process evolves, the Facility will need both to ensure the reports and graphs provide the most important information in easily understandable formats and to expand to additional conditions. Nurse Educators had implemented the State's mandated Clinical Indicators for Health Status Change Class and had trained all of the 619 incumbent staff. They had begun teaching this class at New Employee Orientation.

#	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.	Adequacy of assessments and evaluations remained problematic at this visit. Throughout this report, there are examples in which assessments were not routinely completed on a timely basis. As reported in Provision F1d, current assessment practices at RSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, a PSP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate PSP meeting were frequently not done in time for PST members to review each other's assessments prior to the PSP meeting, nor were assessments completed with sufficient thoroughness. Examples include: • As reported in Provision O.2, five of 27 individuals (19%) were provided with a comprehensive assessment by the PNM team or relevant Habilitation therapist that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. Furthermore, zero of five (0%) individuals who were diagnosed and/or hospitalized with a PNM issue were assessed by the	Noncompliance

#	Provision	Assessment of Status	Compliance
		PNMT or PST. • There were 28 individuals who had Reiss screens that indicated they needed psychiatric evaluation, but these had not yet been done. • The PST started the assessment process within five working days of the individual initially being identified as at risk for two of 16 (13%) sampled individuals. • Nursing assessments, both quarterly and annual, were generally completed timely. However, although both timeliness and quality had improved, they continued to contain some incomplete and inaccurate assessment data. As reported in Provision F.1d, even when assessments were completed, the PSTs did not consistently use the available results appropriately to develop, implement, and revise the PSP as necessary. The Facility had taken action to improve timeliness of psychological assessment by hiring an individual to fulfill the role of completing intellectual and adaptive testing and write Psychological Assessment reports. She had just completed new employee orientation, so it was not possible to see examples of her work. Assessments of newly admitted individuals were not consistently done timely, as the following indicate: • OT/PT assessments screenings were completed within 30 days of admission for those individuals who were newly admitted. Assessments indicated whether or not the individual required OT/PT supports and services. • One of three newly admitted individuals received a communication assessment or screening within 30 days of admission.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Psychiatric diagnoses were generally in the DSM IV format, except that the psychiatric diagnoses listed in the Active Problem Lists for four individuals (#27, #29, #152, and #615) were not in the DSM format. Furthermore, as reported in Provision J.2, there were a significant number of Not Otherwise Specified (NOS) or Rule Out psychiatric diagnoses. When such diagnoses were resolved, there was often no clear documentation of the clinical thinking. Medical diagnoses were consistent with the current version of ICD. Medical diagnoses generally fit the corresponding assessments and evaluations. However, as reported for some cases in Provision L.1, there were times when additional diagnostics might have provided valuable information but were not ordered or were not carried out when ordered.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In some cases, diagnoses were not documented consistently throughout an individual's record. For example, for Individual #239, psychiatric diagnoses of the treating psychiatrist were different than those cited on the Active Problem List.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The Facility did not have a plan or procedure in place to ensure or monitor that treatments and interventions were implemented timely. Several examples were provided in Provision L.1 showing lack of adequate and timely follow-up to diagnostic findings. Provision O.2 reports that assessments were not adequate to ensure appropriate treatments and interventions would be provided. While interventions were included in the assessments, few PNM assessments reviewed contained clear investigation as to why interventions (e.g., adaptive equipment, bed elevation) were appropriate. Provision K.9 reports examples of prolonged delays in implementation of behavioral programs as well as concerns that assessments were not adequate to ensure appropriate interventions.	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The development and use of clinical indicators of efficacy of treatments and interventions had resulted in improvements in some areas but was still too recent to show routine implementation or effects on health status. The Facility had begun to identify clinical indicators of chronic conditions. Policy I.31 Chronic Clinical Indicators had been implemented. This policy established a process by which chronic disease topics would be researched and standards of care recommended. For each, a database is to be developed to track and analyze data on chronic conditions. The policy describes a quarterly medical data analysis meeting for each chronic disease tracked. The policy also states "The Individual's Personal Support Team (PST) attends the medical data analysis meeting and the QDDP documents the meeting in an addendum and makes action plans as needed." Although the involvement of the PST is a welcome and important aspect of the process, it was unclear how the data analysis meeting, which appears to involve review of all individuals with a specific chronic condition, would involve PSTs for each individual. The Facility should review the policy and clarify how facility-wide review and review of individuals are done. The Facility also provided chronic condition documents for several conditions. These included clinical guidance, indicators such as labs, and information about the conditions. The formats of these reports varied across conditions. Although these provided a good start, it would be important to develop a standardized format to ensure the crucial issues are covered.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility had established a pilot QA project to track diabetes. A database had been populated, and graphs of some indicators were available. For example, there was a monthly average graph of Hgb A1C for all individuals with diabetes and graphs of percent of individuals taking specific medications and of individuals who have particular complications. As this process evolves, the Facility will need both to ensure the reports and graphs provide the most important information in easily understandable formats and to expand to additional conditions. The Facility reported it had begun implementation of an Acute Clinical Indicator Form for each individual and a monitoring process for these forms. However, this form and process were inactivated "per request of State Office." The Monitoring Team understands also that DADS continues the process of developing clinical indicators of health status and guidelines for care. As reported in Provision M.4, the Nurse Educators had implemented the State's mandated Clinical Indicators for Health Status Change Class and had trained all of the 619 incumbent staff. They had begun teaching this class at New Employee Orientation. The objectives for the Class were to train support staff how to identify common clinical indicators (signs and symptoms), and respond and report changes in individuals' health status. These initiatives were still in early stages but hold potential for helping the Facility make decisions on systemic changes and establish standard medical care practices. Nevertheless, at this time, the Monitoring Team found examples in which clinical indicators were not identified or were not used to identify efficacy of treatment. For example: • As reported in Provision I.3 about risk plans, none of the sampled plans included appropriate and measurable objectives to allow the PST to measure the efficacy of the plan. • As reported in Provision O.7, while PNMPs were reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at a high risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). Examples of positive steps in implementing and using clinical indicators include the following: • The Facility adequately collected and presented data to physicians, P&T committee, and at Psychiatric Medication and Behavior Management Clinics, on	

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		the use of STAT medications, • For PT and OT interventions, The interventions in place were well documented and had established measurable and functional goals. The Aspiration Trigger Data Sheet provides an example of both a promising procedure and difficulties in implementation. The Aspiration Trigger Data Sheet was implemented for the individuals who had an aspiration event in the past two years or who were enterally fed. The tdata sheet was designed to monitor the presence or absence of triggers related to potential aspiration. The development of this data sheet is a positive step forward in better being able to identify signs and symptoms. However, there was a lack of individualized triggers. Aspiration trigger data sheets contained information that was not relevant to the individuals (i.e., an individual who eats by mouth had a trigger that states to watch for formula in the mouth) and therefore there was a lack of clinical indicators being assessed and monitored for individuals. The Facility had made significant progress. Establishment of clinical indicators and clinical guidance across the Facility for both acute and additional chronic conditions will bring the Facility closer to compliance with this provision. The Facility will need to develop procedures to ensure implementation is occurring.	
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.	One approach used by the Facility to monitor the health status of individuals was the risk assessment process implemented in January 2011. Although this process holds promise for monitoring and addressing health status in an integrated manner, the PSTs were still learning how to address risks accurately and effectively. In several sections of this report, there are examples in which risk was not re-evaluated following risk incidents (for example, on return from hospital) or where risk levels were not assigned accurately. A second means for monitoring health status is the monitoring of implementation of treatments and interventions. 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: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • 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 • Evidence that results of monitoring activities in which deficiencies are noted are	Noncompliance

#	Provision	Assessment of Status	Compliance
		formally shared for appropriate follow-up by the relevant supervisor or clinician. The chronic care database for diabetes provides a possible approach to identify and track clinical indicators of health status both for individuals and systemically. It is still in an early stage and limited to diabetes; the Monitoring Team will be interested in seeing how this evolves. Another critical area for monitoring status is Physical and Nutritional Management (PNM). A QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team did not exist. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The Facility did not have clear guidance on the use of clinical indicators or on when treatments and interventions should be modified. In the medical arena, DADS is working on selecting or developing clinical pathways, which should include such guidance. The chronic condition indicators and process being developed by the Facility could also provide this guidance. Currently, though, there were examples in which treatments and interventions were not modified when indicated. For example, Behavior Services staff and the PST at times failed to recognize when data suggested undesired behavior to be worsening. The following examples were noted: • For Individual #17, target behaviors had increased beginning in May 2011. Documentation did not reflect any attempt to analyze the change in behavior in order to identify and implement any necessary changes to the treatment plan. • For Individual #440, despite increases in the target behavior, progress notes for several months stated that the individual continued to make progress. Neither recent behavior trends nor a comparison with baseline reflected any evidence of improvement. Provision L.1 provides examples of lack of aggressive follow up to chronic conditions. For example: • Individual #124 had degenerative disease of the cervical spine and worsening loss of ambulation and transfer skills, but this did not lead to follow-up and assertive management.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with	A draft DADS state policy addressed provisions G and H together. The policy was not yet completed or disseminated. The majority of the policy addressed section H and appeared	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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). RSSLC had implemented a policy to address chronic clinical indicators shortly before the compliance visit. The Monitoring Team looks forward to reviewing the implementation of this policy at the next compliance visit. In addition, as reported in Provision M.4, the Facility had implemented training for direct care staff on how to observe and recognize indicators of health status change. The training included guidelines for reporting and documentation. The Monitoring Team was not provided information on when the training was provided but encourages the Facility to ensure that it is periodically provided as a refresher.	

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

1. Develop means to monitor and ensure that interventions and treatments are implemented timely. (Provision H.5)
2. Periodically provide refresher training on observing and reporting indicators of health status change. (Provision H.7)
3. For the Chronic Clinical Indicators policy, clarify how facility-wide review and review of individuals are done. (Provision H.4)

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) 10/10/11 2. RSSLC Policy At-Risk Individuals 2/18/11 3. RSSLC Policy D.23 Using Bed Rails (3/16/06) 4. DADS At Risk Policy 006.1 (1/1/11) 5. Integrated Risk Rating Form for Individuals #58 and #680 6. Samples of completed Health Risk Assessment Rating Tools 7. Record reviews of Individuals #7, #58, #84, #173, #233, #239, #320, #353, #372, #513, #558, #621, #625, #630, #723, and #791 8. Records review specific to aspiration/choking for Individuals #84. #162, #173, #372, and 558 9. List of all Individuals using bedrails 10. September, 2011 Work Order Log 11. Bedrail Safety at Richmond SSLC 10/27/11 12. Section I At Risk Individuals Trend Analysis Report 9/30/11 **People Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. David Taylor OTR 3. Sally Martinez RN 4. Wilma Parker RN 5. Robyn Partridge, RN **Meetings Attended/Observations:** 1. Meal observations on Trinity, Leon, and San Antonio 2. Risk Assessment meetings for Individuals #58 and #680 3. PSP Annual Meeting for Individual #60
	Facility Self-Assessment: The Facility's self-assessment reported the RSSLC was not in substantial compliance with any provision of this section of the settlement agreement (SA). The Facility's POI did not offer a rationale for its self-assessment rating. RSSLC's monitoring/auditing of this section of the SA reported significant implementation issues. Monitoring done by staff external to the QA Department reported an overall compliance rate of 77%. Monitoring done by the QA Department reported an overall compliance rate of 2%. The review completed by the Monitoring Team suggests that the QA Department monitoring is much more reflective of actual performance than the monitoring done by others. The Monitoring Team's review substantiated the Facility's self-assessment of lack of compliance with this section of the SA.

	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, had been initiated. The implementation of at-risk procedures at the RSSLC was ineffective as described in Provisions I.2 and I.3. Policies and procedures appear to be misunderstood in many cases, and not followed in others. For example, RSSLC's monitoring of this section of the SA reported significant implementation issues, many of which may result from inadequate training of those responsible for implementation. Monitoring done by staff external to the QA Department reported an overall compliance rate of 77%. This may indicate that staff believes, that for the most part, they are implementing the at-risk policy correctly. Monitoring done by the QA Department reported a compliance rate of 2%. This may indicate the QA Department does not believe staff understands the policy with sufficient scope and depth to provide for effective implementation. The review completed by the Monitoring Team suggests that the QA Department monitoring is much more reflective of actual performance than the monitoring done by others. The Facility's risk assessment process did not assess risk associated with the use of bedrails. Nearly 50% of the individuals living at the RSSLC used bedrails. Because of the potential for entrapment, the use of bedrails presents an inherent risk to individuals. During residential tours the Monitoring Team observed many beds with mattresses and bedrails that presented an entrapment danger. Additionally, many bedrails in use at the RSSLC appear to be in need of regular repair or replacement. Use of bedrails is not listed as a required area of risk assessment in State policy but the Facility has the option to include it in the "other" category. The RRSLC processes to demonstrate compliance with this section of the SA continue to be insufficiently organized to achieve compliance with this section of the SA. The statewide risk assessment procedure, with guidelines for rating risk, had been in use for at least nine months. However, in nearly 90% of records sampled, risk assessments were not conducted within five working days of risk identification or a change in circumstances. This data is nearly identical to data reported in the prior review indicating little improvement. 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.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18	The RSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Facility's POI did not offer a rationale for its self-assessment rating.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 statewide risk assessment procedure, with guidelines for rating risk, had been initiated. The implementation of at-risk procedures at the RSSLC was ineffective as described in Provisions I.2 and I.3. Policies and procedures appear to be misunderstood in many cases, and not followed in others. For example, RSSLC's monitoring of this section of the SA reported significant implementation issues, many of which may result from inadequate training of those responsible for implementation. Monitoring done by staff external to the QA Department reported an overall compliance rate of 77%. This may indicate that staff believes, that for the most part, they are implementing the at-risk policy correctly. Monitoring done by the QA Department reported a compliance rate of 2%. This may indicate the QA Department does not believe staff understands the policy with sufficient scope and depth to provide for effective implementation. The review completed by the Monitoring Team suggests that the QA Department monitoring is much more reflective of actual performance than the monitoring done by others. The Monitoring Team observed one PSP meeting specifically to assess the adequacy of the risk assessment process. Appropriate disciplines necessary for the risk discussion were present and the staff present at the PSP was the actual staff that worked with the individual. This included Direct Care Professionals. The individual was also present at the PSP meeting observed by the Monitoring Team. The PST used the Risk Level Guidelines established as part of the state procedure for assessing and managing risk when determining risk levels for the PSP meeting observed by the Monitoring Team. The PSP meeting observed by the Monitoring Team included open discussion among PST members including presentation and discussion of clinical data. There was clinical discussion among appropriate team members in decisions regarding risk. The team provided adequate justification of designated risk levels. There was little discussion addressing how risk impacted potential alternative placement, or affected the daily life of the individual. The PSP facilitator kept the team discussion focused. The Monitoring Team conducted a review of five records of individuals who experienced an aspiration or choking event. None of five (0%) records reviewed accurately identified individuals who were at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individual #84, #558 and #173 were identified as being at a "medium risk" of aspiration but per risk assessment guidelines should have been listed at "high risk" due to recent aspiration events. • Individual #372 and #558 were identified as being at a "medium risk" of choking	

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		but per risk assessment guidelines should have been listed at "high risk" due to a recent choking event. • Individual #162 experienced over five falls in the last 6 months and suffered two injuries that resulted from the falls but was listed as "low risk." The PST had the ability to lower the risk rating; however, there was no evidence in the records reviewed of a rationale supporting the lower risk score. Failure to properly identify individuals at increased risk results in an increased likelihood that care will reactive rather than proactive. Based upon observations and the samples reviewed RSSLC was not identifying individuals appropriately as it relates to their level of risk thus increasing the likelihood that individuals at risk were not being provided the services needed to manage or mitigate risk. An issue identified by the Monitoring Team was the lack of consistency in identifying individuals who were diagnosed with pneumonia. The Monitoring Team requested a list of individuals who were diagnosed with pneumonia and received two conflicting lists. Per report, one list was pulled from the hospital admit list and the other was pulled from the hospital discharge diagnosis list. RSSLC was made aware of the issue and stated that this would be addressed. Accurate information is needed to provide what the Facility needs to monitor whether risk is being accurately identified as well as to provide guidance to PSTs in rating risk. The Facility's risk assessment process did not assess risk associated with the use of bedrails. Nearly 50% of the individuals living at the RSSLC used bedrails. Because of the potential for entrapment, the use of bedrails presents an inherent risk to Individuals. During residential tours the Monitoring Team observed many beds with mattresses and bedrails that presented an entrapment danger. These observations were primarily in the Trinity unit. Additionally, many bedrails in use at the RSSLC appear to be in need of regular repair or replacement. The Facility provided the Monitoring Team with a "work order log" that reported 16 instances of repair/replacement in September. Extrapolated this would project to nearly 200 instances over the course of a year. Use of bedrails is not listed as a required area of risk assessment in State policy but the Facility has the option to include it in the "other" category. Facility policy D.23 (Using Bedrails) required that RNs ensure that bedrails meet standards for fit and safety. The Facility was unable to produce any evidence that this fit and safety review occurred in any systematic manner that could be documented. The Policy also required that the PNMP Coordinator, along with the RN, train staff on the use of bedrails including the risk of entrapment. The Facility was unable to produce any evidence that this training occurred in any systemic manner that could be documented.	

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		The Facility needs to engage in a series of activity that represent a bedrail safety program. Also, to decrease risk associated with bedrail use the Facility should explore some of the bed/mattress products currently available that can eliminate the need for bedrails, and/or improve the likelihood of safe use. The Monitoring Team provided the Facility with web-based information to assist in this process. In response to concerns raised during the review by the Monitoring Team the Facility presented a document describing current and planned bedrail safety practices and proposed steps to enhance and improve practice. The Monitoring Team looks forward to reviewing documentation associated with these processes at the next review. 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 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. The Facility's POI did not offer a rationale for its self-assessment rating. Review of 16 records for individuals initially determined by the PST to be at risk (Individuals #7, #58, #84, #173, #233, #239, #320, #353, #372, #513, #558, #621, #625, #630, #723, and #791) showed there was documentation that the PST started the assessment process as soon as possible but within five working days of the individual initially being identified as at risk for two (13%) individuals. Records that did not contain documentation of this requirement included: Individuals #7, #58, #84, #173, #233, #239, #320, #353, #372, #513, #558, #621#630, and #791. The records of these 16 individuals were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. There were examples of risk events or changes in status. When anything about an individual's life changes in a manner that would likely effect risk status the PST must start an assessment process as soon as possible but within five working days of the individual changes. In the Monitoring Team's sample of 16, an at-risk condition for two (13%) individuals had changed since the initial identification of risk and assessment that followed. In one of those two (50%) the assessment process related to the change in circumstance was initiated within 5 days. This was for Individual #723. Based on a review of records of a sample of 6 individuals (Individuals #58, #233, #239, #621, #625, and #723) for whom assessments had been completed to address the	Noncompliance

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		individuals' at risk conditions, four (67%) included an adequate nursing assessment to assist the team in developing an appropriate plan. The records that did not contain documentation of this requirement were for Individuals #58 and #621. The following provides an example of an assessment that was not comprehensive: the assessment for Individual #58 did not contain adequate rationale in all risk categories from various disciplines to provide information from which an accurate assessment of risk could be logically determined. The only data evident to the Monitoring Team was a list of current medications and previous diagnoses. Based on a review of records of an additional sample of four individuals (Individuals #84, #173, #372, and #558) 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. The following provides an example of an assessment that was not comprehensive: Individuals #372 and #558 were identified as being at a "medium risk" of choking but per risk assessment guidelines should have been listed at "high risk" due to a recent choking event. No rationale was provided for a lower risk rating. Based on a review of records of six individuals (Individuals #7, #320, #353, #513, #630, and #791) with polypharmacy risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included a risk assessment to assist the team in developing an appropriate plan. Separate from the records reviewed for data tabulation the Monitoring Team identified other issues. Zero of five (0%) individuals who were diagnosed and/or hospitalized with a PNM issue were assessed by the PNMT or PST. For example: • Individual #372 had a choking event on 5-6-11. On 5-9-11, the OT conducted an observation but there was no evidence of a tableside swallowing assessment. • Individual #84 was diagnosed with aspiration pneumonia on 6/12/11 and 6/30/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the PST meeting to discuss the event but the discussion was limited to what had already occurred and did not focus on potential indicators or triggers that led to the aspiration event as well as the need for assessment. In this case, the individual vomited and had emesis in bed on 6/12/11 but there was no evidence that a bed positioning assessment ever occurred or was discussed. Emesis and vomiting occurred a second time on 6/30/11. • Individual #173 was diagnosed with aspiration pneumonia on 7/31/11 but there was no evidence of comprehensive reassessment upon return from the hospital or while in the infirmary. The PST met on 8/15/11 and simply stated to	

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		continue with plan.	
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. The Facility's POI did not offer a rationale for its self-assessment rating. Based on a review of 12 records for individuals determined to be at risk (Individuals #7, #58, #233, #239, #320, #353, #513, #621, #625, #630, #723, and #791), 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 six (50%)) cases. Records that did not contain documentation of this included: Individuals #7, #239, #320, #353, #630, and #791. ▪ Implemented a plan that met the needs identified by the PST assessment in zero (0%) cases. Records that did not contain documentation of this included: Individuals #7, #58, #233, #239, #320, #353, #513, #621, #625, #630, #723, and #791. ▪ Included preventative interventions in the plan to minimize the condition of risk in two (17%) cases. Records that did not contain documentation of this included: Individuals #7, #58, #233, #239, #320, #353, #621, #625, #630, and #791. ▪ When the risk to the individual warranted, took immediate action in zero (0%) cases. Records that did not contain documentation of this included: Individuals #7, #58, #233, #239, #320, #353, #513, #621, #625, #630, #723, and #791. ▪ Integrated the plans into the PSPs in two (17%) cases. Records that did not contain documentation of this included: Individuals #7, #58, #233, #320, #353, #621, #625, #630, #723, and #791. ▪ In three (25%), 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 #7, #58, #233, #239, #353, #625, #630, #723, and #791. ▪ In zero (0%) 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 #7, #58, #233, #239, #320, #353, #513, #621, #625, #630, #723, and #79. ▪ Included the clinical indicators to be monitored and the frequency of monitoring in zero (0%) cases. Records that did not contain documentation of this included: Individuals #7, #58, #233, #239, #320, #353, #513, #621, #625, #630, #723, and #791. None of the risk plans reviewed by the Monitoring Team were adequate to meet the	Noncompliance

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		Individual's needs.	

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

1. The Facility should assure all PSTs are provided with continued training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the PSP process. QDDPs/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. (Provisions I.1, I.2, and I.3)
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 policy is implemented. (Provisions I.1, I.2, and I.3)
3. This Facility should consider including bedrail use as a required risk assessment category in the Risk Assessment process. (Provisions I.1, I.2, and I.3)
4.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 10/10/2011 2. Presentation Book for Section J, including all information on actions taken to reach compliance, forms and procedures for monitoring status of the Facility relevant to this section, and other information to document compliance or progress 3. DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11) 4. RSSLC Policy I.00d Psychiatry Services (08/30/11) 5. A list of all individuals who receive psychiatric care, the current psychiatric diagnosis for each individual, and the name of the psychiatrist to whom each individual is assigned for care 6. Appendix B psychiatric evaluations for Individuals #86, #42, #210, #216, #239, #253, #316, #372, #379, #665, #672, #718, #746, and #757, all completed since the last compliance tour 7. A list of any individuals for whom the psychiatric diagnoses have been revised since the last compliance review, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) 8. Separate lists of individuals for whom each of the following was prescribed: Anti-epileptic medications being used as a psychotropic medication, Lithium, Tricyclic antidepressants, Trazodone, Beta blockers being used as a psychotropic medication, Clozaril/clozapine, Mellaril, Reglan, Anticholinergic medications, and Benzodiazepines 9. Lists of individuals prescribed intra-class polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 10. A list of all Reiss screens and scoring sheets done that reached or exceeded cut-off values designated by the instrument guidelines 11. A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend 12. A list and copy of all forms used by the psychiatrists 13. A description of administrative support offered to the psychiatrists (e.g., secretarial, administrative scheduling of psychiatric consultation, etc.) 14. A list of continuing medical education activities attended by psychiatry staff for the past 6 months 15. A list of individuals diagnosed with tardive dyskinesia 16. A list of individuals who during the past year had DISCUS ratings of "5" or higher, and the four recent DISCUS exams for those individuals 17. Review of psychotropic medications that were first prescribed during the last six months: Individuals #10 (Zoloft, Ativan), #27 (Ambien and Seroquel), #39 (Paxil), #58 (Clozaril and Lithium), #68, (Seroquel), #110 (Abilify), #155 (Prozac), #210(Clozaril and Haldol), #316, (Zyprexa), #447 (Abilify), #493 (Abilify) , #513 (Abilify), #529 (Lithium), #570 (Zoloft), #585 (Abilify), #596 (Doxepin), #760 (Flexeril), #779 (Invega). Materials reviewed included copies of informed consent forms for psychotropic and HRC reviews for those psychotropic medications 18. Neurology clinic notes and IPNs for individuals reviewed in neurology clinic for both psychiatric and

	neurological issues 19. Copies of SFAs and PBSPs for Individuals # 39, #239, and #568, who were reviewed in HRC on 10/24/11 20. Copies of IPN and other clinical materials for Individuals #39, #239, and #568, who were reviewed during Psychiatry and Behavior Management Clinic (PBMC) on 10/25/11 21. Copies of IPNs and other clinical materials for Individuals #58, #353, and #404,who were cited by Facility staff during the Monitoring Team entry meeting as examples of good practices 22. Copies of IPNs and other clinical materials for Individual #694, who was discussed at the integrated clinical meeting on 10/26/11 23. Facility spreadsheet for Reiss Screens 24. Facility spreadsheets for the Monitoring of Side Effects (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) evaluations 25. Sample of individuals who had new medications, new diagnoses, or who were recently admitted to the Facility (Sample J1): Individuals #27, #29, #39, #58, #110, #152, #155, #210, #239, #404, #410, #424, #447, #493, #499, #529, #615, #672, #747, and #757. Materials included the individual's social history, most recent Personal Support Plan (PSP), most recent Health Risk Assessment Rating – tool and team meeting sheet, if the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors – copies of the plan to reduce risk (PSP addenda), medical and/or dental plans to increase cooperation/participation (hygiene, desensitization, etc), most recent PBSP, most recent safety plan, most recent functional behavior assessment, most recent annual medical summary, most recent annual nursing summary, most recent active problem list (APL), most recent Psychiatric Evaluation, all PBMC Reviews for the past six months, most recent MOSES/DISCUS side effects screenings, most recent quarterly drug regimen review (QDRR), Reiss Screen, and most recent neurology consultation 26. Sample of individuals who experienced medical restraint (Sample J2): For dental procedures done under intravenous (TIVA) sedation, Individuals #124, #155, #426, #470, #551, and #508. For dental procedures done under oral pre-treatment sedation, Individuals #16, #119, #148, #212, #296, #388, #465, #694, #719, and #751. For medical procedures done under oral pre-treatment sedation, Individuals #10, #180, #718 (Sample J2). Materials reviewed included medical orders for sedation, physician specified monitoring schedule, standard Facility protocol for medical monitoring during the relevant type of restraint, PSP information regarding the development and implementation of program to minimize the need for pretreatment sedation including completed data sheets if a program was developed and implemented 27. Review of chemical restraints (Sample J3): Individual #68 (three episodes of restraint) and Individual #502 28. Sample of monthly reviews for individuals treated with Polypharmacy: (Sample J4): Individuals #68, #99, #110, #225, #239, 315, #424, #530, #570, #613, #714, and #800. Materials reviewed were the most recent QDDR and PBMC notes **People Interviewed:** 1. Bobby Buckner, BACB, Chief Psychologist 2. Shelley Evan, Associate Psychologist V 3. Wanda Hartensteiner, Director of Medical Records

	3. Carol Heath, DDS, Dental Director 4. Elizabeth Ohiku, MD, Staff Psychiatrist 5. Joan Poenitizsch, Quality Assurance Director 5. Tran Quan, DO, Director of Medical Services 6. Michael Shatz, Pharm D., Clinical Pharmacist **Meeting Attended/Observations:** 1. Behavior Support Committee, 10/24/11 2. Psychology Department Meeting, 10/24/11 3. Psychiatric and Behavior Management Clinic, 10/25/11 4. Risk Assessment Meeting, 10/25/11 5. Integrated Clinical Meeting, 10/26/11 6. PSP for Individual #51
	Facility Self-Assessment: The Facility provided a self- assessment in a document called a Plan of Improvement (POI). The document provided to the Monitoring Team indicated that the POI had been updated on 10/10/2011. For each provision of Section J, of the POI, the Facility provided several statements or short paragraphs that described steps taken by the Facility to respond to the requirements of the provision items. The statements were listed chronologically for each provision item. The earliest comments dated to early 2010, and the most recent were from October 2011. Following the comments for the various provisions, the POI provided action steps that outlined in more detail what was done to respond to comments made during previous tours of the Monitoring Team. There were four such action steps, all of which were related to provision J3. In these action steps the Facility stated that the Lead Psychiatrist had ascertained that the psychiatric working diagnosis was consistent in all records for each individual who was seen in the psychiatric medication clinic, physicians had written orders to update the active problem list with individuals' current psychiatrist diagnosis, behavior analysts had updated the Facility records for the current diagnosis via database updates known as DG-1s, and an email had been sent by the Lead Psychiatrist to members of the PST regarding changes in diagnosis. However, the Monitoring Team found that some inconsistencies remain, and the records continue to cite out-of-date diagnoses, some of which are not in the DSM format. The Facility did not indicate the activities taken by the Facility to conduct the self assessment, and the POI did not include information that was available to the Facility relevant to the self assessment. For example, in the opinion of the Monitoring Team positive quantitative data on reductions in rates of polypharmacy (see provision item J11) was evidence of progress that could have been cited. During the tour this was discussed with the pharmacy, and the Clinical Pharmacist clarified that since it was possible that the data was only a trend, he wanted to be conservative regarding claims of progress. The Monitoring Team respected the judgment that was made, but emphasizes that whenever reliable quantitative data is available, the Monitoring Team would like to be informed.

	The POI also provided a self-rating regarding compliance on the various provision items. The Facility self-assessed for compliance on provision J1 (qualifications of psychiatrists) but not for the other provision items. The Monitoring Team additionally found that provision item J11, on polypharmacy practices was in substantial compliance. Both case report and Facility-wide data show that there is a substantial process in place to monitor for polypharmacy and to encourage its reduction whenever it is clinically possible to do so. The Facility might find it useful to ask the Quality Assurance and Psychiatry Departments to develop a tool to monitor activities and processes required by the SA.
	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, some individuals did not yet have a psychiatric evaluation, the Monitoring Team continued to find cases where different diagnoses were cited in the various sections of an individual's clinical record, where individuals had unresolved "not otherwise specified" (NOS) or "rule out" (r/o) diagnoses, and where 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 were no medication plans in place, and in psychiatric clinics, known as PBMCs, medications were not linked to specific behavioral characteristics of proposed disorders. In addition, PBSPs did not provide needed details about how the use of medication was part of an overall treatment program. **For Provision J4:** The provision was determined to be not in compliance. Medical and Dental Support Plans were in place for many individuals, but there was no program in place to review the technical adequacy of newly developed support plans, and there was no system in place to monitor existing support plans to determine whether they were effective. **For Provision J5:** The provision was determined to be not in compliance. Efforts continue to recruit a full-time psychiatrist to fill a vacancy, 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. New evaluations had improved but the evaluations did not provide the justifications needed to substantiate the diagnoses that were made.

	For Provision J7: The provision was determined to be not in compliance. Reiss Screens were administered to all individuals who required them, but individuals who needed psychiatric evaluations had not yet received them. **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. Improvements were noted and psychiatrists authored the section on risk/benefit. However improvements were needed in the discussions of potential benefits and treatment alternatives, and Primary Care Physicians (PCPs) needed to be included in the PST process. **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, and evidence was presented which showed decreases in polypharmacy rates across the campus. **For Provision J12:** The provision was determined to be not in compliance. Individuals received required screens for medication side effects, and the Facility had established a process for Facility-wide monitoring of the results of the screening. However, not all screens were signed by the prescribing physician, and it is possible that not all individuals who were rated as having dyskinesia had the diagnosis added to their APLs. F**or 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:** Informed consent for psychotropic medication had improved, but discussions of risk/benefit were not complete and the Monitoring Team could not confirm that informed consent was in place for all psychoactive medications. **For Provision J15:** The provision was determined to be not in compliance. The staff psychiatrists attended neurology clinics, but arrangements were not in place to include coordination of neurological and psychiatric care for the consulting psychiatrist.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility	Dr. Elizabeth Ohiku was the lead psychiatrist for the Facility and was employed on a full	Substantial

	shall provide psychiatric services only by persons who are qualified professionals.	time basis. Dr. Ohiku has been board certified in general psychiatry since 2006, and she has been board certified in child and adolescent psychiatry since 2010. Prior to her employment at the Facility, Dr. Ohiku had worked in a variety of clinical settings, including inpatient psychiatric units, partial hospital programs, the juvenile court system, and a substance abuse recovery program, a community mental health facility setting and adult forensic psychiatry. Dr. Ohiku now has about a year of experience in intellectual and developmental disability psychiatry, through her work at the Facility. Since she is relatively new to the specialty, she sought out additional learning in the area, and she took the initiative to obtain mentorship in the area from Dr. Sara Flick, Director for Intellectual Disability/Mental Illness for the Mental Health and Mental Retardation Authority (MHMRA) of Harris County. Additionally, Dr Ohiku, the Facility Director, and Drs. Flick and Schnee from the MHMRA have been exploring ways to combine efforts to best support individuals with dual diagnosis, whether it be in a facility setting, an inpatient psychiatric setting, or in the community. Dr. Ohiku is a member the American Psychiatric Association and NADD, an association for persons with developmental disabilities and mental health needs. Psychiatric treatment services were also provided by Dr. Rafael Guerrero. Dr. Guererro had worked at the Facility on a part time basis for many years. He continued to provide two day-long psychiatric clinics twice per month, and he was the attending psychiatrist for 71 individuals. Dr. Guerrero was board certified in general psychiatry. Drs. Hermant Patel and Dominic Joseph were contract psychiatrists focused on psychiatric evaluations of individuals who lived at the Facility. Dr. Patel was board certified in general psychiatry. Dr. Joseph was board certified in general psychiatry and he was also certified in Forensic Psychiatry.	Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	<u>The number of individuals who received psychotropic medications:</u> A t the time of the tour, 154 individuals of the 376 (41%) of the individuals who lived at the Facility took psychotropic medications. This number was derived by examination of the pharmacy's printout of all individuals who received at least one central nervous system (CNS) medication, also referred to as psychoactive medications. These medications included all medications prescribed for psychiatric symptoms or diagnoses, medications prescribed by the neurologist for brain disorders such as epilepsy, and medications prescribed by Primary Care Physicians (PCPs) for general medical indications (such as propanolol for hypertension) which were nonetheless active in the CNS. The pharmacy listed each medication taken by the individual and the reason it was prescribed. The combined list contained 154 individuals who took one or more CNS medication for psychiatric symptoms or diagnoses (see related discussions of polypharmacy monitoring under provision J11).	Noncompliance

		The process in place for evaluation and diagnosis: The focus of the provision was to make sure that prescriptions of psychiatric medications were done on the basis of evaluations and diagnoses by board certified psychiatrists. The Monitoring Team inquired with the Lead Psychiatrist as to how psychiatric diagnoses were generated and updated. Dr Ohiku clarified that each individual who received care was assigned to either herself or to Dr. Guerrero for ongoing care. The Facility provided a list of 170 individuals who received psychiatric care, and the list provided the name of the treating psychiatrist. 99 individuals were under the care of Dr. Ohiku, and 71 individuals were under the care of Dr. Guerrero. Per the Lead Psychiatrist, the treating psychiatrist determined individual's psychiatric diagnoses. All individuals assigned to a psychiatrist for ongoing care met with the psychiatrist at least quarterly. This meeting took place in the psychiatry clinic, known at the Facility as the Psychiatric and Behavior Management Clinic (PBMC). These appointments were also attended by several PST team members, including the QDDP, psychologist /behavior analyst, nurse case manager, clinical pharmacist, and selected DSPs who knew the individual well. Appointments lasted at least 30 minutes and more typically they lasted about 45 minutes. At the beginning of each appointment the individual's psychologist or behavior analyst provided a several page summary that included details of the individual's progress since the last appointment. Information included the individual's DSM IV diagnoses, psychotropic medications, and the psychiatric symptoms. As described under provision J6, some individuals also had Appendix B psychiatric assessments with one of two consulting psychiatrists (Drs. Patel and Joseph), who were not involved in the individual's treatment. The assessments were available to the treating psychiatrists for their consideration. Diagnoses were reviewed regularly as part of PBMC, and diagnoses were updated at the discretion of the psychiatrist. Whenever such a change was made, the PST psychologist submitted a form to the Medical Records Department that allowed Facility records to be updated about the changes. During the tour a PBMC clinic was scheduled for three individuals who were under Dr. Ohiku's care. The Monitoring Team attended the clinic and observed the clinical process. The notes that follow focus on the manner in which these individuals' diagnoses were reviewed at the PBMC. Other aspects of PBMC care are noted elsewhere in this report under provisions J3, J8 and J9. In each of the PBMC appointments that were observed, the psychiatrist met with and interviewed or examined the individual whose care was being reviewed. Details of the appointments were as follows: Individual # 239: The individual had been admitted to the Facility in May of 2011. The	

		meeting was attended by the individual, his behavior analyst, nurse case manager, QDDP, clinical pharmacist, and several DCPs. The behavior analyst presented a five page single spaced report to the group, and the nurse case manager presented a two page report. The report cited key psychiatric symptoms which included yelling, depressed mood, aggression and auditory hallucinations. The meeting lasted about 45 minutes. The individual had good verbal skills, and he participated actively. Although he was relatively new to the Facility, the individual had established good rapport with the behavior analyst, with the psychiatrist, and with other team members. The psychiatrist conducted a mental status examination, during which she asked the individual in some detail about the current status of several psychiatric symptoms including voices. The individual denied current voices, acknowledged that he'd had them in the past, and PST members confirmed that whereas in the early part of his stay the individual had indeed seemed to respond to non-present stimuli, at present he did not. The individual was treated with an antipsychotic medication (Seroquel) and the dose of Seroquel had been gradually increased over the past several months. This was felt to have been helpful in suppressing the hallucinations he experienced earlier. The individual confirmed that he felt sad, and the nurse contributed that a recent MOSES screen confirmed changes in appetite and weight. Data were reviewed for nighttime sleep, daytime sleep, and meals refused. Amongst other things discussed during the appointment, the psychiatrist addressed the issue of the psychiatric diagnosis, and stated that in her opinion the individual had experienced an episode of major depression with psychotic features, that the individual was now much improved, but still had symptoms and was not at baseline. The Monitoring Team reviewed the various sources of information in the record that related to diagnosis. The Appendix B psychiatric evaluation listed dysthymia, major depression, and several rule out diagnoses which included bipolar II disorder, mood disorder due to multiple medical conditions, and intermittent explosive disorder. The diagnoses listed in the PBMC were depressive disorder NOS and psychotic disorder NOS. The APL listed anxiety and depressive disorders. In summary, the Monitoring Team observed careful and attentive psychiatric care during the clinic with attention to mental status and relevant discussion of symptoms. However, the diagnoses of the treating psychiatrist were different than those cited on the APL, and this should not have been the case. It is possible that the electronic Facility database was updated but not the paper form of the APL that was in the record. NOS diagnoses remained unresolved. <u>Individual #39</u> had most recently been seen in the PBMC one month earlier. He was an individual who had been followed by Dr. Guererro for many years and had been diagnosed per the PBMC materials with OCD, autism and PICA. Dr. Ohiku assumed the care of the individual in January 2011. The PBMC clinic was attended by the individual, the nurse case manager, the QDDP, the behavior analyst, and by DCPs. The review was	

		detailed and included a period of observation and examination by Dr. Ohiku. The individual was non-verbal, and did not interact, but he was attentive to what was going on around him. There was a careful review of medications, side effects, laboratories and clinical course over the past several months. There was discussion of the individual's diagnosis. References were made to the individual's symptoms of compulsions, and these were documented in the 08/09/11 PBMC note at a time that he was particularly symptomatic – "compulsively touches people and objects… OCD symptoms worsening". Over the past year the individual had been gradually taken off Paxil, a medication that can help with OCD. Symptoms such as hesitancy that were associated with OCD then increased and discussion offered that this supported the diagnosis of OCD. The individual had an Appendix B diagnostic evaluation in 2010. The primary diagnosis in that evaluation was mood disorder due to head injury. Four other diagnoses were listed which included OCD and autism, but not pica. The key issue of whether the symptoms attributed to OCD might have been stereotypy related to autism was not addressed, and the diagnosis of OCD was not supported by responses to the requirements of the DSM. A "rule out" diagnosis of ADHD was not resolved. Dr. Ohiku provided the Monitoring Team with an IPN that explained her decision to maintain Dr Guerrero's diagnosis. This was reasonable, but the issues regarding diagnosis should have been addressed earlier, and they remained unresolved. Individual #568 was also seen in the PBMC with attendance of her nurse case manager, QDDP, psychologist, clinical pharmacist and DSPs. Like the other PBMC appointments attended, the care was attentive and detailed. The individual was non-verbal but she was active and explored her environment. The psychiatrist carefully observed her behavior and asked about the relevant symptoms that included aggression, hitting, scratching, hair-pulling, grabbing or hitting others with objects thrown. PBMC notes documented the diagnosis of bipolar disorder, most recent episode manic and without psychosis. A psychiatric evaluation had been done that listed psychiatric symptoms of impulsivity, euphoria, irritability, increased stripping, expansive mood, high energy states and risk taking behaviors (albeit these were not specified), sleep and appetite were cited, and a medical workup for medical causes of her difficulties was documented. Marked impairment in the individual's occupational functioning was documented. As a result, DSM criteria A – E were all met. Overall, the Monitoring Team witnessed careful and attentive clinical care that was attended by the relevant clinical staff, and which covered the relevant clinical areas, including review of diagnosis. However, in only one of the three cases was the Monitoring Team able to state that prescriptions of psychiatric medications were done on the basis of clinically justified evaluations and diagnoses that met the requirements of the SA.	

		To further explore routine diagnostic practices the Monitoring Team examined the records of all 20 individuals included in Sample J1, with the following results: The number of individuals who had a psychiatric evaluation in place: All 20 individuals had working psychiatric diagnoses, per the PBMC notes and IPN. However, only 13 of the 20 individuals (65%) had been evaluated by a board certified psychiatrist. . The number of individuals for whom evaluations were completed in a timely manner: The Monitoring Team had requested that individuals who were newly admitted to the Facility should be included in the treatment sample. There were three new admissions, and all received psychiatric care. They were Individuals #239 (admitted on 5/9/11), #746 (admitted on 08/29/11), and #672 (admitted on 08/01/11). All three individuals had Appendix B psychiatric evaluations in place and they received care via PBMC. The target symptoms for psychotropic medications: The 20 records in sample J1 were examined for the presence of psychiatric symptoms that were identified as targets for psychiatric medication treatments. These were found in PBMC notes and in PBSP descriptions of medications. These were located in 14 of the records. In 5 of 14 (36%) cases psychiatric symptoms were identified. In 9 of 14 (64%) of the cases, the symptoms for psychiatric treatment overlapped with the targets of the behavioral treatment. Departments of Psychiatry and Psychology should review and address the cases where the same behavioral targets are the focus of both behavioral and psychiatric interventions. If both are needed, the reason(s) should be addressed as part of the rationale statements in the medication treatment plan and elsewhere. Follow-up to resolve NOS and "rule out" diagnoses. PBMC and appendix B evaluations were examined for the presence of such diagnoses. Ten of the 14 psychiatric evaluations (71%) contained unresolved "rule out" or NOS diagnoses. As described under section J2 above, there were many examples where the psychiatrist who completed the evaluation was not the treating psychiatrist. It follows that resolution of NOS and rule out diagnoses should have been done by the treating psychiatrist. The Monitoring Team examined PBMC notes for the 10 individuals in question. The Monitoring Team had been given PBMC notes for eight of the individuals and for six of them found that NOS diagnoses and rule diagnoses were no longer listed in the PBMC notes (exceptions were Individuals #239 and # 424). This indicated that treating psychiatrists were attentive to the need to have diagnostic specificity. However, the Monitoring Team was not clear about how the "rule out" diagnoses were considered and rejected. In addition for three of the eight individuals (Individuals #39, #155 and #239) new diagnoses were added and the clinical thinking and diagnostic justifications for some of those were not clear. Adequacy of the process to track diagnoses and diagnostic updates. In previous reports the Monitoring Team noted that different sections of the record contained different	

		clinical diagnoses. The action step at the end of POI was to review the active problem list, behavior analyst notes, psychiatric evaluations, and psychiatry clinic notes, to ascertain that the working/active psychiatric diagnosis was consistent in all records for individuals seen in the psychiatric medication clinic. As reviewed elsewhere in this report (see provisions J6, J8 and J13) some of the differences were due to the fact that in many occasions, the psychiatrist who completed the diagnostic evaluation was not the treating psychiatrist and the diagnoses of the two psychiatrists differed. The Lead Psychiatrist clarified that the final clinical authority was the treating psychiatrist, who resolved any differences and documented the results in the PBMC notes. The resulting diagnosis was referred to in the POI as the working/active psychiatric diagnosis. The Monitoring Team then inquired how facility records for psychiatric diagnosis were updated when necessary. The answer was that when a diagnosis was changed in the PBMC, the psychologist/behavior analyst completed a form (known as PG1A update) that was used to update the Facility records for diagnosis, which should then have been reflected in the APL. The Lead Psychiatrist also provided the Monitoring Team with a list of all individuals who received psychiatric care, the name of treating psychiatrist and the working/active diagnosis for each individual. The Monitoring Team compared the APLs and the working/active diagnoses for the 20 individuals from sample J1. Nine of 20 (45%) had the information in the two sources, but eight of 20 (40%) did not. Three individuals (15%) did not have active problem lists. In addition, the psychiatric diagnoses listed in the APLs for four individuals (#27, #29, #152, and #615) were not in the DSM format. In a subsequent discussion with the Director of Medical Records the Monitoring Team learned that Medical Records personnel examined PCPs' APLs after the annual medical evaluations were completed and corrected the Facility database accordingly. Since there appear to be overlapping processes for updating records, it is possible that there are simple procedural issues that account for the lack of consistent reporting across the record. For example, it is possible that updates were made in the Facility database as described by the Lead Psychiatrists, but PCPs completed annual updates based on the previous year's evaluation and without consulting the database. The goal of all involved is that the psychiatric diagnostic process should be transparent, diagnoses should be specific and justified, and the correct diagnosis should be listed in all parts of the record. The Monitoring Team is encouraged by the Facility plans to have annual psychiatric updates done by the treating psychiatrist. These will provide the psychiatrist with a natural venue to provide comments about all aspects of the individual's diagnoses, including changes made in during the year, the manner in which rule out diagnoses were considered, as so forth. Additionally, there should be procedures in place for updates to be recorded in APL when the changes occur, not only	

		at the time of annual updates. Primary care physicians (PCPs) do have the final clinical authority for medical staff, but PCPs should have easy access to the thinking of their colleagues in psychiatry regarding psychiatric diagnoses, to avoid unintended citation of outdated diagnoses. The Facility is encouraged to examine the relevant administrative issues, and at the next tour the Monitoring Team will review again the manner in which diagnoses and diagnostic updates are made and tracked. If this is not already done, the Facility should consider a way to update the APL in the record when changes take place, either by replacing the APL in the chart when a change is made or by manually updating the APL in the record.	
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.	To assess for compliance with the requirements of the provision, the Monitoring Team explored several questions which were: <u>Was there an active treatment program?</u> The provision required that individuals prescribed psychotropic medications must have a treatment plan, and in the SSLC system that is most fully described in the PBSP. PBSPs were provided for eighteen of twenty individuals from Sample J1. Individuals #672 and #746 were newly admitted, and did not yet have a full PBSP in place, but PSPs were present and they indicated that an overall treatment program was in the process of development. <u>Did PBSPs meet generally accepted standards of care?</u> In many cases, PBSPs did not provide the information that was necessary for the Monitoring Team to understand how and why the medications used were part of the overall treatment plan. In the report for the previous tour, the Monitoring Team found that 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. This was felt to be due to both inadequate data collection and presentation practices. During the entry presentation for the current tour, the Facility emphasized that the Facility was now focused on improvements that were planned that will positively impact the quality of PBSPs. These include improvements in data collection, an increased emphasis on treatment integrity, and a new format for presentation of the program in the Structural Functional Assessment (SFA) and PBSP. To assess progress in these areas, the Monitoring Team attended the Behavior Support Committee (BSC), during which a number of PBSPs were reviewed. The Chief Psychologist emphasized during the meeting that programs needed to present clearly what was being done for individuals, and why. During the meeting the Monitoring Team witnessed examples of improvements in areas previously identified as problematic. For example, in the PBSP for Individual #596 there was a section titled "Evaluating the	Noncompliance

		Effectiveness of this Plan." There were two well-constructed graphs that described the failure of the medication Ambien to increase nighttime sleep without effecting adversely daytime sedation. Similarly, the graph clarified why melatonin was discontinued and why Doxepin was added. The text accompanying the graphs further clarified key points in the underlying thinking of the treatment team as it related to the medications. In another example, the PBSP for Individual #772 presented clearly that the psychotropic Depakote had been targeted for reduction since the rates of target behaviors were low. The PBSP documented the gradual taper and discontinuation of the medication, the continued monitoring of the individual for 4 months to assure continued stability, and the eventual discharge of the individual from the psychiatry clinic. However, the Monitoring Team also observed examples of continued lack of clarity about the role of psychiatric treatment in the PBSP. For example, the PBSP for Individual #529 outlined the changes in medication given to the individual over the course of the year. The text clarified that several medications were discontinued since they were not effective and the text identified that Invega was being used instead. Nonetheless, the plan went on to provide details (side effects, benefits) of lithium, a medication that the individual was no longer taking, and it provided no information about the Invega, the sole psychotropic that the individual was taking. In particular, there was no information about why Invega was used, or the target symptoms or behavioral characteristics that it targeted. <u>Was there an overall case formulation to guide the use of psychotropic medications?</u> The source of the information in the PBSP about the particulars for the use of the psychotropic medications, (the relevant psychiatric diagnosis and rationale for the use of the medication, the behavioral targets for their use, and the manner in which efficacy would be determined) was the interdisciplinary process that took place at the level of the PST, and in particular the work that took place in the PBMC. With that in mind, the Monitoring Team examined PBMC records for information about medications. In this area, persistent problems were noted. Broadly, there was a notable absence of documented case formulations that explained the overall psychiatric approach. In their absence, it was sometimes difficult to understand why a medication was used, to which psychiatric diagnosis it was linked, and how efficacy would be established. This matter was discussed with the Lead Psychiatrist. The Facility's plan is for psychiatrists to conduct annual psychiatric reviews/updates, of which a case formulation is a component. These had not yet been put in place (please refer to Provision J5 regarding staffing limitations). In their absence it will remain difficult for PBSPs to integrate psychiatric information into an overall and integrated plan of behavioral treatment. . <u>Was medication treatment linked to a psychiatric diagnosis or specific behavioral-pharmacological process?</u> The Monitoring Team examined PBSP records to examine routine medication practices. In all cases a psychiatric diagnosis was provided but in	

		many cases it was difficult to understand the linkage between the diagnosis and the medication treatment that was provided. For example: For Individual #155 there was a diagnosis of Bipolar disorder, but Zyprexa was prescribed for aggression. For Individual #424 the PBSP stated that Geodon, an antipsychotic, was prescribed for mood disorder due to seizures. The connection was not clear. According to the PBSP, Individual #410 was prescribed Ativan for depression. Individual #757 took Tegretol for schizophrenia. Individual #447 took Paxil for intermittent explosive disorder. Individual #615 took Risperdal for mood disorder secondary to seizures. These were only a few examples of cases where medications were not linked in a meaningful way to a psychiatric diagnosis. <u>Were medications used for staff convenience?</u> The Monitoring Team addressed this question by examination of the records, and by observations made during PBMCs, during BSC, during the psychology department meetings, and in interviews with staff. There was no direct evidence that medications were used deliberately for staff convenience. However, there were many plans in place where the only identified targets continue to be disruptive behaviors that were not directly linked to any psychiatric diagnosis. For example: Individual #110 (Depakote for aggression), Individual #155 (Zyprexa for aggression), # 239 (Ativan and Seroquel for aggression and yelling), Individual #529 (Zyprexa for aggression and non compliance), Individual #615 (Risperdal for aggression and self injury), #404 (Risperdal for aggression, for leaving home and work area without notifying staff, verbal aggression and non compliance). <u>Were medications used for punishment?</u> The Monitoring Team considered observations made during the tour, examined the records of the 20 individuals in Sample J1 and examined the records of 4 episodes of chemical restraint for Individuals #68 and #502 (Sample J3). There was no evidence that medications were used for punishment.	
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	<u>Background:</u> Individuals who lived at the Facility were seen in the dental clinic for routine care such as annual appointments, for preventative and restorative dental care, and where necessary, for dental emergencies such as dental abscesses. Pre-treatment sedation was determined to be necessary if an individual experienced repeated episodes of behavioral difficulty during dental or medical appointments, and the difficulties were of sufficient magnitude to preclude participation in the procedure. The procedure to initiate the use of pre-treatment sedation was started when difficulties were encountered during an individual's appointment that was not preceded by the use of pre-treatment sedation. Those difficulties were documented in a Behavioral Incident Report (BIR). Dental BIRs were typically completed by Dr. Heath. Items on the BIR allowed a good reconstruction of what the difficulties had been. These included designations of where the difficulty occurred (e.g. dental clinic, reception room, and hallway), and what the nature of the problem had been. Check-off boxes were provided for about 25 common scenarios (did not come, would not come in, slid out of chair,	Noncompliance

	services, and shall be monitored and assessed, including for side effects.	verbal abuse, bit toothbrush, grabbed instruments, grabbed staff/ hitting kicking, etc.). Dr. Heath explained that before pre-treatment was determined to be necessary, the individual was rescheduled several times, in the hope that sedations would in the end not be needed. If, following repeated efforts, the difficulties could not be overcome, Dr. Heath and her staff determined that pre-treatment sedation was needed. Depending on the circumstances and the kind of procedure needed, sedation involved either oral medications or intravenous sedation (TIVA). Details of the procedures were provided in previous reports of the Monitoring Team and had not changed. A similar procedure was followed when difficulties were noted with general medical procedures, in which case staff working in the relevant area of healthcare completed BIRs. The use of pre-treatment sedation required the PST to develop a plan to minimize the need for the sedation. These were known as dental support plans (DSPs) or medical support plans (MSPs). These were developed by PSTs and were included in PSPs. Implementation of action plans was done by PST members and was typically guided by the PST psychologist. The use of the sedative and the support plan required guardian/LAR consent and review by HRC. DSPs were also developed for other dental issues/needs, such as plans to help individuals develop better oral hygiene practices. <u>Rates of use of pre-treatment sedation:</u> The dental clinic provided data that showed that between March and September 2011, oral sedation was used between 6% (May) and 14% (September) of dental visits. There appeared to be a slight upward trend in the use of oral pre-treatment over the time period, since the rates between March and June varied from 6% to 8%, while the rates from July to September varied from 9% to 14%. The rate at which TIVA was used for dental exam and treatment during the period of April and August 2011 varied between 2% (April) and 5% (July). <u>Monitoring for safety when pre- treatment sedation was used:</u> The Monitoring Team reviewed records for 10 uses of dental oral pre-treatment sedations, for six cases of TIVA, and for three cases of medical pre-treatment sedation (Sample J2). Selection of the samples is described as part of Section C of this report. Results were as follows: 1. <u>Oral pre-treatment sedation for dental procedures</u>: Medical orders were written for the day of the procedure, typically for Ativan. Medical monitoring for safety was guided by nursing sedation protocol and was documented on the Medical Monitoring Form. This involved medical monitoring every 30 minutes for 24 hours. The orders did not specify whether vital signs (blood pressure, O2 saturation, etc) were included in the monitoring, and this was done per nursing discretion. Standard cautions (checked on a case-by-case basis) included fall precautions with wheelchair for 24 hours and dorm rest for 24 hours. The protocol was followed uneventfully in the 10 cases that were reviewed. 2. <u>TIVA sedation</u>: The full protocol for TIVA sedation was detailed in previous reports	

		of the Monitoring Team. Anesthesia was responsible for safety during the actual procedure. Upon its completion, individuals were evaluated with REACT scores for level of sedation. Per the pre-post sedation protocols, individuals were held in the medical areas until a REACT score of 8 was obtained (higher scores indicated a higher level of alertness). Post-op orders were written to guide further care and were guided by nursing acute care plans. In the case of TIVA there was a specific acute care plan for TIVA; this delineated medical monitoring for the following 72 hours and provided nursing actions such as vital signs to every 15 minutes x 4, then every 30 minutes x2. Implementation was additionally guided by completion of an individualized medical monitoring form that provided additional care instructions. Documentation was provided which detailed that medical monitoring was provided per the protocols in the 6 cases that were reviewed. 3. Oral pre-treatment sedation for medical procedures: Medical monitoring for safety was similar to the monitoring provided for pre-treatment sedation for dental procedures. A physician order designated that the nursing sedation protocol was used, and implementation was initiated by the nurse with the use of a medical monitoring form. This allowed for individualization of the care provided. For example, for Individual #718 on 9/9/11, the nurse indicated that the individual's monitoring should be continued for an additional 24 hours due to continued sedation, and the individual should be seen in "sick call" (documentation was reviewed and recovery was uneventful). The three cases reviewed by the Monitoring Team were for a mammogram, for an otolaryngology appointment, and for an abdominal ultrasound due to excessive vomiting. The protocol for medical monitoring was followed for all three cases. Status of development of pre-treatment sedation plans: Development of the protocol for the individual remained with the PST, led by the QDDP with input from psychology staff. Many times, but not always, the core of the desensitization program consisted of gradual familiarization with the dental clinic and apparatus. Since much of the desensitization work took place in the dental clinic area, the dental suite area was reserved one afternoon each week for the administration of dental desensitization protocols. Dental clinic staff provided most of the care in the dental suite itself. Psychologists and Direct Care Professionals (DCPs) provided additional care for activities that took place outside the dental clinic. Examples were activities such as oral hygiene care that took place on the home, or activities to support individuals' willingness to go to the dental suite. Depending on the individual's circumstances, acclimatization could be limited to sitting in the waiting area or might include walking into the dental suite itself, or sitting in the dental chair. In many cases other elements for desensitization were used. For example, some individuals were not willing to go to the dental suite. In such cases psychologists worked on the home unit providing desensitization services, or perhaps worked with the individual to be willing to accept leaving the home and walking toward the dental clinic area.	

		The Monitoring Team confirmed that Dental Support Plans (DSPs) and Medical Support Plans (MSPs) were in place for the 19 cases in sample J2. All 16 individuals (100%) who were reviewed for dental pre-treatment sedation (oral and TIVA) had a dental support plan. In most cases data sheets were received that confirmed that the plans were implemented. Data sheets were not received, however, for Individuals # 10, #296, #551, or #719. The three individuals who were reviewed for medical pre-treatment sedation had both MSPs and data sheets that indicated that the program was implemented. In the POI, the Facility reported that DSPs were in place for 267 individuals, and MSPs were in place for 109 individuals. However, no data was reported that would have allowed the Monitoring Team to determine if DSPs and MSPs were successful in reducing the need for pre-treatment sedation. The Monitoring Team reviewed with the Chief Psychologist the need to have Facility-wide assessments of MSPs and DSPs for technical adequacy, and for the Facility to provide reports about whether efforts to minimize the use of pre-treatment sedation were successful. The Chief Psychologist informed the Monitoring Team of his intention to bring individuals' DSPs and MSPs before the BSC, where they will be reviewed alongside other behavioral treatment plans and to use the new Data Review Committee to review. The Monitoring Team considered that to be a positive step.	
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.	One hundred and fifty-four individuals received psychotropic medication. This group represented 41% of the 376 individuals who lived at the Facility. Staffing at the Facility continued with the four psychiatrists employed by the Facility at the time of the last tour. 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. At the time of the tour there was no administrative support offered to the psychiatrists (e.g., secretarial, administrative scheduling of psychiatric consultation, etc.) other than use of a medical transcriptionist. RN Case Managers completed MOSES and DISCUS assessments, and two psychology assistants provided support for assessments and other clinical responsibilities. The combined level of effort for the psychiatric group was about 63 hours per week, or	Noncompliance

		1.57 full time equivalents. The number of individuals supported by the psychiatrists was about 170. 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. During the tour the Monitoring Team met with the Lead Psychiatrist and requested that the Facility provide an estimate for the number of hours needed to provide adequate staffing that will enable psychiatrists to provide services to support the psychiatry clinic and other clinical responses needed across the campus, to provide admission evaluations and quarterly/annual assessments, to attend to administrative issues, and to participate in meetings where the psychiatrists' participation is required. This will be provided at the time of the next review.	
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 Facility reported that Drs. Patel and Joseph continued to complete Appendix B psychiatric evaluations for individual who received psychiatric services, and Dr. Ohiku took the lead for individuals newly admitted to the Facility. Not all individuals who lived at the Facility had psychiatric evaluations in place. In the POI the Facility reported that 31 individuals who received services had not yet been evaluated. In addition, review during the current tour for results of Reiss Screen evaluation found that there were 28 individuals who had Reiss screens that indicated they needed psychiatric evaluation, but these had not yet been done. The Monitoring Team was provided the names of the individuals on the second list, but not the first. It is possible that there is some overlap between the two lists. In previous reports and during discussions with Facility staff, the Monitoring Team had emphasized that evaluations needed to provide more details about observable psychiatric symptoms/behavioral characteristics. To assess how the Facility had responded to that need, the Monitoring Team reviewed the 14 Appendix B psychiatric assessments that had been completed since the last tour. These were for Individuals #86, #42, #210, #216, #239, #253, #316, #372, #379, #665, #672, #718, #746, and #757. The evaluation showed an increased focus on psychiatric symptoms, past and present. The Monitoring Team also reviewed psychiatric evaluations for all individuals in Sample J1. Appendix B Psychiatric evaluations were provided for 13 of 20 individual (65%). The Monitoring Team reviewed the evaluations to verify that documentation was sufficient to substantiate the psychiatric diagnoses in terms of all the symptoms that would be required to fulfill the complete diagnostic criteria set forth in the DSM IV or the Diagnostic Manual of Intellectual Disability (DMID). In some cases the Monitoring Team could not do so. Examples were Individual #404 (for schizophrenia) and Individual #29 (for schizoaffective disorder).	Noncompliance

		The Appendix B evaluations reviewed included listings of various possible diagnostic formulations. A majority of the evaluations contained suggestions for a number of "rule out" diagnoses. How the treating psychiatrist considered these was not always clear. The Monitoring Team understands that annual psychiatric evaluations will be done by the treating psychiatrist when staffing allows. Such evaluations will be an excellent opportunity for the treating psychiatrist to examine the various documents that address diagnosis, to explore the issues raised by the various clinicians involved in the care of the individual, and to document how these contributed to decisions about whether diagnoses should be modified.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	At the time of the tour Reiss screens had been completed for all individuals who lived at the Facility. Per the tool guidelines, Reiss screens were scored for both a total score, and for seven subscales. The cutoff value for the total score was 9. Cutoff scores for the subscales varied from one subscale to another. Two hundred ninety-two individuals had Reiss screen scores that were below the designated cutoffs for a positive screen. The Monitoring Team received a list of these individuals and selected a 20% sample of the individuals by taking the second name on the list followed by every 5th name thereafter. The Monitoring Team reviewed the Reiss screen and data sheets and agreed with the results reported by the Facility. Fifty-one individuals had Reiss screen scores that reached or exceeded the designated cutoffs and had also received psychiatric evaluations. Forty-eight of these individuals received routine psychiatric care via PBMC. Individuals #216, #235, and #302 did not receive ongoing psychiatric care. The psychiatric evaluations and overall clinical circumstances for Individuals #216, #235, and #302 will be reviewed during the next tour of the monitoring team. Twenty-eight individuals had Reiss screen scores that reached or exceeded the designated cutoffs, but had not yet received psychiatric evaluations. Eleven of these individuals received routine psychiatric care from Facility Psychiatrists. Seventeen other individuals did not receive psychiatric care.	Noncompliance
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	At the time of this visit, the process for integrated care was in transition and development. For many years, psychiatric care was provided by an outside consultant who provided two ten-hour PBMCs each month, one of which typically took place on a weekend. The baseline report of the monitoring team from May 2010 described the functioning of the PBMC, when it was the sole venue for psychiatric care. Even under those conditions of limited psychiatrist availability, some elements of integrated care were present: Participation in clinic included the Qualified Developmental Disability	Noncompliance

	other interventions through combined assessment and case formulation.	Professionals (QDDP), the nurse case manager, behavioral analyst and Direct Care Professionals (DCPs). A detailed report for each individual reviewed was prepared prior to the clinic by Facility staff, and the report was presented to the consultant as the basis for his examination and further discussion. Discussion and collaboration between the disciplines was in place. Psychologists and others who attended the PBMC were able to provide some psychiatric information to venues where it was needed, such as the PBSP. While the past model of care may have reflected the best use of limited resources, the system was not adequate to support needed psychiatric and interdisciplinary care. Shortcomings included: 1. There were no psychiatric evaluations. 2. Psychiatric case formulations/treatment plans were absent, and as a result combined behavioral case formulations could not be made. 3. Psychiatric care typically focused on the behavioral targets of the psychologists' behavior plans, many of which dealt with learned behaviors. Psychiatric care was not linked to psychiatric diagnoses, or to symptoms/behavioral characteristic of those disorders. In a large majority of cases, the identified targets for psychiatric care were aggression and self-injury. 4. Annual documents which reported on behavioral healthcare such as the Positive Behavior Support Plan (PBSP) did not provide basic information such as psychiatric diagnosis and treatment, and medication treatments could not be justified (see provisions J2 and J3 of this report). RSSLC Psychiatry Policy 1.00d (revised 08/30/2011) now makes clear how integrated care must be provided, by stating "*RSSLC must develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined case analysis and case formulation."* Integrated care is also addressed by the requirement that "*the neurologist and psychiatrist must coordinate the use of the medications, through the PST process, when medications are prescribed to treat both seizures and a mental health disorder."* These requirements parallel what the SA requires. The first is a requirement of this provision, and the second is the focus of provision J15, addressed below. Since the Lead Psychiatrist joined the Facility about one year ago, there has been progress toward more integrated care. For example, the Lead Psychiatrist has reduced the number of individuals who are under the care of the outside consultant from over 100 to 71. As reported by the Lead Psychiatrist, one consequence is that the number of individuals seen at the consultant's PBMCs is limited to 20 per clinic, therefore assuring that at least 30 minutes will be available for each appointment. In addition, sufficient appointment times are now available to allow individuals who are treated with polypharmacy to be seen monthly. In the PBMC clinic attended by the Monitoring Team, the PST spent about 45 minutes of careful review for each individual seen. Details of the	

		integrated care that was provided in the PBMC are described in some detail under provisions J2 (for diagnosis), J3 (for overall medication practices), and J13 medication (regarding medication plans). The Facility also made progress toward integrated treatment in other venues. These include the initiation of a weekly Integrated Clinical Meeting (ICM) which is a multidisciplinary meeting that includes medical services, psychiatry, behavioral services, nursing, pharmacy, habilitation, nutrition, dental, QDDPs, residential services and other services impacting the individual's health (see RSSLC Policy 1.29, effective 09/07/2011). The conference is led by the Medical Director and is structured around a detailed review of an individual who has challenging circumstances that are best reviewed in an interdisciplinary manner. During the tour the Monitoring Team attended an ICM for Individual # 694, who had experienced a sudden and unexplained weight loss. Many possible explanations were explored, including psychiatric. The Monitoring Team also reviewed ICMs for Individuals #235 and #353, for whom psychiatric factors were also part of the differential diagnosis. Two of the Individuals (#235 and #694) did not receive psychiatric care prior to the consultation and the conference included discussion about the possibility of initiating such care. Integrated care was evident at other meetings too. This included PST meetings about risk. During the tour the Monitoring Team attended a PST discussion that evaluated risk in an individual who had brittle diabetes, and for whom there were questions about the risk and benefits as related to the psychotropic medications chosen for his care. Integrated care was also more evident at PSP meetings, which the Lead Psychiatrist attended when her schedule allowed. During the tour the Monitoring Team attended the PSP for Individual #51. The Lead Psychiatrist was an active participant and made positive contributions for the plan for the coming year. Provision J8 calls for consideration of "other" interventions (for example speech and language, OT/PT etc). During the tour, Habilitation Therapies were invited to provide examples of positive contribution toward behavioral healthcare programs. Individual #410 was cited as an example where speech and language contributed an action plan to assist the individual with a communication device that will allow him to express his needs more effectively. Progress and improvements notwithstanding, many challenges remain. For example: <u>Lack of good interdisciplinary case formulations:</u> While good clinical discussion was witnessed by the Monitoring Team in both PBMC and BSC, the focus in each venue was specific to the areas of concern to psychiatry and psychology, respectively. There was little discussion of how historical information and current level of functioning of the individual are combined to provide an overall sense of the individual's overall behavioral	

		health needs. A good discussion of what is needed for case formulations may be found in the following article: Ross, D.E. (2000): A method for developing a biopsychosocial formulation. Journal of Child and Family Studies, 9(1), pp 1-6. <u>Coordination of behavioral and pharmacological treatments:</u> As described under provision J3 and J13, the area of coordination of behavioral and pharmacological treatment remains problematic, since the targets of psychiatric treatment were often not defined, and measures with which to establish treatment efficacy were not in place. As a result, clinical discussions amongst behavioral healthcare professionals were often anecdotal and not evidence based. Worse, due to the availability of data for the behavioral but not psychiatric targets, psychiatric treatments appear to be unduly influenced by data that were available rather than relevant. <u>Integration of psychology and psychiatry:</u> Psychiatry is becoming more integrated into the treatment team and good discussions were evident between professionals from the two disciplines. However, the process is held up by what is missing. For staffing reasons, it is not yet possible for psychiatry to attend venues such as the BSC. During the visit the Chief Psychologist outlined plans for new initiatives, several of which support efforts at interdisciplinary integration of care. For example, the plan to review dental and medical support plans at the BSP will support integration of effort to reduce the use of pre-treatment sedation in medical/dental settings. The newly proposed Data Review Committee and the additional focus on treatment integrity will also provide a place to better coordinate behavioral and pharmacological care. The planned use of the Restraint Reduction Committee as a venue for treatment reviews of challenging cases will allow many clinical discipline to work together proactively, to reduce the need for restraint.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other	In the Facility Self Assessment for this provision, the Lead Psychiatrist commented that since there was only one full time psychiatrist, she managed available psychiatric time with a clear set of priorities. Eight types of activities were listed and ranked. Higher priorities were given to psychiatric crises, to consults, to follow-up on priority cases, and to PBMCs. The Monitoring Team agreed with the need to actively manage the priorities, and found that the judgments that were made were wise. Necessarily, this meant that the required psychiatric participation in PST planning process was not always possible, and the provision could not be found in substantial compliance. The Monitoring Team also reviewed longstanding Facility practices regarding psychiatric involvement in the planning process for behavioral healthcare. Such plans were developed by the individual's PST; they were described and reviewed in annual documents managed by psychology (Functional Assessment and PBSP) and then summarized in the overall annual PSP. Over the years, psychiatry had not participated in	Noncompliance

	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 development of the PBSP and did not attend the BSC (known previously as Behavior Support Review Committee), where those plans were reviewed. At present psychiatrists do not sign PBSPs. The Lead Psychiatrist said that she hoped to change many of these things when staffing allows her to do so. The Monitoring Team reviewed the process that was in place, per the three items required by the SA provision. <u>The PST should determine the least intrusive and most positive interventions.</u> The records of the 20 individuals included as Sample J1 were reviewed for the presence of statements (in the PBSP or elsewhere) that the PST had considered the proposed treatment program and made efforts to assure the program used the least intrusive and most positive interventions. Results were as follows: PBSPs reviewed did contain statements that the PST tried to use less restrictive practices. For example: • The PBSP for individual #410 stated: "*Members of the individual's Personal Support Team will evaluate the individual's response to drugs for behavior management at least monthly. Consideration will be given to reducing or discontinuing the medication when the medications appear to have no effect on decreasing the maladaptive behavior, or at least annually. Per the psychiatrist, the medication is being tapered with the plan to discontinue the medication."* • *The PBSP for* Individual # 58 stated: "*Consideration will be given to reducing or discontinuing the medications whenever her behavior decreases to zero episodes per month for 6 consecutive months, and at least annually during (the individual's) personal goals planning meeting. The following drug changes occurred during the past year (details provided)"* • The PBSP for Individual # 29 stated: *"Consideration will be given to reducing or discontinuing clomipramine when aggression remains at a zero rate for 12 consecutive months and at least annually."* <u>The PST shall determine whether the individual will be best served primarily through behavioral, pharmacology, or other interventions, in combination or alone</u>: Some PBSPs described the role of behavioral treatment and medications: For example: • For Individual # 529: *" These supports are designed to provide contingent and non-contingent reinforcement, avoid the known trigger for her inappropriate behavior and provide environmental support in conjunction with the psychiatric treatment being provided through psychotropic medication."* • For Individual #29: "*Members of the PST will evaluate his response to drugs for behavior management at least monthly. Consideration will be given to reducing or*	

		discontinuing clomipramine when aggression remains at a zero rate for 12 consecutive months and at least annually. However, these and other PBSP's simply described that behavioral and medication treatments were both provided. Among the 20 records reviewed, the PBSP for Individual #58 had the best description of why more than one treatment was provided: *"Behavioral treatment intervention in (the individual's plan requires a combination of procedures which include the use of psychoactive medications and training.)"* Even then, however, there was no description of <u>why</u> the PST determined that both treatments were needed, what each treatment was intended to address, and how the treatments would interact or improve the effectiveness of one or both treatments. The Monitoring Team did not find examples of "other" interventions, for example via habilitation or other modalities of treatment. <u>If the PST concludes that the individual is best served through psychotropic medication, the PSP must also specify non- pharmacological to treatments to minimize the need for medication:</u> PSPs for individuals who took psychotropic medications outlined that there was a PBSP in place with behavioral interventions, but there was no discussion of how the interventions were chosen or why.	
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.	RSSLC Psychiatry Policy 1.00d, (revised 08/30/2011) provided guidance on how discussions of risk and benefit for psychotropic medications: "*The psychiatrist must solicit input from and discuss with the PST any proposed treatment with psychotropic medication."* The policy then repeated the language of the SA provision regarding risks, benefits, and alternative treatment strategies. The Monitoring Team reviewed with the Lead Psychiatrist how the new policy was implemented. Dr Ohiku described that discussions about new medications started either as the result of a new psychiatric referral (either new admission or referral from within the Facility) or were part of PST discussions, and these often took place at the PBMC. Available treatments, alternatives, risk and benefits were considered. If the PST decided that a new medication was needed the psychiatrist led the PST discussion of relevant risk/ benefit information. The psychiatrist then presented the information to the guardian/LAR as part of the informed consent process. Once consent was obtained, the new medication was reviewed by the HRC. Some of the process described above was witnessed during the PBMC attended by the Monitoring Team during the tour. During that PBMC there was discussion about the possible addition of benztropine for Individual #568 and also discussion about several	Noncompliance

		possible future medications for Individual #239. The discussions were clinically substantive, they included discussion of possible benefits and risk, and they included input from the clinical pharmacist about how the medications might interact with existing medications. Following this exploratory discussion, the PSTs did not decide to actually initiate the new medications during the PBMC. Although these discussions involved only a part of the entire interdisciplinary review that was intended to lead toward decisions regarding treatment, they were positive examples of integrated discussion. To further assess Facility process and practice, the Monitoring Team also reviewed each of the 24 psychotropic medications that were reviewed by the HRC during the six-month period that preceded the compliance visit. For each medication, the Monitoring Team reviewed the HRC form and the informed consent that had been obtained by the psychiatrist. Documents were reviewed for the following elements: <u>Authorship of the risk benefit statement:</u> Informed consents were developed and signed by the treating psychiatrist. This was a positive development. <u>Potential and realized medication side effects:</u> These were the principal risks associated with the medication and they were listed for each medication. <u>Potential or realized medication benefits:</u> In most cases the most important benefit was the alleviation of the symptoms of the psychiatric disorder to be targeted by the medication. In many of the cases, however, the informed consent, the HRC review (or both) contained language that was too broad and non-specific. For example, the following language appeared in a number of informed consents, "*The expected benefits of treatment with this psychotropic medication include: Elimination or reduction in rates of aggression to others, aggression to self and refusals and replacement with socially acceptable and adaptive behaviors, improving learning of new skills, increased participation in schedule treatment programs and leisure activities and access to less restrictive setting.*" For example, see the informed consent for Ambien for Individual #27 and for the same individual, for Seroquel, or the informed consent for Haldol for Individual #210. Some consents did provide more specific information about the psychiatric targets of treatment, and linked the statement about potential benefit to those targets. These were informed consents for Individual #10 (Lorazepam), for Individual #58 (lithium), for Individual #110 (Abilify), for Individual l #155 (Prozac), and for Individual #447 (Abilify). Those informed consents were written in a new format, and all were reviewed in August 2011 or later. In each case the IC listed the psychiatric diagnosis and target psychiatric symptoms. These informed consents were clear that a potential benefit of the treatment was alleviation of the named symptoms.	

		Rationale as to why the benefits could be expected and a reasonable estimate of the probability of success: Each of the five consents that used the newer format contained a section titled "reason for starting (name of the medication)." However, the statements focused primarily on the need for the treatment. For example, for Individuals #58, and #110 the cited reason was the failure of other treatments, for Individual #10 it was the severity of symptoms, for Individual # 447 it was the need for augmentation of existing treatment, and for Individual #155 it was the favorable side effect profile of the medication. More focus should be added on the reasons that benefits could be expected. Reasonable treatment alternatives: The newer consents all included an entry titled "other possible choice for medications." In that section the psychiatrist listed alternative medications. However, the language of the provision was not limited to alternative medications. Each individual's circumstances will vary, but in some cases the focus should be broader than a list of available medications, and reasonable alternatives might include non- pharmacological treatments or no treatment at all.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The Facility monitored polypharmacy for all psychoactive medications. The pharmacy reported medications based on three categories of polypharmacy which were: 1. Medical polypharmacy: Individuals treated for a general medical condition such as a seizure disorder, hypertension constipation, etc 2. Psychiatric polypharmacy: Individuals treated for psychiatric illness as defined by DSM criteria 3. Mixed Index Treatment polypharmacy: Individuals who were treated with 3 or more psychoactive medications for multiple medication conditions, diseases or disorders. The pharmacy provided the Monitoring team with a description of polypharmacy reviews which was as follows: There were three tiers of review: Tier 1: All polypharmacy was reviewed and commented upon by the clinical pharmacist during the quarterly QDRR process. As described under provision J3, all individuals seen in the psychiatry clinic (PBMC) were reviewed at least quarterly and during the quarterly review were conducted with the presence of the clinical pharmacist who elaborated on the details related to polypharmacy. Tier 2: All psychiatry polypharmacy regimens were reviewed monthly during PBMC. This corresponded to the decision by the psychiatry department to have monthly PBMC reviews for individuals with polypharmacy. Polypharmacy was one of several triggers for the more frequent PBMC reviews – clinical instability was another. But for all individuals who had psychiatric polypharmacy per Facility definitions, this layer of additional review was in place,	Substantial Compliance

		Tier 3: Many individuals with polypharmacy were reviewed during the ICMs described under provision J8. At the time of the tour, the pharmacy informed the Monitoring Team that a fourth level of review was being proposed, and that was an establishment of a formal polypharmacy review panel to be made up of healthcare providers that will review individuals formally, per the request of any healthcare provider that had concerns about an individual under their care. The pharmacy provided a statistical breakdown of polypharmacy trends. Information on psychiatric polypharmacy was provided for April, August and September 2011, and the totals for the three months were 50, 46, and 43 respectively. For the mixed index group figures were available for August and September and the numbers were 46 and 41. The Monitoring team requested information about the number of individuals who were treated with intraclass polypharmacy. There were five (Individuals #68, #110, #316, #530, and #714). In order to further study the manner in which monthly reviews for individuals who had polypharmacy took place, the Monitoring Team examined the most recent PBMC notes for the seven individuals from Sample J1 who were treated with polypharmacy. Six were treated with interclass polypharmacy and one was treated with intraclass polypharmacy. Their recent PBMCs and their most recent QDRRs were examined. QDRR issues related to polypharmacy included discussion of drug/drug interactions (for example Individual #424), effort to minimize clinically unnecessary polypharmacy (for example, Individual #58), interactions with medication prescribed by other specialties (for example, Individual #29), and review of labs relevant to the medications (for example, Individual #615). The Monitoring Team also selected a sample of 12 individuals from the list of individuals identified with Polypharmacy. The selection was made so as to include several individuals treated with intra-class polypharmacy, several individuals with inter-class polypharmacy, and to additionally include individuals treated with different classes of medication (for example antipsychotics, mood stabilizers, and antidepressants). The dates of the PBMCs (September and October 2011) demonstrated that reviews were done monthly. The PBMCs included review of the polypharmacy. QDRRs were done quarterly and included more extensive reviews of drug-drug interactions. Example of items that were reviewed included labs that were relevant to the particular classes of medications (Individuals #225 and #315 for drug levels), for monitoring for metabolic syndrome (Individuals #239 and #613), for possible effects of atypicals on seizures (Individual #99) for possible additive effects when two medications from the same class were used (Individual #68), for specific side effects of medications (priapism and trazodone, Individual #99), for receptor profile matching of medications (Individuals #110 and #530), for cardiac monitoring with EKG (Individual #530), for	

		labs such as platelets (Individual #714), and for recent FDA guidance regarding the dose of Citalopram (Individual #225). Discussions of efforts to reduce polypharmacy were included in PBMC notes (Individuals #68 and #110). The Monitoring Team also noted improved medication practices during several case reviews. Individual # 404 improved on a simplified medication regimen, and Individuals #596 and #772 successfully discontinued treatment with psychotropics.	
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 Monitoring Team reviewed the MOSES and DISCUS examinations for each of the 20 individuals in Sample J1. The review showed the side effect screens were completed and were reviewed carefully (for example, the comment on the DISCUS for Individual #29 on the concomitant diagnosis with Parkinson's disease that could have compounded the examination). Evaluations were all signed, although attention should be paid to the requirement that DISCUS evaluations should all be reviewed by the psychiatrist (the DISCUS for Individual #152 was not). The Monitoring Team also observed how DISCUS and MOSES information was used by the PST, by observing how side effect information was used during the PBSP attended by the Monitoring Team. In the case of Individual #568 a discussion of a movement disorder noted during the appointment was a main focus of the PST's clinical discussion. IPNs from the previous PBMC showed that the psychiatrist had been attentive to the side effects, considered the fact that DISCUS scores were likely confounded by cerebral palsy, and the psychiatrist also noted that the individual also experienced movements which could have been an acute side effect of antipsychotics, not dyskinesia. The psychiatrist thought it likely that the main problem was dystonia and akathesia, and lowered the medication accordingly. The overall results had been positive with a diminution of the movements. During the PBMC attended by the Monitoring team the psychiatrist questioned whether the DISCUS screen results (which were done several days earlier) corresponded to her examination of the client during the appointment, and good discussion followed. That showed that side effect screens were reviewed carefully, and were the basis of relevant clinical discussion. The Monitoring Team campus-wide tracking of monitoring of side effects. These included: 1. A spreadsheet prepared by the Facility that reported campus wide data on the most recent MOSES and DISCUS screening (when appropriate) for all individuals who were given psychotropic medications and other medication that can cause dyskinesia. 2. Listings for individuals diagnosed with dyskinesia. 3. A listing of all DISCUS screens done over the past year that were rated five or higher.	Noncompliance

		The Facility response to the request for a list of individuals diagnosed with tardive dyskinesia was that Individual (#199) was diagnosed with dyskinesia. The Facility reported that Individuals #119, #199, #465 and 144 had DISCUS ratings that were 5 or higher and inspection of the Facility Spread sheet for DISCUS showed that Individuals #25 and #101 also had high ratings. Inspection of the DISCUS and neurology clinic notes showed that in one individual the movements were due to cerebral palsy, not dyskinesia. The data reviewed suggested that it is possible that not all individuals who have dyskinesia had been so diagnosed. It is important to do so for several reasons, including the higher level of review that is required for any use in those individuals of medications that can worsen dyskinesia.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	The language of the provision details what is required for psychotropic medication plans, and the same requirements were also cited in Facility Policy 1.00d *Psychiatry Services* (revised 08/30/2011). At the time of the tour such medication plans were not in place and the provision remains in noncompliance. The Lead Psychiatrist informed the Monitoring Team that she does plan to have psychiatrists complete treatment plans for new medications, but that it had been difficult to do so given the staffing shortage. Nonetheless, the improved consent form for new medications does contain some of the items required by the provision. Five of the most recent informed consents used the new format and they contained information about relevant diagnosis, the reason the medication was added, and the target symptoms and behaviors. The consents in question were for Individuals # 58 (for lithium), # 110 (for Abilify), #10 (for Ativan), #447 (for Abilify), and #155 (for Prozac). The provision requires that the PST should provide ongoing monitoring of psychotropic medication at least quarterly, and this was a requirement of the Facility policy for psychiatry as well. The reviews took place in the PBMC clinic appointments. This was a minimum requirement, and some individuals, for example individuals treated with polypharmacy, were reviewed monthly. Individuals were also added to the clinic schedule on the basis of need. Individuals whose needs were more urgent were seen individually by the Lead Psychiatrist, outside of the clinic setting, and in such cases, documentation was provided in IPNs. The Monitoring Team reviewed the records of the 20 individuals in Sample J1, and found that in all cases the requirement of frequency of review had been met. The Monitoring Team reviewed PBMCs for the 20 individuals to determine whether data-based symptom tracking was present for medication treatments. In a few cases, psychiatric symptoms were mentioned in the PBMC as targets for medication treatment. These were Individuals #424 (irritability), #58 (paranoid/somatic delusion), #493 (possible paranoia), #152 (anxiety, depression, irritability) and #240 (mood lability). In none of the cases, however, were these measures defined and no data were reported. The symptoms appeared to be guidelines for discussion during PBMC and were not the basis	Noncompliance

		for data based decision-making. The Monitoring Team reviewed the process of the treatment reviews, by attending and observing the PBMC clinic that took place during the tour. The general structure of the clinic and the way diagnoses were discussed was described under provision J2. The review here focuses on the matters related to medication treatments. Each PBMC consultation was accompanied by a form that listed the individual's psychoactive medications, the psychiatric diagnosis that was linked to the medication, and any target behaviors/ symptoms that were linked to the medication. The form also included pertinent background information including all medications taken by the individual, pertinent labs drawn since the last PBMC, current DISCUS and MOSES examinations, body mass index, weight, waist circumference (when appropriate), and any "sick calls" or other medical updates. The form also listed details of changes in medication doses, the presence of polypharmacy, and whether or not there were any neurology appointments during the review period. The form concluded with several paragraphs of commentary by the psychologist/behavior analyst that included analysis, commentary and recommendations as to whether reevaluation of the medication regimen was needed. The Monitoring Team observed PBMC reviews for Individuals #39, #239, and #568. In each of the clinic appointments the individual was interviewed/examined, and each of the participants reviewed information relevant to his/her area of expertise. For example, the nurse case manager reviewed general medical information and side effect information, and the clinical pharmacist reviewed drug interactions and polypharmacy. QDDRs were done quarterly, and were not scheduled to be done at the PBMC that was attended by the Monitoring Team. After the presentation there was general discussion about the individual's progress. In each case the discussion was guided by the data that had been collected by the psychologist regarding the behavioral targets identified for the individual. In each case there was some discussion of the underlying diagnosis. In each of the three appointments there was evidence of positive elements of treatment. These included: • For Individual # 39, the discussion focused on what had been learned from the challenge to long-standing treatment with Paxil for what was described as OCD behaviors. The individual had been treated with a high dose of Paxil and the PST was not convinced that benefits were evident, or perhaps were no longer evident. Over the course of more than a year, the medication was gradually reduced and eventually discontinued altogether. While the medication taper was initially successful there was an eventual breakthrough of repetitive symptoms which required reinstatement of the Paxil and subsequent decreases in target symptoms (body fluid smearing and hesitation).	

		• For Individual #568 the discussion focused on seemingly successful treatment with the antipsychotic Seroquel for symptoms of mania, described as aggression and agitation. The team reviewed that at the last clinic there has been concern about an increase in those same symptoms, but the psychiatrist had recognized that the seeming relapse could have been secondary to medication side effects including dystonia and akathisia. The individual's dose was reduced; the individual did well, and has now been able to resume more normalized activities, including attendance at religious services of her family's choice. • For Individual # 239, the discussion focused on how increasing doses of Seroquel had helped resolve target symptoms of aggression to others and yelling, that the team had linked to the psychiatric diagnosis of depression NOS and psychosis NOS. The PST's discussion in each of the above cases included attention to medication side effects, laboratories and other medical data. Similar to what was noted in the records for individuals from Sample J1, the PBMC observed did not include review of appropriate data for psychiatric measures. Instead, the discussion for Individual # 239's depression was guided by data for agitation and yelling. Auditory hallucinations were mentioned as symptoms that were related to the depression with psychotic features, but no data were reported. For Individual # 568 data cited to support treatment for mania was aggression to others and stripping. The PST members recognized that data was needed for psychiatric symptoms and they discussed ways to provide that kind of data. To achieve compliance, the Facility should improve the process by which targets for psychiatric treatment are identified, and the process under which data on those targets are collected and reported, so that decisions about medications can be linked to that data.	
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	RSSLC Psychiatry Services Policy required that the Facility must obtain informed consent (except in the case of emergency medications) prior to the administration of psychotropic medications. During previous reviews the Facility clarified that HRC approval was obtained prior to the administration of the medication, and that consent for medication was re-obtained on an annual basis. During the current tour the Monitoring Team confirmed with the Lead Psychiatrist that psychiatry is now responsible for the informed consent and that the psychiatrist spoke directly with the guardian/LAR about the medication. This was a positive practice since it provided the psychiatrist with the opportunity to review with the LAR /guardian the information that was contained in the informed consent, and to answer any questions. In the POI, the Facility reported that the revised process for consent with input from the psychiatrist continued to be implemented during the six-month period that was reviewed.	Noncompliance

associated risks.

The Monitoring Team reviewed the informed consents and HRC reviews for all 22 psychotropic medications approved by the HRC during the past six months and found that an informed consent signed by the LAR/Guardian was present for all consents, and the treating psychiatrist (either the Lead Psychiatrist or consulting psychiatrist) signed 16 of 22 (73%) of the consents.

The Monitoring Team reviewed the template for the informed consent that was in use at the time of the tour, which was present for five of the more recent informed consents, which were for Individual #10 (Lorazepam), for Individual #58 (lithium), for Individual #110 (Abilify), for Individual #155 (Prozac), and for Individual #447 (Abilify). Results of the use of the new template and HRC review were as follows:

Informed Consent element	Monitoring Team findings
The five axis DSM psychiatric diagnosis	Provided in all cases
The medication	Provided in all cases
Target symptoms and behaviors	Yes, but neither medication plans nor data bas in place, and there were no operational defini symptoms and behaviors.
Reason for starting the medication	In one of the five cases (Individual #447) ther Axis I diagnoses. The consent implied that Ab to treat mania, but this should have been mad
Other choices for medication	As discussed under provision item J10 the re provide treatment alternatives is not limited t medications.
Expected benefits of treatment with the medication	For Individuals #58, #110, and #447 the dura was linked to achievement of stability. How st assessed (for example resolution of specified s not spelled out.
Dosing	The five medications reviewed were all prescr indications and FDA guidelines for dosing wer
Monitoring	This was provided for medical monitoring.
Side effects/risk versus risk considerations	See comments on risk/benefit under Provisio comments apply here too.
Common and serious side effects of the medication which were relevant to the individual, accompanied by more detailed information about the	Present

		medication that was provided with a medication information handout.		
		HRC review	The justification for Individual # 447 was too broad and did not correspond to what was provided in the informed consent . Side effects cited for the same individual did not correspond to those listed in the informed consent. In all five cases different information is presented in the HRC review for Risk vs. Risk, as compared to the informed consent.	
		The Monitoring Team also reviewed the records of the 20 individuals in Sample J1 for the presence of signed consents for medications that had been in place for more than six months. These could not be located for the following: Individuals #39 (Anafranil), #58 (Tegretol, Invega, Depakote, Inderal), #110 (Inderal, Depakote, and Seroquel), #152 (Geodon, Lunesta, Depakote), #210 (Klonopin, Depakote), #404 (Risperdal), #447 (Depakote, Paxil, Restoril), #493 (Lexapro), #499 (Seroquel), #615 (Depakote, Risperdal), and #757 (Tegretol, Geodon).		
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.	RSSLC Psychiatry Policy I.00d addressed the topic of integrated care between psychiatry and neurology as follows: "*The neurologist and psychiatrist must coordinate the use of the medications, through the PST process, when medications are prescribed to treat both seizures and a mental health disorder."* The Lead Psychiatrist continued to attend the neurology clinic and consulted with Dr Croft on consolidation of pharmacotherapy for individuals who were under psychiatric care and who were also treated for epilepsy. The consulting psychiatrist was not able to consult with Dr. Croft in person and received copies of neurology reports during PBMCs. The Monitoring Team reviewed Sample J1 for individuals who were prescribed medications to treat both seizures and a mental health disorder, and identified Individuals # 27, #239, #424, #615, and #746. Neurology clinic notes were provided for Individuals #27, #239, and #615. These showed review of neurological but not psychiatric issues. The Monitoring Team reviewed broader collaboration between psychiatry and neurology, via review of individuals' neurology clinic appointments that addressed matters relevant to both disciplines. The topics reviewed were severe dyskinesia and neck movements in an individual treated with Risperdal (Individual #477), staring spells in an individual not known to have epilepsy (Individual #210), an initial evaluation of a newly admitted individual with a remote history of a seizure and current treatment with an anticonvulsant for a behavioral disorder (Individual #757), and management of		Noncompliance

		known dyskinesia and seizures in individuals also treated for psychiatric disorders (Individuals #465 and #483, respectively). All were examples of good collaboration between the Lead Psychiatrist and the consulting neurologist. The Lead Psychiatrist provided the example of Individual #404, who was treated with Keppra for seizures and who had difficulties with anxiety. Since anxiety is a possible side effect of Keppra, the Lead Psychiatrist discussed the matter with the neurologist, and the two physicians decided to try to replace Keppra with another medication. This was done, and the individual's anxiety was much improved. This too was an example of a good interdisciplinary process. Efforts are needed to better integrate treatment of the individuals who are under the care of a consulting psychiatrist. To reach compliance, the Facility must ensure all psychiatrists coordinate use of medications with consulting neurologists.	

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

1. Initiate annual psychiatric (re) evaluations, and use those evaluations to resolve conflict between different diagnoses that are in the records, rule out diagnoses, and (whenever possible) NOS diagnoses (Provisions J2 and J6).
2. Review and address the cases where the same behavioral targets are the focus of both behavioral and psychiatric interventions. If both are needed, the reason(s) should be addressed as part of the rationale statements in the medication treatment plan and elsewhere (Provisions J2, J3, J8, J9, and J13).
3. Develop measures to assess whether DSPs and MSPs are effective and provide data on those measures (Provision J4).
4. Develop a long term staffing plan for psychiatry that will include psychiatrists and support staff (e.g., secretarial, administrative scheduling of psychiatric consultation, etc.) to make it possible for the psychiatrists to provide required services (Provision J5).
5. Improve the process for the PST, including the psychiatrist and psychologist, to formulate combined assessments and case formulations (Provision J8).
6. PSTs should discuss whether individuals treated with psychiatric medications are best served by behavioral pharmacological or other interventions, and why. The conclusions should be documented and should be included in evaluations that are updated annually, such as the PBSP and PSP (Provision J9).
7. Include discussion of what benefits could be expected and reasonable alternative treatments in analyses of risks and benefits for new medications (Provision J10).
8. Review individuals with elevated DISCUS ratings for possible dyskinesia, and make sure that individuals who have dyskinesia have the diagnosis added to APLs (Provision J2 and J12).
9. Develop a plan to implement medication treatment plans (Provision J13).
10. Link psychiatric treatments to psychiatric diagnosis and symptoms/behavioral characteristics of the disorder (Provision J13 and J14).
11. Identify the psychiatric symptoms/behavioral characteristics that will be used to monitor the efficacy of each psychiatric medication. The selected measures should have operational definitions and data should be collected and reported in the customary fashion (Provision J13).
12. Improve the manner in which risk/ benefits for medications are described and make sure that the same information is reported in medication plans, informed consents, HRC reviews, and related documents (Provision J10 and J14).

The following are offered as additional suggestions to the Facility:

1. The Department of Psychiatry might find it useful to develop spreadsheets that track the diagnosis and psychotropic medications for each individual who is supported by psychiatry.
2. The Facility might find it useful to ask the Quality Assurance Department and Psychiatry to develop a tool to monitor activities and processes required by the SA.
3. The Facility should consider a way to update APL in the record when changes take place, either electronically or by manually updating the APL in the record.

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) (10.10.2011) 2. Facility Policies and Procedures - (J.6 – 09.08.2011) 3. Minutes from the Behavior Service departmental meetings (6.6.2011 and 8.29.2011) 4. Minutes for the Behavior Services peer review committee meetings (4.29.2011 through 9.19.2011) 5. Annual PSP, PSP updates, Training Objectives (TOs), 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: #16, #17, #51, #137, #152, #160, #177, #193, #235, #267, #320, #325, #351, #399, #413, #426, #440, #448, #558, #630, #669, #713, #718, #757, and #794 **People Interviewed:** 1. Lloyd Robert Buckner, MS, BCBA – Behavior Services director 2. Cynthia Fannin – Director of Education and Training 3. Carol Agu – QDDP Coordinator 4. Billie Dejean, MA, BCBA – Psychologist 5. Shelly Evan, MS – Psychologist 6. Tranika Jefferson, MS – Psychologist 7. Lora Peters, MA – Psychologist 8. Emma Williams, MS – Psychologist 9. Derric Anglin, MA – Psychologist **Meetings Attended/Observations:** 1. Behavior Support Committee (10/24/2011) 2. Behavior Service departmental meeting (10/24/2011) 3. Active Treatment Committee (10/25/2011) 4. Risk Process meeting (10/25/2011) 5. PSP for Individual #156 (10/26/2011) 6. Restraint Reduction Committee (10/26/2011) 7. Human Rights Committee meeting (10/27/2011) 8. Observed training, active treatment, staff interaction and meals at the following residences and programs: Angelina (10/27), Colorado (10/26), Leon (10/26), Neches (10/26), Nueces (10/25), Pecos (10/25), Sabine (10/25), San Jacinto (10/25), and Trinity (10/25)
	Facility Self-Assessment: At the time of the site visit, RSSLC reported that Provisions K.2 was in substantial compliance with the SA. The Monitor was in agreement with the Facility in relation to Provision K.2.

	The Facility also reported a limited number of actions that had been taken since the last site visit. For some of these actions, such as the revision of formats for PBSPs and SFAs, the process had not been completed. For other actions, such as the addition of Behavior Service staff to the Behavior Support Committee, the process had been completed. Sufficient time had not passed since the completion, however, to allow for the assessment of benefit. One additional action taken by the Facility, the hiring of a new Behavior Service director, led to substantial compliance on K2. The Facility Self-Assessment of Section K consisted primarily of the documentation of specific events, such as the start or completion of a specific task. Qualitative statements, when provided, were not based upon objective criteria. Rather, these statements were presented in an informal narrative, such as indicating that a particular effort required further improvement. Based upon such statements, it was not clear that the Facility had implemented a comprehensive and systematic process to measure progress toward compliance with the SA. The Facility Self-Assessment also included a Plan of Improvement. This Plan of Improvement typically comprised discrete events or practices to be completed. The evidence listed by the Facility for these items included statements such as "Data sheets submitted with each PBSP" and "Assessment list" for people to receive adaptive and intellectual assessment. This approach to self-assessment reflected an emphasis upon the occurrence of specific events rather than upon qualitative improvement relating to required practices. As with the implementation of a behavior change program, RSSLC must approach compliance with the Settlement Agreement in a systematic and evidence-based manner. Measures of compliance must reflect procedures that capture the salient elements of the task as part of an ongoing process rather than a discrete event that is either in compliance or not. This also requires the Facility demonstrate the ability to use objective measures of performance, openness to measurement outcomes, a consistent and effective use of resources, and a well-organized process for documenting and reporting progress. Without such an approach, the Facility will be challenged to make the changes necessary to satisfy the Settlement Agreement.
	Summary of Monitor's Assessment: One challenge the Facility faced since the previous site visit was the need to fill the vacancy in the Director of Behavior Service position. This position was not filled for several weeks, and the new director did not fully assume responsibilities until a few weeks prior to the current site visit. As a result, many of the efforts to meet compliance with the SA fell dormant. Despite this challenge, the Facility did provide evidence of modest progress in a few areas. The staff and resources necessary to provide intellectual and adaptive assessment were obtained. In addition, the peer review process was revised to provide improved review and follow-up. Overall, however, the Facility had not progressed toward compliance with the Settlement Agreement in numerous areas. Observations, interviews and record reviews were conducted on-site at RSSLC from 10/24/2011 through 10/28/2011. Record reviews continued off-site for several days following the site visit. Only one Provision

	of the SA, Provision K.2 was found to be in substantial compliance. Based upon information obtained as part of the site visit, it was apparent that little substantive progress had been achieved by the Facility. Progress toward credentialing staff as BCBAs had stagnated. Due to the number of psychologists not working toward board certification, it was not clear that the Facility would be able to satisfy the provision of the SA in the near future. Although new data collection forms had been implemented, these forms were not yet consistently used, even in the most recent PBSPs. The graphical presentation of behavior data and the use of those data in formulating treatment plans continued to reflect weaknesses noted during previous site visits. The structural and functional assessments, although more often including widely accepted instruments such as the FAST and MAS, continued to lack comprehensive use of behavior-analytic principles. As a result, it was not possible to demonstrate that PBSPs were evidence-based and likely to provide adequate supports and teaching.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>K1</td><td>Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td>During the October 2010 site visit, it was noted that Behavior Services department at RSSLC had one employee with board certification as a behavior analyst and 11 more staff who were either participating in or who had completed BCBA classes. In May 2011, the number of BCBA credentialed staff employed by the Facility had increased to four. In addition, 15 staff members had enrolled in or completed the training courses. It was disconcerting at that time that 25% of the Behavior Services staff were not participating in any training related to board certification in applied behavior analysis.

During the current site visit, documentation reflected that the number of BCBA credentialed staff had fallen to three. Of the remaining 16 staff eligible for board certification, only nine were actively pursuing board certification.

<table><tr><td></td><td>4/2010</td><td>10/2011</td><td>Change</td></tr><tr><td>Total number of BCBAs</td><td>0 (0%)</td><td>3 (16%)</td><td>16%</td></tr><tr><td>Total staff enrolled in/completed BCBA classes</td><td>4 (21%)</td><td>9 (47%)</td><td>26%</td></tr></table>
Although progress over baseline was noted in regard to BCBA training, the actual progression toward demonstrably competent staff at RSSLC had retreated. This lack of development in staff competence was likely a contributing factor in the high number of PBSPs at RSSLC that failed to meet standards of practice in applied behavior analysis. Findings in this report corresponding to Provisions K4, K5, K6, K7 and K9 of the</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		Settlement Agreement document more fully the limitations noted in behavior assessment and intervention. In relation to Provision K1, it was evident that PBSPs generally were unlikely to promote the development of skills and abilities in the people living at the Facility.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	Since the May 2011 site visit, RSSLC had hired a new Director of Behavior Services, The new Behavior Services Director, Mr. Lloyd Robert Buckner, MS, had been employed by RSSLC less than two months at the time of the current site visit. Mr. Buckner possessed board certification in applied behavior analysis and had extensive experience in working with people with intellectual and developmental disabilities. Based upon his credentials, Mr. Buckner satisfied the requirements of the SA in relation to Provision K2.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	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 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. In addition, RSSLC had 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 May 2011 site visit, it was reported that the peer review process had again	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. During the current site visit, it was reported by the Facility that some changes had been made in the peer review process, and additional changes were likely in the coming months. The changes reported by the Facility included the following. • The peer review process was altered to require that the peer review committee chair conduct a second review of submitted materials in circumstances when the committee had recommended revisions or corrections. This secondary review was to ensure that the necessary changes had been implemented and reflected adequate adherence to the standards of applied behavior analysis. • The responsibility of reviewing Safety Plans was added to the peer review process. • The membership of the peer review committee was altered to included staff psychologists as voting members. The changes introduced to the peer review process were welcome, but, at the time of the site visit, too little time had passed to determine what effect that changes had produced. Observations conducted at the peer review meeting during the current site visit reflected a comprehensive discussion of the strengths and weaknesses of each submitted PBSP and related assessments. Neither the discussion during the meeting nor the more detailed review of materials prior to the meeting included the use of a structured approach to ensuring that the materials included all necessary components. Therefore, it was difficult to determine if the review process was capable of fulfilling the obligations of a peer review process. The adoption of a formal rubric or checklist of the criteria for necessary for acceptance would be beneficial to this process. As changes to the review process had only recently been implemented, and further changes were anticipated, it was not possible to develop any extensive conclusions about the status of peer review at RSSLC.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures	During the baseline visit in April of 2010, it was noted that data collection for PBSPs at RSSLC was inadequate to the task of measuring behavior and determining the need for or benefit from behavioral or psychopharmacological interventions. 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	Noncompliance

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	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.	collection practices remained essentially unchanged during the October 2010 and May 2011 site visits. At the time of the October 2011 site visit, the Facility reported that changes to the data collection process had been introduced, including the following. • Data collection was expected to involve the use of individualized data collection forms and procedures. • Use of the "DRA Data Sheets" that were often inadequate was discouraged. • Data collection forms were to be included in the materials reviewed during the peer review process. Although this process had been initiated in July 2011, as of October 2011 the Facility reported ongoing difficulty with obtaining consistent measures of target and replacement behavior. A review of the data collection process during the current site visit did reflect improvements. • For Individuals #440 and #137, data collection included total frequency counts of the target behaviors rather than less precise measures. • All data collection forms reviewed included some level of instruction on the how to implement the PBSP and document target and/or replacement behavior. Improvements, however, were noted to be inconsistent. • Several PBSPs continued to rely upon the "DRA Data Sheets." • For several individuals, including Individual #160, not all target behaviors were included on the data collection form and the PBSPs did not indicate how the additional targets were to be measured. • For several individuals, including Individual #794, behaviors to be measured often included multiple actions over a period of several minutes, such as aggression that might be displayed as a series of hits and kicks. In such circumstances, neither the PBSP nor the data collection form offered detailed instructions of whether to record the event as a single display of the behavior or multiple displays. Based upon the information gathered during the site visit, it was evident that, despite improvements, the data system lacked coherence, needed to be more sensitive to each individual's behavior, and lacked the specific instructions for data recording necessary for valid and reliable measurement. 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	

#	Provision	Assessment of Status	Compliance
		graphing of treatment data at RSSLC continued to present substantial weaknesses. These weaknesses or limitations included the following. • In 10 of 10 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 10 of 10 records (100%), treatment objectives were stated in terms of total frequency while data were presented as daily mean frequency per week. • In 10 of 10 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. 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 10 records (33%), 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 10 of 10 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. 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. Furthermore, Behavior Services staff and the PST at times failed to recognize when data suggested undesired behavior to be worsening. As a result, it was not possible to reach the conclusion that RSSLC used clinical indicators as part of an evidence-based approach to treatment. The following examples were noted: • For Individual#017, target behaviors had increased beginning in May 2011. Documentation did not reflect any attempt to analyze the change in behavior in order to identify and implement any necessary changes to the treatment plan. • For Individual #440, despite increases in the target behavior, progress notes for several months stated that the individual continued to make progress. Neither recent behavior trends nor a comparison with baseline reflected any evidence of improvement. The continued lack of revision to inadequate data collection and presentation practices	

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		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 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.	Intellectual and adaptive testing results play an integral role in understanding an individual. While a functional assessment may provide vital information regarding a single behavior or functional class of behaviors, intellectual and adaptive testing can prove useful in the development of teaching 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, as well as how those abilities and limitations are manifested in the person's daily activities. All previous site visits to RSSLC reflected no improvement in conducting intellectual and adaptive assessment or incorporating such assessments into the Psychological Evaluation. At the time of the current site visit, however, the Facility indicated concrete steps toward meeting the requirements of this Provision. In August 2011, a person had been hired to fulfill the role of completing intellectual and adaptive testing and write Psychological Assessment reports. This staff member, Karen Hernandez, completed facility orientation training only several days prior to the site visit. As a result, it was not possible for the Facility to provide a sample of her work. 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. It is therefore essential that behavior assessment be conducted in as organized and formal a manner as possible. All previous site visits to RSSLC revealed substantial and pervasive limitations in the assessment of behavior function. In May 2011, a sample of 18 structural and functional assessments of behavior revealed weaknesses in areas such as use of widely accepted assessment practices, identification of setting events and antecedents, and the identification of specific functions of the undesired behavior.	Noncompliance

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		Between the May 2011 site visit and the current site visit, the Facility reported that minimal changes had been made in the structural and functional assessment process. This was largely due the lack of a Director of Behavior Services during much of the interval. Rather than conduct a large sample of existing assessments known to reflect limitations, the new Director of Behavior Services was asked to provide examples of the best structural and functional assessments completed since the last site visit. Although some modest changes were noted, all examples reflected limitations similar to those encountered during previous site visits. Presented below is a review of one structural and functional assessment completed for Individual #757 that represented the common limitations. • Problem behaviors that were noted anecdotally to be of interest included, "hurts self, hurts others, destructive, disruptive, unusual habits, socially offensive, withdrawn/inattentive and uncooperative." All of these behaviors were indicated to be barriers to community integration. The structural and functional assessment (SFA) focused upon noncompliance, verbal aggression, inappropriate touching, leaving an area without notifying staff, and aggression to others. It is not necessary, and can often be counterproductive, to attempt to assess all anecdotally suggested target behaviors. There does, however need to be a rationale for the selection of behaviors that will be the focus of assessment. The SFA for this individual did not provide a rationale or justification for why some behaviors were selected over others. • Both the Functional Assessment Screening Tool (FAST) and the Motivational Assessment Scale (MAS) were used as anecdotal assessments of behavior function. Results of the FAST were presented in bar graphs while the results of the MAS were presented in tables. Although the two instruments organize identified function differently, no effort was made to integrate the findings and present an interpretation of function for any of the target behaviors. Furthermore, the results of the assessment were often ambiguous with no clear primary function. The assessment report did not address the ambiguity or attempt to refine the assessment results. • The SFA indicated that the FAST was completed on May 26 2011 and MAS was administered on May 26, June 6, and in August (No specific August date was provided). No rationale for the prolonged assessment period was provided. In addition, it was not indicated whether separate behaviors were assessed with the MAS on different dates, or if all behaviors were targeted for repeated assessments. It should be noted that behavior often changes over time and assessment results obtained in May might not be comparable with results obtained three months later. • A brief mention was offered in the assessment report of direct observations in relation to noncompliance. No other direct assessment of behavior was	

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		presented. • Conclusions were presented in the SFA report regarding establishing operations, setting events, antecedents and consequences. Although the FAST and the MAS are widely used instruments, they are most helpful in identifying functions rather than specific setting events, establishing operations and behavior contingencies. As no other assessments capable of providing information on such elements were described in the SFA, it was unclear how conclusions were reached for these elements. Furthermore, these conclusions were presented in a general narrative rather than organized to reflect the relation of each conclusion to each of the target behaviors. As a result, it was not clear how, if at all, the information contributed to the understanding of the target behaviors or could be used to develop effective interventions. • Hypotheses regarding function were presented. These identified functions lacked specificity and often included three or more functions for each behavior. Although a two to three sentence explanation of function was provided for each targeted behavior, the explanations were not supported by comprehensive assessment. • Several proposed interventions were included in the SFA. Due to the organization of the document, it was not possible to identify a process by which assessments led to the proposed interventions. Furthermore, the interventions were not organized in a coherent manner. These issues suggested the lack of a systematic approach to behavior change. • Additional issues also suggested a disorganized approach to the assessment process. For example, the SFA was dated June 9 2011 and, as has been discussed, the assessment continued through August. In October, however, the Behavior Support Committee minutes reflected that additional targets were added to the PBSP based upon this SFA. These issues were seen consistently across the reviewed Structural and Functional Assessments. This suggested that, although the Behavior Services staff was familiar with some aspects of applied behavior analysis, there was a pervasive lack of sophistication and the ability to take the disparate components of behavior analysis and construct a coherent assessment. As a result, despite small pockets of competence, it was unlikely that staff possessed the skill set necessary for effective intervention development. 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	

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		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. Eight of 10 records submitted by the Behavior Services Director 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. 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 May 2011 site visit, nearly 100% of individuals had been screened at some point for mental illness using the Reiss Screen for Maladaptive Behavior (Reiss Screen). Unfortunately, during the current site visit it was evident that very little further 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. Examples of this included the following. • For Individual #17, the SFA included extensive quotes from the psychiatrist's clinical observations. The noted observations included indications of suspiciousness, anxiety, obsessions, compulsions, and somatic complaints. It was also indicated that the psychiatrist had offered a diagnosis of Obsessive-Compulsive Disorder and Mood Disorder. Following this presentation, however, no potential symptoms of mental illness were presented in the SFA in association with the factors contributing to undesired behavior. • For Individual #713, the psychiatrist had offered a diagnosis of Major Depressive Disorder, Severe with Psychotic Features. Potential symptoms presented by the individual were described as depressed mood, irritability, sleep disturbance, withdrawn behaviors, fatigue, and hallucinations and/or delusions. On the Reiss Screen, the Individual had been given a Total Score rating of 17, indicating the need for mental health supports. Despite this information, neither the SFA assessments nor the conclusions offered for establishing operations or setting events included any consideration of mental illness.	

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		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 K5.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Based upon the information presented in K5, minimal documentation in the record reflected assessment findings that were demonstrated to be current, accurate or complete.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	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. As discussed in Provision K5, RSSLC had recently hired a psychologist to conduct intellectual and adaptive assessments, as well as write Psychological Assessment reports. Due to the psychologist having been only recently hired, there were not sufficient examples of work available to assess the testing process adequately.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	At the time of the current site visit, the Facility reported that a variety of counseling strategies were utilized for the 13 individuals involved in non-PBSP psychological services, but that such strategies lacked formalization and did not adhere to evidence-based or empirical practices. Although a template for non-PBSP treatment plans had been developed since the previous site visit, the Facility had not implemented the template. This was the third consecutive visit that RSSLC was unable to show evidence of an evidence-based approach to non-PBSP psychological services. Due to the lack of treatment plans, it was not possible to review non-PBSP psychological services at RSSLC. As this provision calls for the provision of such services when the need has been identified, at the time of the site visit the Facility had failed to comply with this provision of the Settlement Agreement.	Noncompliance
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary	The Facility had a PBSP in place for each individual identified as requiring behavior intervention. Consent and approval forms were typically in the active record for PBSPs, restrictive procedures and the use of psychotropic medication. Documentation of the consent and approval process reflected that the consent process at times was not well	Noncompliance

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	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.	organized, failed to incorporate a review of the latest information regarding the individual, and was not completed in a timely manner. As a result, Facility documentation did not consistently reflect that the review and consent process offered adequate protections for the individuals living at RSSLC. • For Individual #440, the PST approved the proposed PBSP on 7/26/2011. Approval from the BSC was not obtained until 8/24/2011, with HRC approval following on 9/29/2011. No discussion was provided in the record to account for the prolonged delay in implementing the behavior intervention. • For Individual #757, consent was obtained for the PBSP on 8/25/2011, followed by HRC approval on 9/8/2011, and BSC approval on 10/20/2011. Documentation reflected that changes to the SFA and PBSP including the addition of target behaviors, was required by the BSC. No follow-up review was completed by the HRC following these changes and new consent was not obtained. Due to pervasive weaknesses in the assessment process, it was likely that only limited understanding of the individual's treatment targets was gained and only minimal support for intervention strategies was provided. Without comprehensive assessment, and the resulting poor support for provided interventions, it was unlikely that the information contained in the consent and approval documents was valid, that treatments for which consent and approval were requested could be supported, and that the those who were requested to provide consent were 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	

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		had often failed to meet the obligation of providing sufficient information to the consenter. As a result, the Facility was not able to substantiate that valid and informed consent had been obtained. The majority of PBSPs reviewed at RSSLC included preventative measures, as well as teaching strategies and safety precautions. Without rigorous and comprehensive assessment, however, it could not be demonstrated that interventions intentionally focused upon the most salient aspects of the undesired behavior or made use of behavior change methods derived from valid and reliable data.. Such interventions possess a low probability for success and can precipitate the eventual use of more intrusive procedures. Between the May 2011 site visit and the current site visit, the Facility reported that minimal changes had been made in the PBSP format or development. This was largely due the lack of a Director of Behavior Services during much of the interval. There were PBSP samples that reflected a more evidence-based foundation and that were well organized. In a sample of PBSPs completed during the previous six months, selected by the Director of Behavior Service as reflecting the best work of the psychologists/BCBAs, however, there was a much higher prevalence of weak PBSPs. Presented below is a review of one PBSP completed for Individual #757 that represented the limitations common across the sampled PBSPs. • The Target Behaviors section is where Direct Care Professionals (DCPs) are to be provided with the specific definitions of the behaviors for which they are to offer intervention. For Individual #757, the Target Behavior section listed treatment goals in relation to the targeted behaviors rather than definitions. For example, the following statement was offered about the target of verbal aggression, "Teach [the Individual] to express anger/discontent/frustration with appropriate language." This might have been an appropriate goal for the individual. The statement, however, did not provide the staff with information needed to recognize the behavior targeted for intervention. • It was suggested in the SFA and summary of functions that undesired behavior could be used by the individual to obtain attention. The PBSP contained an Environmental Supports section where instructions on how to alter the environment and reduce the need for undesired behavior were to be provided. Nowhere in this section were instructions provided on how to ensure that abundant attention for desired behaviors was provided. This suggested that the PBSP was not likely to reduce the need for undesired behavior in order to obtain attention. As a result, it was probable that staff intervention would involve responding to displays of undesired behavior rather than proactively strengthening desired behavior.	

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		• Effective behavior interventions should include instructions on how to change the environment to reduce the individual's need for the undesired behavior and remove the environmental events likely to evoke the undesired behavior. The Environmental Supports section mentioned above included some such information. Several sections throughout the PBSP, however, contained similar although not redundant information. This lack of organization increased the difficulty for DCPs to readily identify the requirements of the PBSP and effectively act to change behavior. • Despite the suggestion that some undesired behavior was maintained by attention, several elements of the PBSP provided attention for undesired behavior. For example, a multistep instruction for addressing poor cooperation included some form of attention on several steps. Although such an intervention might eventually result in cooperation, it was also probable that such a strategy would strengthen poor cooperation or delayed responding. • Several facets of the Prevention of Target Behavior section of the PBSP for Individual #757 could make implementation of the intervention more difficult. o The multistep section began with the later, more severe form of the behavior and progressed toward the earlier, least severe form. When attempting to prevent or avoid the display of a behavior, staff needs instructions on how to act as early in the chain of behavior as possible. By presenting the later behaviors first, this process was made more difficult for staff. o Some of the steps in this section included "Evaluate the situation" and "Attempt to determine what or whom in the immediate environment that may be causing the problem." No additional instructions or guidance was offered on how to implement these steps. It would have been helpful to include common environmental conditions that contribute to such behavior or specific evaluations that could be used. o One of the steps in this section included the instruction to prompt the individual to perform his replacement behavior. No formal process for prompting was provided. If the individual's arousal and agitation were increasing, the presentation of a formal teaching session could evoke greater arousal or anger. In such circumstances, staff require precise instructions. • The format of section headers and bullet points was not consistent throughout the PBSP. Such formatting provides cues necessary for reading and comprehending the material presented. The inconsistent format could increase the difficulty of implementation for the DSPs and increase the latency of program implementation. • The PBSP included baseline data for the target behaviors. Baseline was collected	

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		for one month; from 4/18/11 until 5/18/11. Although it was positive that a baseline was provided, and that the baseline was recent, there were weaknesses noted. o The baseline for the month was presented as a single number for each target. This did not provide sufficient information regarding whether the behavior was increasing, decreasing, or stable. Such information can be important in determining intervention efficacy. o The baseline number for some targets was presented as a decimal number. There was no indication in the PBSP that the baseline reflected an average across time or the intervals used in formulating an average. It was therefore unclear how some data points could have comprised decimal numbers. • The PBSP included objectives or treatment expectations for the intervention. Each of these objectives was presented in terms of success. For example, one objective included the criteria of eight or fewer episodes of aggression per month for three consecutive months by 4/18/12. Several limitations were noted in this approach. o No criteria were provided for determining the PBSP to be ineffective. As a result, the PBSP would be required to continue for a full year before efficacy could be determined. It is important that each target be provided with treatment expectations that define both success and failure. In this example, the failure criteria might have been a decrease of less than 20% within 45 days of initial implementation of the PBSP. o It is also important to establish criteria for success with a timespan of less than one year. It is reasonable to expect some clinical success within 90 days of implementation. Continuing even an effective teaching strategy beyond the point of mastery can create the potential for training to become a punisher. o For Individual #757, baseline data for several of the targets were at or near success criteria. It was not evident from documentation the reason for the provided treatment expectations. • Although information about mental illness and prescribed psychotropic medications was provided, none of the intervention strategies included instructions for displayed symptoms of the diagnosed mental illness. In the PBSP for Individual #757, as well as several of the additional PBSP selected by the Director of Behavior Service, there were areas of strength. For example, several of the PBSPs reflected information gained from anecdotal assessments such as the FAST or MAS. Frequently, however, it was not apparent that the FAST and MAS were integrated into a systematic approach to understanding the reason for a behavior and developing an appropriate intervention. Furthermore, many PBSPs were not organized to reflect a	

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		systematic and evidence-based approach to intervention. The result was that any benefit from these areas of strength was overshadowed and minimized. 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.	
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. Some changes in the data collection process were initiated in July 2011 (See Provision K4). At the time of the current site visit, however, the Facility reported ongoing difficulty with obtaining consistent measures of target and replacement behavior, and there was no evidence that assessment of accuracy and validity of data was assessed through interobserver reliability checks. In addition to limitations noted in data collection, the practices used in the compiling and graphing of treatment data at RSSLC had not been revised since the previous site visit. In May 2011, data graphs at RSSLC had been found to lack coherent use of data intervals and measures, inconsistent Y-axis scales, and failure to provide demarcation of condition and treatment changes on the data graphs. As reflected in the examples below, these same weaknesses were evident during the current site visit. • In 10 of 10 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 10 of 10 records (100%), treatment objectives were stated in terms of total frequency while data were presented as daily mean frequency per week. • In 10 of 10 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 #678 included four data graphs with four different Y-axis maximum values (4.50, 6.00, 0.12 and 1.00). 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 10 records (30%), 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 10 of 10 records (100%), no indications of treatment conditions were	Noncompliance

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		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. Despite the areas of progress, the quality of data and data graphs at RSSLC fell far below accepted standards for applied behavior analysis.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	During the current site visit, RSSLC indicated that substantial revisions were underway in the format of the PBSPs. In August 2011, DADS had distributed a draft for a new PBSP format. In September 2011, the Behavior Service director at RSSLC had begun further revisions to the PBSP format. Part of the intent for the revision process was to improve the readability of the PBSPs. With extensive revisions underway, it was decided to await completion of the revision process before conducting a review for this Provision.	Noncompliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	At the time of the baseline visit in April, 2010, the Monitoring Team determined that a competency-based approach to staff training for PBSPs was not in place. During the baseline visit, it was both observed and reported that training on PBSPs in many residences consisted of being read or asked to read the intervention plan. Staff was 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 and May 2011 site visits, 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. Although the Facility had indicated in May 2011 that a new staff training initiative was being implemented, there was no indication in October 2011 that changes had been implemented in the staff training process.	Noncompliance
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. This represented approximately one BCBA for every 153 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 42 individuals residing at the facility. RSSLC currently employs 12 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. This is of particular importance while a substantial number of Behavior Services staff are not demonstrably competent in applied behavior analysis. (K1, K3, K4)
2. The Facility should consider the use of a rubric or list of required components for SFAs and PBSPs as part of the Peer Review practices. (K3)
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. (K9)
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 followed. (K1, K3, K4)
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. (K5, K6)
6. The Facility should act to ensure that a comprehensive case formulation process is implemented that includes a) the formal integration of behavior assessment into the process for diagnosing and treating mental illness, as well as the inclusion of mental illness into 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. (K5)
7. 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. (K4, K10)
8. 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. (K8)
9. 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 (POI), dated 10/10/2011 2. Clinical records for Individual #124, #290, #364, #353, and #30 3. Behavior support plans for Individuals #680, #625, #530, and #723 4. Most recent PSP for Individuals #680, #625, #530, and #723 5. Medical and Administrative mortality reviews on Individuals #6, #473, and #348 6. Collaborative Practice Agreement/Practice Protocol For A Nurse Practitioner Or Other Advanced Practice Registered Nurse in Texas. No date, no policy number 7. Printout of electronic database for diabetes mellitus 8. RSSLC Policy I.29 Integrated Clinical Meeting undated 9. Draft policy for "Medical Emergency Response" RSSLC 911/4444 (no date) 10. Completed Medical Provider Quality Assurance Audit forms for round 3, September 9, 2011 11. Acute Clinical Indicator draft policy (no date/no number) 12. Draft policy, "Communications and Expectations between Community Hospital Emergency Department and RSSLC (no date/no number) 13. Draft, Clinical Pathway for Pneumonia (no date/no number) **People Interviewed:** 14. Tran Quan, MD, Medical Director **Meeting Attended/Observations:** 15. Observations of Individuals at Living areas Trinity and Leon 16. Integrated Clinical Meeting 17. CLDP for Individual #124
	Facility Self-Assessment: L1: The Facility indicated that it remains noncompliant with Provision L1. The Facility reported that it implemented many new processes, such as conducting weekly interdisciplinary meetings for select cases, developed and implemented standard orders for acute and chronic conditions, and developed a quarterly review process to address chronic medical conditions, among other activities as outlined in the POI. The Monitoring Team noted the Facility's accomplishments, and concurred with the Facility in that they had made advancement towards compliance. The Monitoring Team noted, however, that the Facility's activities have not enhanced the overall practice of medicine at the Facility. L2: The Facility noted that is remains noncompliant with Provision L2. The Facility reported participating in the DADS Central Office External Medical Provider Audits on three separate occasions. The Monitoring Team determined that the current QA audit process does not meet the standards of the Settlement Agreement, as it does not provide a clinical performance review of the clinician. L3: The Facility determined itself to be noncompliant with Provision L3. The Facility reported developing a database for the management of diabetes mellitus, which was assessed by the Monitoring Team and determined to an excellent mechanism to assist in the management of diabetes mellitus. The Monitoring

	Team noted that the Facility did not have a comprehensive Medical Quality Assurance process in place, as required by Provision L3, hence the Monitoring Team concurs with the Facility and determined it to be non-compliant. L4: The Facility assessed itself as being noncompliant with Provision L4, and recognized that it must continue to work with DADS Central Office to implement practice protocols that will help ensure acceptable standardized care at the Facility. The Facility had not implemented practice standard policies or procedures, except for the management of diabetes mellitus. The Monitoring Team was unable to assess or comment on the Facility's efforts to achieve compliance because the self-assessments only lists action items completed and does not offer benchmarks and projected completion dates. The Facility should consider developing a plan of improvement that delineates specific benchmarks and timelines.
	Summary of Monitor's Assessment: L1: The Monitoring Team concurs with the Facility, and determined that the Facility remains noncompliant with Provision L1. It is imperative that the Facility immediately develop and implement a meaningful process that ensures prompt follow-up of acute and chronic conditions, intra-facility consultations and diagnostics, consultations, and procedures. The Facility must ensure that all acute and chronic conditions are addressed per current standard of care practice. L2: The Monitoring Team compliments the Facility on its current Medical Quality Assurance process; however, the current process did not enable a clinical performance review of clinicians practice at the Facility. A clinical performance assessment must be a component of the overall review process. For this reason, the Monitoring Team determined the Facility to be noncompliance with Provision L2. L3: The Monitoring Team concurs with the Facility, and determined that it remains noncompliant with Provision L3. Compliance will require a comprehensive quality assurance process that monitors and assesses outcomes data of clinical conditions at the Facility. Trends analysis should be used from the QA process to enhance clinical services and future outcomes. The Monitoring Team compliments the Facility on the high caliber of its newly developed database for the management of diabetes mellitus. L4: The Monitoring Team determined that the Facility had not implemented a comprehensive policy or policies that would delineate acceptable standard of care practice at the Facility, and determined that the Facility remains noncompliant with Provision L4. Compliance will require DADS, and Facilities to agree upon and implement formal policies and procedures that will ensure acceptable standard of care practice at the Facility.

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L1	Commencing within six months of	To assess compliance with Provision L1, the Monitoring Team assessed the clinical	Noncompliance

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	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.	management of the following Individuals. Following its review, the Monitoring Team determined that the IDT lacked insight into Individual's medical needs; the Facility lacked the ability to ensure appropriate documentation and communication of health care issues that would ensure continuity of care and appropriate cross coverage by alternate clinical staff and other health care disciplines; the Facility was devoid of a meaningful and functional process for scheduling diagnostics, consultations and intra-facility follow-up of care needs. Review of Physician Services: The Monitoring Team reviewed physician and support services for physicians at the Facility. The Monitoring Team was informed that the Facility had four full-time physicians who are dedicated to 280 individuals, which results in a caseload of 70 individuals per physician. In addition, there was a Physician Assistant (PA), who reports to Dr. Quan, the Medical Director, and has a caseload of 75 Individuals. The PA was on contract, and was covering for one of the two Nurse Practitioners who is on extended leave. The second of two Nurse Practitioners was responsible for 20 Individuals. Physician Services had a dedicated clerical support person. The Facility had appropriate policies in place that ensure proper supervision of advanced practice nurses; however, the Facility did not provide evidence that specific protocols are in place for physician assistants, who are distinct form nurse practitioners. The Monitoring Team is satisfied with the clinician/patient ratio, but had concern over the supervising agreement with the physician assistant. Case examples revealed issues that need to be addressed by the Facility, such as failure to assess and provide follow-up of chronic medical conditions and lack of timely follow-up of consultations. Individual #124: The Monitoring Team attended the Community Living Discharge Plan (CDLP), and reviewed clinical records for Individual #124. The Monitoring Team determined that medical issues were not adequately represented at the CDLP, and important medical conditions were not appropriately managed and followed up upon: 1. Quarterly PSP, dated 9/11, indicated that the Individual was to use a gait belt for transfers and ambulation, and a "wheelchair for long distances and as tolerated". An MRI of the cervical indicated multilevel degenerative disease of the cervical spine, with severe bilateral foraminal stenosis of C3-C4, moderate bilateral stenosis at C4-C5, posterior osteophytes with effacement of the anterior CSF space with cord flattening at level C6-C6, and severe bilateral foraminal stenosis at C6-C7, among other pathologies of the spine. There was no ongoing medical management of this serious medical condition of the spine noted in the clinical record. The individual was known to experience frequent and severe falls, and	

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		the most recent PT/OT evaluation completed on 4/14/10 indicated that the individual had worsening loss of ambulation and transfer skills, and required assistance and equipment for transfers and ambulation; however, no specific OT/PT recommendations were provided on the seriousness of the issue and need for assertive management, and to ensure that the individual does not fall. Recommendations made during the CLDP for the abnormal MRI of the spine stated, "monitor for falls." Given the individual's spine disease, the individual should have had on-going medical follow-up. The only recommendation presented to the accepting agency was to "monitor for falls," without further explanation or recommendation. In this particular situation, more assertive follow-up for the individual's severe spine disease, along with more attention to fall prevention, was necessary. The follow-up and treatment care of this particular condition exemplifies the Facility's lack of assertive management of degenerative spine and other orthopedic conditions known to occur at the Facility. Such conditions are chronic in nature and result in worsening debilitation, result in severe pain and discomfort, and are potentially lethal conditions. 2. The Annual Dental Summary indicated that the individual did not allow his teeth to be brushed regularly, that he had three teeth extracted, had very poor oral hygiene, and required i.v. sedation for all dental procedures and deep cleaning. Dental issues were not addressed during the CDLP and when the Monitoring Team asked the accepting agency about the individual's oral hygiene and dental service needs, they were unaware of what was required. The agency was not made aware of the comprehensive nature of the individuals dental health care needs, and resources needed to support this Individual. 3. The individual underwent a colonoscopy in 2009, and three polyps were removed. Follow-up colonoscopy was done in 2010, and a tubuloadenoma was removed; this is considered a pre-cancerous lesion, and given the three previously removed polyps, the individual may have required more assertive follow-up. The IDT, including the physician, was unaware that the individual had a colonoscopy in 2009, and the only recommendation provided at the CDLP was the need for follow-up colonoscopy in five years 4. The individual was prescribed Zyprexa for "mood disorder." During discussion at the CDLP, it was mentioned that the individual was experiencing more frequent seizures. There was no consideration that the prescribed Zyprexa could have exacerbated the individual's seizure disorder. After the Monitoring Team brought this issue to their attention, the psychiatrist concurred that this needed to be assessed. The issues raised in this example demonstrate a systematic failure in assessing chronic medical conditions, failure to follow-up on critical issues, such as follow-up consultations, and very poor integration of health care issues by the PST.	

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		Individual #290: A chart review of Individual #290 was conducted, and it was noted that the individual was to start treatment for H-pylori infection of the stomach, on 7/12/11. There was no follow-up to assess efficacy of the treatment. Because of a 25 pound weight loss during the past seven months, an order was written for a GI consultation and possible endoscopy, on July 21, 2011. At the time of this review, the GI consultation had not been processed, resulting in over a four-month delay in treatment. The Monitoring Team determined that follow-up to medical issues was not timely. Individual #364 This individual was seen by a consulting Obgyn on March 4, 2011, for dysfunctional uterine bleeding. The individual was to promptly return for an endometrial biopsy, and a follow-up appointment was scheduled for March 28, 2011, during which time the consultant was unable to take the biopsy because of behavior issues. Follow-up was to be scheduled under sedation. Because of significant scheduling issues, and lack of coordination on the part of the Facility, at the time of this review the individual was still pending follow-up biopsy. Dysfunctional uterine bleeding could be a manifestation of uterine or cervical cancer and prompt follow-up is essential. The Monitoring Team directed this issue to the Facility's Medical Director for review. There was no documentation to indicate that the PST was aware of this issue. Individual #353: The clinical record of this individual was reviewed. Because of severe psoriatic arthritis, and related skin manifestation, the Individual was seen by a rheumatologist on June 2, 2011. The consultant recommended treatment with methotrexate. Because of inadequate documentation, poor follow-up, and communication practices by the Facility, the recommendations made by the consultant were not appropriately acted upon, resulting in more then a three month delay in treatment. There was no documentation to indicate that the IDT was aware of this issue. Individual #30: Following a comprehensive review of the individual's clinical records, it was noted that this individual had many chronic and serious conditions that required frequent clinical assessment, including spastic quadriplegia, cerebral palsy, restrictive lung disease, left ventricular hypertrophy with diastolic dysfunction, cholelithiasis, nephrolithiasis, bilateral spermatocele and varicocele, and chronic kidney disease. A chest x-ray dated 1/15/10 demonstrated a cardiac enlargement, and degenerative changes of the shoulder. There was no on-going clinical management for any of these conditions noted in the clinical record; there were no orders for consultation follow-up for these conditions. The PSP did not reflect the extent of the individual's health care issues or important supports	

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		and services needed to provide adequate care. The Monitoring Team determined that the PST was not actively involved in the management of the individual's health care issues, and appropriate follow-up on the individual's chronic medical conditions was inadequate. <u>Management of Diabetes</u> To assess a comprehensive approach to the management of diabetes mellitus (DM), the Monitoring Team requested the behavior support plans for Individuals #680, #625, #530, and #723. The behavior support plans for Individuals #530 and #723 clearly identified DM as an issue that required behavior intervention and included DM within the context of the behavior support plan. There was no comment about behavior supports for DM for Individuals #530 and #723. Following review of the most recent PSP for the above individuals, the Monitoring Team noted lack of comprehensive awareness of the supports and services required for the management of DM. The Monitoring Team strongly recommends that the Facility develop a more inclusive IDT approach for Individuals with chronic care conditions, including the management of DM. The Monitoring Team reviewed the Facility's newly developed database for diabetes mellitus. The database enables all relevant clinical data required to regularly assess diabetes to be captured and analyzed longitudinally. This newly developed process will be exemplary, once implemented. <u>Management of Chronic Disease Conditions</u> Following its onsite observations of individuals and review of the above clinical records, the Monitoring Team determined that the Facility did not adequately manage chronic conditions. More assertive follow-up, regular use of consultants and appropriate diagnostics, are necessary. <u>Integration of Health Care into the PST Process</u> The Monitoring Team was made aware of the Facility's new process to improve integration of health care into the IDT process, and reviewed the new policy for the "Integrated Meeting." This process appears to be working well for individual cases reviewed at the weekly Integrated Clinical Meeting; however, following review of the clinical records for Individuals #124, #290, #364, #353, and #30, the Monitoring Team determined that in general, clinical issues are not routinely integrated into the PST process. <u>Emergency Medical Drills</u> Improvements had been made in emergency medical drills. Please refer to Provision M.1 for an extensive review of this issue.	

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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.	The Monitoring Team reviewed the Facility's methods of conducting a medical review system that consists of non-SSLC physician case review and assistance to facilitate the quality of medical care and performance improvement. The Facility had participated in the DADS Medical Provider Quality Assurance Audits on three separate occasions. Following review of Round 3 of the audits, it was noted that external physicians conducted the reviews and appropriate recommendations were forwarded and tracked for follow-up. As discussed in reports for the previous two visits to this Facility, the current process of the Medical Provider Quality Assurance Audits does not provide for a performance assessment of the clinicians' clinical ability. Compliance with Provision L2 requires that clinicians are assessed on their ability to provide medical care, hence, clinical performance. The current process must be enhanced to include assessment of clinical performance. The current process does provide meaningful information for system improvements, and should continue. This process is working very well. <u>Mortality Review Process</u> As part of the review of medical services, the Monitoring Team assessed the Facility's Mortality Review process. The following cases were reviewed to assess the administrative review process only, not an in depth clinical review: Individual #6: Following its assessment of the administrative and clinical mortality review process, the Monitoring Team noted that a Root Cause Analysis of precipitating factors leading up to the death was not completed. A root cause analysis should be incorporated into the mortality review process. In this particular case it would be important for the Facility to better understand causative factors of the person's bowel adhesions and obstruction, and how to better monitor individuals with similar clinical manifestations and to avert perforation and other adverse consequences. Individual #473: The Facility was excellent in identifying issues related to enhanced intra-facility communication and continuity of care, and enhancing it communication process with outside hospitals. Individual #348: The Monitoring Team Recognized that the Facility offered comprehensive and appropriate recommendations following it review of this case. In general, the Monitoring Team noted marked improvement with the Facility's mortality	Noncompliance

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		review process, and is complimentary of its committee structure and function. Additional emphasis on Root Cause Analysis and physician recommendations would be advantageous to the process. Importantly, the Monitoring Team did not identify a means for the Facility to track and perform longitudinal trends analysis on mortalities at the Facility. A mortality trends analysis should be integrated into the mortality review committee and periodically reported to the Facility's Governing Body and QA/QI Council.	
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.	The Facility had yet to develop and implement a comprehensive mechanism to maintain a medical quality improvement process that collects data relating to the quality of medical services; assess such data by trends analysis; and initiate outcome related inquiries, and corrective action. The Facility had developed a process to monitor outcomes of the management of diabetes mellitus. This process included a database, which would enable trends analysis. Development and implementation of the diabetic databases is exemplary. The Facility reported plans to expand this process for other chronic health care conditions in the future. Compliance of L3 will require a comprehensive quality assurance process that monitors and assesses outcomes data of clinical conditions at the Facility. Trends analysis should be used to enhance clinical services and future outcomes.	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 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 several activities with regards to establishing practice standards at the Facility. The Facility developed a policy for acute and chronic clinical indicators (no date/no number). The policy would help ensure that acute and chronic care issues would be followed up by the clinician. According to the POI and interviews of Facility staff, DADS Central office requested that the Facility not implement the process. The Facility had developed a clinical pathway for aspiration pneumonia, and submitted to DADS Central Office for review. This pathway had not yet been implemented at the Facility. Physicians had reviewed and signed the nurse practitioner (NP) agreement, and the NPs' cases were supervised by physicians. However, the Facility had recently contracted with a physician assistant (PA), and the Facility, and DADS Central Office did not have PA agreements in place. The Facility must ensure that an agreement is in place and that it meets or exceeds physician licensure requirements for the State. The Facility had developed and implemented a standard practice for the management of diabetes mellitus (DM). The database used to collect, and assess data related to DM was	Noncompliance

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		noted to be excellent. The Facility should, however, ensure that all cases of DM are comprehensively addressed through the PST process. As noted within the context of Provision L1, DM was not routinely addressed comprehensively by the PST. The treatment of DM requires a comprehensive, multidisciplinary approach, which include behavioral health, dietary, nursing, physician, direct care personal, PT/OT services to be directly involved in the overall care and support of individual with DM. Following discussion with the Facility's Medical Director, and review of the Clinical records for Individuals #124, #290, #364, #353, and #30, the Monitoring Team determined that the Facility's policies and procedures were not yet developed to the point that they ensure provision of medical care consistent with current, generally accepted professional standards of care . The Monitoring Team was informed that DADS Central Office continues to work on developing meaningful practice standards, that will be implemented at the Facilities.	

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

1. Ensure a Facility wide process that will enable prompt, and efficacious scheduling and follow-up of all clinical matters, including intra-facility consults and follow-up to acute and chronic care issues, all diagnostics and external consultations and procedures. (Provision L1)
2. Implement a process that will enable clinicians the ability to regularly assess chronic conditions and follow-up on acute conditions. The process must include an assessment by the clinician, as well as review of relevant clinical data. (Provision L1)
3. Develop a mechanism that ensures health care integration into the PST process. (Provision L1)
4. When considering transfer to an community agency, ensure that all clinical issues are clearly and comprehensively made aware to the receiving agency. (Provision L1)
5. It is imperative that prompt attention be made to musculoskeletal and neuromotor conditions, including cerebral palsy, degenerative spine disease, congenital anomalies of the skeletal systems and arthritic conditions. (Provisions L1 and L4)
6. Ensure that the mortality review process includes trends analysis of relevant clinical and demographic information and that the Governing Body of the Facility and QA/QI Council periodically review the data. (Provision L3)
7. Ensure that a comprehensive analysis is completed on all contributing and potentially contributing factors causing death. (Provision L3)
8. Enhance the current Medical Provider Quality Assurance Audit process to include a mechanism that ensures a clinical performance review of the clinician, such as a formal peer review process. (Provision L2)
9. Develop and implement a quality assurance program for medical services. (Provision L3)
10. Ensure that all PAs and supervising physicians have signed appropriate practice agreements and that such agreements meet or exceed physician licensure requirements. (Provision L4)
11. Develop and implement practice standards that will ensure that the provision of medical care is consistent with current, generally accepted professional standards of care. (Provision L4)

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI), 10/10/2011 2. RSSLC Section M Presentation Book 3. Texas Department of Aging and Disability Services, State Supported Living Centers, Statewide Policy and Procedures, Emergency Response, Policy Number: 044.2, Effective 9/7/2011, Replaces: 044.1 4. Texas Department of Aging and Disability Services, State Supported Living Centers, Statewide Policy and Procedures, Policy: Nursing Services, Policy Number: 010.1, Effective: 5/11/2011 5. Texas Department of Aging and Disability Services, State Supported Living Centers, Statewide Policy and Procedures, Policy: Nursing Peer Review, Policy Number: 049.1, Effective: 5/9/2011, Replaces: 049 6. RSSLC Health Care Services, POI Nursing Monitoring Tools for Internal Compliance, Revision: 9/1/2011 7. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: Skin Management and Wound Prevention, Date: 5/2011 8. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: PICA, Date: 5/2011 9. RSSLC Providing Health Care Services, Documenting Nursing Staff Coverage, Policy Number: I.23 (under revision) 10. RSSLC Providing Health Care Services, Ensuring Nursing Staff Coverage, Policy Number: I.22, Revised: 9/20/2011 11. RSSLC Providing Health Care Services, Providing Acute Health Care, Policy Number: I.6, Revised: 4/29/2011 12. RSSLC Providing Health Care Services, Admitting to Infirmary for Acute Care, Policy Number: I.10, Revised: 2/20/2010 13. RSSLC Health Care Services, Monitoring Episode of Acute Illness/Use of Sedation, Revision: 4/27/2011 14. RSSLC Nursing Procedure Manual, Physicians' Quarterly Orders, Policy Number: F-04, Revised: 7/11/2011 15. RSSLC Providing Health Care Services, Routing Off Campus Consultations, Policy Number: I.12, Revised: 1/6/2011 16. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Medication Administration Guidelines, Date: 2/2011 17. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Medication Administration Observation Guidelines, Date 7/2011 18. RSSLC Pharmacy Policy and Procedure Manual: Policy, Medication Errors/Variances, Policy Number: 01.05.20, no date 19. Texas Department of Aging and Disability Services, State Supported Living Centers, Policy: Medication Variance, Policy Number: 053, Effective: 9/23/2011 20. Texas Department of Aging and Disability Services, State Supported Living Centers, Procedure: Medication Errors/Incidents, Date: 11/2009 21. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol:

	Seizure Management Guidelines, Date: 2/2011 22. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: Vagal Nerve Stimulator, Date: 2/2011 23. RSSLC Acute Illness/Injury Physician Phone Notification Form, 10/17/2011 24. RSSLC Nursing Organizational Chart 25. RSSLC Nursing Staffing Reports for the past three months 26. RSSLC RN Case Managers' Caseload 27. RSSLC Nursing Positions as of 10/13/2011 28. RSSLC Infirmary Admission Logs for past year 29. RSSLC Class Title: In-service on new CPR Checklists and new Emergency Policy, 9/11/2011 30. RSSLC List of Emergency Response Committee Core Members 31. RSSLC Emergency Medical Response Committee Meeting Minutes, 4/14/2011 and 8/26/2011 32. RSSLC Completed Mock Medical Emergency Drill Sheets for the past six months 33. RSSLC List and Campus Map Indicating the Location of Automated External Defibrillators (AEDs) 34. RSSLC Course Due/Delinquent Lists for Basic Life Support (BLS) for Health Care Providers - Cardiopulmonary Resuscitation (CPR) and AED and CPR Basic, Printed 10/21/2011 35. RSSLC Completed Emergency CPR Drills Schedule, 3/2011 through 8/2011 36. RSSLC Mock Emergency CPR Drill Tracking Data Reports, 4/2011 through 9/2011 37. RSSLC Emergency Equipment Checklists Completed for the past six months 38. Texas Department of Aging and Disability Services, State Supported Living Centers, Infection Control Reference Manual for State Supported Living Centers, 2011, First Edition 39. RSSLC M – Infection Control Count of Internal Audits by Month, Date Range: 4/1/2011 through 9/29/2011 40. RSSLC Infection Control Manual, Hepatitis B Vaccination Consent/Declination Form, Reviewed and Revised: 6/20/2011 41. RSSLC Infection Control Orientation Training Curriculum 42. RSSLC Infection Control Policy and Procedure Committee Meeting Minutes, 7/19/2011, 8/2/2011, 8/9/2011, 8/16/2011, and 8/23/2011 43. RSSLC Infection by Type Report, Date Range: 7/1/2011 through 9/30/2011 44. RSSLC Nursing POI Committee Meeting and Review of Internal and External QA Monitoring Data of Nursing Care Monitoring Tools, 9/7/2011 and 10/24/2011 45. RSSLC Health Services – POI Nursing Monitoring Tools, Internal Program Compliance Procedure 46. RSSLC Health Care Services, Internal Nursing Monitoring Tools Procedures 47. RSSLC Quality Assurance Nurses Responsibilities, 10/4/2011 48. RSSLC Nursing Care Monitoring Tools Internal Audit (audits completed by nursing staff), 4/1/2011 through 9/30/2011 49. RSSLC Completed Nursing Monitoring/Audit Reports (External to the Nursing Care Monitoring Tools) for the past six months 50. University of Houston Victoria, School of Nursing, Fall 2011 Preceptor Workshop, Certificate of Participation for Chief Nurse Executive (CNE), 10/14/2011 51. RSSLC Wound Care/Skin Integrity Committee Meeting Minutes, 4/6/2011, 4/20/2011, 5/4/2011, 5/11/2011, 5/18/2011, 6/1/2011, 6/8/2011, 7/20/2011, 7/22/2011, 8/3/2011, 8/10/2011,

	8/17/2011, 8/24/2011, 9/7/2011, 9/14/2011, 9/21/2011, and 9/28/2011 52. RSSLC Nursing In-service Training and Training Tracking Database, 7/1/2011 through 8/31/2011 53. RSSLC Quality Assurance (QA) Nurses' Responsibilities, no date 54. RSSLC Completed Medication Observation Audits by nursing staff for the past six months 55. RSSLC Pharmacy and Therapeutic Committee Meeting Minutes, 4/12/2011 and 7/14/2011 56. RSSLC Medication Variance Meeting Minutes, 4/12/2011, 5/5/2011, 6/16/2011, 7/21/2011, 8/25/2011, and 9/21/2011 57. RSSLC Medication Error Report, Date Range: 4/1/2011 through 8/31/2011 58. RSSLC Medication Errors/Variances per Month, Date Range: 3/1/2011 through 9/1/2011 59. RSSLC Mode of Medication Errors, Date Range: 3/1/2011 through 9/1/2011 60. RSSLC Nursing Reports to Medication Variance Committee, 5/5/2011, 6/2011, 7/2011, and 8/2011 61. RSSLC 10 most recent Medication Error Reports 62. RSSLC Medication Error Reports, Medication Errors/variances per Month, Date Range: 3/1/2011 through 9/1/2011 63. RSSLC Medication Error Reports, Total Medication Errors, Date Range: 4/1/2011 through 8/31/11 64. RSSLC Safety Committee Monthly Meeting Minutes, 1/2011 through 9/2011 65. RSSLC Schedule of Meeting Requiring Nursing Participation during the week of the Monitoring Team's visit. 66. RSSLC Minimum Staffing for Nursing, Campus Nurse Report, 9/28/2011 67. RSSLC Nursing Staffing Patterns (schedules) for the past six months 68. RSSLC Nursing Regular Comp Hours Earned, Fiscal Years 2009-2010 and 2010-2011 69. RSSLC Health Risk Screening Reports 70. RSSLC Individuals' Personal Support Plan Schedule for Annual and Quarterly Nursing Assessments 71. Records reviewed for Individuals: #248, #286,#723, #107, #202, #625, #155, #184, #680, #358, #379, #719, #58, #239, #233, #621, #718, #283, #353, #585, #651, #30, and #583 **People Interviewed:** 1. Valarie Kipfer, RN, State Office Nursing Coordinator 2. Jane Purcell, Assistant Director of Programs 3. Charlene McCurry, RN, Chief Nurse Executive 4. Constance Bowie, RN, Nurse Operations Officer 5. Genniffer Moore, RN, Program Compliance Nurse 6. Kay Rudasill, RN, Nurse Recruiter/Nurse Educator 7. Emma Purvey, RN, Infirmary/Campus Director 8. Adriano Soria, Jr., RN, Hospital Liaison Nurse 9. Ugo Nweke, RN, Nurse Educator 10. Wickiff Fawibe, RN, Skin Integrity Coordinator 11. Reneda Simmons, RN, Infection Control Nurse 12. Wilma Parker, RN, Quality Assurance Nurse 13. Robyn Partridge, RN, Quality Assurance Nurse 14. Clinic Licensed Vocational Nurses **Meeting Attended/Observations:** 1. Nursing POI Committee Meeting, 10/24/2011

	2. Risk Assessment Meeting/Training, 10/25/2011 and 10/26/2011 3. Meeting with Nursing Administration and Nurse Managers, 10/25/2011 4. Risk Rating Records Review with Nursing Administration, Nurse Managers and RN Case Managers, 10/25/2011 and 10/26/2011 5. Medication Variance Committee, 10/26/2011 6. Pharmacy and Therapeutic Committee Meeting, 10/26/2011 7. Infirmary Rounds, including Medication Administration Observations, and Mock Medical Emergency Drill, 10/27/2011
	Facility Self-Assessment: The Facility's Plan of Improvement, updated 10/10/2011, provided comments and the status for Sections M.1 through M.6 of the Settlement Agreement. The Facility indicated it was in noncompliance with Provisions M.1 through M.6. This was consistent with the Monitoring Team's findings as provisions M.1, M.2., M3. M.5 and M.6 were found to be noncompliant. Since the last compliance review the Monitoring Team found that significant progress had been made in all provisions, most notably in provision M.4, which was found in compliance. The Facility's Self-Assessment information reported was inadequate to determine the progress made toward compliance for all provisions. The data included in the Facility's POI contained activities repeated in past compliance reviews as well as activities completed since the last compliance review. The information provided for the various provisions did not always relate to the Settlement Agreement requirements for the specific provisions. There were no analyzed and summarized data contained in the self-assessment data that indicated how those activities were moving the Facility toward compliance within the respective provisions. There was no clear sequential framework or timelines established to identify how they expected to reach compliance. The Facility needs to ensure that the activities and action steps included in the POI reflect only the requirements set forth in the Settlement Agreement for that specific provision. The information included should only include activities and action steps that have been completed since the last review or that were in process from previous reviews. Through the Monitoring Team's review of the Presentation Book for Section M, record reviews, interviews, and observations, the Monitoring Team was able to validate the activities listed in the Facility's Self-Assessment were carried out; and in most cases showed improvement in moving the Facility toward compliance for all provisions. Only one provision was found to be in compliance, e.g., Provision M.4. These activities and improvements were discussed in the Monitor's Assessment and throughout the report.
	Summary of Monitor's Assessment: Provision M.1: This provision was determined not to be in compliance. The Nursing Department continued to demonstrate a high degree of enthusiasm and commitment to moving toward compliance with all provisions of the Settlement Agreement. RSSLC's Nursing Department had essentially remained stable since the last compliance review. Several staffing realignments were made to improve nursing services. Due to the closing of one Unit several

	nursing positions had been converted to other positions and other nurses were reallocated to perform other nursing duties. One Nurse Manager assumed the position as the Program Compliance Nurse, overseeing the Nursing Care Monitoring Tools for compliance. Several other Registered Nurses were assigned as Campus Nurses for all three shifts. A new Infection Control Nurse was hired to manage the Infection Control Program. The Infection Control Nurse needed some additional training on the requirements for the Infection Control Program. Plans were in process for her to acquire additional training at one of the other State Supported Living Centers. A Data Entry Clerk had been hired for the Infection Control Program. Although there was a reduction in the nursing positions the Nursing Department did not use agency nurses. As a result, the amount of nursing overtime had increased. The requirement for the management of acute changes in status had improved since the last compliance review but there remained opportunities for continued improvement for all aspects of managing and documenting care according to the Acute Illness and Injury Protocols, as described in the report. The Nursing Care Monitoring Tools continued to be completed. The rolling months' data were becoming more complete and accurate. The data now analyzed should be useful in developing corrective action plans. The Nursing Department and the Quality Assurance Nurses formed a Nursing POI Committee to review the monitoring data to reconcile disparities between the monitoring tool completed by the nursing staff and those completed by the Quality Assurance Nurses. As a result of this effort the degree of agreement for the inter-rater reliability checks was becoming closer to agreement. A problem identified that needs to be resolved was the lack of weighting the significance of each item on the tools. Items of less significance were weighted the same as those of critical importance. The process of inter-rater reliability monitoring was still being refined and was not fully implemented to yield reliable data. Since the last compliance review the Facility had continued to make improvements in the Emergency Response System. The Facility had adopted and implemented the revised Emergency Response Policy, 044.2 and had begun training the required staff on the policy. Mock Medical Emergency Drills were completed according to schedule. Corrective action was taken when necessary for staff who failed to perform satisfactorily. Additional emergency equipment was purchased and issued for all areas needing such equipment. It was positive to find since the last compliance review that CTD had implemented the revised American Heart Association's 2010 CPR Training Curriculum. The Facility continued to have employees who were delinquent in Basic CPR and Basic Life Support for Health Care Providers, although the number of delinquent employees was significantly reduced from previous compliance reviews. The Facility continued to have an Emergency Response Committee to review, analyze and trend Mock Medical Emergency Drills and other emergency response issues, as well as to make recommendations for corrective action when indicated. The Emergency Response Committee needs to develop a mission statement and procedures for the Committee's functions. Although compliance was not met for this requirement, significant progress had been made since the last compliance review. Refer to the report below for findings and recommendations for further improvements to meet compliance with this provision's requirements. Provision M.2: This provision was determined not to be in compliance. Although great strides had been made to improve the quality of the nursing assessments, the nursing summaries need continued

	improvement to critically analyze clinical data derived from the assessments, for each identified nursing problem/diagnosis, to accurately reflect whether individuals' health status was improving, maintaining, or regressing. As the RNs complete the Physical Assessment Class, their enhanced knowledge and skills should improve their ability to critically analyze clinical data and summarize it to accurately reflect individuals' health status. Provision M.3: This provision was determined not to be in compliance. It was apparent that much effort had been put forth to improve the quality of the health care plans. However, they continued to lack adequate individualization to meet individuals' specific problems. Plans did not demonstrate an integration with other disciplines to meet the total needs of individuals. The Nursing Department needs to continue to individualize health care plans, collaborate with other relevant disciplines in developing plans, and ensure the plans include the frequency of interventions/actions to be carried out, and by whom, when and where to document interventions/actions carried out. The effectiveness of the plans need to be evaluated when the goals/objectives are not met to prevent or minimized the identified problems. Provision M.4: This provision was determined to be in compliance. There was evidence that all core State and Facility nursing policies, procedures, and processes, had been finalized. The Nurse Educators maintained an excellent tracking database and were able to validate that 97% to 100% of the nursing staff had been trained in the core policies, procedures, and processes. The Nurse Educators were using the Nurse Education Handbook for new nurse orientation and annual refresher training. The Nurse Educators had trained 1005 of the incumbent staff on mandated Clinical Indicators of Health Status Change Class and were teaching it at New Employee Orientation. Provision M.5: This provision was determined not to be in compliance. The nursing staff had been trained on the At Risk Individual Policy and associated procedures. The RN case managers were completing the health/medical risk criteria and presenting their findings at the Risk Screening Assessment meetings for PSTs to review and rate levels of risk. The nurses need to collaborate with the physicians who hold joint responsibility for completing the health/medical risk assessments, as well as with other relevant disciplines to ensure that all related health/medical issues were identified and considered in determining risk ratings before the risk assessments were presented at the At Risk meetings for the PSTs to review. This continued to be an evolving process. Provision M.6: This provision was determined not to be in compliance. However, this provision had made significant progress toward compliance. The Facility had recently implemented the State's Medication Variance Policy, 053, which should assist in continuing to improve all aspects of medical administration practices. Due to the low number of medication errors reported there was a concern that errors were under reported by all disciplines responsible for medication administration practices. The Facility had a comprehensive Medication Error Database to track, analyze and trend medication errors using a root cause analysis approach. The Medication Variance and Pharmacy and Therapeutic Committee should better utilize the data derived from the database to identify causative/contributing factors for the medication errors. More emphasis should be placed by these two committees on ensuring all medication variances are reported by each discipline responsible for medication administration practices. While compliance was not

	met much progress had been made toward achieving compliance with this provision.

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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.	This provision contained a number of requirements that addressed various areas of compliance. The requirements included: staffing, availability of pertinent medical records; assessment and documentation of individuals' acute changes in status; infection control; medical emergency response systems, and quality enhancement efforts. In order to meet compliance with this provision all requirements of the provision must be found in compliance. Additional information regarding the nursing assessment process and the development of care plan interventions is found below in Sections M.2, and M.3 of the Settlement Agreement. Information addressing assessment and documentation regarding restraint use is included in Section C. of the report. <u>Staffing</u> At the time of the compliance review there were 376 residents residing at the Facility. This represented a reduction of eight individuals since the last compliance review when the Facility census was reported as 384. At the time of the review the Nursing Department reported a total of 152 nursing positions, of which 87 were Registered Nurses (RNs) and 60 Were Licensed Vocational Nurses (LVNs). At last compliance review a total 173 nursing positions were budgeted, of which 106 were RNs and 67 were LVN. At the first compliance review a total of 182 nurses were reported. Since the onset of the Settlement Agreement this represents a significant reduction in the total number of nurses, a reduction of 30 nurses. Apparently the lost nursing positions were reallocated to other departments. When comparing the Facility's Regular Comp Hours Earned – Fiscal Year 2010 to Fiscal Year 2009, there was an increase of 3,855.25 hours of overtime used; this did not include the number of overtime hours used in August, 2011. Working nurses overtime over a prolonged period of time has the potential to cause fatigue and burn-out, which could result in clinical errors and increase staff turnover. While the Facility census had been reduced, the increase in use of overtime while there has been reduction in nursing positions was a serious concern regarding the Facility's ability to provide adequate nursing care for the individuals and to meet the requirements set forth in the Settlement Agreement and Health Care Guidelines. According to the Facility's POI and interview with the CNE the Neches Unit was closed after the last compliance review. Some of the nursing staff had been reallocated to the Units where the individuals moved or were reassigned to other areas or duties. One RN was Assigned to the Clinic and was also given responsibility for managing Immunizations and Tuberculosis Screening for employees. Twenty-one RNs were realigned as Campus Nurses who work out of the Infirmary to cover all three shifts. The Nurse Manager for Neches was reassigned to Nursing Administration. A new experienced Infection Control	Noncompliance

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		Nurse had been hired and a position was posted for an Infection Control Assistant Nurse. In addition, a much needed Data Entry Clerk had been hired for the Infection Control Program. In spite of the reduction in nursing positions, the Nursing Department had remained stable. The Nursing Administration and Management Nurses continued to be highly motivated and dedicated to providing high quality nursing services. The Nursing Department was fortunate to have experienced and competent specialty nurses, e.g., a certified Wound Care Nurse, Nurse Educators, Hospital Liaison Nurses, and Infection Control Nurse who had experience as an Infection Control Nurse at a local long term acute facility. This was demonstrated through interview and record reviews of their documented assessments and management of conditions related to their area of expertise, as well as evidence of collaboration with other relevant disciplines. Refer to information reported below in this section related to specialty areas of nursing practice. The Nursing Department does not use agency nurses. It was positive to find that the Nursing Department had revised Ensuring Nursing Staff Coverage, Policy, I.22. This policy provided guidance for assigning nursing staffing and ratios to meet acuity needs of individuals served. According to the CNE and review of staffing patterns, the Facility had met the required ratios. When there was a shortage in coverage, the Campus Nurses or nurses from other units who had staffing over the required ratio were pulled to cover the shortage. A copy of staffing patterns/ratios was provided for each home based on the acuity level of the individuals served. In order to meet compliance with the requirements of this provision, positive practices identified in the report must be maintained, and the other improvements should be made. The Nursing Department should consider making the following staffing improvements: Ensure that established nursing ratios for the Units and Infirmary are consistently met. <u>Quality Assurance Efforts</u> Since the last compliance review the Nursing Department had made significant improvements with regard to quality assurance efforts. According to the Section M POI there had been increased training on the Nursing Care Monitoring Tools, which was validated through a review of the signed training records contained in the Section M Presentation Book. A formalized procedure had been developed entitled Internal Nursing Monitoring Tools to define the process for completing the monitoring tools. The QA Nurses Responsibilities were formalized. These procedures clearly outlined the process for conducting audits on the 12 Nursing Care Monitoring Tools. On June 1, 2011, the Nursing Department had added a Program Compliance Nurse who	

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		was given the responsibility of ensuring the monthly assigned Nursing Care Monitoring Tools were completed, tracked and trended, and areas of non-compliance identified, and to reconcile the areas where wide disparity was found between the monitoring results obtained by the Quality Assurance (QA) Nurses and those of the nursing staff. In June, 2011 a Nursing POI Committee was formed. The Program Compliance Nurse chairs this committee which meets weekly with the QA Nurses, Nursing Administration, Nurse Managers, and RN Case Managers to review and reconcile the monitoring data. On 9/7/2011 the Nursing Department met with the QA nurses to initiate inter-rater liability checks on the monitoring tools; to evaluate monitoring data to identify problems, to design solutions to improve the interpretation of the monitoring criteria; and begin to develop corrective action plans. The focus was on ensuring inter-rater reliability between monitoring results found by the internal audits completed by the nursing staff and the results of the external audits completed by the QA Nurses. A review of the Nursing POI Committee Meeting Minutes and the Monitoring Team's onsite review of the Nursing POI Committee, found the formation of this committee to be a positive step forward in their quality assurance efforts. As this process evolves many issues that cause disparity between the internal and external monitoring results will be resolved. It was evident through review of the recent Nursing Care Monitoring data that improvements in the interpretation of the tools' criteria by the nursing staff had begun. The QA Nurses continued to maintain a monthly schedule and selected and assigned the responsible nurse the records to be audited for each nursing monitoring tool. The QA Nurses also tracked the completion of the monitoring tools to ensure they were all completed according to schedule. When monitoring tools were not completed Nursing Administration was notified. A review of Section M's POI, Presentation Book and other documents, revealed that the QA Nurses thoroughly reviewed each month's monitoring tools completed by the nursing staff. They identified problems found on the tools and communicated their findings to Nursing Administration for correction. On 8/8/2011, the Nurse Managers and RN Case Managers were retrained on completing the monitoring tools. As a result of this oversight and training by the QA Nurses, all monitoring tools were completed correctly and turned in for September, 2011. This represented an improvement from previous compliance reviews where all of the monitoring tools were not consistently completed correctly and/or submitted; therefore the data at those reviews were skewed and unreliable. It was positive to find since the last compliance review that the QA Department had developed and implemented an excellent system and database for tracking and trending data. The system compared internal and external inter-rater reliability data, both by the percentage of compliance of individual items on each monitoring tool as well as the overall percentage of compliance for each tool. The data were represented in graphic	

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		form for ease in interpreting data results. This provided definitive data for areas falling below 80% agreement. Thus, areas of disparity between the two sets of raters were readily identifiable; from which sound decisions could be made to formulate corrective actions to reduce the degree of disparity. As the system matures and when the disparity between the internal and external monitoring data are reconciled and inter-rater agreement reaches at least 80%, or greater, agreement, the Facility and the Monitoring Team will be able to have greater confidence in the reliability of the monitoring data and the status of compliance with the monitoring tools. The chart below for the Trend Analysis Report, 5/1/2011 through 8/31/2011, represented the status of the degree of agreement between the internal and external overall percentage of compliance with the monitoring data for the Nursing Care Monitoring Tools audited:	

Trend Analysis Report

Monitoring Tools Audited	Internal Audit Results	External Audit Results	Degree of Agreement Between Internal and External Audits
Skin Integrity	95.5%	40%	44.23%
Acute Illness and Injury	94.47%	80.90%	56.58%
Annual Nursing Assessment	96.%	97.45%	87.55%
Annual Nursing Care Plans	89.59%	44.92%	62.33%
Urgent Care/Emergency Room Visits and Hospitalizations	90.98%	51.02%	48.16%
Documentation	92.42%	69.81%	42.65%
Infection Control	93.82%	85.71%	78.33%
Management of Chronic Respiratory Distress	85.25%	52.05%	59.68%
Medication Administration and Documentation	99.50%	96.12%	89.35%
Pain Management	94.47%	53.85%	50%
Prevention	98.28%	77.78%	73.08%
Seizure	71.09%	79.78%	71.43%

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The information above will be used by the Monitoring Team as a benchmark for future compliance reviews to measure compliance with the Nursing Care Monitoring Tools. Additionally, Corrective Action Plans (CAPs) derived from the results of the monitoring data will also be reviewed.

The Facility had a formalized process for developing and implementing CAPs. Data from the monitoring tools was set for an 80% compliance rating. A CAP was required for item(s) on the monitoring tools that fell below 80%. The Nursing Department had developed corrective action guidelines for each of the 12 Nursing Care Monitoring Tools. There were no actual CAPs available for review.

The Facility was using the State's database for entering and analyzing monitoring data. It was positive to find the high degree of detail the QA system had generated in analyzing and trending data derived from the results of the monitoring tools. By providing this level of detail in the report these monitoring tools can measure progress or regression toward compliance for each monitoring tool as well their individual data items. From this information the Nursing Department and the QA/QI Council should be able to make rational decisions regarding areas that need to have systemic CAPs developed and implemented.

After the Monitoring Team reviewed the monitoring trend data for the Nursing Care Monitoring Tools, it was realized that the data items on the monitoring tools were not weighted by value of significance. Therefore, when preparing overall compliance reports for the tools, the most critical data item counts the same as the least significant.

According to the QA Plan requirements, each data item on the various monitoring tools falling below 80% compliance required a CAP. The Nursing Department in collaboration with the QA Nurses was beginning to develop and implement CAPs for those items on the various monitoring tools falling below 80% compliance. The CAPs identified the item that required improvement, the date of implementation, the person responsible, and the date of completion. While it was important to address individual items on the tools falling below 80% compliance for a CAP, with the amount of rolling months data that was being generated, the overall compliance with the monitoring tools should be considered and a systemic approach to developing and implementing CAPs on the monitoring tools' whose overall percentage of compliance fell below 80% compliance.

The monitoring process and development of outcome data for Section M of the Settlement Agreement continued to make progress since the last compliance review. However, the process was still maturing and should soon provide comprehensive

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		measurement of outcomes toward compliance with all Section M provisions. The State Office had developed guidelines for completing the Nursing Care Monitoring Tools that primarily references to the Settlement Agreement and Health Care Guidelines. While useful, they did not provide specific instructions to ensure consistency in ratings between the auditors. Consequently, without specific instructions, compliance ratings may be determined by each auditor's clinical judgment. Therefore, the outcome data for the ratings may be skewed, rendering it unreliable. In addition to internal and external audits completed by the nursing staff and QA Nurses, the Nursing Department conducted numerous other audits monthly on nursing practices. The Monitoring Team was provided copies of raw data from those completed audits; however, there were no data analyses or summaries provided on the items audited. The items audited included: • Medication Room Inspections • Nurse Managers Review of Documentation • Medication Administration Observations • Emergency Equipment Checklists • Second Signature on Physician's Orders • Second Signature on Quarterly Orders • Acute/Illness/Injury for Physician Notification. • Mealtime Monitoring • Peer to Peer Review It is essential that the data derived from the above audits are analyzed, trended, and summarized in order to identify individual as well as systemic trends that may require CAPs. This is necessary for internal management purposes as well as for the Monitoring Team's assessments of these items. In addition to maintaining the positive practices identified in the report, and in order to meet compliance with the requirement of this provision the Nursing Department should consider making the following improvements: • Ensure that all nursing auditors rating the monitoring tools are clinically competent and that there is consistency between auditors. • Collaborate with the State Office to develop specific instructions for each of the Nursing Care Monitoring Tools. • Collaborate with the Quality Assurance Department and State Office to develop a system for "weighting" each data item on the monitoring tools by value of significance, where appropriate. This will aid in prioritizing the most critical items that need CAPs. • Develop CAPs for specific problems identified through monitoring specific units,	

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		shifts and/or other localized situations, as well as CAPs for systemic problems identified through the broader analysis of trend data for campus-wide improvements. • Ensure that audits conducted on items other than the Nursing Care Monitoring Tools are analyzed, trended, and summarized in order to identify individual as well as systemic trends that may require CAPs. This is necessary for internal management purposes as well as for the Monitoring Team's assessments of these items. <u>Availability of Pertinent Medical Records</u> Since the last compliance review, the Facility had added additional tabs in the Active Medical Records for the nursing sections. This made the locating the various nursing related documents easier and more readily accessible. During the compliance review several nursing related documents were not in the charts and had to be located and returned to the records. The Nurse Managers complained that staff frequently removed documents and did not put them back in the records. They also complained that the record clerks were slow to fill records. Such was the case when looking for some Annual and Quarterly Comprehensive Nursing Assessments completed in 10/2011. The Nursing Department had developed and implemented the use of an Acute Illness/Injury Physician Phone Notification Form to improve communication with physicians' in notifying them of changes in individuals' health status. The form contained pertinent clinical assessment data that the nurses need to communicate to the physicians; however, the form was not approved for use in the active medical record. This vital information had the potential not to be documented again in the active medical record. Consequently, vital medical information could be lost. The purpose of maintaining a unified record system is to have all of individuals' pertinent information located in a centralized place so that it is readily available for providers to use for managing their care. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> A review of 16 individuals' active medical records (Individuals: #248, #286, #723, #107, #202, #625, #155, #184, #680, #358, #379, #719, #58, #239, #233, and #621) showed significant progressive improvement over the past six months in following the Acute Illness and Injury and Documentation Protocols. This was no doubt attributable to the increased training and re-training and increased monitoring of acute care issues. Although there was improvement shown the Nursing Department needs to continue the efforts put forth for continued improvement in the items listed below: <u>Areas that show improvement:</u> • The SOAPE method of charting was consistently used. • The method temperatures were taken was more consistently documented. • Oxygen saturations levels more consistently documented whether they were based	

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		on room air or oxygen. • There was an improvement in the quality of focus and comprehensive nursing assessments and documentation of individual's changes in health status including the assessment of individual's mental status and level of comfort or distress. • Physicians were notified more promptly of individual's change in health status. • Acute Care Plans (ACPs) for acute changes for individual's health status were more consistently developed and implemented. Documentation that the direct care professionals were trained on the plans was more frequently included. There was evidence that the nursing staff more consistently carried out the plans through to resolution, with documentation in the Integrated Progress Notes when ACPs were initiated and resolved. • Monitoring of individual's health status contained more consistent documentation in the Integrated Progress Notes as well as describing what continued to be monitored. The notes consistently included instructions to the direct care professionals. • The Personal Support Team (PST) members were more consistently informed of changes in individuals' change in health status and of any plans of care that were initiated. • When antibiotics or other new medications were prescribed allergies were consistently documented. • The nursing assessments of injuries/wounds were better described, documented, and followed-up through to resolution. • There was better compliance with the Hospitalization/Transfer and Discharge Policy. • The 24-Hour Clock was almost always used. • Approved standard abbreviations were consistently used. • Individuals experiencing seizure activity were better assessed with documentation contained on both the seizure record and in the Integrated Progress Notes. Individuals were more consistently monitored for at least 24 hours after seizure activity. <u>Areas that did not show significant improvement:</u> • The use of the Evaluation (E) for follow-up documentation did not consistently provide adequate assessment data, particularly vital signs, and other relevant focus assessment data. • The notifications to the physicians of individuals' change in health status were not consistently documented in the Integrated Progress Notes. The nursing staff did not document the assessment findings that were communicated to the physician in the Integrated Progress Notes. It was only through review of the physicians' notes that the assessment information the nurses reported to the physicians were found. • Assessments for individuals who had episodes of vomiting did not consistently	

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		contain assessment of lung sounds. • When Medical Monitoring was initiated the frequency and duration of monitoring was not indicated on the initial Integrated Progress Note. • The therapeutic responses to new medications, treatments, and per necessary (PRN) pain medications were not consistently documented. • The legibility of some nurses' handwriting continued to be difficult to read. • Frequently, documentation was written below the last line on the Integrated Progress Notes. The Nursing Department had developed an Acute Illness/Injury Physician Phone Notification. The Monitoring Teams had concern over its use because it was not part of the active medical record. Because of this, there may be documentation that is contained on this form that does not get entered into the Integrated Progress Notes. Any notification to the physicians, by the phone or otherwise, should be thoroughly documented the active medical record. In addition, this form appears to be a duplication of effort in documentation. <u>Hospital Liaison Nurse Activities</u> The Hospital Liaison Nurses continued to follow-up on individuals who were hospitalized through daily (except for weekends) onsite visits or by phone. The hospital rounds included visual assessments, chart reviews, and interviews with nurses and physicians providing care to individuals to ascertain individual health status and response to treatment. Individuals' skin status was assessed at each visit. If skin integrity issues were identified the Wound Care Nurse was notified, and if needed he visited the individual in the hospital to further assess the skin integrity issue. After the visit to the hospital, all medical information was documented in each individual's Integrated Progress Notes and scanned into the shared drive in order to make it available to medical providers, nursing staff, and other relevant PST members. The Hospital Liaison Nurse attended morning rounds and reported on hospitalized individuals. He maintained communication with the RN Case managers, Unit Directors, Qualified Mental Retardation Professionals (QDDPs), Wound Care Nurse, Occupational and/or Physical Therapist, and other PST members as necessary. The PST members were notified as soon as pending discharges were known in order to discuss any necessary training or equipment needed on discharge. By the PSTs having the Hospital Liaison Nurses' information readily available regarding hospitalized individuals' status, they should be able to identify when there are significant changes in status that would require revising their risk ratings. The Monitoring Team asked the Hospital Liaison Nurse if he attended the PST meetings after individuals were discharged with significant change in health status. He said he did not but agreed he should start attending those meetings. The Hospital Liaison Nurse's attendance at the post discharge meeting would provide	

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		valuable first hand knowledge of the individual's health status at the time of discharge. This information was validated through an interview with the Hospital Liaison and a joint record reviews. The Monitoring Team, along with the Hospital Liaison Nurse, reviewed the records for Individuals #107 and #286. The Monitoring Team independently reviewed Individual #233's record. These were individuals who were recently hospitalized or were currently hospitalized at the time of the compliance review. • Individual #286 was admitted to the hospital on 10/9/2011 with hypothermia and sepsis and was discharged on 10/18/2011. The Hospitalization/Transfer and Discharge Policy assessments and documentation were completed as required pre and post discharge. The Hospital Liaison Nurse followed-up daily on Individual #286's hospitalization course and kept the relevant PST members informed. Upon return to the Infirmary and when discharged ACPs were implemented for sepsis and hypothermia. The direct care professionals were in-serviced on their responsibilities for care, and the plan was carried out through to resolution on 10/23/2011. It was positive to find that after discharge on 10/20/2011 the PST met and completed a risk screening assessment. Individual #286 was found to be at high risk for respiratory compromise, constipation, gastrointestinal problems, osteoporosis, seizures, infections, hypothermia, and polypharmacy; and medium risk for choking, aspiration, weight, skin integrity, falls, fractures, and fluid imbalance. Individual #286 had previous HMPs for all risks, except for hypothermia and urinary tract infection. These new HMPs were developed and implemented on 10/25/2011. • Individual #107 was admitted to the hospital on 9/30/2011 with new onset hypoxia secondary to left lobe pneumonia, pelvic mass, possible neoplasm, and an abscess on the back and remained in the hospital at the time of the compliance review. Unfortunately, the required Pre-hospital Assessment and Hospital Transfer Forms were not in the record. The NOO located them and discovered they had inadvertently been sent to the hospital with Individual #107. The forms were retrieved and found to be completed according to policy. The Hospital Liaison continued to follow-up with visits and contacts with the hospital and kept the PST informed of Individual #107's hospital course. • Individual #233 was admitted to the hospital on 9/8/2011 and was diagnosed with aspiration pneumonia. A review of Individual #233's record showed he had a history of frequent episodes of pneumonia, with the last episode of pneumonia (aspiration) secondary to vomiting in 3/2011. He also had an active medical problem for GERD and hiatal hernia, with a fundoplication for GERD. He was receiving oral feedings supplemented with enteral feeding via G-tube to maintain weight. Prior to the episodes of vomiting leading up to the hospitalization, there were no recent episodes of vomiting documented in the Integrated Progress Notes.	

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		His primary heath problems over recent month had been due to low blood platelets. There were no nursing notes in the Integrated Progress Notes documenting the vomiting episodes on 9/8/2011 prior to the physician's note at 3:45 p.m. indicating that the nurse had notified the physician of the vomiting episodes with a decreased oxygen saturation of 91% on room air, and was manifesting dyspnea and respiratory compromise. The physician order Individual #233 transferred to the hospital with a probable diagnosis of aspiration pneumonia. He was subsequently admitted to the hospital and remained there at the time of the record review. The next nursing documentation was after the physician's note, that included a focus assessment of the respiratory system, the completion of the Hospital Transfer Form and Nurse to Nurse Report/Pre Hospital Nursing Form, and notification to relevant PST members and Individual #233's family/guardian. The Nursing Department had begun using an Acute Illness/Injury Physician Phone Notification Form that was not an approved form for the active medical record. The form included a space for pertinent assessment information such as, chief complaint, assessment of appropriate body system, complete set of vital signs, including oxygen saturation, brief summary of health history, current medications and treatments in the past 72 hours, allergies, injuries over the past 72 hours, and the nurse's signature and time. It was of concern that the notification of the physician and the assessment information was not documented in the Integrated Progress Notes. It was plausible to wonder if the phone notification to the physician regarding the vomiting episode and nursing assessment was documented on this form that was not approved for use in the active medical record. The use of a form to document clinical information that is not part of the active medical record is not an acceptable practice. The Acute Illness/Injury Physician Phone Notification Form was comprehensive and had the potential to provide physicians with pertinent medical information. If the form is to continue to be used it should be approved and added to the active medical record. If not, the pertinent information contained on the form should be documented in the Integrated Progress Notes. <u>Infirmary Activities</u> According to the Section M's POI, Presentation Book, and other documents reviewed, the Infirmary nursing staff had received intensive retraining in all areas of nursing practice since the last compliance review. Before conducting medication administration observations in the Infirmary, the Infirmary Director took the Monitoring Team on a tour of the Infirmary and Clinic areas. The Monitoring Team was also accompanied by the CNE and the two Nurse Educators. It was impressive to observe that significant improvements had been made in the Infirmary's physical environment and the individuals appeared comfortable and to be receiving good care. At the last review individuals' rooms were cluttered with one individual's personal effects lying on the	

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		floor. At the last compliance visits, the individuals' Individual Notebooks were not brought from their homes to the Infirmary; therefore the direct care professionals supporting individuals in the Infirmary did not have access to their plans of care. Several individuals' 90-day orders had not been signed and medications were being given on expired orders. While onsite the Monitoring Team observed that Individual #353's Individual Notebook was not present. The Infirmary Director explained it had been removed to add some information. His Individual Notebook was returned to the Infirmary before the Monitoring Team left the Infirmary. However, the Individual Notebook looked new and did not appear to have been used. The individuals present in the Infirmary at the time of the tour were observed. All individuals were positioned according to their PNMPs. One individual whose head of bed was elevated did not have measuring chains attached to the head of the bed, although the head of the bed appeared to be properly elevated at 45 degrees. The Monitoring Team suggested, to the Infirmary Director, the use of measuring chain or inclinometer on the beds of individuals who required head of bed elevation to ensure the correct degree of elevation ordered. The Infirmary Director was receptive to the use of the inclinometers and will consider ordering the devices. <u>Wound Care Nurse Activities</u> As was recommended at the last compliance review, the Wound Care Nurse had developed and implemented a Wound Assessment and Documentation Course. A review of the course contained course objectives, lesson plan, and competency-based testing. Training records indicated that 12 training sessions were completed with 100% of the nursing staff trained. In addition, the Wound Care Nurse had developed and implemented a Skin Assessment Sheet to be completed by the direct care professionals for the early identification of skin integrity issues. The completed sheets were turned in to the Would Care Nurse at the end of the month for review and analysis, or before if there was a change in the status of the individual's skin integrity observed by the direct care professionals. There was documented evidence in records of individuals with skin integrity issues that the Wound Care Nurse collaborated with other relevant disciplines to provide integrated care. Issues of concern identified through record review and discussion with the Wound Care Nurse regarding wound management for Individuals #723 and #621 included: • Individual #621 did not have the ACP for a Stage 2 skin wound on the back in the active record, and the record had to be retrieved from the home. The original ACP should be in the record with a functional copy kept in the home until the problem is	

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		resolved. • After reviewing Individuals #723 and #621s' Integrated Progress Notes, ACPs, and HMPs with the Wound Care Nurse, the Monitoring Team found that the Individuals' care plans related to skin integrity issues did not consistently contain all of the interventions that were recommended by Wound Care Nurse and were being carried out. The Monitoring Team suggested to the Wound Care Nurse, in addition to his assessment and wound care management, that he also review the HMPs and ACPs developed to manage individuals' with skin integrity issues. The Wound Care Nurse continued to conduct the integrated Skin Integrity Committee meetings. The individuals with skin integrity issues and pressure sores were reviewed and discussed, and recommendations for care were made at the meetings. This was validated through review of the Skin Integrity Committee Meeting Minutes for the past six months. Unfortunately, as was found at the last compliance review, the Wound Care Nurse did not have a formalized tracking system for skin integrity issues and pressure sores. Such a tracking system is necessary to track, analyze, and trend the incidents of skin integrity and pressure sores over time, whether they were facility acquired or acquired in the hospital or other outside facilities. Such a system also identifies skin integrity problems that may require corrective action to prevent or minimize their occurrence. The most recent Skin Integrity Meeting Minutes, 9/28/2011, indicated there were two individuals with active pressures sores. At the time of the compliance review there were no pressures sores reported. It was commendable that there were no individuals found with pressure sores considering the Facility's large population with many individuals determined to be medically fragile. This was no doubt attributable to the competent skills and commitment of the Wound Care Nurse and his efforts to ensure integrated care. <u>Infection Control Nurse Activities</u> Since the last compliance review the Infection Control Nurse and Assistant Infection Control Nurse had resigned. A new Infection Control Nurse was recently hired who had experience as an Infection Control Nurse in a local long term acute care facility. A data entry clerk had also been recently hired for the Infection Control Program. The data entry clerk was entering the backlog as well as current infection control data into the infection Control Database. The Infection Control Nurse was just beginning to assume her responsibilities when she had to take medical leave. She did come in while the Monitoring Team was onsite for an interview. The Monitoring Team explained the Infection Control Program requirements for the Settlement Agreement. The State Nursing Coordinator was present during the interview and told the Infection Control Nurse she would make arrangements for her to spend time with one of the Infection Control Nurses at another State facility to help her acclimate to her new role and responsibilities. Because of the changes there had been little progress made in the	

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		Infection Control Program since the last compliance review. Some of the activities performed by the recently hired Infection Control Nurse included: • Produced Infection by Type Reports. • Conducted Handwashing and Use of Glove Training for all (100%) of the residential staff. • Began conducting handwashing observations and conducting environmental surveillance. • Developed a Nursing Protocol for "Real Time" monitoring for acute infectious disease to ensure that infections were reported timely and completely to the Infection Control Program. • Began revising Infection Control Policies and Procedures using the new Infection Control handbook. As the policies and procedures were developed and implemented, the nursing staff were trained on the revisions. • Conducted the Assigned Nursing Care Monitoring Tools for Infection Control and other related tools. • Developed competency-based training on Ringworm of the Skin. • Conducted Infection Control Training at the New Employee Orientation. As the Infection Control Nurse receives some additional training and matures in her role and responsibilities, the Infection Control Program should focus on the requirements of the Settlement Agreement. The issues that should be addressed include but not are limited to the following: • Review, analyze, and trend of data from the Infection by Type data report to identify local and systemic trends that may require corrective action. • Conduct Infection Control Committee Meetings according to the Infection Control Committee Policy. • Develop a system to ensure the reliability of the infection reports. • Review, analyze, and trend Epidemiological Reports and Antibiograms in order to evaluate the effectiveness of the antibiotics prescribed to treat various infections. The Infection Control Nurse should regularly attend the Pharmacy and Therapeutic Committee meetings and share the findings of the effectiveness of the antibiotics prescribed by the physicians. • Review the ACPs and HMPs for infections with the RN Case Manager to ensure that all infection control measures are included in the plans. • Track the status of seasonal flu vaccines to ensure that individuals are vaccinated. • Track the status of tuberculosis skin testing and periodic screenings for individuals who have a converted tuberculosis skin test. • Track the status of individuals' immunizations to ensure they are up to date or have their history of prior immunizations or diseases documented in their record. This includes populating the existing Immunization Database.	

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		• Develop and implement a tracking system to analyze, trend, and summarize handwashing and environmental surveillance monitoring data in order to identify trends that may require corrective action. Although improvements were made, requirements for this provision were not found in compliance. In order to meet compliance with this provision of the Settlement Agreement the positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements: • Ensure that all records and forms created and used to document clinical information are approved for use in the active medical record. • Ensure that the nursing staff document in the Integrated Progress Notes assessment findings reported to the physicians. • Ensure that the Wound Care Nurse reviews all skin integrity/wound care ACPs and HMPs for appropriateness and the inclusion of all pertinent care interventions. • Ensure that the Hospital Liaison Nurse attends post-discharge PST meetings for individuals who have experienced a significant change in health status. • Ensure that the Infection Control Nurse receives additional training for managing the Infection Control Program. <u>Emergency Response System/Mock Medical Emergency Drills</u> Since the last compliance review the Facility had continued to make improvements to the Emergency Response System and in Mock Medical Emergency Drills. Improvements included the following: • The Facility had adopted and implemented the State's revised Emergency Response Policy, Policy Number: 044.2, Revised: 9/7/2011. There was documentation that employees were in the process of being trained on the revised policy. The policy included standardized procedures and forms for the nursing staff to check emergency equipment daily. In addition, the revised policy strengthened the Quality Assurance component of the emergency response system. In addition to tracking and analyzing drill data monthly, the Risk Management Department will conduct Emergency Equipment Walkthrough checks at least monthly on all areas that contain emergency equipment. Any corrective action will be documented on the checklist and will be followed up to resolution by the person completing the walkthrough. Risk Management will review and analyze walkthrough checklist data at least quarterly to identify trends. Trends will be reported by Risk Management to the Quality Assurance (QA)/Quality Improvement (QI) Committee. Since the policy was recently implemented there were no trend data reports available for the items listed above. • A review of completed Emergency Equipment Checklists indicated that they were	

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		consistently checked as required, e.g., daily or on each shift. Nurse Managers or designees consistently reviewed the Checklists as required. The nursing staff had begun using the standardized Emergency Equipment Checklist in 9/2011. • According to review of the completed Mock Medical Emergency Drill Schedule, all drills were completed as scheduled for the period 5/2011 through 8/2011. The statement whether drills were passed or failed had been added to the revised 9/7/11, Mock Medical Emergency Drill form. A review of the completed drills 5/2011 through 8/2011 indicated "on the spot" corrective action was taken when indicated; staff who failed to perform after prompting were sent to CTD for re-training in CPR. • An impromptu Mock Medical Emergency Drill was conducted in the Infirmary at 2:37 p.m. on 10/27/2011 and was passed. It was positive to find that the nursing staff responded within less than 30 seconds to the drill, bring all of the required emergency equipment. The drill was executed successfully with minor prompting regarding the correct placement of the AED pads on the manikins' chest and to plug in the suction machine to ensure proper working order. This was a positive finding and a significant improvement because two previous impromptus drills requested by the Monitoring Team during compliance reviews were failed by the Infirmary nursing staff. • 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. This was validated through review of the Mock CPR Reports, 5/2011 through 9/2011. • According to the Facility's Section L. POI, the physicians were to begin participating in the Mock Medical Emergency Drills in 9/2011. A review of the 9/2011 drills did not show that the physicians had participated in the drills. • The Facility had purchased and issued AEDs for each dorm/home, Laundry, Maintenance, Administration, Infirmary, Clinic, Central Kitchen, Hippodrome, Colorado Workshop, Pool, and Angelina. Signs indicating the location of the AEDs were in process. In addition crash carts were purchased for each dorm/home. Each cart had a designated spot that included oxygen, AEDs, basic airways, suctions machines, gloves, and Ambu Bags. Each cart was labeled with the required equipment. The nursing staff was responsible for completing the Emergency Equipment Checklist daily verifying that the cart was checked at each shift. The direct care professionals were in-serviced on the location of the carts. This was a positive finding from previous compliance reviews. • The CTD Due/Delinquency Training Lists identified two employees (one nurse and one physician) delinquent in BLS for Health Care Providers. The CTD Course Delinquency Lists identified 16 employees who were delinquent in CPR Basic. This represented a decrease in the number of delinquent employees in BLS for Health	

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		Care Providers and Basic CPR Training since the last compliance review. The Facility should ensure that all required employees are current with Basic Life Support and/or Basic CPR training. • Since the last compliance review CTD had begun using the latest version of the American Heart Association's 2010 CPR Training Curriculum. • The Facility continued to have an Emergency Response Committee which was supposed to meet monthly to monitor the effectiveness of training, and review Mock Medical Emergency drills for effectiveness, identifying trends, and make recommendations for corrective action. The core membership consisted of the CTD Director, Medical Director, Nursing Director, Security Manager and Risk Manager or designee. This was validated through review of the Emergency Response Committee Minutes 4/14/2011, 6/26/2011, and 8/26/2011. The monthly Emergency Response Committee Minutes for 5/2011, 7/2011, 9/2011, and 10/2011 were not available for review; therefore; it could not be determined if those monthly meetings occurred. The Emergency Response Committee Meeting, 8/2011, was only attended by the Risk Manager and the Medical Director. The minutes indicated since most of the committee members were unable to attend the meeting; the Committee will meet again in 10/2011. Apparently, the Committee must have been changed to meet every other month, although there was no documentation indicating the monthly meeting had been changed. The 8/2011 minutes indicated that the Mock Medical Emergency Drills completed over the past three months were reviewed and no deficiencies were found. It was determined that a mission statement and procedure statement would be written. Although the Facility had not met compliance with this requirement of the Settlement Agreement, significant progress had been made in all aspects of their emergency response system and with compliance in conducting and executing Mock Medical Emergency Drills and were close to achieving compliance with this requirement. In addition to maintaining the positive practices identified in the report, and in order to meet compliance with the requirement of this provision the Facility should consider making the following improvements to the emergency response system: • Ensure that all required employees are trained on the revised Emergency Response Policy, 44.2 and that staff adhere to the policy. • Ensure that the physicians participate in Mock Medical Emergency Drills. • Ensure that posters are placed in the areas where emergency equipment items are located throughout the campus. • Ensure that the Emergency Response Committee develops a mission statement and procedures for the Committee and establish the frequency for the Committee to meet. • Ensure that all required employees are current in Basic CPR and Basic Life Support	

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		for Health Care Providers Training.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	The Facility's Section M POI indicated that compliance was not met with this provision of the Settlement Agreement. The Monitoring Team concurs that the Facility had not met compliance with this provision. Although the Facility had not yet met compliance with this provision, it was evident through review of the Facility's Section M.2 POI, the detailed and comprehensive Presentation Book for Section M.2, interviews with the Nursing Administration and Management staff, review of training records, and review of individuals' active medical records, that the Nursing Department had put forth concerted effort since the last compliance review to improve the quality of the Annual and Quarterly Comprehensive Nursing Assessments in order to move the Facility forward in meeting compliance with this provision. However, there remained the need for continued improvement, as indicated in the report below. Since the last compliance review, additional headings had been added to the Comprehensive Nursing Assessment's form in the overall nursing summary section. Additional headings included: Personal Focus Assessment, Review of Health Status from previous quarter/annuals, Health Risk Reviews, Self-Administration of Medication's progress and recommendations, Nursing Problem/Diagnosis, identified and reason for the diagnosis, Health Management Plans and progress, Recommendations, and Community Integration. While onsite the Monitoring Team met with the CNE, NOO, and two groups of Nurse Managers and their RN Case Managers and reviewed their records for Individuals #723, #625, #358, #239, #107, and #248. The focus of the review and discussion was on At Risk Screening Assessments, Risk Action Plans, PSPs/PSPAs, Annual and Quarterly Comprehensive Assessments, and Health Maintenance Plans (HMPs). The group stated they found the review beneficial and the discussion provided insight into the requirements for compliance with these items. They were able to self-identify problematic trends that needed improvement. One of the Nurse Managers stated that the PSP Action Plans were not consistent with the established nursing care plans. When the Monitoring Team asked the group if they reviewed the final PSPs/PSPAs to ensure that the nursing related action steps were correct and/or included all of needed nursing action steps, they stated the PSPs/PSPAs were not reviewed. The nursing responsibility for completing the At Risk Screening Assessments was discussed. The need to exercise clinical judgment and critical thinking was emphasized, in addition to the At Risk Guidelines, when assessing risk factors. Interrelated risk factors should be considered when assigning levels of risk. The PSP schedule submitted by the Facility for the Monitoring Team to review for timely completion of the Annual and Quarterly Comprehensive Nursing Assessments did not	Noncompliance

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		include the specific due dates for the quarterly nursing assessments. Therefore, it was not possible to accurately determine the dates they were due. According to the Nurse Managers and RN Case Managers, the Qualified Mental Retardation Professionals (QMRPs—now called Qualified Developmental Disabilities Professionals, or QDDPs) usually gave them the quarterly due dates at the end of the month for the actual dates they were due. The quarterly nursing assessments reviewed usually followed a quarterly pattern. The annual nursing assessment due dates were usually correct and consistent with the dates found on the annual nursing assessments. The QDDPs' should consider providing the RN Case Managers with a PSP schedule that includes the actual date quarterly nursing assessments are due. The PSP schedules should provide more advanced notice than at the end of the month in order to allow the RN Case Managers adequate time to gather information and prepare the quarterly nursing assessments timely. The Monitoring Team selected a sample of records to review from each Unit for a total of 16 records. The sample was selected to review in each Unit's nursing's compliance with the requirements for completing Annual and Quarterly Comprehensive Nursing Assessments. Records were reviewed for Individuals #248, #286, #723, #107, #202, #625, #155, #184, #680, #358, #379, #719, #58, #239, #233, and #621. For the 16 individuals' records reviewed, a total of 32 Annual Comprehensive Nursing Assessments and 46 Quarterly Comprehensive Nursing Assessments were reviewed. The review revealed the following findings: • Thirty-two of the 32 (100%) Annual Comprehensive Nursing Assessments that were due were completed according to the PSP schedule. • Forty-two of 46 (91%) Quarterly Comprehensive Nursing Assessments were completed quarterly. Two of the Quarterly Comprehensive Nursing Assessments that were due in 10/2011 were not in the records. • Fifty-nine of the 62 (95%) Annual and Quarterly Comprehensive Nursing Assessments reviewed contained BRADEN skin assessments. • Fifty-two of the 62 (84%) Annual and Quarterly Comprehensive Nursing Assessments reviewed contained the signature and date of the RN Case Manager completing the assessments. • Fifty-seven of the 62 (92%) Annual and Quarterly Comprehensive Nursing Assessments reviewed contained documentation that the Qualified Mental Retardation Professionals were notified of the completed assessments. Although the Nursing Department continued to show progress in completing the Annual and Quarterly Comprehensive Nursing Assessments, they continued to contain some incomplete and inaccurate assessment data. Occasionally high and/or medium risk levels and active medical problems were not found on the individuals' nursing	

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		problem/diagnosis lists. The Annual/Quarterly Comprehensive Nursing Assessments reviewed contained significantly more data, including the new headings. However, they did not significantly improve the quality of the overall nursing summaries. The most improvement noted included the listing of individuals' risk factors and relevant active medical problems in the nursing problem/diagnosis section with some degree of rationale. With rare exception, Health Maintenance Plans (HMPs) were developed for the identified risk factors, as well as the identification of other active medical and nursing problems/diagnoses. Although it was apparent from the increased amount of data included in the overall nursing summaries that efforts were made to improve the quality of the summaries, problematic concerns remained. The overall nursing summaries for the more recently completed summaries were better organized, using a more uniform format in addressing each nursing problem/diagnosis. However, some of the summaries continued to vary in format and content from RN Case Manger to RN Case Manager. The summaries more consistently addressed each problem/diagnosis identified. Individuals' health status for the specific quarter was better summarized but the summaries failed to adequately reflect individuals' health status progress or lack of progress from quarter to quarter or annually, as well as the effectiveness of their HMPs. The summaries of the problems/diagnosis continued to contain lists of raw clinical data related to sequential events, such as hospital/emergency room or infirmary admissions, clinic visits, medication and treatments received, diagnostic and lab results, with no associated analysis of the data indicating if the health issues were getting better or worse. Based on the findings of this review, as well and in past reviews, it was apparent the Nursing Department was consistently putting forth effort to improve the analysis and quality of the summaries in the Comprehensive Nursing Assessments. However, a continuing need was identified to assist the RN Case Managers to understand how to analyze, summarize and document clinical health data that will result in adequately and accurately summarizing the individuals' progress or lack of progress toward their established goals and objectives. An adequate and accurate analysis and summary of individuals' clinical health data is not only necessary for the RN Case Managers in appropriately planning and evaluating individuals' care but it is also important for the PST to incorporate into individuals' PSP and/or PSPA. Examples of issues identified in the review of the Annual/Quarterly Comprehensive Nursing Assessment are listed below: • Individual #723's annual and quarterly assessments consistently contained incomplete and/or inaccurate information for the following items:	

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		o The History, Functional, and Psychosocial Section was not marked for heart disease and hypertension. His Active Medical Problem list included hypertension with high risk for cardiovascular heart disease and cerebrovascular accident due to hypertension and diabetes mellitus. He did have an Inactive Active Problem listed for a small Hiatal Hernia diagnosed in 1/2008 that was not included in the history. The box for GERD was marked but Individual #723 did not have an Active Medical Problem for GERD. o The Immunization Sections for the status of Hepatitis A and Varicella were not documented. The date and results of the PPD (Tuberculosis Skin Test) was not documented. The assessment for prophylactic treatment was marked "no" even though, according to the Inactive Medical Problem List, the PPD was Positive in 10/1997 and Individual #723 was treated for six months with prophylactic INH therapy. The last chest x-ray was 11/2008. o The Physical Assessment Sections for vital signs did not have the method the temperature was taken marked or the SPO2 assessment marked whether on room air or on oxygen. o The Physical Assessments Section - Skin and Nails did not mark the toenails assessment for fungus. Individual #723 had an Active Medical Problem for bilateral onychomycosis and inverted toenails and was receiving treatment for fungus. o The overall Nursing Summaries for the last two quarters were better organized with each nursing problem/diagnosis summarized separately. The status of each nursing problem/diagnosis was better summarized for the quarter. However, the summaries did not indicate progress, or lack of progress, from quarter to quarter or the effectiveness of the accompanying HMPs. • Individual #239's significant weight loss not addressed in the quarterly nursing assessment. o Individual #239's weight on the admission nursing assessment, 5/10/2011, was 256.4 pounds and was not listed on the subsequent quarterly nursing assessment, 8/15/2011. His desired weight range was 175 – 200 pounds. The weight on the subsequent quarterly nursing assessment was listed as 227.2 pounds. He had a diagnosis of diabetes mellitus and was placed on an 1800 calorie diabetic diet. While he was on a planned weight loss diet, the loss of 29.2 pounds or 11.4% over the past quarter should have been of significant concern because this was a greater than 7.5% weight loss in one quarter the RN Case Managers should addressed the weight loss in the Nutrition and Weight Management Summary as well as in the overall nursing summary; of which it was not addressed. • In many cases, immunization status was not indicated in the Immunization section. Examples:	

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		o Individual #239's immunization status for measles, mumps, and rubella (MMR), hepatitis A and varciella was not indicated in the Immunization Section. The first injection for the Hepatitis B series was documented but the dates for the remainder of the series were not indicated. o Individual #155's immunizations status for varciella was not indicated on the immunization section. On the History, Functional, and Psychosocial Section, constipation and bowel management was not marked, although there was an Active Medical Problem for constipation, and Individual #155 was receiving medications for constipation, and had a HMP for constipation. o Individual #202's immunizations status for measles, mumps, and rubella (MMR), hepatitis B and varciella was not indicated on the Immunization Section. • Individual #358 had a medium risk level for choking but it was not included on the nursing problem/diagnosis list. Consequently there was no HMP for choking. • Individual #626 had a HMP for hypertension but hypertension was not listed on the nursing problem/diagnosis list. • Risk issues and medical conditions were not always listed on the nursing problem/diagnosis list until the next quarterly and/or annual nursing assessments were due. Examples: o Individual #107 was placed at medium risk for urinary tract infection and hypothermia after the quarterly nursing assessment was completed. HMPs had been developed and implemented for these problems but the nursing assessment was not updated to include the change in status. o Individual #621 was at high risk for aspiration, respiratory compromise and had an Active Medical Problem for chronic bronchitis but these problems were not included on the current annual nursing assessment. The Nursing Department reported that 34 RNs had completed the State's mandated Physical Assessment Class that also included training on documentation. The remaining RNs were scheduled to complete the class by January 2012. As the RNs complete this class, there should be improvement in the RN Case Managers' ability to analyze and summarize health data into a more concise and meaningful way to adequately and accurately represent individuals' health status and measure the effectiveness of their HMPs. The progress made toward improving the analysis and summary of health data, as a result of the Physical Assessment Class, will be evaluated at the next compliance review. According to the State Office Nursing Coordinator the State Supported Living Centers Nurse Workgroup was in the process of developing a Community/Transfer Discharge Nursing Assessment format. Of the last five individuals who transferred to the	

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		community, only one formal Nursing Discharge Summary had been completed at the time of the compliance review. Individual #583's Nursing Discharge Summary was reviewed. The discharge summary identified Individual #583's nursing problems/diagnoses, current health status, goals, treatments, medications, and interventions in relation to the identified problems/diagnoses; this was found inadequate to assist the receiving agency to understand Individual #583's problems and needs. The development and implementation of the Community/Transfer Discharge Nursing Assessment should provide enhanced guidance and strengthen the nursing discharge processes. The Monitoring Team will follow-up on the progress made toward improving nursing's community discharge assessment at the next compliance review. Although improvements were made, this provision was not found in compliance. The Nursing Department needs to ensure that all RNs complete the Physical Assessment and Documentation Class as soon as possible. In order to meet compliance with this provision of the Settle Agreement the positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements: • Ensure that the RN Case Managers understand the timelines required by the PSP schedule for completing the Annual/Quarterly Nursing Assessment and that they maintain a current PSP schedule for completing the assessments. • Ensure that the RN Case Managers review individuals' finalized PSPs and PSPAs for accuracy and completeness related to the corresponding nursing's health care plans. • Ensure a standardized format is used for completing the overall nursing summaries on the Comprehensive Nursing Assessment template. • Ensure that the RN Case Managers thoroughly review individuals' active medical records prior to completing the Annual and Quarterly Nursing Assessments in order to identify any changes in health status. Individuals' immunizations status and risk levels, and active medical problems need to be reviewed to ensure they are up to date and included on the assessments. • The RN Case Managers' need to continue to enhance their ability to analyze and summarize health data into more concise and meaningful documentation in order to adequately and accurately represent individuals' health status and measure the effectiveness of their HMPs.	
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,	The Facility's Section M POI indicated that compliance was not met with this provision of the Settlement Agreement. The Monitoring Team concurs that the Facility had not met compliance with this provision. Although the Facility had not yet met compliance with this provision, it was evident through review of the Facility's Section M POI, the detailed and comprehensive Presentation Book for Section M.3, interviews with the Nursing Administration and Management staff, review of training records, and review of	Noncompliance

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	including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	individuals' active medical records, that the Nursing Department had put forth concerted effort since the last compliance review to improve the quality of nursing care. In order to move the Facility forward in meeting compliance with this provision. However, there remained the need for continued improvement, as indicated in the report below. Records were reviewed for Individuals #248, #286, #723, #107, #202, #625, #155, #184, #680, #358, #379, #719, #58, #239, #233, and #62. For the 16 individuals a total of 104 care plans were reviewed (86 HMPs and 18 ACPs). The following trends were identified: • A review of 104 HMPs and ACP found: o Ninety-one of the104 (86%) had adequate baseline information. Frequently only the diagnoses were listed for the baseline data. o Seventy-nine of the 104 (76%) had realistic and measurable goals established. o Ninety-two of the 104 (92%) were individualized to some degree, but not totally. Some merely included the individuals' first name added to the interventions/actions on the template with little modification. o One hundred-one of the 104 (98%) contained the signature of the Home Leaders and or signed training sheet validating that the direct care professionals were trained on the HMPs and or ACPs. • A review of 86 HMPs indicated that 67 (78%) were reviewed by the RN Case Managers annually and/or quarterly. • A review of 18 ACPs indicated that 16 (89%) were followed through to resolution with documentation in the Integrated Progress Notes validating the problems were resolved. • Other trends identified in review of the HMPs and ACPs included: o Frequently, when medical monitoring was ordered every 30 minutes on an ACP, the monitoring was not documented in the Integrated Progress Notes, but was completed every shift, with the exception for the Units that did not have a nurse on the 10-6 shift, then there was documentation that the monitoring occurred only on the 6-2 and 2-6 shifts. o The HMPs for Seizure Management in-service training for the direct care professional staff included instructions for managing seizure activity but did not include preventative measures, or instruction on the signs and symptoms to observe for side effects related to anticonvulsant medications. o It was rare to find preventative measures contained in the HMPs and/or ACPs. o The HMPs and ACPs did not contain integration with other relevant disciplines. Occasionally there was documentation in the plans to refer to the PNMP and PBSP. o The ACPs used for conjunctivitis did not include instructions for the proper disposal of contaminated linens and waste produces to prevent cross-	

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		contamination. When managing conjunctivitis, since it is usually contagious, proper disposal of linens and other waste products should always be included in the instructions to the direct care professionals. o The instructions provided to the direct care professionals on the HMPs and/or ACPs were often were written in terminology at a level only a nurse could understand or carry out. The copies of HMPs and ACPs provided as a reference for the direct care professionals to use should be written on a level they can readily understand and follow. For example: Individual #680's HMP for Diabetes Mellitus, Insulin Dependent, demonstrated some instructions where it was doubtful the direct care professions could understand and follow, as well as some interventions that could only be carried out by a nurse. This information included the following instructions: ▪ Monitor for side effects of medication used to control blood glucose. The names of the medication and their side effects were not included in the instructions. ▪ Emergency treatments for hypo and hyperglycemia were listed but did not include the signs and symptoms for hypo and hyperglycemia. The instructions for the emergency treatments were too complicated for the average direct care professional to understand, e.g.: ✓ Hypoglycemia: » Mild: 10 -15 grams carbohydrate » Moderate: 20-30 grams carbohydrate or Glucagon, 1 mg subcutaneously or intramuscularly » Severe: 25 grams D-50 dextrose intravenously or Glucagon 1 mg intramuscularly or intravenously ▪ Monitor condition of skin at injection site and stick sites at the time of each procedure. Report results to the nurse or Physician per necessary (PRN). ▪ Implement glucometer and urine tests and administer medications as ordered. ▪ Monitor for signs and symptoms of diabetic complications, such as infections, vascular complications, neuropathy, and retinopathy, and report to appropriate clinician. It was apparent the RN Case Manager who developed this HMP copied it directly from the stock care plans without giving thought to the instructions appropriateness for the direct care professionals. It is essential when using the stock care plans that the nurses carefully review the content to ensure it is relevant to the individuals' problem and those instructions for the direct care professionals are written at level they can understand and follow.	

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		While improvements had been made in the adequacy and quality of the HMPs and ACPs, the Nursing Department continued to use the templates from the Health Care Protocols for Developmental Disability Nurses, resulting in plans that continued to consist of generic content that did not adequately meet individuals' unique needs for care. These protocols should only be used as a reference guide in developing health care plans. Content that was not applicable to the individuals' unique health problems should be eliminated from the plans. The use of the stock care plans should not limit the RN Case Managers' ability to use their clinical judgment in developing health care plans to meet the individuals' unique needs. After review of the HMPs it was doubtful that the RN Case Managers actually reviewed the appropriateness of some of the interventions/actions contained in the protocol templates as they developed HMPs to address specific heath problems. It was a concern that these protocols may function as deterrent to RN Case Managers in using their clinical judgment and critical thinking skills by solely relying on the protocols to develop HMPs and ACPs. The effectiveness of the Health Care Protocols for Developmental Disability Nurses to develop individualized care plans should be further explored by the Nursing Administration and Management staff and/or the State Supported Living Centers' Nurse Workgroup and the State Office Nursing Coordinator. While there was improvement found in the HMPs and ACPs since the last compliance review, in general they continued to lack adequate individualization to meet individuals' needs. The baseline data contained on the HMPs and ACPs describing the problems leading to the need for the plan of care and their health status had significantly improved but some only contained the medical or nursing problems. The goals and objectives established for the HMPs and ACPs had also improved but were not consistently clinically appropriate, realistic, and measurable in relation to the identified health problems. The HMPs and ACPs included interventions/actions to address the immediate problem but rarely contained proactive interventions directed at preventing or minimizing the specific health risks. The HMPs did not contained adequate instructions to specify to the nursing staff the frequency interventions/actions were to be carried out, by whom, where, and when to document interventions/actions that were taken. There was documentation found on the HMPs that the RN Case Managers were beginning to review/revise them quarterly. It was rare to find that HMPs were revised, although the individuals may have continued to have reoccurrence of the problems for which the plans were designed to resolve or minimize, e.g., episodes of emesis, urinary tract infections, skin integrity issues, and constipation. The effectiveness of the plans was not addressed in individuals' Annual/Quarterly Comprehensive Nursing Assessments. It is essential that the RN Case Managers continuously evaluate the effectiveness of the HMPs, particularly when individuals' problems are not resolving or minimizing. When the HMPs are not found effective they need to be revised and re-evaluated. The effectiveness of the HMPs need be documented in individuals' records and summarized in their	

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		Annual/Quarterly Comprehensive Nursing Assessments. The health care plans were not integrated with other disciplines, with exception of the instructions provided to direct care professionals. The Sections F and G of the Settlement Agreement requires collaboration with other disciplines regarding care plans so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in to all HMPs to adequately meet the total health care needs of individuals. It is essential that the RN Case Managers collaborate with other relevant disciplines when developing heath care plans that would require their expertise to meet the total needs of individuals. Although improvements were made, this provision was not found in compliance. In order to meet compliance with this provision, the positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should continue to make the following improvements: • Ensure that HMPs and ACPs are integrated with other relevant disciplines to meet the individuals' total health care needs. • Ensure that HMPs and ACPs have clinically appropriate goals/objectives that are realistic and measurable in relation to the identified health problems. • Ensure that HMPs and ACPs are individualized to meet individuals' unique health care needs. The RN Case Managers should carefully review the content of the stock care plans for relevance and appropriateness to individuals' unique health problems. Content that is not relevant or appropriate to individuals' unique health problems should be eliminated from the care plan template. • Ensure that the HMPs and ACPs include proactive interventions that are directed at preventing or minimizing the specific health risks. The interventions need to provide specific instructions for how frequently they are carried out, by whom, and where to document nursing actions. • Ensure that in-service training instructions provided to the direct care professionals on care plans are written at a level they can understand and follow. • Ensure the RN Case Managers continuously evaluate the effectiveness of the HMPs, particularly when individuals' problems are not resolving or minimizing. When the HMPs are not found effective they need to be re-evaluated and revised accordingly. The effectiveness of the HMPs need be documented in individuals' records and summarized in their Annual/Quarterly Comprehensive Nursing Assessments.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting	The Facility's POI stated they were not in compliance with this provision but the Monitoring Team did not concur. Although the Facility did not find this provision in compliance after careful review of the Facility's Section M's POI, the detailed and comprehensive Presentation Book for Section M.4, interviews with the Nursing	Substantial Compliance

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	protocols sufficient to address the health status of the individuals served.	Administration and Management staff, review of documents, and review of training records; the Monitoring Team found this provision to be in substantial compliance with this provision. The Nursing Department had adopted and implemented all of the core State nursing policies, procedures, protocols, and processes developed to date by the State Nursing Workgroup as well as nursing local policies, procedures, protocols, and processes. The Monitoring Team reviewed the nursing policies, procedures, protocols, and processes and found them to be consistent with current standards of practice for nursing assessment and reporting sufficient to address the health status of the individuals served. The Facility trained nurses on these. This was validated through the Monitoring Team's review of all of the Facility's policies, procedures, protocols, and processes, as well as through review of the Facility's training records and training database. Since the last compliance visit Nursing Education had been revamped to improve the quality of the education and to track the required training of each nurse through to completion. The Nurse Educators were placed under the supervision of the NOO. The NOO was also an instructor at the University of Houston, Victoria at Sugarland's School of Nursing. The Nurse Educators had implemented the Nurse Educator's Handbook and had begun using it for New Nurse Employee Orientation and for the Annual Competency-based Fair. The Nurse Educators Handbook contained competency-based material, in accordance with the Nursing Competency Based Training Curriculum Procedure. The nursing orientation process had been extended to six weeks and included a Preceptor Program to mentor the new nurses during the orientation period. The Nurse Educators had adopted and implemented the State's approved Preceptor Program Curriculum for training the nurses who were serving as preceptors to the nurses in orientation. In addition, the CNE attended the Fall 2011 Preceptor Workshop, presented by The University of Houston Victoria, 10/14/2011. The Nurse Educators had developed and implemented an excellent Nursing Education Database for tracking and reporting all required nursing training by each nurse through to completion. The Nursing Education Database produced the following reports: Training Rosters, Name of In-service by Months and Number of Staff Trained, Training Completed by the Employee, Graphs to Show Percentage of Nurses Training on Each Course, and New Hire Training. This was a significant improvement, since there was no training tracking system in place at the last compliance visit. As a result of the implementation of the Nursing Training Database, the Nurse Educators were able to provide the Monitoring Team with copies of the training reports and training records to validate training activities. This included the core State nursing policies, procedures, protocols, and processes developed to date by the State Nursing Workgroup as well as nursing local policies, procedures, protocols, and processes as well as other training	

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		activities. The report indicated that 95% to 100% of the nursing staff had completed the required training. The nurses who had not yet completed the required training were projected to complete the training by 10/20/2011. At the time of review the status of the nurses yet to receive the required training was not available for review. The list below includes the status of training completed on policies, procedures, processes, and guidelines: • Acute Illness and Injury (including Chronic Restrictive Airway Disease) • Hospitalizations, Transfers and Discharges • Health Care Plan Development • Documentation • 24-Hour Clock • Urine Dipstick Chemical Analysis • Enteral Medication Administration • Stool Collection for Hemoccult • Nasogastric Tube Re-insertion • Gastrostomy Tube Insertion • Comprehensive Nursing Assessments • Medication Administration Guidelines • Self-Administration of Medications Guidelines • Medication Variance • Medication Errors • Neurological Assessment • Seizure Management • Vagal Nerve Stimulator Policy • Diastat Administration • Nursing Peer Review • Weight Management • Pre-treatment and Post Sedation Monitoring • Post/Pre Anesthesia Care – Nursing Care Protocol • Nursing Services • Skin Management and Wound Prevention • Emergency Response • Pica • MOSES/DISCUS Assessments • Physical Assessments • Vital Signs/Clinical Indicators • Nursing Peer Review • At Risk Individuals • Rights/Restrictions/Restraints	

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		• Physicians' Quarterly Orders • Acute Illness and Injury Notification It was commendable that the Nursing Department had achieved 97% to 100% compliance with the required training on the core nursing procedures, protocols, and guidelines. The effectiveness of the training on the above procedures, protocols, and guidelines will be evaluated by the Monitoring Team in Sections M.1, M.2, M.3, M.5., and M.6. In addition to the training listed above, the following training was provided: • The Nurse Educators had received Nurse Educator Training (included Nurse Educators from other SSLCS taught by State Office Nursing Coordinator and Nursing Consultants) at the Denton State Support Living Center. The training included: Critical Thinking, Effective Communication, Principle of Adult Learning, Dysphagia, and Respiratory In-Service. The Nurse Educators will assist with training the RNs on the State's mandated Physical Assessment and Documentation Class. At the time of the compliance review 34 of the 87 (39%) RNs had completed the State's mandated Physical Assessment and Documentation Class. The remaining RNs were projected to complete the Class by January 2012. As the RNs complete the Physical Assessment Class, their enhanced knowledge and skills should improve the RNs' ability to complete an accurate comprehensive physical assessment, critically analyze clinical data, and summarize it to accurately reflect individuals' health status. • The Nurse Educator had developed and was in the process of implementing Protocol Cards for the nursing staff to carry on a ring to remind them of the key requirements to follow for each of the protocols. The cards will be reduced to an approximately 3" by 4" size and laminated. The Protocol Cards developed included: o When Contacting the Primary Care Provider (PCP), document what you provided o Vomiting o Diarrhea o Constipation o Temperature Elevations o Antibiotic Therapy o Respiratory Distress/Aspiration o Pre-Treatment and Post-Sedation o Head Injury • The Nurse Educators had implemented the State's mandated Clinical Indicators for Health Status Change Class and had trained all of the 619 incumbent staff. They had begun teaching this class at New Employee Orientation. The objectives for the Class were to train support staff how to identify common clinical indicators (signs and symptoms), and respond and report changes in individuals' health status. It is	

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		essential that front line staff are adequately trained to recognize, respond, and report clinical indicators, since they are usually first to notice changes in individuals' health status. In addition, the direct care professionals were trained on Warning Signs and How to Recognize and Report Illness in Individuals. Since the last compliance visit, the Nursing Department had obtained a teaching manikin and other needed equipment to use in performing practicum skills for physical assessment as well as other clinical skills. The limited and inadequate space available to the Nursing Department for education and other administrative functions was of concern. At the time of the compliance review the space available to the Nursing Department was undergoing construction. The Nursing Department has the largest number of staff, only second to the number of residential staff. It is essential that they have adequate space to conduct nursing education as well as other administrative functions. In addition, the Nursing Department needs a dedicated space large enough to store and secure expensive clinical lab materials, as well as to accommodate a large number of staff for clinical training. Although this provision was found in compliance, in order to maintain compliance with this provision, the positive practices identified in the report must be maintained, and all nurses must receive training on any newly developed and implemented nursing policies, and procedures, protocols, and processes. The Facility needs to provide the Nursing Department with an adequate space to accommodate training and secure clinical training materials.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs. Since the last review, the Facility continued to report in the POI that all required staff had been trained on the At Risk Individual Policy. Individuals' level of risk were continuing to be assessed using the Risk Guidelines, which contained criteria to serve as a guide to assist the PSTs in determining appropriate risk levels for designated risk categories. A review of risk categories and the assignment of risk levels occurred during the PSP meetings. The RN Case Managers, in conjunction with the physicians, continued to be responsible for assessing risk factors in the following categories: Aspiration, Respiratory, Compromise, Cardiac Disease, Circulatory, Constipation/Bowel Obstruction, Diabetes, Gastrointestinal (GI) Problems, Osteoporosis, Seizures, Infections, Fractures, Fluid Imbalance, Hypothermia, and Urinary Tract Infections. To assess the Facility's risk screening process the Monitoring Team observed two	Noncompliance

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		individuals' (Individuals #58 and #680) special risk meetings that were held to review their risk level. Overall, the Team Members observed marginal improvement since the last review. The PSTs were reminded that the Risk Guidelines were just guidelines and that other interrelated risk categories should also be considered to ensure that risk ratings reflect an accurate assessment of individuals' risks. The PSTs were beginning to engage somewhat more in clinical discussions using supporting clinical data, and exercising to some degree more critical thinking than had been observed at past risk meetings. It was positive that the individuals' entire teams were present and participated in the meetings. Having the entire team present and actively participating is essential to accurately identifying individuals' risk factors, assigning risk levels, and in developing appropriate and integrated Risk Action Plans for each identified risk factor with a score of high or medium. The Monitoring Team reviewed six individuals' (Individuals #723, #625, #58, #291, #233, and #239) most recent PST and PSPA meeting minutes, Risk Screening Assessments, and Risk Actions Plans. The review found that none (0%) of the six records reviewed met compliance with all of the At Risk Individual and/or PSP Policy's criteria. The Risk Screening Assessment rationales were weak in substance and failed to reflect due deliberation of the interrelatedness of the various risk categories. Neither did there appear to be interdisciplinary involvement in completing the Risk Screening Assessments nor was there involvement in the development of Risk Action Plans. The dates of implementation on the Risk Action Plans typically were stated as "on going." Hence, it could not be determined when the plans were actually implemented. The frequency at which the Risk Screening Assessments were conducted followed the previous policy. Therefore, it was difficult to ascertain when changes were made and to determine if the Risk Action Plans were changed and/or incorporated into the PSPs/PSPAs. The plans' action steps where primarily directed toward nursing care with little or no inclusion of other disciplines. Even so, the plans' action steps most often stated to refer to the nursing care plans without specifying the interventions to be taken. None of the Risk Screening Assessments and their accompanying Risk Action Plans were adequate to meet individuals' needs, if only the PSPs/PSPAs were used to identify individuals' risk levels and plans of care. A review of the individual disciplines' assessments and plans of care were reasonably adequate in identifying risk category levels and designing appropriate care plan interventions. The Facility staff urgently needs retraining on the At Risk Individual Policy. Examples of findings: • Individual #723 - PSP did not include all risk category levels identified. The PSP, Risk Screening Assessments, and accompanying Risk Action Plans were inadequate to address all risk category levels. No measurable action steps or outcomes were included in the plan for the risk category levels identified. The plans stated to continue nursing services and ACPs as needed without providing measurable actions	

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		steps and outcomes for each risk category identified. The plans were not integrated to include other disciplines. • Individual #233 - PSP did not include all risk category levels identified. The PSP, Risk Screening Assessments, and accompanying Risk Action Plans were inadequate to address all risk category levels. No measurable action steps or outcomes were included in the plan for the risk category levels identified. The plans stated to continue HMPs for the risk levels without providing measurable actions steps and outcomes for each risk category identified. The plans were not integrated to include other disciplines. Based on Individual #233's past medical history and related diagnoses he should have been rated high on aspiration, respiratory compromise, and gastrointestinal problems. After a hospital admission for thrombocytopenia (low blood platelets) in 8/2011, the PST conducted a Risk Assessment Screening. The risk levels for aspiration, and gastrointestinal problems remained at medium risk and respiratory compromise remained at low risk. These risk levels were not adequately addressed in the rationale and were not changed. The accompanying Risk Action Plan did not address aspiration, respiratory compromise, and gastrointestinal problems. • Individual # 58 – PSP, Risk Assessments, and accompanying Risk Action Plans were inadequate, incomplete, and were not integrated. There was no documentation of other disciplines' input. The PST relied heavily on the information and outcomes from nursing's HMPs. It was apparent from interviews with the Nursing Administration, Nurse Managers, and RN Case Managers, review of the individuals' Comprehensive Nursing Assessments used for the At Risk Screening Assessments, and observations made by the Monitoring Team during the meetings found that the PST members, particularly the clinical team members, primarily deferred clinical information to the RN Case Managers. The PST members should review clinical information for their respective disciplines regarding individuals' risk factors prior to the meeting and be prepared to discuss relevant risk issues at the meeting. It is essential that each discipline responsible for their respective risk categories thoroughly complete an assessment of individuals' mental and medical health, as well as behavior status though collaboration with other relevant disciplines. The assessments should include interviews with the individuals' direct care professionals. They should thoroughly review clinical records prior to completing their portion of the risk assessment in order to bring comprehensive information to the PST meetings so that risk factors are accurately identified. Since the RN Case Managers typically take the lead on completing the medical/health related risk categories, it is essential that they corroborate their risk assessment findings with individuals' physicians prior to the PST meetings to ensure that all medical/health related risk factors are identified; and that the	

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		risk levels are accurately scored. Establishing a competent and reliable At-Risk system is essential in ensuring that those individuals who warrant the most clinical intensity are appropriately identified and provided appropriate care related to identified risk factor levels. The Monitoring Team discovered that Aspiration Pneumonia/Enteral Nutrition Evaluations had not been completed on individuals identified at risk for aspiration/aspiration pneumonia. This was discussed with the CNE who said she would investigate the matter. Refer to Section O for information regarding the completion of Aspiration Pneumonia/Enteral Nutrition Evaluations. In order to meet compliance with this provision of the Settlement Agreement, the positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements: • Ensure the RN Case Managers, who are responsible for completing the medical/health related risk categories, corroborate their risk assessment findings with individuals' physicians prior to the PST meetings to ensure that all medical/health related risk factors are identified; and that the risk levels are accurately scored. • Ensure that the RN Case Managers, and other relevant nursing staff consistently meet all criteria contained in the At Individual Risk Policy and associated documents, e.g., Aspiration Pneumonia/Enteral Nutrition Evaluations and Aspiration Trigger Sheets.	
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	The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs. Although the Facility had not yet met compliance with this provision, it was evident through review of the Facility's Section M.6, the detailed and comprehensive Presentation Book for Section M.6, interviews with the Nursing Administration and Management staff, review of documents, review of training records, and through observations; that the Nursing Department had put forth concerted effort since the last compliance review to improve medication administration practices in order to move the Facility forward in meeting compliance with this provision. Since the last compliance review the State Office had issued the Medication Variance Policy, 053. The Facility had adopted and implemented the new Medication Variance Policy, 053. The implementation of this policy provided broader guidelines for all aspects of medication administration practices. The policy provided guidelines to ensure medication variances related to the prescribing, ordering, transcribing, preparation, dispensing, delivery and/or administration of medication to individuals were reported, documented, investigated, regularly trended, and reviewed. The Policy also promoted	Noncompliance

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	care with regard to this provision in a separate monitoring plan.	and ensured quality care by making all providers aware of the nature and causes of medication variances. Through periodic review of medication variance reports, identification of common causalities, use of processes, and improvement techniques; the Facility should be able to eliminate or reduce the potential for reoccurrence of medication variances. Since the last compliance review the Nursing Department had continued to conduct Quarterly Medication Observations on each nurse who administers medication. This was validated though the Monitoring Team's review of the completed Medication Administration Observations forms for the past six months. The review rarely found deficiencies on the completed forms. However, there was no analysis of findings summarized for the observation data available for review. The Nursing Department's Nursing Administrative and Management staff conducted monthly audits on the Medication Administration and Documentation Monitoring Tools. A sample of eight records was developed by the QA Nurses for audit. The results of the audits for 6/1/2011 through 10/12/2011 included the overall compliance scores for 32 internal audits completed by the Nursing Department staff and six external audits completed by the QA Nurses. In addition to the overall compliance found in the internal and external audits, the QA Nurses identified the degree of inter-rater agreement between the internal and external audits. The audits included the following results: • Internal Audits for Medication Administration and Documentation overall compliance was 99.58%. • External Audits for Medication Administration and Documentation overall compliance was 97.96%. • The degree of agreement between Internal and External Audits for Medication Administration and Documentation was 88.89%. It was positive to find the degree of agreement between internal and external audits for medication administration observations over the past five months. This indicated confidence in the consistency of the data audited. The Nursing Department had developed Medication/Enteral Administration Observations: Corrective Action Plan Guidelines, effective, 10/11/2011. At the time of the review there were no corrective action plans available for review. Review of any Corrective Action Plans implemented will be done at the next compliance visit. In addition to conducting quarterly Medication Administration Observations and auditing the Medication Administration and Documentation Monitoring Tool, the Nursing Department's Nursing Administrative and Management staff had conducted a variety of additional internal monitoring items to further improve medication administration practices. The additional monitoring data included audits on the	

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		following items: • Medication Administration Records every shift for medications not signed, which constitute medication errors. • Medication Administration Record Audit sheets and Narcotic Sheets signed by two nurses each shift. • Emergency Response Audits, for three nurses weekly. • Acute Care Plan Audits that included interviewing two direct care professionals on each shift to assess their understanding of selected individuals' Acute Care Plans and where they were located. • Medication Room Inspections. The inspections included daily checks to monitor each refrigerator and medication room temperatures. • Medication Excess/Shortage Form. The frequency of the audits was not indicated. Only raw data sheets were available for review of these audited items. There was no analysis of findings summarized to indicate the degree of compliance with the items audited. In order for the data derived from the above audits to be useful for internal management purposes, the data must be analyzed and trended such that corrective action plans can be developed and implemented for identified deficiencies, both for individual specific deficiencies as well as for systemic deficiencies. The Nursing Department had developed Medication Administration Record Audits and Medication Room Inspection: Corrective Action Plan Guidelines, effective, 9/7/2011. At the time of the review there were no corrective action plans available for review. Review of any Corrective Action Plans implemented will be done at the next compliance visit. The Monitoring Team's review of the Facility's 12 most recent Medication Error Reports submitted through the document request revealed the following findings: • Three of the 12 (25%) medication errors were discovered and reported within approximately 24 hours of discovery. One of the 12 (8.3%) medication errors was discovered and reported two days after the error occurred. One of the 12 (8.3%) medication errors was discovered and reported 3 days after the error occurred. One of the 12 (8.3%) medication errors was discovered and reported 4 days after the error occurred. Two of the 12 (16.8%) medication errors were discovered and reported 10 days after the error occurred. Three of the 12 (25%) medication errors were discovered and reported 17 days after the error occurred. One of the 12 (8.3%) medication errors was discovered and reported 50 days after the error occurred. This represented a significant delay in discovering and reporting the medication errors. • Although 12 of 12 (100%) medication errors were reported to the physician upon discovery, the delay in reporting errors to the physicians had the potential to have a negative impact on the individuals because it would have been too late to accurately	

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		assess individuals for any change in status resulting from the medication errors and to provide prompt medical intervention should the individuals have had changes in status. This is particularly important when individuals miss critical medications, such as seizure, psychotropic, diabetic, and cardiac medications, to mention only a few. For example, the Medication Error Report, 6/22/2011, resulted in 102 medication errors. The medication errors were the result of Individual #718 having been seen in Neurology Clinic on 6/22/2011 where the neurologist ordered tapering off of Topamax (seizure medication). The direct care professional returning the chart failed to notify the dorm nurse of the new order. The medication errors were not discovered and reported to the physician until 8/12/2011 at 1340--50 days after the medication errors occurred. Upon notification, the physician rewrote the order to taper the Topamax. There was no documentation that indicated the failure to taper Topamax resulted in harm to Individual #718. However, the failure to taper off the seizure medication as ordered could have had a negative impact on Individual #718's health status if the dosage had been too high. There was documentation that the corrective action was taken and a system was implemented to flag charts returning from clinics with new orders. Of further concern was the fact that 102 medication errors were reported on one Medication Error Report form. Reporting multiple medication errors on one report has the potential to skew the data and to inaccurately report the number of medication errors. This also represented underreporting of medication errors. It is essential that all medication errors be reported. • Twelve of the 12 (100%) medication errors contained documentation for corrective action taken on the nurses committing the medication errors by the responsible supervising RN. However, in 10 of the 12 (83%) medication errors there was a delay of two or more days before the medication errors were discovered and corrective action was taken. This represented a significant delay in corrective action. It is essential that prompt corrective actions are taken with nurses committing the errors or for other factors contributing to the medication errors to prevent the occurrence of future medication errors. Even though the Medication Error Report form section for "Follow-up by the Nursing Supervisor" did not include the requirement to document the date corrective action was taken, the supervising RNs should include the dates to ensure that corrective action was taken promptly. A review of the Nursing Report to the Medication Variance Committee Meeting Minutes, 9/21/2011, which reported the number of medication errors for August 2011, found the report did not include the 102 medication errors resulting from the Medication Error Report described above. For August 2011, a total of 38 medication errors were reported. Apparently since all of the 102 medication errors were reported on one form, only one medication error was counted. • One of the 12 (8.3%) medication errors was correctly classified as a Category C, that	

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		is., errors that reached the individual but did not cause harm. Nine of 12 (75%) were classified a Category A and/or B, that is., circumstances or events that have the potential to cause error or an error occurred but the medication did not reach the consumer. These medication errors were as a result of omissions and should have been classified as Category C, as defined in the Medication Variance Policy, 053. The example given in the policy for Category C states, "Omitting a prescribed medication (dispensing/administering)." One of the 12 (8.3%) medication errors was correctly classified as Category A. One medication error was not classified by Category. These examples indicate that the nurses completing the Medication Error Reports do not understand the definitions for the Categories listed on the Severity Index. • Four of the 12 (33%) Medication Error Reports did not have the location of the error identified. The identification on the Medication Error Report of the location where the error occurred is essential for nursing management to locate, follow-up on, and to correctly enter the Medication Error Report into the database. It is essential that Nursing Administration and Nursing Management staff critically review and investigate all Medical Error Reports to ensure: • The accuracy of the reports, including correctly rating the medication error Category. The nursing staff completing the Medication Error Reports should be retrained on the definitions for the Categories listed on the Severity Index. • Timely reporting, discovery, and notification to the physician of errors. • Timely implementation of corrective actions with the nurses committing the medication errors by the responsible supervising RNs. The supervising RNs need to include the dates the corrective actions were taken. • Each medication error is reported separately as opposed to combining multiple medication errors on to one report. • The locations where the medication errors occur are documented on the Medication Error Reports. The Monitoring Team, along with the CNE and Nurse Educators reviewed Individuals: #283, #353, #585, #651, and #30s' Medical Records and Medication Administration Records with the focus on reviewing the 90-day medication orders to ensure they had been renewed. All 90-day orders were signed and were current. Individual #585's 90-day medication orders were expiring on the day of the review. The CNE and Nurse Educators said they would ensure that the 90-day medication orders were renewed before the end of the day. Individual #651's Medication Administration Record was found to have a few blanks. The CNE and Nurse Educators said they would follow-up on the blanks found on the Medication Administration Record with the Infirmary Director. The Monitoring Team conducted medication/enteral administration observations in the	

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		Infirmary. The nurse followed the correct procedure for administering enteral medications. It was impressive to find that the nurse crushed each medication separately and put the crushed medications in individual medication cups. Then, the medications were administered individually. This was correct procedure that was not often found when conducting enteral medication observations. Often nurses were observed mixing the crushed medication together in water, and then administering the medications, unless there was a contraindication to mixing some of the medications. A concern identified was the Infirmary's antiquated medication carts. They were in poor repair with the metal drawers bent and difficult to open and close. For security purposes and ease of use the Facility should consider replacing these outdated medication carts. The CNE stated that the antiquated medications carts in the Unit which were identified in previous reports had been replaced with six new carts. In addition adopting and implementing the State Medication Variance Policy, 053, the Facility guidelines included the requirement that all medication errors/variances shall be reviewed monthly for the trend analysis and corrective action taken by the Medication Variance Committee prior to reporting their findings to the Pharmacy and Therapeutic Committee. On a quarterly basis, the Pharmacy and Therapeutic Committee shall review the medication errors. The head of each discipline will take corrective action for the errors or variances resulting from the staff belonging to their discipline. At the last compliance review the Pharmacy had developed and implemented a Medication/Errors/Variance, Policy 01.05.20. While this was a good start on addressing medication variances, the State Office Medication Variance Policy, 053 was more comprehensive. The Chief Pharmacy Director chaired both the Medication Variance Committee and the Pharmacy and Therapeutic Committee. According to the policy the CNE or designee was responsible for chairing the Medication Variance Committee. This responsibility was discussed at the Pharmacy and Therapeutic Committee Meeting, 10/26/2011, in which the State Office Nursing Coordinator and Monitoring Team attended. The State Office Nursing Coordinator explained the intent of the policy for the CNE to chair the Medication Variance Committee. At the conclusion of the discussion it could not be determined whether the CNE or the Chief Pharmacy Director would chair the meeting. This issue will be followed-up at the next compliance review. The Monitoring Team reviewed the Nursing Reports to the Medication Variance Committee, Medication Variance Committee Meeting Minutes, and the Pharmacy and Therapeutic Committee Meeting Minutes. The Nursing Report to the Medication Variance Committee, July 2011, reported an excess of 1376+ medication errors attributable to physicians who failed to sign the 90-day renewal medication orders. This	

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		was not addressed in the 7/14/2011 Pharmacy and Therapeutic Committee Minutes. It was not until the Pharmacy and Therapeutic Committee Meeting on 9/21/2011, that the physicians' failure to sign the 90-day renewal medication orders was reviewed and discussed. Little remediation was discussed to prevent the problem from reoccurring, except to offer the physicians assistance in alerting them each time the Pharmacy sends the order to the Units. There was no discussion of the ramification of the 1376+ medication errors that occurred as a result of the failure to have the 90-day renewal medication orders signed by the physicians. While this was primarily the responsibility of the physicians to renew and sign the 90-day orders, the nursing staff had the responsibility to check the medication orders before administering medication. This was a significant breakdown in the medication administration system and should have garnered more concern by all relevant disciplines and administration. The Monitoring Team attended both the Medication Variance and Pharmacy and Therapeutic Committee Meetings on 10/26/2011; there was little discussion and problem solving efforts made toward exploring causative factors contributing to the incidents of Medication Errors/Variances and corrective action to prevent or reduce them. The State Office Nursing Coordinator suggested that the CNE and/or NOO visit the Nursing Department at the Brenham State Supported Living Center to review their process for identifying and solving medication error/variance issues. The CNE was agreeable to scheduling a visit. The Facility had an excellent Medication Error Database that was comprehensive and contained all the data necessary to analyze and trend medication errors/variances using a root cause analysis approach. The Medication Variance Committee and Pharmacy and Therapeutic Committee should take full advantage of the medication error/variance data reported in the Medication Error Database. The data need to be analyzed and trended in order to identify causative and/or contributing factors to medication errors/variances and to make decisions regarding corrective action to prevent and/or reduce the incidents of medication errors. Nevertheless, for these data to be useful, the Facility must ensure they are accurate. The concern identified in the report above regarding 102 medication errors discovered on 6/22/2011, was not reported as such in the Nursing Report to Medication Variance Committee Meeting Minutes, 9/21/2011. For August 2011, a total of 38 medications errors were reported. Apparently since all the 102 medications errors were reported on one form, only one medication error was counted. This issue was discussed briefly in the Pharmacy and Therapeutic Committee Meeting Minutes, 9/21/2011. However, there was no discussion regarding the 102 medication errors caused by the failure to transcribe the 6/22/2011 physician Order's to taper Individual #718's Topamax. Since	

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		all the medication errors were reported on one Medication Error Report it was assumed to only represent one medication error as opposed to 102 medication errors. This represented underreporting of medication errors and skewed the medication error report for August 2011. The minutes did discuss the corrective action implemented to prevent transcription errors by having the RN Case Managers check the charts when individuals return from clinic visits. Also, starting in September 2011, the charts were to be checked daily instead of weekly. The Nursing Department Reported the following number of monthly medication errors: May – 11, due to omissions June – 2, due to wrong individual July – 5, due to omission, of which 3 were secondary to transcription errors August – 38, of which 37 were due to omissions and one due to wrong dose The increase in medication errors was reported as due to the new auditing system implemented by Nursing Administration. As a result of this finding the nurses who committed the medication errors were counseled, retrained, and a medication administration observation was completed with each nurse prior to allowing them to pass medication alone again. The Nursing Department should ensure that all medication errors are reported to avoid underreporting, to identify the causative factors that contributed to the medication errors, and take corrective action as indicated to prevent or reduce the occurrence of future medication errors. It was evident that the Nursing Department had put forth much effort in training the nursing staff on medication administration practices and had increased monitoring activities for medication administration; the Facility had not yet met compliance with this provision, although they were close to meeting compliance. In order to meet compliance with this provision of the Settlement Agreement, the positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements: • The Nursing Department should ensure: o The accuracy of the Medication Error Reports, including correctly rating the medication error Category. The nursing staff completing the Medication Error Reports should be retrained on the definitions for the Categories listed on the Severity Index. o Timely reporting, discovery, and notification to the physician of errors. o Timely implementation of corrective actions with the nurses committing the medication errors by the responsible supervising RNs. The supervising RNs need to include the dates the corrective actions were taken. o Each medication error is reported separately as opposed to combining multiple	

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		medication errors on to one report. o The locations where the medication errors occur are documented on the Medication Error Reports. o A process in in place to assure that all medication errors are reported to avoid underreporting, to identify the causative factors that contributed to the medication errors, and take corrective action as indicated to prevent or reduce the occurrence of future medication errors. • The Medication Variance Committee and Pharmacy and Therapeutic Committee should take full advantage of the medication error/variance data reported in the Medication Error Database. The data need to be analyzed and trended in order to identify causative and/or contributing factors to medication errors/variances and to make decisions regarding corrective action to prevent and/or reduce the incidents of medication errors.	

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

1. The Nursing Department should consider making the following improvements: (Provision M.1)
   - Ensure that all nursing auditors rating the monitoring tools are clinically competent and that there is consistency between auditors.
   - Collaborate with the State Office to develop specific instructions for each of the Nursing Care Monitoring Tools.
   - Collaborate with the Quality Assurance Department and State Office to develop a system for "weighting" each data item on the monitoring tools by value of significance, where appropriate. This will aid in prioritizing the most critical items that need CAPs.
   - Develop CAPs for specific problems identified through monitoring specific units, shifts and/or other localized situations, as well as CAPs for systemic problems identified through the broader analysis of trend data for campus-wide improvements.
   - Ensure that audits conducted on items other than the Nursing Care Monitoring Tools are analyzed, trended, and summarized in order to identify individual as well as systemic trends that may require CAPs. This is necessary for internal management purposes as well as for the Monitoring Team's assessments of these items.
2. The Nursing Department should make the following improvements: (Provision M.1)
   - Ensure that all records and forms created and used to document clinical information are approved for use in the active medical record.
   - Ensure that the nursing staff document in the Integrated Progress Notes assessment findings reported to the physicians.
   - Ensure that the Wound Care Nurse reviews all skin integrity/wound care ACPs and HMPs for appropriateness and the inclusion of all pertinent care interventions.
   - Ensure that the Hospital Liaison Nurse attends post-discharge PST meetings for individuals who have experienced a significant change in health status.
   - Ensure that the Infection Control Nurse receives additional training for managing the Infection Control Program. Ensure that the following Infection Control issues are addressed by the next compliance review:
     - Review, analyze, and trend of data from the Infection by Type data report to identify local and systemic trends that may require corrective action.
     - Conduct Infection Control Committee Meetings according to the Infection Control Committee Policy.
     - Develop a system to ensure the reliability of the infection reports.
     - Review, analyze, and trend Epidemiological Reports and Antibiograms in order to evaluate the effectiveness of the antibiotics prescribed to

treat various infections. The Infection Control Nurse should regularly attend the Pharmacy and Therapeutic Committee meetings and share the findings of the effectiveness of the antibiotics prescribed by the physicians.
    - Review the ACPs and HMPs for infections with the RN Case Manager to ensure that all infection control measures are included in the plans.
    - Track the status of seasonal flu vaccines to ensure that individuals are vaccinated.
    - Track the status of tuberculosis skin testing and periodic screenings for individuals who have a converted tuberculosis skin test.
    - Track the status of individuals' immunizations to ensure they are up to date or have their history of prior immunizations or diseases documented in their record. This includes populating the existing Immunization Database.
    - Develop and implement a tracking system to analyze, trend, and summarize handwashing and environmental surveillance monitoring data in order to identify trends that may require corrective action.
3. The Nursing Department should make the following improvements: (Provision M.2)
    - Ensure that the RN Case Managers understand the timelines required by the PSP schedule for completing the Annual/Quarterly Nursing Assessment and that they maintain a current PSP schedule for completing the assessments.
    - Ensure that the RN Case Managers review individuals' finalized PSPs and PSPAs for accuracy and completeness related to the corresponding nursing's health care plans.
    - Ensure a standardized format is used for completing the overall nursing summaries on the Comprehensive Nursing Assessment template.
    - Ensure that the RN Case Managers thoroughly review individuals' active medical records prior to completing the Annual and Quarterly Nursing Assessments in order to identify any changes in health status. Individuals' immunizations status and risk levels, and active medical problems need to be reviewed to ensure they are up to date and included on the assessments.
    - The RN Case Managers' need to continue to enhance their ability to analyze and summarize health data into more concise and meaningful documentation in order to adequately and accurately represent individuals' health status and measure the effectiveness of their HMPs.
4. The Nursing Department should continue to make the following improvements: (Provision M.3)
    - Ensure that HMPs and ACPs are integrated with other relevant disciplines to meet the individuals' total health care needs.
    - Ensure that HMPs and ACPs have clinically appropriate goals/objectives that are realistic and measurable in relation to the identified health problems.
    - Ensure that HMPs and ACPs are individualized to meet individuals' unique health care needs. The RN Case Managers should carefully review the content of the stock care plans for relevance and appropriateness to individuals' unique health problems. Content that is not relevant or appropriate to individuals' unique health problems should be eliminated from the care plan template.
    - Ensure that the HMPs and ACPs include proactive interventions that are directed at preventing or minimizing the specific health risks. The interventions need to provide specific instructions for how frequently they are carried out, by whom, and where to document nursing actions.
    - Ensure that in-service training instructions provided to the direct care professionals on care plans are written at a level they can understand and follow.
    - Ensure the RN Case Managers continuously evaluate the effectiveness of the HMPs, particularly when individuals' problems are not resolving or minimizing. When the HMPs are not found effective they need to be re-evaluated and revised accordingly. The effectiveness of the HMPs need to be documented in individuals' records and summarized in their Annual/Quarterly Comprehensive Nursing Assessments.
5. The Nursing Department should: (Provision M.5)
    - Ensure the RN Case Managers, who are responsible for completing the medical/health related risk categories, corroborate their risk assessment findings with individuals' physicians prior to the PST meetings to ensure that all medical/health related risk factors are identified; and that the risk levels are accurately scored.
    - Ensure that the RN Case Managers, and other relevant nursing staff consistently meet all criteria contained in the At Individual Risk Policy and associated documents, e.g., Aspiration Pneumonia/Enteral Nutrition Evaluations and Aspiration Trigger Sheets.
6. The Nursing Department should ensure: (Provision M.6)

- The accuracy of the Medication Error Reports, including correctly rating the medication error Category. The nursing staff completing the Medication Error Reports should be retrained on the definitions for the Categories listed on the Severity Index.
- Timely reporting, discovery, and notification to the physician of errors.
- Timely implementation of corrective actions with the nurses committing the medication errors by the responsible supervising RNs. The supervising RNs need to include the dates the corrective actions were taken.
- Each medication error is reported separately as opposed to combining multiple medication errors on to one report.
- The locations where the medication errors occur are documented on the Medication Error Reports.
- A process in in place to assure that all medication errors are reported to avoid under reporting, to identify the causative factors that contributed to the medication errors, and take corrective action as indicated to prevent or reduce the occurrence of future medication errors.

7. The Medication Variance Committee and Pharmacy and Therapeutic Committee should take full advantage of the medication error/variance data reported in the Medication Error Database. The data need to be analyzed and trended in order to identify causative and/or contributing factors to medication errors/variances and to make decisions regarding corrective action to prevent and/or reduce the incidents of medication errors. (Provision M.6)

The following are offered as additional suggestions to the Facility:

1. The Facility should consider making the following improvements to the emergency response system: (Provision M.1)
   - Ensure that all required employees are trained on the revised Emergency Response Policy, 44.2 and that staff adhere to the policy.
   - Ensure that the physicians participate in Mock Medical Emergency Drills.
   - Ensure that posters are placed in the areas where emergency equipment is located throughout the campus.
   - Ensure that the Emergency Response Committee develops a mission statement and procedures for the Committee and establish the frequency for the Committee to meet.
2. The Facility should consider replacing the outdated medication carts in the Infirmary for security purposes and ease of use. (Provision M.6)

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 (POI) 10/10/11 2. Medication Variances, Policy and Procedure, RSSLC Pharmacy Policy and Procedure Manual 01.05.20, dated 11/2/11 3. Policy Physician Order Review By Physician; RSSLC Pharmacy Policy and Procedure Manual, 01.05.15, dated 10/20/11 4. Adverse Drug Reactions Policy; RSSLC Pharmacy Policy and Procedure Manual 01.05.25, dated 5/15/11 5. Drug Uses Evaluation and Due Process Policy and Procedure; RSSLC Pharmacy Policy and Procedure Manual 03.15, dated 5/12/11 6. Medication Variance Report Form, SSLC 053A 7. Medication Error Report date range: 3/1/2011 – 9/30/2011 8. Medication Variance Committee Meeting Minutes for May, 2011 through October, 2011 9. Last ten completed interventions for Pharmacy Review of New Orders (Individuals #525, #358, #680, #483, #266, #579, #134, #166, #526, and #160—Sample N1) 10. Last completed QDRRs for Individuals #436, #145, #73, #146, #783, #500, #101, #144, #202, and #39 (Sample N2) 11. Restraint Reduction Committee Minutes, dated 9/21/11 12. Emergency (STAT) Medication Monitoring Chart and data fields for 11/1/10 through 10/24/11 13. Metabolic Syndrome Monitoring Policy, RSSLC Pharmacy Policy and Procedure, 03.20, dated 2/15/11 14. Last ten completed QDRRs associated with the use of neuroleptics 15. Last five completed Psychiatric Medication and Behavior Management Clinic forms 16. Last six months of MOSES and DISCUS assessments for Individuals #110, #542, #513, #316, #193, #137, #529, and #68 (Sample N3) 17. Drug utilization reports: Reclast, 9/12/11; Lubiprostone, 6/11; Citalopram, 8/24/11; phenytoin, 9/11; and Avandia, 10/26/11 18. List of adverse drug reactions (ADRs), and data analysis from 1/1/11 through 10/24/11 **People Interviewed:** 1. Dr. Michael Shatz, Clinical Pharmacist 2. Anto Parambil, Director of Pharmacy **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: Provision N1: The Facility reported noncompliance with Provision N1, but noted its implementation of a new policy, Physician Order Review By A Pharmacist, dated October 10, 2011. The Monitoring Team noted that the Policy would facilitate compliance with Provision N1.

	Provision N2: The Facility reported continued compliance with Provision N2, and noted that it had hired an additional clinical pharmacist to support the QDRR, and DUE process at the Facility. The Monitoring Team concurs with this action step and determined the Facility to remain in substantial compliance with Provision N2. Provision N3: The Facility reported continued compliance with Provision N3. The Monitoring Team concurs with the Facility's self-assessment. N4: The Facility reported continued compliance with Provision N4. The Monitoring Team concurs with the Facility's self-assessment. Provision N5: The Facility self reported noncompliance with Provision N5. The Facility reported that the clinical pharmacist closely monitors to ensure that all MOSES and DISCUS assessments are completed. The Facility also reported that MOSES and DISCUS are reviewed by the psychiatrist to ensure that side effects are accurately noted. The Clinical Pharmacist developed a program to train physicians, PCP, and nurses on how to monitor TD, using MOSES and DISCUS assessment tools. The Monitoring team was made aware of effort to enhanced the efficacious use of the MOSES and DISCUS tools; however, the Monitoring Team noted significant issues with MOSES and DISCUS reports not being completed by the prescriber, and more frequent monitoring for TD was not obtained as clinically indicated. The Monitoring Team Concurs with the Facility and determined noncompliance with Provision N5. Provision N6: The Facility self-reported noncompliance with Provision N6. The Facility reported that it conducts annual training on ADRs, and that ADRs are reported by nursing staff via the ADR reporting form. The Facility revised its policy on its ADR process to reflect its current practice and that it developed, and implemented a database to conduct trends analysis on ADRs at the Facility. The Monitoring Team concurred with the Facility's activities towards compliance, and determined that the Facility is in substantial compliance with Provision N6. Provision N7: The Facility self-reported noncompliance with Provision N7. The Facility noted that they developed a policy and procedure for the DUE process at the Facility. The Facility utilized standards for providing DUEs based on the University of Arizona School of Pharmacy and the United States Pharmacopeial Convention recommendations for conducting DUEs. DUEs were provided as scheduled, and when clinically needed. The Monitoring Team concurred with the Facility's approach to Provision N7, and determined that the Facility is in substantial compliance with the Provision. Provision N8: The Facility reported that it remains noncompliant with Provision N8. The POI noted significant enhancement with regards to its medication variance process. The Facility had developed and implemented a Medication Variance Committee, developed, and implemented a policy for medication variances, and established a database for medication variances. The Monitoring Team concurs with the Facility's self-assessment, and determined the Facility to be noncompliant with Provision N8. The Monitoring Team concurs with the direction of the Facility, and with its Medication Variance policy, database, and Committee structure.

	Summary of Monitor's Assessment: Provision N1: Given the new practice standard at the Facility, a policy that clearly directs a meaningful review by the pharmacist for all new orders, and appropriate response on nine out of ten Interventions, the Monitoring Team determined that the Facility is in substantial compliance with Provision N1. The Monitoring Team cautions the Facility to ensure that there is assertive follow-up of physicians' clinical rationale for not addressing a pharmacist's concern. Provision N2: To assess continued compliance, the Monitoring Team reviewed the last 10 completed QDRRs, and associated physician response. Following review of the last, most recent QDRRs completed by the Pharmacy, the Monitoring Team noted the effectiveness and quality of the reviews, and determined continued compliance with Provision N2. Clinical pharmacists and physicians are collaborating extremely well with this process. Provision N3: The Monitoring Team concurs with the Facility, and determined continued compliance with Provision N3. The Facility adequately collected and presented data to physicians, Pharmacy &Therapeutics Committee (P&TC), and at Psychiatric Medication and Behavior Management Clinics, on the use of STAT medications, benzodiazapines, anticholinergics, and on risk factors for metabolic syndrome. Further enhancements would include ensuring that abdominal girth is assessed for metabolic syndrome, and that the use of all STAT medications, regardless of class, be regularly assessed by the Facility; this would include the use of non-behavior related STAT medications. Provision N4: The Monitoring Team assessed compliance of Provision N4 by reviewing the last ten completed QDRRs. All ten QDRRs were completed appropriately, and physicians responded to all recommendations made by the clinical pharmacists. The Monitoring Team determined the Facility is in substantial compliance with Provision N4. Provision N5: Based on its findings, the Monitoring Team determined that the Facility is noncompliant with Provision N5. The Monitoring Team determined significant issues with prescribers appropriately completing MOSES and DISCUS assessments, and that assessments were not obtained more frequently when clinically indicated. More assertive monitoring of tardive dyskinesia (TD) must be obtained whenever a neuroleptic dose is increased, decreased, initiated or discontinued. While increasing or initiating a neuroleptic may cause TD, decreasing or discontinuing a neuroleptic may unmask TD. Many people with intellectual disabilities cannot adequately express side effects, such as TD, and must be closely monitored. The Facility must ensure that assessments are fully completed, reviewed in a timely fashion, and provided more frequently when clinically indicated. Provision N6: Following its review, the Monitoring Team determined that the Facility is in substantial compliance with Provision N6. Nevertheless, the Monitoring Team strongly recommends that the Facility enhance its ADR reporting form by including a physician signature line, and ensure that they are completed appropriately.

	Provision N7: Because the Facility ensures meaningful and consistent DUEs, as determined by the P&TC, and when clinically necessary, and because of its use of standardized guidelines to conduct DUEs, the Monitoring Team determined that the Facility is in substantial compliance with Provision N7. The Monitoring Team is complimentary of the quality and consistency of the DUE provided by the Clinical Pharmacist. Provision N8: The Monitoring Team has determined that the Facility is noncompliant with Provision N8. Compliance will require the Facility to perform more in depth analysis of medication variances, ensure follow-up to remedial actions, enhance physician collaboration, and improve reporting practice of medication variances.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The Facility developed and implemented a new policy to address Pharmacists review of new medication orders, Physician Order Review By A Pharmacist policy, dated 10/20/11. The Policy clearly delineates the necessary activities to facilitate the pharmacist monitoring action of new medications, as outlined by Provision N1. The Monitoring Team reviewed the last ten Interventions for Pharmacy Reviews of New Orders (Individuals #525, #358, #680, #483, #266, #579, #134, #166, #526, and #160), and noted that the pharmacist clearly outlined issues related to the potential drug interaction, and in nine of the ten reviewed (90% of sample selected), all interventions were appropriately addressed by the physician. For one of the ten, Individual #160, the pharmacist raised concern over a potential drug interaction that could possibly affect the individual's heart rhythm, and the physician instructed the pharmacist to "make no change and continue as ordered due to short term use." The Monitoring Team did not identify further action on the part of the pharmacist. Given the severity of the potential interaction, more assertive follow-up would be warranted on the part of the pharmacist. In this particular case, obtaining an EKG to assess the individual's QT interval and/or ensuring staff monitor the Individual more closely, should have been considered. Pharmacists are obligated to take assertive action whenever a physician provides questionable rationale for continuing a medication that is associated with high-risk interactions. Given the new practice standard at the Facility, a policy that clearly directs a meaningful review by the pharmacist for all new orders, and appropriate response on nine out of ten Interventions, the Monitoring Team determined that the Facility is in substantial compliance with Provision N1. The Monitoring Team cautions the Facility to ensure that assertive follow-up of physicians clinical rational for not addressing a pharmacists concern.	Substantial Compliance

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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 was found to be in substantial compliance with Provision N2 following the last monitoring review. Since then, the Facility has enhanced its ability to provide quality QDRRs by adding an additional clinical pharmacist. To assess continued compliance, the Monitoring Team reviewed the last completed QDRRs, and associated physician response of Individuals #436, #145, #73, #146, #783, #500, #101, #144, #202, and #39. The Monitoring Team noted the effectiveness and quality of the QDRRs, noting that each QDRR indicated careful review of blood levels of medications requiring diagnostic monitoring in all ten examples, resulting in 100% compliance. The Monitoring Team determined continued compliance with Provision N2.	Substantial Compliance
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.	To assess continued compliance with Provision N3, the Monitoring Team assessed the Facility's process for reviewing metabolic syndrome, use of STAT medications, benzodiazepines, and anticholinergics. The Monitoring Team noted that the Facility continued to appropriately provide data on the use of STAT psychotropic medications, and benzodiazapines. The Facility maintained data and conducted longitudinal data analysis on STAT psychotropic use. Data were reviewed by the Restraint Reduction Committee, as demonstrated by review of the Committee's minutes from 9/21/2011. The Monitoring Team noted that the Emergency Medication Monitoring Chart did not delineate actual numbers of STAT medications administered for a given month, and only provided a percentage for each medication class used as a restraint. For example, 40% of the drugs prescribed as STAT medications for 01-2011 were benzodiazapines, while 60% were neuroleptics. Specific data regarding the use of each medication were provided within the context of a database generated report. Because actual numbers were not provided, and because the time period of this report was unclear, the Monitoring Team could not reconcile the data or determine how meaningful it could be in making decisions about systemic actions the Facility might take. The Facility continues to assess the risk for Metabolic Syndrome at the time of conducting QDRRs. Each QDRR associated with a neuroleptic or other drug that can manifest in metabolic syndrome assesses for blood pressure, blood sugar, triglycerides, HDL and body weight. Abdominal girth is not assessed. The Monitoring Team reviewed the last ten QDRRs, associated with the use of neuroleptics, and noted all ten QDRRS as appropriately assessing metabolic syndrome risk factors. The Monitoring Team noted when reviewing the last ten most recent QDRRs (Individuals #436, #145, #73, #146, #783, #500, #101, #144, #202, and #39), the pharmacist documented issues related to anticholinergic use on the QDRR report for the physicians to review.	Substantial Compliance

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		The Pharmacy continued to assess all individuals for polypharmacy, and reported to the P&T. Polypharmacy was also assessed at the time of individual case reviews during the Psychiatric Medication and Behavior Management Clinic. The Monitoring Team reviewed the last five Psychiatric Medication and Behavior Management Clinic reviews and noted appropriate documentation and action on the use of anticholinergics and polypharmacy. Following its review, the Monitoring Team concurs with the Facility, and determined continued compliance with Provision N3. The Facility adequately collected and presented data to physicians, P&T committee, and at Psychiatric Medication and Behavior Management Clinics, on the use of STAT medications, benzodiazapines, anticholinergics and on risk factors for metabolic syndrome. Further enhancements would include ensuring that abdominal girth is assessed for metabolic syndrome, and that the use of all STAT medications, regardless of class, be regularly assessed by the Facility. This would include the use of non-behavior related STAT medications.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The Monitoring Team assessed compliance of Provision N4 by reviewing the last completed QDRRs (Individuals #436, #145, #73, #146, #783, #500, #101, #144, #202, and #39 - sample N2. All ten QDRRs, 100% of the sample, were completed appropriately by the pharmacist, and physicians responded to all recommendations made by the clinical pharmacists, and appropriately documented their action. The Monitoring Team determined the Facility is in substantial compliance with Provision N4.	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 Monitoring Team reviewed the past six months of MOSES and DISCUS reports for Individuals #110, #542, #513, #316, #193, #137, #529, and #68 (sample N3). The sample consisted of the last eight individuals who had a neuroleptic dose change. The Monitoring Team determined that 100% of the sample of both MOSES and DISCUS were obtained on time for routine assessments. The Monitoring Team noted significant errors with completion of both MOSES and DISCUS. Seven of a total of 16 MOSES assessments (44%) were not appropriately completed by the prescriber (Individuals #68, #529, #513, #542, #110). Eight of 24 DISCUS assessments (33%) were not appropriately completed by the prescriber (Individuals #68, #529, #137, #193, #316, and #110). Of sample N3, 100% of the cases did not have more frequent assessment of MOSES and	Noncompliance

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		DISCUS when a dose change of a neuroleptic occurred. The following data indicates the Individual, medication name, dose change and date dose change occurred. • Individual #68, Seroquel discontinued on July 23, 2011, and more frequent monitoring of DISCUS and MOSES was not obtained. • Individual #529, Zyprexa dose was decreased on 7/23/11, and more frequent monitoring of DISCUS and MOSES was not obtained. • Individual #137, Seroquel was increased on 6/29/22, and more frequent monitoring of DISCUS and MOSES was not obtained. • Individual #193, Risperdal was increased on 10/21/11, and more frequent monitoring of DISCUS and MOSES was not obtained. • Individual #316, Zyprexa was increased on 10/21/11, and more frequent monitoring of DISCUS and MOSES was not obtained. • Individual #513, Seroquel was decreased on 10/21/11, and Abilify was increased on 7/23/11, and more frequent monitoring of DISCUS and MOSES was not obtained. • Individual #542, Zyprexa was discontinued on 8/26/11, and more frequent monitoring of DISCUS and MOSES was not obtained. • Individual #110, Abilify was increased on 8/8/11, and more frequent monitoring of DISCUS and MOSES was not obtained. The Monitoring Team determined significant issues with prescribers appropriately completing MOSES and DISCUSS assessments, and ensuring that assessments were obtained more frequently when clinically indicated. More assertive monitoring of tardive dyskinesia (TD) must be provided whenever a neuroleptic dose is increased, decreased, initiated or discontinued. Additional monitoring should also be considered when adding medications that can alter the metabolism of a prescribed neuroleptic. While increasing or initiating a neuroleptic may cause TD, decreasing or discontinuing a neuroleptic may unmask TD. Many people with intellectual disabilities cannot adequately express side effects, such as TD, and must be closely monitored. The Monitoring Team determined that the Facility is noncompliant with Provision N5.	
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 Monitoring Team was made aware that the Facility's clinical pharmacist provided annual in-services for nurses on reporting Adverse Drug Reactions (ADRs). The Facility had a comprehensive policy for its ADR process, which clearly delineates appropriate action steps to be taken in the event of a ADR, and on reporting ADRs. For ADR forms completed, the follow up action was documented. The Monitoring Team did not do independent review to confirm the actions. The Monitoring Team reviewed data of ADRs reported at the Facility from January 1, 2011 through October 24, 2011. The data collected and used for analysis was noted to be	Substantial Compliance

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		appropriate for an ADR program. There were a total of 33 ADRs reported since January 1, 2011 through October 24, 2011. Given the populations and medication dosing volume, 33 ADRs may be considered low for the Facility. The Monitoring Team selected the five most recent ADR reporting forms to review (Individuals #284, #316, #459, #404, and #672): • Individual #459: ADR form was completed appropriately and timely • Individual #679: ADR form was not commented on by the physician • Individual #284: ADR form was completed appropriately and timely • Individual #316: ADR form was not completed. Omissions noted on duration of ADR event, relevant medical history, and what treatment given. There was no area for physician to sign, albeit physician did sign and commented on the ADR • Individual #404: ADR form was completed. Physician did not comment on ADR The Monitoring Team noted that one of the five ADR forms was not completed appropriately (Individual #316), and two ADR forms (Individuals #404 and 679) were not commented on by the physician. The Monitor Team observed that the ADR reporting form does not have an area for physicians to sign. Review of Pharmacy and Therapeutics Committee Meeting Minutes, dated October 26, 2011 demonstrated that ADR issues, including trends analysis, was presented to the committee. The Monitoring Team determined that the Facility is in substantial compliance with Provision N6. The Monitoring Team strongly recommends that the Facility enhance its ADR reporting form by including a physician signature line, and ensure that they are completed appropriately.	
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	The Monitoring Team reviewed the Facility's policy for its Drug Utilization program, Drug Uses Evaluation and Due Process Policy and Procedure, dated 5/12/11. The Policy clearly indicates that a DUE will be conducted at least quarterly and more often as necessary. Members of the P&T Committee select medications to be reviewed through the DUE process based on clinical need, narrow therapeutic index, and other risks. DUEs at the Facility follow a standardized model based on the Guidelines for Implementing Drug Utilization Reviews in hospitals and those formats endorsed by the United States Pharmacopeial Convention and the University of Arizona School of Pharmacy. Information gained through the DUE process is presented to the P&T Committee and relevant clinical issues are conveyed by email directly to prescribers and nurses. The	Substantial Compliance

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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.	Monitoring Team finds the Facility's DUE process to be excellent. In addition to quarterly DUEs, as delineated in Provision N1 of this report, the dispensing pharmacist reviewed each new medication order to ensure for appropriate dose, indication, drug-drug intervention, contraindications, side effects and allergies. The Monitoring Team reviewed the last five DUEs (Reclast, 9/12/11; Lubiprostone, 6/11; Citalopram, 8/24/11; phenytoin, 9/11; and Avandia, 10/26/11), and determined that the Facility is following its policy and procedure for DUEs. It should be noted that in addition to the quarterly DUE conducted in June, 2011, on Lubiprostone, and in September, 2011, on phenytoin, the Facility provided three additional DUEs (Reclast; Citalopram, and Avandia) secondary to FDA advisories. Because the Facility ensures meaningful and consistent DUEs as scheduled, and when clinically necessary, and because of its use of standardized guidelines to conduct DUEs, the Monitoring Team determined that the Facility is in substantial compliance with Provision N7. The Monitoring Team is complementary of the quality and consistency of the DUE provided by the Clinical Pharmacist.	
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 had recently developed and implemented a committee structure to oversee medication variances at the Facility. The Committee is Chaired by the Director of Pharmacy, meets Monthly, and reviews trends of medication variances. Analysis of medication variance data is presented to the Pharmacy and Therapeutic Committee (P&T). DADS and the Facility developed a new policy for medication variances. The Monitoring Team reviewed the policy and determined that the DADS policy is consistent with requirements of the Settlement Agreement. The Facility policy was essentially consistent with the SA but had items that needed to be clarified for consistency with DADS policy. The Monitoring Team reviewed the Medication Variance Error Reports for March, 2011 through September, 2011 and Medication Variance Meeting Minutes, for August, 2011 through October, 2011. The minutes reflected an overview of reported medication variances, and solutions for some identified issues. As delineated in Provision M6, of this report, the Monitoring Team determined that a more in depth analysis of the medication errors, and more assertive recommendations, with follow-up to ensure recommendations are attended to, would be advantageous to the process. Importantly, specific remediation action should be delineated for physicians, as well as other disciplines.	Noncompliance

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		Specific for Provision N8, the Monitoring Team did not assess medication reporting practice by various disciplines, such as nursing, physician and pharmacy services. Provision M6 documents significant concerns about the reporting practices regarding medication variances. Minutes of the Medication Variance Committee document concerns that the Facility is potentially underreporting medication variances, and the Monitoring Team concurs with the Facility's assumption of possible underreporting. The Monitoring Team has determined that the Facility is noncompliant with Provision N8. Compliance will require the Facility to perform more in depth analysis of medication variances, ensure follow-up to remedial actions, enhance physician collaboration, and improve reporting practice of medication variances.	

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

1. Include abdominal girth as a component of metabolic syndrome risk assessment. (Provision N.3)
2. Ensure that data are collected and reviewed on all STAT medications used by the Facility, including STAT medication used for non-behavioral health issues. (Provision N.3)
3. MOSES and DISCUS assessment must be completed by the prescribers, reviewed timely, and performed more often when clinically indicated. (Provision N.5)
4. Improve the ADR reporting form by including a signature line for physicians and ensure that all components of the ADR form are completed appropriately. (Provision N.6)
5. Develop a process to follow-up to remedial action initiated for medication variances. (Provision N.8)
6. Improve on the reporting of medication variances to the P&TC. Make sure that details of the ADR are clearly delineated in the minutes. (Provision N.8)
7. Ensure that Physician Services is actively involved in the medication variance process. (Provision N.8)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Documents Reviewed: **Steps Taken to Assess Compliance:** 1. RSSLC Plan of Improvement (POI), dated 10/10/2011 2. RSSLC Physical and Nutritional Management Policy K.01 (1/31/11) 3. Record reviews: • Sample 1: Individuals #84, #173, #372, #523 and #558 • Sample 2: Individuals #16, #41, #150, #192, #308, #503, and #621 • Sample 3: Individuals #30, #31, #233, #283, #385, #402, #436, #500, #535, #551, and #553 • Sample 4: Individuals # 119, #225, #253 and #701 4. Community Living Discharge plan for Individual #124 5. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 6. A list of continuing education sessions or activities participated in by PNMT members since last review (5/2011) 7. Minutes, including documentation of attendance, for the PNMT meetings for the past 6 months 8. Individual PNMT reports as available for individuals reviewed above 9. Tools used to screen and identify individuals' PNM health risk level 10. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 11. A list of PNM assessments and updates completed in the last two (2) quarters 12. PSPs for the sample individuals 13. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 14. Tools used to monitor implementation of PNM procedures and plans 15. A list of individuals for whom PNM monitoring tools were completed in the last quarter 16. Tools utilized for validation of PNM monitoring 17. For the past two quarters, any data or trend summaries used by the Facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans 18. PNMP template and any instructions for use of template 19. Dining Plan template 20. PNM spreadsheets generated by the Facility 21. Lists of individuals: (a) On modified diets/thickened liquids; (b) With BMI equal to greater than 30; (c) With BMI equal to less than 20; (d) Since May 2011, who have had unplanned weight loss of 10% or greater over six (6) months; (e) During the past six months, have had a choking incident; (f) During the past six months, have had a pneumonia incident; (g) During the past six months, have had skin breakdown;

	(h) During the past six months, have had a fall; (i) During the past six months, have had a fecal impaction; (j) 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.); (k) With poor oral hygiene; and (l) Who receive nutrition through non-oral methods 22. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 23. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 24. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans 25. Since the last review, a list of competency-based training sessions addressing foundational skills in PNM **People Interviewed:** 1. David Taylor OTR- Acting Director of Habilitation Therapies (HT) 2. Sally Martinez RN 3. Brandie Rabe SLP 4. Jean Cuevo PT 5. Emma Purvey RN Infirmary Director 6. Seven DCPs (3-Trinity and 4-Three Rivers) **Meeting Attended/Observations:** 1. PNMT meeting 10/25/11 and 10/27/11 2. At Risk Meeting (Individuals #58 and #680 3. Mealtime and Transition Observations (Trinity, Pecos, TJ 5, TJ 6, and TJ 7) 4. Infirmary Walkthrough
	Facility Self-Assessment: RSSLCC Plan of Improvement, updated 10/11/2011, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was in noncompliance with all provisions. The findings of RSSLC were consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The POI also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the eight provisions but did not provide a clear sequential framework in which they expected to reach compliance. Even in narrative form, the monitoring team's review and observation did not agree with the actions stated in the POI. For example, RSSLC stated that the PNMT met twice weekly but upon review, the team was incomplete in attendance and therefore could not be counted as meeting the stated criteria. Another example was that Monitoring was stated to be

	conducted and the data was discussed at the QA/QI council. This information was not found to be analyzed in any form at any meeting. The current format listed activities, but did not present clear steps and strategies required to meet the provisions with timelines of completion. The majority of statements present focused on general status and activities. Missing was evidence of data acquired to help RSSLC determine if they were in compliance with each provision.
	Summary of Monitor's Assessment: **Provision O.1:** This provision was determined to be not in compliance. A Physical and Nutritional Management Team (PNMT) had been formed and focused on clinical issues and assessment and served as a resource to the PST. Lacking from the team was review and analysis of the PNM system and whether interventions recommended were having a positive impact on the individuals living at RSSLC. There was still no evidence that data were collected and the team was reviewing these data to better identify system issues or respond to recurrent issues on a regular basis. **Provision O.2:** This provision was determined to be not in compliance. A new risk process that is intended to more accurately identify individuals at risk had been developed and implemented; however, lack of use of clinical judgment and critical thinking when the PSTs had to move beyond the guidelines often resulted in inaccurate assignment of risk. Individuals were not provided with comprehensive assessments in response to changes in status or as part of an annual assessment due to often referring to outdated tests and external assessments. Additionally; supports regarding the areas of oral care, head of bed assessment, bathing positioning, and medication administration were missing from the assessment process and were not comprehensively included in the PNMP. **Provision O.3:** This provision was determined to be not in compliance. PNMPs were not comprehensive due to the plans lacking information regarding oral care and medication administration strategies. While the plans did contain positioning for these activities, strategies intended to mitigate risk were lacking in detail thus resulting in an increased risk of variance when implementing the activity among multiple staff. **Provision O.4:** This provision was determined to be not in compliance. Staff was observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline. Individuals were not provided with safe dining strategies. Per interview, staff again was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being. **Provision O.5:** This provision was determined to be not in compliance. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. **Provision O.6:** This provision was determined to be not in compliance. The monitoring form template covered all aspects in which the individual was determined to be at increased risk; however, there was not a formal monitoring process in place and the monitoring that occurred did not address all the areas covered by the monitoring form

	Provision O.7: While PNMPs were reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at a high risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). **Provision O.8:** This provision was determined to be not in compliance. An Aspiration Pneumonia/enteral Nutrition evaluation was developed which was a positive step. The issue was that the evaluation was not consistently completed as indicated by the policy. Overall, while some improvement have been noted, primarily with the PNMT due to the addition of a PNM nurse, RSSLC still needs to make substantial improvements in order to in mitigate the risks associated with physical and nutritional supports. Lack of comprehensive assessment as well as lack of an organized and efficient PNM system may continue to result in a high occurrence of pneumonias and will place individuals at an unnecessary risk. Steps must be taken to ensure individuals who are identified as being at an increased risk of pneumonia are provided with a comprehensive assessment that focuses on all aspects of PNM (such as Medical, Habilitation Therapy, and Active Treatment) and identifies not only the current status but provides investigation into the etiology of the illness and/or risk. All interventions identified as being relative to mitigating PNM risk should have clear rationale as to what they address as well as what will be done to potentially withdraw support and increase independence. Positive practices included participation by PNMT in the medical morning meetings as well as grand rounds thus allowing for the increased sharing of issues between multiple committees and implementation of suction tooth brushing for individuals who were at an increased risk of aspiration, had a history of pneumonia or who received enteral nutrition. Implementation of suction tooth brushing will assist RSSLC in better mitigating the risk associated with the aspiration of liquids and bacteria during oral care. Another positive practice was that many components on the PNMP provided detailed information for staff to implement regarding the safety of the individuals. Areas covered in detail included transfer instructions and mealtime strategies.

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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	RSSLC had developed a Physical and Nutritional Management Team (PNMT). The PNMT focused on clinical issues and assessment and served as a resource to the PST but lacked evidence of systemic review and/or analysis of recommendations to determine if there a resulting positive impact. The Physical and Nutritional Management Team (PNMT) consisted of: • David Taylor OTR Acting Habilitation Therapy (HT) Director • Jean Cuevo PT	Noncompliance

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	("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, 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.	• Sally Martinez RN • Brandie Rabe SLP PNM Team from 6/24/11 to 10/18/11 documented inconsistent attendance by the four PNM Team standing members. The PNMT lead (HT director /OT) attended all meetings as did the PNMT nurse. The PT attended seven of 14 meetings (50%) and the SLP attended five of 14 (35%) of the meetings. The makeup of the PNMT was not in compliance with standards set forth by the Settlement Agreement due to the lack of a dietitian serving as a regular member of the team. Another issue with the PNMT was that minutes were not developed in a manner that provided clear evidence of discussion. Minutes reflected an overall impression of the meeting but did not provide clear actions plans needed to ensure all responsibilities and discussions are documented. Review of documentation of PNM clinical instruction submitted revealed opportunities for PNMT members to participate in trainings relevant to increasing their knowledge of PNM. The courses offered focused on: • Introduction to PNMT • Introduction to Assessment Technologies • Dysphagia • Settlement Agreement Sections I, O, P, and R • Localized OT/PT policy K.05 Frequency of the PNMT meetings was not clearly stated but upon review of PNMT signature sheets and per report of David Taylor OTR -Acting HT director, meetings were held twice weekly. In addition to the state policy, the Facility had developed a localized PNMT policy K.01 that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the Personal Support Team (PST). Missing from the policy was a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. Per review of the minutes and report by HT director, referrals by the PST were not occurring on a consistent basis and routinely in response to significant changes in status. A QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team did not exist. Reviewing and identifying trends	

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		and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed. PNMPs were not in alignment with current best practice standards. For issues related to this component, please refer to provision O.3. PNMPs were not clearly developed with input from all members of the PST or reviewed consistently by the PST. For examples, please refer to provision O.3. A positive practice that were noted included participation by PNMT in the medical morning meetings as well as grand rounds thus allowing for the increased sharing of issues between multiple committees. The issue was that participation in these meetings did not guarantee referrals at the time of the review.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	Individuals for sample #1 were chosen from the list of individuals who were diagnosed with an aspiration and/or choking event over the past 6 months. The sample consisted of four individuals who accounted for 100% of the individuals who experienced an aspiration event and one individual who accounted for 100% of the individuals who experienced a choking event. Sample #2 consisted of seven individuals who were chosen from a list provided by RSSLC of individuals who were identified as being at a high risk of choking or aspiration. The sample was chosen by choosing every fifth name on the aspiration list and every other name on the choking at risk list. The sample consisted of approximately 20% of those who were at a high risk of aspiration and 50% of those who were at a high risk of choking. Sample #3 consisted of 11 individuals or 20% of the individuals at RSSLC who received enteral nutrition. The sample was chosen by selecting every fifth individual on the enteral nutrition list provided by RSSLC. Sample 4 consisted of four individuals or 20% of the individuals at RSSLC who experienced a downgrade in their diet texture or fluid consistency. This sample was chosen by selecting every fourth name on the provided list. Based on a review of 27 individuals' (sample #1, #2, #3, and #4) most recent OT/PT assessments, five of 27 individuals (19%) were provided with a comprehensive assessment by the PNM team or relevant Habilitation therapist that focused on nutritional health status, oral care, medication administration, mealtime strategies,	Noncompliance

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		proper alignment, positioning during the course of the day and during nutritional intake. The swallowing components of the OT/PT assessment were vague and did not provide consistent information regarding the impact on functioning. For example: • Individual #225's OT/PT assessment stated the individual did not have chewing effective for regular foods but did not describe oral motor status, spillage, pocketing, or residue or the lack thereof. • Individual #162's OT/PT assessment stated there was a regression with oral motor skills but did not provide any more information. The Oral Care and Medication Administration sections of the OT/PT assessment were vague, missing or contained a general statement of positioning but did not contain any information indicating assessment of the areas. For example: • Individual #621's oral care section stated the positioning but did not provided any information regarding the acquisition of skills regarding this activity. While interventions were included in the assessments, one of 27 (4%) (Sample #1 #2, #3, and #4) assessments reviewed contained clear investigation as to why interventions (e.g., adaptive equipment, bed elevation) were appropriate. For example: • Individuals #16, #41, and #192 were all recommended to have the head of their beds elevated; however, there was no evidence of assessment that clearly explained why the recommended degree of elevation was appropriate or individualized to the person. A comprehensive PNMT evaluation was completed by the PNMT as based on referral by the PST. Components of this assessment included: • Risk Factors • Nutritional Management Assessment • PNM History • Treatments • Physical Management Assessment • PNMT Analysis • PNMT Recommendations • Measurable Outcomes Per report from the Acting HT director, three evaluations had been completed since the previous visit and the PNMT was having difficulty with PST knowledge of the referral process. In addition to the three assessments, eight head of bed (HOB) assessments had been completed.	

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		Based on a review of five (sample #1) records of individuals who experienced an aspiration or choking event, zero of five (0%) records reviewed accurately identified individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individual #84, #558 and #173 were identified as being at a "medium risk" of aspiration but per guidelines should have been listed as a "high risk" due to recent aspiration events. • Individual #372 and #558 were identified as being at a "medium risk" of choking but per guidelines should have been listed as a "high risk" due to a recent choking event. • Individual #162 experienced over five falls in the last 6 months and suffered two injuries that resulted from the falls but was listed as "low risk." The PST had the ability to lower the risk; however, there was no evidence of the rationale behind the lower risk score. Failure to properly identify individuals at increased risk results in an increased likelihood that care will reactive rather than proactive. Based upon observations and the samples reviewed, RSSLC was not identifying individuals appropriately as it relates to their level of risk thus increasing the likelihood that individuals at risk were not being provided the needed services. Also, many new programs were scheduled to roll out based upon level of risk; therefore, it is essential that people be accurately identified and assigned a level of risk. Another issue that was noted was lack of consistency in identifying individuals who were diagnosed with pneumonia. The Monitoring Team requested a list of individuals who were diagnosed with pneumonia and received two conflicting lists. Per report, one list was pulled from the hospital admit list and the other was pulled from the hospital discharge diagnosis list. RSSLC was made aware of the issue and stated that this would be addressed. Lack of critical clinical thinking and discussion was noted when the PSTs had to move beyond the risk guidelines. This lack of clinical judgment impacted the risk scores and increased the likelihood of inadequate supports being provided to the individual. An example was Individual #523 who has oral dysphagia and a tendency to eat at a fast unsafe rate and who pockets food but was listed as only a medium risk. More information regarding the identification of risk may be found under section I. Zero of five (0%) individuals who were diagnosed and/or hospitalized with a PNM issue	

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		(sample #1) were assessed by the PNMT or PST. For example: • Individual #372 had a choking event on 5-6-11. On 5-9-11, the OT conducted an observation but there was no evidence of a tableside swallowing assessment. • Individual #84 was diagnosed with aspiration pneumonia on 6/12/11 and 6/30/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the PST meeting to discuss the event but the discussion was limited to what had already occurred and did not focus on potential indicators or triggers that led to the aspiration event as well as the need for assessment. In this case, the individual vomited and had emesis in bed on 6/12/11 but there was no evidence that a bed positioning assessment ever occurred or was discussed. Emesis and vomiting occurred a second time on 6/30/11. • Individual #173 was diagnosed with aspiration pneumonia on 7/31/11 but there was no evidence of comprehensive reassessment upon return from the hospital or while in the infirmary. The PST met on 8/15/11 and simply stated to continue with plan. Lack of critical thinking as mentioned above in identifying risk as well as lack of discussion surrounding aspiration events was consistently noted. A positive finding was that Dental in coordination with the PNMT and PST were in the process of implementing suction tooth brushing for individuals who were at an increased risk of aspiration, had a history of pneumonia or who received enteral nutrition. Implementation of suction tooth brushing will assist RSSLC in better mitigating the risk associated with the aspiration of liquids and bacteria during oral care.	
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	All persons identified as requiring PNM supports were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans were not comprehensive as they did not contain information regarding oral care and medication administration and specifics regarding head of bed elevation. Based on a review of 27 individual PNMPs (sample #1, #2, #3, and #4), individuals were not provided with a comprehensive PNMP. • In zero of 27 PNMPs reviewed (0%), strategies for oral hygiene were included. • Twenty-seven of 27 PNMPs (100%) that indicated the need for increased head of bed elevation lacked detail regarding the degree in which the person should be elevated. • In zero of 27 PNMPs reviewed (0%), PNM triggers to be observed and reported were listed as part of the plan.	Noncompliance

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	are likely to provoke swallowing difficulties.	Including the degree of head of bed elevation is important as it allows the information regarding head of bed elevation to be easily transferrable to an off grounds location such as a hospital or a more integrated living environment. It is important to help ensure accurate implementation and trailing at RSSLC. As of this review, the PNMP stated only that the head of bed is elevated. RSSLC was in the process of providing HOB assessments but these were not consistently provided as indicated by a need of the individual or by a change in status. As of this review, only eight HOB assessments had been completed. Per report, the HOB assessments were being completed if the individual had pneumonia in the past year or was identified as a high risk. This represented a reactive approach to the assessment issue. Additionally, the risk identification process as mentioned in O.2 was not sufficient in identifying those who were "high risk" and therefore many individuals would not be provided with the needed assessment. Oral Care and Medication Administration were included in the PNMP but lacked detail regarding number of pills that can be safely tolerated at one time and strategies on how to assist during oral care. Per the acting HT director, the oral hygiene plan developed by dental will be placed in the PNMP folder behind the PNMP. As of this review, the oral hygiene plans had not been implemented; therefore, review of the plans was not possible at this time. There were, however, several positive practices that the Facility should ensure continue. • In 27 of 27 PNMPs (100%) reviewed, positioning instructions for wheelchair and alternate positions instructions were included as applicable. • In 27 of 27 PNMPs (100%) reviewed, transfer instructions were included as applicable. • In 27 of 27 PNMPs (100%) reviewed, the mealtime/dining plan included intake information for mealtime and snacks • In 27 of 27 PNMPs (100%) reviewed, the mealtime/dining plan included food/fluid textures as applicable. • In 27 of 27 PNMPs (100%) reviewed, the mealtime/dining plan included behavioral concerns related to intake. • In 27 of 27 PNMPs (100%) reviewed, individual adaptive equipment was included. • In 27 of 27 PNMPs (100%) reviewed bathing/showering positioning and instructions were included Based on a review of an identified sample of 27 individual records (Samples #1, #2, #3 and #4) PNMPs were not formally developed with input from the PST. In zero of 27	

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		records reviewed (0%), PNMPs were clearly developed with input from the PST with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the PSPs that the PNMPs were included, but there was no evidence of discussion or input from other team members.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	PNMPs were generally developed by the therapy clinicians with limited input by other PST members as described above. Generally, the PNMP was located in the PNMP notebook that followed the individual on Leon, San Antonio, and Trinity. The PNMPs, however, on Three and Four Rivers were located in group books; therefore. there was not a clear method in place to ensure the PNMPs followed individuals if they separated from their groups for activities on and off grounds. At no time during any of the observations was staff observed referring to the PNMPs outside of mealtime. Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Mealtime observations demonstrated that staff failed to 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 five of 15 (33%) observations, staff were following mealtime strategies and positioning listed in plans. • In one of five (20%) observations staff were following positioning instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: • Individual #146 was provided with full spoonfuls when the plan called for the spoon to be only 1/3 filled. • Individual #145 was provided with a ¼ cup of liquids when this was not noted on the plan. The cup was large and filled only to a ¼ resulted in hyperextension of the neck. • Individual #125 was observed hyper-extending his neck when drinking and receiving drinks when food remained in the oral cavity. Coughing was noted post observation. • Individual #701 was not provided with 1-2 sips between each bite and allowed ten seconds between bites as stated per plan. • Individual #635 was provided with spoonfuls of food when the oral cavity still had a substantial amount of food from the previous presentation. • Individual #728 was not provided with prompts to decrease the rate of intake	Noncompliance

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		therefore placing him at an increased risk of choking. • Individual #100, #663, and #728 did not have their food cut into bite size pieces thus increasing the risk of choking. One observation revealed staff not cutting up foods appropriately. This resulted in on the spot training by the acting HT director. Immediately after training, the Monitoring Team observed staff still did not cut food to the correct size; the staff either refused or was not knowledgeable of how to implement the strategy. When the Monitoring Team brought this to the attention of the acting HT director, he provided immediate on-the-spot retraining. Lack of understanding or implementation of bite size food items was pervasive on Three Rivers. Per review of the nutrition training curriculum, staff were trained on food textures and how to ensure items were cut appropriately; therefore, this appeared to be a performance issue rather than training. General Observations demonstrated that staff failed to implement interventions and recommendations outlined in the PNMP which were most likely to mitigate the risk of reflux and/or aspiration: For example: • Individual #330 was observed slumped in his bed and significantly leaning to his right with no pillows under his head and shoulder to provide support. • Individual #84 was observed in supine position when the plan called for either right or light semi-side lying. This individual had a significant history of aspiration pneumonia secondary to emesis and vomiting in bed. • Individual #283 and #551 were observed slid down in bed and with inadequate supports under their legs resulting in an increased risk of reflux aspiration and poor contracture management. Staff did not understand rationale of recommendations or were not knowledgeable of the interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with five DCPs: • In seven of seven (100%) interviews with staff, they were able to identify the location of the PNMP and/or mealtime plan. • In two of seven (28%) interviews with staff, staff could describe individual-specific PNMP strategies. • In one of seven (14%) interviews with staff, staff could describe the schedule for implementation of PNMP strategies. • In two of seven (28%) interviews with staff, staff stated they had received individual-specific training for PNMP strategies.	

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		Examples when direct support professionals were not able to describe the following PNMP indicators included: • DCP on Trinity was not able to explain why it is important to allow individual #701 ten seconds between swallows. • DCP on San Antonio was not able to describe the rationale for alternating liquids and solids. • DCP on TJ 6 was unable to describe "bite size" pieces. This lack of knowledge results in individuals being placed at an increased risk due to lack of staff understanding of the rationale for implementing strategies listed in the physical and nutritional management plans or dining plans. If staff are unaware of these, they may not observe for and report related health concerns or ensure their actions do not contribute to these risks. Per interview with nursing staff in the Infirmary, elevating the HOB per the PNMP was accomplished by eyesight alone and did not have a method that insured the appropriate degree of elevation was consistently accomplished. This was noted with Individual #283. Additionally, Infirmary staff were not unaware of who had PNMPs and who did not. This was noted when nursing stated that an individual who had a PNMP did not need or have the document.	
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 during new employee orientation. Review of the Facility's training curricula revealed that it did include PNM training in the following areas: • Body mechanics • Optimal alignment and support in seating systems and alternate positions • Mechanical lift transfers • Manual transfers approved by facility policy • Mealtime positioning • Nutrition • Safe presentation techniques for food and fluid • PNMPs. Per interview with the acting Habilitation Services director, there was no process in place to ensure PNM supports for individuals who are determined to be at an increased	Noncompliance

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		level of risk were only provided by staff who have received the competency based training specific to the individual. As of this review, the home manager was responsible for reviewing the books with pull staff but this review did not consist of any type of formal competency based training. Staff who are untrained will not have the full understanding as to why strategies must be implemented as well as have the knowledge needed to identify individualized triggers associated with a change in status. Person-specific training and training in response to changes to plans of care were provided to staff who routinely work at a specific unit; however, there was no process in place to provide this additional training should a unit have to utilize floating or pull staff from another area. It is essential that PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff that have successfully completed competency-based training specific to the individual. An example is individual #701 who was an individual who has had repeated PNM issues and was observed being fed unsafely by staff who had not received training on his dining plan. Since the previous visit, RSSLC had implemented an I-learn course that focused on the prevention of aspiration. As of this review, approximately 253 staff had completed the training and all staff are expected to complete the training by 12/31/11. Beginning with the new year, the I-learn course will be included in the monthly training schedule.	
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 policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted did not exist at RSSLC. Based on review of the Facility's monitoring practices, a comprehensive PNM monitoring form was in place that was designed to address mealtime as well as areas outside of mealtime. While the form was designed to address mealtime and other PNM areas and had multiple professionals involved, a policy or process was not fully developed that included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • Monitors are re-validated on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, and • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician.	Noncompliance

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		There was also lack of data acquisition and analysis regarding the completion of the monitoring forms. As of this review, the PNMT was unable to pull information regarding inter-rater reliability, and percentage of activities monitored. Per review of the monitoring list, 138 (37%) of the 725 monitoring forms completed addressed areas outside of positioning and dining. This ratio does not support a comprehensive view of how the PNM supports are effective or if they are being implemented in all areas in which the individual was at risk. Areas missing most from the monitoring process included bathing, medication administration, and oral care. There was not a formal process or policy in place that ensured individuals with increased PNM issues were provided with increased monitoring. At the time of the review, this process was informal and directed by the attending clinician. Per review of the PNM policy, the policy stated that individuals should be monitored but did not provide any additional information regarding responsible parties or potential schedule. Per report of the acting HT director, high risk individuals were monitored three times per week in a variety of activities but upon review of documentation, 63% of monitors still occurred at mealtime.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	Based on the review of 27 individual records (Sample #1, #2, #3, and #4), the PNM Team or PST did not document progress of individual strategies on a monthly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators for those individuals with the most complex physical and nutritional support needs. While PNMPs were reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at a high risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). Individuals with PNMPs were reviewed on an annual basis with changes in the interim generally indicated based on referral or the identification of a problem. Routine, proactive review of the plans was not conducted by the clinicians with frequency based on health risk level. All members of the PNM team did not conduct monitoring. There was no system of routine review established to be conducted by the clinicians relative to the health status of those individuals at high risk who were followed by the PNMT. Per review of the monitoring list, 725 monitoring forms were completed over the past	Noncompliance

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		quarter; nine (1%) were completed by someone other than the PNMP Coordinator. There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized these concerns. Even during the annual assessments, the plans were reviewed in a rote manner to continue a strategy, with no clear review to measure or evaluate the actual efficacy of the plan. For example, there was no review that determined if a strategy to address falls or speed of intake for an individual effectively resulted in a reduction from the previous period. There was no detailed comparative analysis of data or assessment findings. The Aspiration Trigger Data Sheet was implemented for the individuals who had an aspiration event in the past two years or who were enterally fed. 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 a positive step forward in better being able to identify signs and symptoms. The issue with the 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. • Lack of consistent and detailed documentation surrounding the occurrence of triggers (e.g., activity in which trigger occurred, positioning of the individual) • Lack of consistent completion by staff (missing data points) • Lack of implementation for all individuals who were identified as being "high risk" • Trigger sheets contain information that was not relevant to the individuals (i.e., an individual who eats by mouth had a trigger that states to watch for formula in the mouth). RSSLC was aware of the lack of individualized triggers and how some triggers were not appropriate for the individual, but the concern was that staff continued to mark data points and, per interview, did not appear aware that the trigger was not relevant to the individual.	
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	The following section was based on a sample gathered from individuals who received enteral nutrition (Sample #3). Eleven of these individuals had been included in the sample reviewed by the Monitoring Team. There were approximately 51 individuals listed as receiving enteral nutrition.	Noncompliance

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	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.	All individuals who received non-oral intake (NPO) in the selected sample had been provided a PNMP that included the same elements described above. One aspect of the At Risk Individuals policy, implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times within the last year, as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nurse case manager based on information provided by the PCP, nursing, Habilitation therapists, dietitian, pharmacist, and other members of the PST. As of this review, this assessment was not completed at RSSLC. Based on the sample of 16 individuals (sample #1 and #3), zero of 16 (0%) individuals had received the interdisciplinary aspiration pneumonia/enteral nutrition assessment provided by the State. The Facility reported that the assessment had been completed for Individual #31 (which would result in 6% of the sample receiving the assessment), but documentation of the assessment was not reviewed by the Monitoring Team. All eleven individuals who received enteral nutrition (sample #3) had received a Habilitation Therapy assessment but content within these assessments was inconsistent and variable between therapists. While most assessments included the rationale of the tube, none of the assessments for those individuals who were NPO identified a clear pathway to oral intake or comprehensively addressed the oral motor status of the individuals. Attempts for oral intake focused solely on intake and did not address the swallowing components that are needed to safely tolerate intake. While transitioning from NPO status to Oral status is possible and appropriate for some individuals, there are many steps in between that are available to focus on. Included in this is oral motor strengthening or skills acquisition training related to mealtime intake. Additionally, the need for continued enteral nutrition was not integrated into the PSP. Based on a review of eleven individuals' PSPs, zero of 11 (0 %) (Sample #3) individual's PSP clearly documented the rationale for the continued need for enteral nutrition. An example of an individual PSP that did not document the rationale for the continued need for enteral nutrition was that Individual #402's PSP simply stated that nutrition is provided enterally. Examples of individuals who received enteral nutrition and did not receive a comprehensive annual assessment focused on pathways to oral intake:	

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		• Individuals #31 #233, #500, and #553. Eleven of 11 (100%) individuals who received enteral nutrition and/or therapeutic/pleasure feedings were provided with a PNMP; however, none of these PNMPs was comprehensive and all were missing the same information as listed in Provision O.3.	

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

1. Integrate into the PNMT process a method for data analyses and review (Provision O.1)
2. The PST must meet in a timely manner in response to changes in status. This meeting should provide comprehensive problem solving and timely implementation. (Provision O.3)
3. Medication administration, Oral Care, and Head of Bed elevation should be expanded to include information regarding number of pills the individual can tolerate at a time, strategies to assist with oral care, and degree level of head of bed elevation. (Provision O.3)
4. PNMPs must follow the individual throughout the day. This may be accomplished by having PNMP books for all individuals rather than individual books on one side of campus and group books for the other side. (Provision O.3)
5. A formal process should be developed that ensures individuals who are at an increased risk receive more intensive monitoring. (Provision O.7)
6. All individuals who are determined to be at an increased risk should only be provided assistance from staff who have received competency based training specific to that individual (Provision 0.7)
7. Aspiration Trigger Data Sheet should be expanded for all individuals who are at a high risk and not just the individuals who are on the target list (Provision O.7).
8. Aspiration Trigger Data Sheet should be modified to include triggers specific to the individual (Provision O.7).
9. As was recommended in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans. At a minimum, such a policy should include
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, toothbrushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.);
    b. A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability;
    c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    d. Formal schedule for monitoring to occur;
    e. Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors;
    f. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    g. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
    h. Establishment of thresholds for staff re-training. (Provision O.7)
10. 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 (Provision O.8)
11. Aspiration Pneumonia/Enteral Nutrition Evaluation should be completed per state guidelines. (Provision O.8).

The following is offered as an additional suggestion to the Facility:

1. RSSLC would benefit from consolidating many of their forms into one flow sheet. For example, consolidating the weight tracking logs, BM, Intake-Output, Aspiration Trigger Sheet, able and Emesis log would not only make it easier to review but also facilitate improved analysis of symptoms.
2. The PNMT would benefit from expansion to include a QDDP. This would assist in the PNMT having a better understanding of has been addressed in the past as well as serve as a liaison to other QDDPs at RSSLC.
3. The PNMT would benefit from clerical assistance during the meeting to assist with minutes so that the clinicians can focus on the topics at hand and the development of needed plans.

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), dated 10/10/2011 2. Record Reviews: a. Sample 1: Individuals #84, #173, #372, #523 and #558 b. Sample 2: Individuals #16, #41, #150, #192, #308, #503, and #621 c. Sample #5: Individuals #95, #207, #425, #442 #618 and #694 d. Sample #6: Individual #239, #672 and #746 e. Sample #7: Individuals #17, #113, #199, #358, and #440 f. Sample #8: Individuals #124, #436, and #579 3. Current Lists of people: (a) Who use wheelchair as primary mobility; (b) With transport wheelchairs; (c) With other ambulation assistive devices, including the name of the device; (d) With orthotics and/or braces; (e) Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution; (f) Who have experienced a falling incident during the past six months, including name of individual, date, location, whether there was injury, and, if so, type of injury 4. OT/PT Services Policy K.05 (1/31/11) 5. OT/PT assessments template 6. Wheelchair seating, PNM clinic assessment templates 7. For the past six months, any summary reports or analyses of monitoring results related to OT/PT generated by the Facility, including but not limited to quality assurance reports, including action plans. 8. List of individuals receiving direct OT and/or PT services and focus of intervention **People Interviewed:** 1. David Taylor OTR Acting Director of Habilitation Services 2. Jean Cuevo PT 3. Sally Martinez PNMT RN 4. Five DCPs (2 Trinity and 3 San Antonio) **Meeting Attended/Observations:** 1. PNMT meeting 10/25/11 and 10/27/11 2. At Risk Meeting (Individuals #58 and #680) 3. PSP (Individual #156) 4. Mealtime and Transition Observations (Trinity, Pecos, TJ5, TJ6, TJ7)
	Facility Self-Assessment: The RSSLCC Plan of Improvement provided comments/status for Sections P.1 through P.4 of the Settlement Agreement. The Facility indicated it was in noncompliance with all provisions. The findings of RSSLC were

	consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The POI provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the eight provisions, but did not present a comprehensive assessment of compliance with each of the indicators. Per the information provided by RSSLC, the Monitoring Team was in agreement that the steps noted had been achieved by RSSLC. Examples included the roll out of the ilearn course, change in monitoring strategy and development of monitoring database. The POI did not include data from its self assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self assessment process, it will be important to ensure that data are used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. Assessments were completed in accordance to the schedule set forth by RSSLC; however, assessments were not being consistently completed in response to a change in status nor were they comprehensive as they lacked objective measurements and detailed information that allowed for comparative annual analysis. **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. Additionally, therapy services were not consistently integrated into the PSP. **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. **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. Based on review of the State and/or Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions which included: • Definition of monitoring process • Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities • Formal schedule for monitoring to occur • Monitors are tested for reliability on an annual basis by therapists • Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor As with PNM concerns, there was a lack of problem solving and identification of issues that contributed to decline. Updates focused primarily on observations and did not include objective testing to clearly identify the cause of decline or clearly identify the functional outcome of the decline and the pathway in which increased independence or return to previous status would be accomplished.

	Positives noted included: • Assessments/screenings were completed within 30 days of admission for those individuals who were newly admitted. • All individuals had received an OT/PT assessment that indicated whether or not the individual required OT/PT supports and services. This high percentage was consistent with the previous compliance. • Central Office had revised the OT/PT assessment to include more of a focus on how deficits were affecting functioning and what supports would be needed to move the individual forward by increasing independence and overall abilities.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The Facility did not provide an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There were five Occupational Therapists (OT), two Certified Occupational Therapy Assistants (COTA), four Physical Therapists (PT) and two Physical Therapy Assistants (PTA). There are openings for two PTs. With the current staffing, ratios for Occupational Therapy were 1:75 and PTs 1:94. If RSSLC was fully staffed, then staffing levels would be adequate to address standard OT/PT practices in addition to the increased demand of physical and nutritional supports. Per report, RSSLC was actively trying to fill the open positions. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with additional supports available from the therapy assistants. Annual assessments/updates were completed by OT and PT collaboratively. Some of those who did not have established PNM needs would likely require occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence. This level of supports and services could not be adequately met with the level of staffing available at the time of the review. Sample #5 was chosen from a list provided by RSSLC of individuals who were identified by the facility as being at a "high risk" of falls. Every other individual on the list was chosen which accounted for 50% of the "high risk" individuals.	Noncompliance

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		Sample #6 consisted of the three individuals who were newly admitted since the previous compliance visit. Sample #7 was gathered by requesting the top ten individuals who experienced the highest number of falls over the past six months and choosing every other name on the list, accounting for a 50% sample in this area. Sample #8 was gathered through observation and report from the Monitoring Team. These individuals were chosen as a focus sample secondary to identified issues noted during the course of the week. Assessments/screenings were completed within 30 days of admission for those individuals who were newly admitted. All (100%) of individuals (sample #6) (new admissions) had received an OT/PT assessment. Assessments indicated whether or not the individual required OT/PT supports and services for 26 of 26 (100%) (Sample #1, #2 #5, #6, #7, and #8) records reviewed. The OT/PT assessment addressed movement, mobility, and range of motion but lacked the following: • Detailed information regarding oral motor status and functioning • Identification of skills needing to be enhanced and the method for obtaining this enhancement or progress • Measurable data as well as explanation of how these deficits are functionally affecting the individual. • There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • In many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. • In the cases in which therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. • There was no comparative analysis of health and functional status from the previous year. • There was no analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. Central Office has revised the OT/PT assessment to include more of a focus on how deficits were affecting functioning and what supports would be needed to move the	

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		individual forward by increasing independence and overall abilities. As of this review, the revised assessment was not implemented but was planned to be implemented within the next month. Zero of the 26 (0%) assessments (Sample #1, #2 #5, #6, #7, and #8) reviewed contained medical issues and health risk indicators and provided information regarding how the risk or medical condition contributed to the overall plan of care. Examples of assessments that did not appropriate rationale included: • Individuals #124 and #150 OT/PT assessment contained a diagnosis list but did not provide information or links to how these diagnoses impacted the level of care. Evidence of communication and or collaboration was present in the OT/PT assessments. Based on review of 26 OT/PT assessments (Sample #1, #2 #5, #6, #7, and #8) 100% included signatures and date of both OT and PT. Based on review of individuals with changes in status (samples #1, #7, and #8), there was not a consistent assessment or comprehensive review as indicated by a change in the individual's status or as dictated by monitoring results. • Individual #372 had a choking event on 5-6-11. On 5-9-11, the OT conducted an observation but there was no evidence of a tableside swallowing assessment. • Individual #84 was diagnosed with aspiration pneumonia on 6/12/11 and 6/30/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the PST meeting to discuss the event but the discussion was limited to what had already occurred and did not focus on potential indicators or triggers that led to the aspiration event as well as the need for assessment. In this case, the individual vomited and had emesis in bed on 6/12/11 but there was no evidence that a bed positioning assessment ever occurred or was discussed. Emesis and vomiting occurred a second time on 6/30/11. • Individual #173 was diagnosed with aspiration pneumonia on 7/31/11 but there was no evidence of comprehensive reassessment upon return from the hospital or while in the infirmary. The PST met on 8/15/11 and simply stated to continue with plan. • Individuals #113 and #199 experienced an increase in falls over the past three months but there was no evidence of formal reassessment of gait and/or PST discussion of environmental factors that may contribute to or decrease the risk of future falls. There was evidence of a PT note post event but the note simply stated the event and whether or not the individual was injured.	

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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.	Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Please refer to Provisions O.2 and P.1 regarding assessments in response to a change in status. Intervention plans related to positioning, oral care, and medication administration for individuals in sample #1, #2 #5, #6, #7, and #8 were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. For example: • Individuals #84, #173, and #372, PNMP stated to have the head of bed (HOB) elevated but there was no assessment present that justified why the assigned degree of elevation was the most appropriate. The issue regarding HOB elevation was a systemic and pervasive issue. The assessment developed by central office regarding HOB elevation had been implemented as of this review but only eight had been completed. Per report by the acting HT director, HOB assessments were being completed on individuals who had aspiration pneumonia in the past year and who were high risk. This is a logical starting point but the practice must be expanded and should occur at the time of the annual assessment as well. Based on reviews of PNMPs for 35 individuals (Sample #1, #2 #5, #6, #7, and #8), equipment was specified for 26 of 26 (100%) plans reviewed. Within 30 days of the annual PSP, or sooner as required for health or safety, a plan was developed as part of the PSP but was not consistently reviewed by the PST. Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP and were generally updated as needed due to a change in status. The main issue was that there was no evidence that the majority of plans were reviewed by the PST related to program changes or changes in status. Please refer to Provision O.3 for more information. Other than direct therapy services, the primary support provided by OT and PT was via the PNMPs. PNMPs addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited when related to promoting independence and skill acquisition; interventions did not focus on skills acquisition or independence. PT intervention was generally designed to address gait and ambulation. OT intervention was focused mostly on range of motion and strength training. The interventions in place were well documented and had established measurable and functional goals. Justification for continued therapy or discharge was well documented in the progress notes. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The PNMP addressed use of positioning devices and/or other adaptive equipment based on individual needs and identified the specific devices and equipment to be used but lacked the specificity needed to ensure safe oral care and medication administration. Please refer to Provision O.3 for additional information.	
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.	As mentioned in Provision O.5, training curricula revealed training in the following areas: • Body mechanics • Optimal alignment and support in seating systems and alternate positions • Mechanical lift transfers • Manual transfers approved by facility policy • Mealtime positioning • Nutrition • Safe presentation techniques for food and fluid • PNMPs. There was not a clear process that ensured pulled staff was provided with individualized training prior to working with individuals who were identified as being at an increased risk of aspiration, falls or other PNM issues. Based on interviews of direct support staff, staff did not understand the rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with direct support professionals: • In five of five (100%) interviews with staff, staff were able to identify the location of OT/PT plans. • In two of five (40%) interviews with staff, staff could describe individual-specific OT/PT strategies. • In one of five (20%) interviews with staff, staff could describe the schedule for implementation of OT/PT strategies. • In three of five (60%) interviews with staff, staff stated they had received individual-specific training for OT/PT strategies. Examples of direct care professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • DCP on Trinity was not able to describe why individuals used modified dining equipment. • DCP on San Antonio was not able to state why alternate positioning was	Noncompliance

#	Provision	Assessment of Status	Compliance
		appropriate and needed.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	The Facility had not yet developed a system to monitor and address all the requirements of this provision. Per maintenance spreadsheet and OT/PT monitors, a system still existed that was designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. A formal 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 (Refer to Provision O.5). A policy/protocol addressing the monitoring process did not exist and did not provide a clear direction regarding its implementation and action steps did not exist at this time at RSSLC. Based on review of the State and Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions that included: • Definition of monitoring process • Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities • Formal schedule for monitoring to occur • Re-evaluation of monitors on an annual basis by therapists and/or assistants • Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor Responses to monitoring findings were not clearly documented from identification to resolution of any issues identified. There was documentation noted directly on the monitoring form but there was no data system to collect and aggregate data obtained from the completion of the monitoring forms; such a system would be useful in identifying areas needing attention (including specific services needing improvement and specific houses and activity programs needing improved performance). Also, development if such a data system would allow RSSLC to direct services at locales and activities in which they were most needed.	Noncompliance

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

1. The assessment format should contain oral care and medication administration as well as information and assessment in these areas. The format should contain objective assessment findings and not just state a recommendation. Additionally, the areas of activity tolerance, ADLs, and balance

should be addressed consistently and in a comprehensive manner. Information should be measurable to allow for comparative analysis from year to year. If there are strategies listed on the PNMP then there should be an assessment indicating why the strategies listed were appropriate and the method for determining these strategies. (Provision P.1).

2. Current therapy services being provided to individuals should be integrated into PSP skill acquisition programs to provide multiple opportunities for incidental teaching, formally and informally (Provision P.2).
3. Policies/procedures should be developed for the OT/PT monitoring system, with identified performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of PNMPs and related equipment, and OT/PT instructional/intervention programs and equipment; staff utilization of the equipment; fit, function, availability, and use of adaptive equipment; and staff competency with PNMPs, therapy instructional/intervention plans, as well as activity plans. There should be established thresholds for staff re-training; identification, training, and validation process for monitors to achieve accurate scoring;, and inter-rater reliability methodologies (Provision P.3 and P.4).
4. Risk indicators should be considered in a more integrated manner throughout the report. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, service and interventions were indicated. These should then be listed as recommendations. The potential for skill acquisition sections should not be used predominately to justify barriers to learning new skills but rather interventions and supports that could teach new skills and mitigate barriers to learning. (Provision P.2)
5. 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. (Provision P.3)
6. Changes in status should trigger an automatic OT/PT assessment or review if related to area of practice (e.g., 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.(Provision P.1)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) 10/10/11 2. Letter and summary outlining Oral Hygiene Behavior Monitoring (untitled, undated) 3. Oral Hygiene Care Plan (OHCP) (no number, undated) 4. Behavior Incident Report (Oral Hygiene), form (no number, undated) 5. Suction Toothbrush Policy and Procedure, draft (no date/number) 6. Memo regarding suction tooth brushing supplies (no date/ untitled) 7. Post Anesthesia Care Policy, P.30, dated May 27, 2011 8. Dental Summaries of Individuals #440, #736, #555, #16, #771, #772, #86, #173, #239, #31, and #16 9. Most recent PSP for Individuals #440, #736, #555, #16, #771, #772, #86, #173, #239, #31, and #16 **People Interviewed:** 1. Carol Heath, DDS, Dentist **Meeting Attended/Observations:** 1. Observed individuals for oral hygiene at the Trinity living area
	Facility Self-Assessment: The Facility determined that it was not in compliance with Provisions Q1, and Q2. The Monitoring Team was unable to determine or comment on the Facility's plan of improvement because, as with other provisions, it only listed activities completed. There were no benchmarks or timelines that delineated its progress and course to achieve compliance. The Monitoring Team is complimentary of the action steps taken, as outlined in the POI, and believes they will help move the Facility closer toward compliance. for example, ensuring the dentist receives training on Developmental Dentistry, the collaborative effort towards enhancing behavior data collection, the suction toothbrush and oral hygiene programs.
	Summary of Monitor's Assessment: Provision Q1. The Monitoring Team noted an excellent process to provide emergency dental services. The Facility had processes in place to closely monitor people following oral sedation and intravenous sedation (TIVA). The Facility had developed an excellent process to enhance oral hygiene at the living area, and will initiate suction toothbrushing in the near future. The Facility must fully implement its oral hygiene and suction toothbrushing programs. The Facility must mitigate its high rate of missed dental appointments, and must consider increasing available TIVA days for individuals who could benefit from additional dental care under anesthesia. Based on limited TIVA opportunities, not fully implementing suction toothbrushing and oral hygiene program, and the high rate of missed dental appointments, the Monitoring Team determined that the Facility is noncompliant with Provision Q1. Provision Q2. Because of the limited number of effective desensitization programs at the Facility, and because the Facility's new process to assess behavioral challenges associated with oral hygiene, and dental care had not been completed, and because dental health care issues were not consistently included in the context of the IDT process, the Monitoring Team determined that the Facility is noncompliant with

	Provision Q2.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	To assess compliance for Provision Q1, the Monitoring Team assessed the Facility's ability to provide dental services by reviewing records, directly observing Individuals at their living area, observing the dental office, and discussion with the dental director. The following issues were explored in depth. <u>Dental Office Staffing</u> The Facility had two full time dentists, two full-time hygienists, one of whom is on extended leave, and one dental assistant. The Facility was recruiting an additional dental assistant. The Monitoring Team noted that direct care can only be provided by a dentist or hygienist when a second individual (usually a dental assistant) is present to provide support; hence, without a dental assistant for each provider, the quantity of dental services can not be maximized and more people could be seen timely. Dentists continued to use material issued by the American Dental Association for Persons with Developmental Disabilities to guide practice, and the dental director recently attended a three-day workshop on special needs dentistry. <u>Oral Hygiene</u> The Monitoring Team assessed the Facility's effort to enhance oral hygiene efforts at the Facility. During its observation on Trinity unit, the Monitoring Team noted, in general, poor oral hygiene of Individuals who reside at the home. The Facility had initiated a large project to facilitate "Oral Hygiene Behavior Monitoring" at the Facility. This project is intended to collect 30 days of data on each individual about behavior during oral hygiene procedures. Data are to be analyzed by the Facility's behavioral health staff and a comprehensive behavior plan for oral hygiene will be developed for all individuals. An "Oral Hygiene Care Plan" that summarizes the individual's oral hygiene needs will be completed. The Monitoring Team reviewed an untitled letter and summary "Oral Hygiene Behavior Monitoring To Improve Oral Hygiene To Reduce Pneumonia" that outlined the process; however, there was no policy or procedure available. The Monitoring Team reviewed a blank copy of the Oral Hygiene Care Plan (OHCP), which appears to be comprehensive and a good tool to assist in providing oral hygiene at the living area. The Facility's effort to implement its oral hygiene program is scheduled to be completed by February, 2012. The Monitoring Team discussed the issue of oral hygiene at the living area with the Facility's Dental Director. The Dental Director concurred with the Monitoring Team's finding of poor oral hygiene at the living areas and commented that she still is confronted	Noncompliant

#	Provision	Assessment of Status	Compliance
		with cases of undisturbed plaque, which indicates oral hygiene has not been offered for at least several, or more days. The Monitoring Team recognizes the exemplary effort to improve outcomes secondary to oral hygiene; however, given that the Facility's efforts will not be completed until February, 2012, the Monitoring Team observed poor oral hygiene at the living area, and the Dental Director reported that cases of undisturbed plaque continue at the Facility, the Monitoring Team determined that at the time of this review, the Facility does not provide adequate oral hygiene to individuals at the Facility. The Monitoring Team is hopeful that the Facility continues its strong commitment to this important issue. <u>Suction Toothbrush</u> The Monitoring Team assessed the Facility's effort to implement a suction toothbrush program for individuals with dysphagia and risk for aspiration pneumonia. The addition of suction toothbrushing is exemplary. The Monitoring Team learned that the Facility received its suction toothbrushing supplies on October 11, 2011, and intends to initiate suction toothbrushing at homes in November. The Facility had a draft policy for suction toothbrushing that it intends to update. Given that the Facility had yet to initiate suction toothbrushing, the Monitoring Team determined that the Facility does not yet provide necessary support for oral hygiene at the Facility. <u>Scheduling</u> The Monitoring Team reviewed the number of missed and rescheduled dental visits. Over six months prior to October 28, 2011, 483 appointments were either missed or rescheduled during that time period. Some rescheduled appointments were missed again; when an appointment is missed, the Dental Office cannot schedule someone in on short notice, so there is down time that could be used to provide care to other individuals. The Monitoring Team recognizes that some missed appointments are secondary to illness and hospitalizations; however, based on its experience, the Monitoring Team has concerns that other factors, such as staffing and system issues specific to scheduling are also involved. The Facility must better address scheduling of appointments and reduce missed appointments. <u>TIVA</u> The Monitoring Team discussed the issue of TIVA use as the Facility. At the time of this review, two TIVA days were available per month, which enabled a total of 8 Individuals to be treated. The exact number of Individuals who require TIVA was not available to the Monitoring Team; however, estimates by the Dental Director suggest additional TIVA days are required to ensure appropriate services are provided to people who require dental services with TIVA support. The Facility must ensure that adequate TIVA is available to support individuals for their dental needs.	

#	Provision	Assessment of Status	Compliance
		General Anesthesia The Facility contracts with a local dentist to provide dental services for the eleven individuals who require general anesthesia. The Monitoring Team determined that the Facility had adequate resources to provide necessary treatment for those Individuals who require general anesthesia. Post Sedation Follow-Up Following review of the Facility's Post Anesthesia Care Policy, P.30, dated May 27, 2011, the Monitoring Team recognized that Individuals who undergo TIVA at the Facility, and intravenous (i.v) sedation off campus, recover at the Facility's infirmary until recovered. The Facility had a procedure, Monitoring Episode of Acute Illness/Use of Sedation, which was revised on April 27, 2011. The procedure outlines medical monitoring for individuals who have had procedural sedation. Given the well known inherent risks of aspiration pneumonia following any dental procedure, especially following the use of sedating medications, in individuals with Developmental Disabilities, it is essential to include longitudinal trends data of dental procedures, when assessing aspiration pneumonia trends at the Facility, to assess whether dental procedures including sedation could contribute to aspiration pneumonia. When the Facility performs its regular root cause analysis and quality assurance program for aspiration pneumonia, the analysis should include assessing if the individual underwent a dental procedure and/ or sedation. Dental Emergencies The Facility had a functional process to address dental emergencies at the Facility. In the event of a dental emergency, the nurse will assess the individual and notify the on-call dentist. The on-call dentist will provide guidance to the nurse, and when necessary return to the Facility to provide necessary dental care. The Facility has an option to transfer the individual to the local hospital when necessary. At the time of this review, the Monitoring Team determined that the Facility remains noncompliant with Provision Q2. The Monitoring Team identified several issues that must be addressed to help facilitate compliance, and include the following: The Facility must implement its current action steps to ensure that its oral hygiene and suction toothbrushing programs are available to those individuals who require such supports; the Facility must also ensure that TIVA is provided and available to all individuals who require TIVA for dental services; Reduction in missed dental appointments must be achieved by enhancing communication protocols with living area staff. Individuals who require more frequent dental services, such as those who could benefit by more assertive deep cleaning, should also be worked into the scheduling of dental appointments at the Facility; the incidence of aspiration pneumonia following dental procedures, with and	

#	Provision	Assessment of Status	Compliance
		without sedation, should be more closely assessed. For example, when the Facility performs its regular root cause analysis and quality assurance program for aspiration pneumonia, they should include assessing if the individual underwent a dental procedure and/ or sedation.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	To assess the Facility's ability both to minimize use of sedating medications and restraints and to incorporate dental services into the PST process at the Facility, the Monitoring Team reviewed dental records, active records, specific PSP reports and conducted a meeting with the Facility's dental director. <u>Interventions to Minimize Use of Sedating Medications and Restraints</u> The dental office was currently working with the behavioral health department on collecting and assessing behavioral data on all individuals regarding oral hygiene and dental care. The Monitoring Team compliments the Facility for initiating this process. The Monitoring Team was made aware that dental programs to minimize use of sedation and restraint, including desensitization, were being addressed by the newly hired director of Behavioral Services.. To Facilitate the implementation of desensitization programs at the Facility, the Monitoring Team also noted that the dental office assisted with the implementation of desensitization programs by enabling individuals to participate at the dental office as part of their desensitization program. The Monitoring Team clearly understands the challenges associated with dental desensitization and other programs to minimize use of sedation and restraint, and the inherent risks associated with providing dental services to individuals with behavioral challenges, and compliments all the Facility's efforts to support dental services for people with intellectual disabilities and challenging behavior issue. It would be advantageous for the Facility to develop a trends analysis that would enable a snap shot of where the Facility stands with regards to its program to minimize use of sedation and restraint. Data such as demographics of individuals who require desensitization, and data to track the progress of those benefiting by a program would be beneficial. <u>Inclusion of Dental Services in the IDT Process</u> The dental office provided an excellent dental summary, which is included in the individual's Active Record. The Summary is to be used by the PST to understand the individual's dental and oral health care needs. The summary is excellent, but, it could be enhanced by including benefit and risk of treatment versus no treatment.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Monitoring Team reviewed the dental summaries of Individuals #440, #736, #555, #16, #771, #772, #86, #173, #239, #31, and #16. The sample was determined by the Facility. The Monitoring Team requested the most recent PSP for Individuals #440, #736, #555, #16, #771, #772, #86, #173, #239, #31, and #16 but was only provided PSPs for Individuals #86, #173, #239, #31, and #16. Of the PSPs provided, Individual #86 did not include comments on necessary supports and services required for oral hygiene and dental care. The PSPs for Individuals #173, #239, #31, and #16 had excellent documentation specific to supports and services for oral hygiene and dental care. Given that 64% of the sample requested did not include documentation demonstrating that supports and services for oral hygiene and dental services were included in the context of the PST, the Monitoring Team determined that dental services was not fully integrated into the PST process at the Facility. The Facility must include the necessary supports and services for oral hygiene and dental care within the context of the PST and the PSP. <u>Oral Sedation:</u> A comprehensive assessment of oral sedation use by the Facility is located in Section J of this report. Timely Provision of Service: The Monitoring Team noted several issues regarding timely provision of services, especially issues related to missed dental appointments. and limited TIVA availability. Refer to sections Q1 of this report for further details.	

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

1. Develop a policy and/or procedure for suction tooth brushing and oral hygiene programs .(Provision Q1)
2. Fully implement suction toothbrushing and oral hygiene programs as soon as possible. (Provision Q1)
3. Ensure that the Facility can track and demonstrate when, and by whom, suction toothbrushing and oral hygiene were provided, and that the process is well integrated into the PST process (Provision Q1)
4. Develop a QA process to help address missed dental appointments. (Provision Q1)
5. Ensure that the Facility provides adequate TIVA services to meet the needs of individuals served. (Provision Q1)
6. Ensure that dental procedures are included in trends analysis for assessing aspiration pneumonia at the Facility. (Provision Q1)
7. The Facility must include the necessary supports and services for oral hygiene and dental care within the context of the IDT and the PSP (Provision Q2)
8. Include risk-benefits of providing dental services and not providing dental services in the context of the dental summary (Provision Q1)

The following are offered as additional suggestions to the Facility:

1. It would be advantageous for the Facility to develop a trends analysis that would enable a snap shot of where the Facility stands with regards to its program to minimize use of sedation and restraint. Data such as demographics of individuals who require desensitization, and data to track the

progress of those benefiting by a program would be beneficial (Provision Q2)

2. To maximize dental services, consider increasing the number of dental assistants to support each clinician.

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), dated 10/11/2011 2. RSSLC Policy: Communication Services K/06 3. Record Reviews: a. Sample #1: Individuals #84, #173, #372, #523 and #558 b. Sample #2: Individuals #16, #41, #150, #192, #308, #503, and #621 c. Sample #5: Individuals #95, #207, #425, #442 #618 and #694 d. Sample #6: Individual #239, #672 and #746 4. A list of people with Alternative and Augmentative Communication (AAC) devices 5. AAC evaluation and Speech Language assessment template 6. Monitoring tools template for ACC and SLP programs 7. Revised Master Plan for Communication 8. List of individuals receiving direct speech services, and focus of intervention 9. Training Roster (last six months) **People Interviewed:** 1. Brandie Rabe CCC-SLP Lead SLP 2. David Taylor OTR Acting Director of Habilitation Services 3. Four DCPs (Pecos, Trinity and San Antonio) **Meeting Attended/Observations:** 1. Mealtimes and Transitions on Trinity, Pecos, San Antonio 2. PSP (Individual #156)
	Facility Self-Assessment: RSSLC Plan of Improvement provided comments/status for Sections R.1 through R.4 of the Settlement Agreement. The Facility indicated it was in noncompliance with all provisions. The findings of RSSLC were consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The POI also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four provisions but did not provide a clear sequential framework in which they expected to reach compliance. Areas of Progress noted by RSSLC were reviewed by the Monitoring Team, which agreed the actions listed had occurred. RSSLC drafted contracts for SLPs and has filled two of the six positions. This approach appeared to document completion of tasks rather than serve as a plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps.
	Summary of Monitor's Assessment:

	Provision R.1: This provision was determined to be not in compliance. RSSLC only had two SLPs on campus. The priority for one of the SLPs was to focus on dysphagia; therefore, the communication caseload for the entire campus belonged to one therapist. The ratio of therapist to client was 1:188, which was too large a caseload for the therapists to actively participate in all facets of care. **Provision R.2:** This provision was determined to be not in compliance. Individuals identified as having decreased communication had not consistently been provided with the needed assessments, and assessments that were provided were not consistently comprehensive in identifying methods to expand communicative functioning. Programs in place to assist some individuals were not being consistently implemented. **Provision R.3:** This provision was determined to be not in compliance. AAC devices were not consistently portable, functional or available 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 had a list of shared devices but did not have a monitoring process that tracked the presence, working condition, and effectiveness of the AAC equipment. Due to the lack of staff availability, progress in these areas continued to show very slow improvement. Implementation of devices and mentoring of staff related to these devices were not occurring with enough frequency to improve the overall level of care as it related to communication expansion. Another issue that was noted focused on the lack of speech involvement with the identification and treatment of cognitive disorders. Issues such as difficulty sequencing and/or memory were not consistently addressed with treatment or with the implementation of assistive technology devices. A positive practice identified was that the majority of assessments identified whether the individual required direct or indirect therapy.

#	Provision	Assessment of Status	Compliance

R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in	The Facility did not provide an adequate number of speech language pathologists or other professionals (for example, Assistive Technology [AT] specialists) with specialized training or experience. At the time of the onsite monitoring review, SLP staffing consisted of two SLPs, with four vacancies to be filled.
		
		General tasks in which Speech Pathology is responsible:
		• Attendance at:
		  • Pre-admission meetings
		  • 30 day planning conferences for all new admissions
			Noncompliance

#	Provision	Assessment of Status	Compliance
	augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	• Annual planning conferences • PNMT meetings • PSP meetings • 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 • Meal Monitoring The current ratio of therapist to client ratio was 1:188. This ratio did not allow for the appropriate follow up or involvement of the SLP in all facets of the individuals care and was not conducive to enhanced participation in the individuals' communication development. This ratio was especially inadequate since one of the SLPs was assigned to swallow studies. Two of 21 individuals (10%) (sample #1, #2, #5, and #6) had a Speech Therapist present at the annual PSP. Lack of a Speech Therapist at the PSP resulted in goals that were not relevant or inadequate to meet the needs of the individuals. Two of 21 (10%) individuals reviewed (sample #1, #2, #5, and #6) had appropriate speech goals. Examples of goals not being written appropriately or not written at all included: • Individual #84's communication assessment recommended textured items be utilized but there was no evidence that this was provided. • Individual #119, #225, and #558's communication assessment identified multiple strategies to utilize and areas to focus on communication but there was no evidence of these strategies being developed into a meaningful goal. • Individual #16's PST requested a Speech assessment but there was no evidence that this was provided.	
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	The communication assessments for samples #1, #2, #5, and #6 were either not present or not comprehensive enough to allow for the identification and potential expansion of communication skills. • In zero of 21 (0%) records reviewed the assessment comprehensively addressed verbal and nonverbal skills. • In 19 of 21 (90%) records reviewed the assessment addressed whether the	Noncompliance

#	Provision	Assessment of Status	Compliance
	identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	individual requires direct or indirect Speech Language services. The issue is that no one was recommended for any form of speech intervention although the PSP as well as other assessments indicated that the person might have benefited from such interventions or devices. While the assessments contained recommended strategies or the use of an actual device, the assessment lacked detail regarding the individual's status. For example: • Individual #84, #150, #207, and #621's assessments stated that gestures, facial expressions or vocalizations were used as a method of expressive language but provided no further information regarding the catalog of gestures or vocalizations utilized. For persons receiving behavioral supports or interventions, the Facility did not have a process designed to identify who would benefit from AAC or speech assistance. The potential for the behavior to serve as communication was not consistently included as part of the behavioral assessment and Speech assessment process. Since the previous review, three individuals were admitted to RSSLC. One of three newly admitted individuals (sample #6) received a communication assessment or screening within 30 days of admission. Per report, the SLP is working on a new master plan that will identify individuals who have severe communication issues paired with aggressive behaviors and will begin to provide assessments accordingly. As of this review, this plan had not been developed or implemented. As of this review, the majority of individuals in samples #1, #2, and #5 had received a communication assessment within the past 3 years. The problem with the completed assessments was that they did not provide a comprehensive view of the individuals' status and how the speech therapist can assist the individual. The speech assessments focused mostly on verbal communication and did not provide adequate investigation into augmentative communication or assistive technologies to assist with daily activities. Examples include Individuals #207, #424, and #618 who had goals to conduct sequencing activities (i.e., shaving, bathing, and dressing). Sequencing boards and schedule boards that are in the domain of the speech therapist were not investigated or provided. Additionally, skills acquisition related to speech often focused on specific activities and completion of those activities rather than addressing the underlying cause and allowing for generalization of those skills. For example: Individual #150 was provided with verbal	

#	Provision	Assessment of Status	Compliance
		cues to go to work rather than focusing on prospective memory in an effort to improve the skills needed to not only remember to go to work but to remember other activities and appointments.	
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.	In zero of the 21records (sample #1, #2, #5, and #6) reviewed (0%), goals and objectives were determined to be functional and meaningful as evidenced by the demonstration of progress and or improvement. Programs, goals and objectives related to the acquisition or improvement of speech or language were not consistently written by the SLP. Zero of the 21 records (0%) (Sample #1, #2, #5, and #6) reviewed had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated included: • Individual #84, #150, #207, and #621's PSP just mentioned that facial expressions were used to communicate. • Individual #694's PSP simply stated that the person needs audiology every three years. • Individual #442's PSP did not mention the individual's speech status. PSPs at times 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. There was no evidence of detailed strategies or translation of nonverbal skills (i.e., communication dictionary) integrated into the PSP to assist staff with methods to increase communication. 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 enhance communication were also very limited. Some examples included: • Zero of the 21 records (0%) (Sample #1, #2, #5, and #6) reviewed clearly identified how the individuals communicate with others and interact with their surroundings. Examples were provided in Provision R.3. • Communication information was not integrated into the daily schedule. Zero of the 21 records (0%) (Sample #1, #2, #5, and #6) reviewed had communication interventions and methods to improve communication integrated into the daily	Noncompliance

#	Provision	Assessment of Status	Compliance
		schedule. General AAC devices were not consistently available in the common areas of homes and when they were present were nonfunctional. For example: • The "ready to eat" devices were located on the wall in the Trinity and Pecos dining room but were not in working order. • The "ready to eat" device in Pecos was located in the dining room but was only accessible at the time of dinner due to the kitchen being locked. • The AAC device in Pecos that expressed the desire to "go outside" was nonfunctional. RSSLC had 37 shared AAC devices but only 18 of the 37 (48%) were functioning properly Communication strategies/devices were not implemented and used. Five observations demonstrated that staff did not implement interventions and recommendations outlined in the Communication Assessment. Examples of individuals where staff did not implement a communication program as written included: • "Parallel Speech" was not utilized for individual #621. • Communication booklet was not used with individual #41.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a 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.	RSSLC did have a list of shared devices but did not have a monitoring system that tracked the presence and working condition of the AAC equipment. Monitoring should cover all areas in which the use of the device is applicable (which should be all the time). Effectiveness of the device may only be determined by a professional with expertise in that related area; therefore, the implementation of the plans should be followed by the Speech Pathologist. Additionally, the results of the monitors were not collected and utilized to drive future speech interventions. Per observation and review, the current monitoring process was not effective in maintaining the proper functioning or implementation of AAC devices, as demonstrated by the examples in Provision R3. DCPs were not knowledgeable of the communication programs as evidenced by: • In one of four interviews (25%), DCPs were able to locate adaptive equipment. • In one of four interviews with staff (25%), staff could describe individual-specific communication strategies for the individuals they served. • In two of four interviews with staff (50%), staff could describe the schedule for implementation of communication strategies.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In zero of four interviews with staff (0%), staff stated they had received individual-specific training for communication strategies. Instances in which staff could not describe individuals' communication included: • Discussion with four DCPs at Trinity indicated that staff were not knowledgeable of the communication dictionary or its contents. • DCPs on Pecos were unable to explain the schedule in which the shared devices would be utilized and the method for providing assistance with these devices.	

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

1. Many recommendations appeared to be left to the PST for the development and implementation of plans. It is critical that SLPs be involved at least in a consultative model to ensure that the plans, materials and implementation are within the scope of the individual's abilities and/or promote enhancement and skill development, as well as to provide modeling and coaching for staff. SLPs should be utilized in the development of instructional plans in a variety of settings to ensure that they are individualized with regard to the communication strategies incorporated into these plans. (Provision R.1).
2. RSSLC should focus on methods to increase staffing, as it was not sufficient to meets all the needs of the individuals. This especially relates to the availability of staff to conduct assessments, participate in meetings, and provide modeling and monitoring of goals and objectives. (Provision R.1)
3. Communication Goals should be followed by the SLP at a level that allows for consistent review of progress with goals and objectives. (i.e., on a monthly basis if service is direct and quarterly if indirect). (Provision R.2)
4. Provide increased guidance for therapists completing the speech assessments thus facilitating improved consistency and comprehensiveness of assessments. (Provision R.2)
5. Assessments must be comprehensive and include not only speech and communication status but investigate the cognitive status of the individual and how assistive technology, memory aids and AAC can benefit the individual in obtaining increased independence.
6. Individual communication programs should be integrated into PSPs through skill acquisition programs, as well as PBSPs (when appropriate), to ensure the AAC device, dictionary, or other communication system is meaningful to the individual and the individual can communicate and be an active participant in multiple environments. (Provision R.3)
7. Monitoring for AAC systems should address effectiveness and implementation versus only availability and condition. This will require professional staff to conduct more frequent and thorough monitoring in addition to that conducted by the Speech Tech. (Provision R.4)

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) (10/10/2011) 2. Facility Policies and Procedures - (J.6 – 09/08/2011) 3. Minutes from the Behavior Service departmental meetings (6/6/2011 and 8/29/2011) 4. Minutes for the Behavior Services peer review committee meetings (4/29/2011 through 9/19/2011) 5. Annual PSP, PSP updates, Training Objectives, 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: #016, #017, #044, #051, #071, #130, #137, #138, #152, #155, #160, #177, #193, #235, #254, #267, #290, #320, #325, #351, #389, #399, #413, #426, #440, #448, #470, #540, #558, #604, #630, #635, #669, #676, #678, #713, #718, #757, and #794 **People Interviewed:** 1. Lloyd Robert Buckner, MS, BCBA – Behavior Services director 2. Cynthia Fannin – Director of Education and Training 3. Carol Agu – QDDP Coordinator 4. Billie Dejean, MA, BCBA – Psychologist 5. Shelly Evan, MS – Psychologist 6. Tranika Jefferson, MS – Psychologist 7. Lora Peters, MA – Psychologist 8. Emma Williams, MS – Psychologist 9. Derric Anglin, MA – Psychologist **Meetings Attended/Observations:** 1. Behavior Support Committee (10/.24/2011) 2. Behavior Service departmental meeting (10/24/2011) 3. Active Treatment Committee (10/25/2011) 4. Risk Process meeting (10/25/2011) 5. PSP for Individual #156 (10/26/2011) 6. Restraint Reduction Committee (10/26/2011) 7. Human Rights Committee meeting (10/27/2011) 8. Observed training, active treatment, staff interaction and meals at the following residences and programs: Angelina (10/27), Colorado (10/26), Leon (10/26), Neches (10/26), Nueces (10/25), Pecos (10/25), Sabine (10/25), San Jacinto (10/25), and Trinity(10/25)
	Facility Self-Assessment: At the time of the site visit, RSSLC reported that no Provision was in substantial compliance with the SA.

	The Monitor was in agreement with the Facility. The Facility Self-Assessment of Section S consisted primarily of the documentation of specific events, such as the start or completion of a specific task. Qualitative statements, when provided, were not based upon objective criteria. Rather, these statements were presented in an informal narrative, such as indicating that a particular effort required further improvement. Based upon such statements, it was not clear that the Facility had implemented a comprehensive and systematic process to measure progress toward compliance with the SA. The Facility Self-Assessment also included a Plan of Improvement. This Plan of Improvement typically comprised discrete events or practices to be completed. The evidence listed by the Facility for these items included statements such as "PSP Observation Checklist" and "Email". This approach to self-assessment reflected an emphasis upon the occurrence of specific events rather than upon qualitative improvement relating to required practices. As with the implementation of a skill acquisition program, RSSLC must approach compliance with the Settlement Agreement in a systematic and evidence-based manner. Measures of compliance must reflect procedures that capture the salient elements of the task as part of an ongoing process rather than a discrete event that is either in compliance or not. This also requires the Facility demonstrate the ability to use objective measures of performance, openness to measurement outcomes, a consistent and effective use of resources, and a well-organized process for documenting and reporting progress. Without such an approach, the Facility will be challenged to make the changes necessary to satisfy the Settlement Agreement.
	Summary of Monitor's Assessment: Observations, interviews and record reviews were conducted on-site at RSSLC from 10/24/2011 through 10/28/2011. Record reviews continued off-site for several days following the site visit. No Provision of the SA was found to be in substantial compliance. Based upon information obtained as part of the site visit, two conditions were substantively apparent. The first of these involved the investment of time and effort by the Facility toward improving services for individuals living at RSSLC. Over two thousand pages of documentation from the previous six months were provided by RSSLC, including staff training records, staff performance assessments, individual assessment records, skill acquisition programs, skill acquisition data, and community participation records. This documentation reflected a good faith effort on the part of the Facility to progress toward compliance with the Settlement Agreement. The second condition noted during the site visit was the inconsistent delivery of services by the staff of RSSLC. In some circumstances, staff displayed outstanding skills in the provision of active treatment and the implementation of skill acquisition programs. For example, in the new classrooms in the Neches building, all staff were observed to implement formal training programs with skill and consistency. In addition, at the Nueces residence, staff during the evening meal were engaging and supportive of all individuals during the evening meal. Documentation also reflected that the Facility had increased the use of

	task analysis to 77% of all skill acquisition programs. Despite these achievements, however, other circumstances at the Facility reflected very poor services. Staff in the living room of the Nueces residence failed to respond when individuals engaged in stereotypic and potentially harmful behavior. In the Pecos residence, staff had not provided leisure materials or engaged individuals until after the arrival of the Monitoring Team on the residence. In addition, despite the expanded use of task analysis in developing skill acquisition programs, documentation did not reflect that improved assessment lead to improvements in the skill acquisition plans. One potential reason for the discrepancy between the effort displayed by the Facility and the outcome achieved could involve the lack of effective monitoring and data collection practices regarding compliance with the Settlement Agreement. Very few of the more than 2000 pages of documents provided by the Facility as evidence included attempts to summarize data or compare efforts with outcomes. Rather, the documentation by the Facility consisted in large part of raw data: individual logs, narratives, memos and data sheets. As a result, it was not possible to document that the Facility was able to identify progress or the lack of progress and modify procedures accordingly. Although the number of individuals employed had decreased since the last compliance visit, three individuals had been provided employment in the community, which demonstrated progress toward community-based training. No data from community training was provided. Based upon the observations, interviews and document reviews conducted as part of the site visit, it could not be determined that RSSLC had achieved consistent and comprehensive progress toward compliance with the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable	Formal skill acquisition programs require many of the same basic components as behavior support plans: Comprehensive assessment of skills and individual resources, the use of formal training methods that include adequate opportunities for training and high levels of reinforcement, an evidence-based and empirical approach to teaching, valid and reliable data collection, and a sound strategy for assessing progress. When one or more of these components are lacking, the ability to provide adequate habilitation services is severely compromised. 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. • A training curriculum was developed 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>safety, security, and freedom from undue use of restraint.</td><td>
trained, as well as follow-up monitoring of acquired knowledge.
• The training of all QDDPs 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 2010, a limited sample of two “best work” examples revealed task analysis was being used for some skill assessments, and that programs had begun to reflect chaining procedures, specific instructions and improved data collection procedures..

In May 2011, a sample of the training programs for 15 individuals revealed some improvement. The sampled training programs at times 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 an individual’s skill acquisition programs. In many cases, instructions for program implementation were unclear. Training programs also often lacked a clear definition of a successful response, and did not clearly reflect how the behavior related to the training objective or how the desired skill would be strengthened. In addition, many problems first identified during the baseline site visit remained unaddressed, such as poor selection of reinforcers, numerous typographical and grammatical errors, and a focus upon recording the number of prompts offered rather than the actual responses of the individual involved in the training.

During the current site visit, a modest degree of improvement was noted in the skill acquisition programs at RSSLC. It was noted that in the 30 records reviewed, many training programs included evidence of a task analysis, as well as discriminative stimuli to cue the individual to the task at hand, specific consequences for correct and incorrect responses, and ample opportunity for the display of the targeted skill or behavior. Overall, however, many of the limitations noted during the baseline visit in May 2010 continued to exist. These limitations included target behaviors or skills that lacked operational definitions, teaching procedures that lacked sufficient specificity to ensure consistent implementation, training sessions that were too infrequent or the number of trials too low for the development of skills, and no specific strategy for generalization and practice.

<table>
<tr><td>Area</td><td>5/2010</td><td>10/2011</td><td>Change</td></tr>
<tr><td>Plan reflects development based upon a task analysis</td><td>0%</td><td>77%</td><td>77%</td></tr>
<tr><td>Behavioral objective(s)</td><td>0%</td><td>37%</td><td>37%</td></tr>
<tr><td>Operational definitions of target behavior</td><td>0%</td><td>3%</td><td>3%</td></tr>
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#	Provision	Assessment of Status				Compliance
		Description of teaching conditions	0%	20%	20%	
		Schedule of implementation comprised of sufficient trials for learning to occur	0%	50%	50%	
		Relevant discriminative stimuli	0%	77%	77%	
		Specific instructions	0%	60%	60%	
		Opportunity for the target behavior to occur	0%	100%	100%	
		Specific consequences for correct response	0%	100%	100%	
		Specific consequences for incorrect response	0%	100%	100%	
		Plan for maintenance and generalization that includes assessment and measurement methodology	0%	53%	53%	

The following specific issues were noted during the review of skill acquisition programs.

Task analysis. Conducting a meaningful task analysis is essential to the development of a skill acquisition program. For many individuals with intellectual and developmental disabilities, tasks and behaviors must be broken down into small, discrete steps that can be more easily learned. Task analysis is the process of breaking complex tasks or skills down into smaller steps in a way most beneficial to the individual who will be provided training. RSSLC at the time of the current site visit had invested several months in the development and implementation of task analysis forms and procedures. Nevertheless, in a sample of 30 of the most recent skill acquisition programs, 77% included a task analysis; this was a significant improvement compared to the findings at the baseline visit. However, almost one quarter of the programs reviewed did not reflect in the methodology or documentation that a task analysis had been completed. As a result, it was not evident in 23% of skill acquisition programs, that the skill to be taught was presented in a manner most likely to facilitate learning in that person.

Behavioral objectives. It is essential that efforts to strengthen skills include objectives comprised of observable and measurable elements of the behavior. In many cases, the goal for a training program consisted of a general statement that did not clearly indicate what specific skill or behavior was to be increased. As a result, it was not evident how the objective related to the specific needs of the individual or contributed to enhancing the individual's abilities. For example, training programs for Individuals #155, #389, and #604 included no specific or measurable training objectives.

Operational definitions. In order for training programs to be implemented correctly, it is imperative that the program specifically defines the behavior to be increased. This requirement informs the person implementing the program exactly what behavior the individual is expected to display. Without an operational definition, the risk of

#	Provision	Assessment of Status	Compliance
		strengthening unintended behaviors and slowing the individual's acquisition of skills is increased. In 97% of the skill acquisition programs reviewed, the operational definitions of training targets consisted of general statements such as bathing, turning on water, or complying with a request. Description of teaching conditions. In order for teaching programs to be implemented as intended, the staff implementing those programs must be given explicit instructions including what materials are to be used, how those materials are to be arranged, where training should be conducted and how the environment should be controlled. Without such instructions, training conditions often drift or change across staff and location. As a result, training is ineffective and can strengthen the wrong behavior. The training programs reviewed at RSSLC during the current site visit often lacked details and failed to ensure that training would be implemented consistently. Specific instructions. As with the teaching conditions, it is necessary that training be conducted in a consistent and specific manner. Without specific instructions, the trainer may use a different prompt than was intended, offer reinforcement in a different way, or strengthen a behavior other than the behavior to be learned. The program for Individual #676 provides an example of what remains to improve. As discussed above, 77% of the skill acquisition programs reviewed reflected some form of a task analysis. This was a step forward for the Facility. The skill acquisition programs based upon these task analyses, however, often lacked specific teaching instructions. For example, for Individual #676, a portion of the teaching instructions included the following. 1. Instructor gives the Initial Request and allows [the individual] to complete the steps already learned (if applicable). 2. At step 3 of the Task Analysis, instructor provides the level of assistance as stated in "A" of the Fading Sequence. 3. If [the individual] responds correctly as outlined in the fading sequence within 5 seconds, instructor provides consequence for correct response and enters initials under "A" on data sheet. The steps in the program for Individual #676 were accurate. The steps were not, however, sufficient to allow the trainer to perform the teaching activity in a consistent and individualized manner. Teaching instructions are more likely to ensure effective teaching if they are presented in less technical language, clearly state the intended activities, provide examples, and describe the teaching activity and people involved in terms that are more person-centered. Sufficient trials. It has been repeatedly demonstrated in research regarding learning that	

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		the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities of reinforcement. Often, lower frequencies of reinforcement result in slower rates of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not compete effectively and efficiently with other reinforcement in the environment. In the majority of skill acquisition programs reviewed at RSSLC, the teaching trials were provided at a rate of one per day or less. Plan for maintenance and generalization. Skill acquisition programs have the ultimate goal of increasing skills in situations outside of the teaching setting. If an individual learns to differentiate colors in the classroom, but does not exhibit that same skill at home or at work or as part of a new and more complex task being learned, then the training has not been fully successful. In order to determine if skills are being used beyond the training setting, it is important that a specific method for monitoring the skill be in place. In the skill acquisition programs reviewed at RSSLC, only 53% included the necessary elements of such a monitoring system. For the remaining programs, some, such as those for Individual #193, included no provisions for generalization or maintenance. For other individuals, such as Individual #635, the process for generalization and maintenance was described as, "While attending class in the Active Treatment classroom." In addition to the weaknesses noted above in the skill acquisition programs, other issues such as data collection hindered the skill acquisition process. In order to assess an individual's progress toward developing skills and behaviors, it is essential to have valid and reliable data. For the majority of skill acquisition programs reviewed at RSSLC, it was not possible to determine the reliability or validity of the training data. Furthermore, in most programs it was not possible to identify specifically what was being measured. Examples of common data issues included the following. • For Individual #44, a data collection form included four sets of initials under Fading Sequence A and one set under Fading Sequence B, for a total of five data entries. The summary at the bottom of the form indicted success by the individual on three out of four trials. It was not evident whether the correct number of trials had been miscalculated or if the data collection process was unclear. • For Individual #193, instructions stated that data collection was to be conducted "M-F"; it was unclear if this indicated Monday through Friday or Monday and Friday. The data reflected that neither interpretation had been fulfilled as data had been collected only 10 times during the month on various days of the week, with only one documented occurrence of the individual refusing to participate.	

#	Provision	Assessment of Status	Compliance
		• For Individual #254, data collection consisted of a series of one-sentence statements describing various activities, including, "listening to music" and "rolled and tore paper". Each data entry was followed by codes for various levels of prompting. It was not evident how the documentation related to the stated objective of increasing leisure activities or whether the data reflected success or failure. The review of training programs during the current site visit did reflect that the Facility had achieved improvement in some areas. Overall, however, the information obtained from various records and observations did not reflect that RSSLC had fully implemented a consistent, coherent and effective strategy for skill acquisition.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Based upon a review of assessment practices, it was noted that 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. Since the May 2011 site visit, RSSLC had adopted the new Functional Skills Assessment (FSA) developed by DADS. The FSA reflected advancement from the previous PALS assessment. Rather than listing a variety of skills as either a strength or weakness, as was required by the PALS, the FSA was constructed more like a task analysis of a variety of skills. Each individual is rated by the level of prompting required for success on skill or task. This provided a more detailed representation of each individual's abilities. Despite the improvement represented by the FSA, it was not clear that the protocol was sufficient for skills assessment. One substantial limitation was the lack of granularity and individualization reflected in the FSA. For example, one item under "Household/General Safety" required the level of prompting necessary for the individual to cooperate with a fire drill. Cooperation during a fire drill is an important skill, but more information than just level of prompting is required to determine an individual's ability in this area. The FSA did not provide a means to capture such information. A second limitation was the apparent inability to assess those individuals with physical limitations upon the use of skills. For example, one item under "Meal Time Skills" was "Eats with a utensil". For some individuals, eating with a utensil would not be physically possible. For other individuals, extra time might be required to control fine motor coordination. These types of circumstances have no relation with the level of prompting required. The FSA included an area for comments on each item, but providing a comment about the inability of the FSA to measure the skills would not equate with assessing that skill.	Noncompliance

#	Provision	Assessment of Status	Compliance
		It would be unrealistic to expect that any instrument designed for the assessment of adaptive skills would possess the ability to capture all underlying circumstances for skill deficits. It is essential, however, that such an instrument include the means by which to measure the individual's abilities in the context of the individual's physical, developmental, cognitive, and environmental circumstances. Without the ability to capture the basic information about individual abilities within these contexts, any assessment results would be of unclear benefit in understanding the individual's needed supports and services, or in the development of skill acquisition plans. In many available instruments, this limitation is in part addressed by standardizing the instrument across variables such as physical ability, intellectual ability and living environment. The FSA reviewed at RSSLC was not a standardized instrument. Therefore, a greater burden is created to ensure that the findings of the FSA provide individualized and relevant insights into the needs of the person being assessed. Based upon the review at RSSLC, the FSA was unable to meet this burden. The Facility had also continued to expand the use of task analysis. As discussed in Provision 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. As a result of the broad weaknesses in assessment practices at RSSLC, it was evident that the Facility had successfully provided annual assessments for every person living at the Facility. It was not evident, however, that the assessments provided adequate measurement of individual abilities or were likely to facilitate the skill acquisition process.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the	• 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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	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. For example, there was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. During the current site visit, observations were conducted in a variety of settings across the RSSLC campus in order to assess skill acquisition implementation. A sample of locations where individuals were expected to be involved in meaningful activities was selected for observational review of engagement and active treatment. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior.	

	Staff Present	Individuals Present	Individuals Engaged	% Engaged
9/21/2011				
Classroom	5	4	4	100
Classroom	2	4	3	75
Nueces – Living Room	2	6	2	67
Nueces – Dining Room	5	7	7	100
Pecos – Porch	3	12	3	25
Pecos – Dining Room	3	6	5	83
Sabine – Living Room	5	8	3	38
Sabine – Dining Room	1	3	3	100
Sabine – Dining Room	2	5	1	20
San Jacinto – Porch	2	4	1	25
San Jacinto – Dining	1	4	1	25
Trinity – Living Room	2	9	3	33
Trinity – Dining Room	4	6	0	0
Trinity – Dining Room	3	6	6	100
	2.86	6.00	3.00	50%

Active engagement by 50% of observed individuals reflected improvement from previous site visits. It should be noted, however, that engagement, even in functional activities, did not necessarily correlate with formal or informal training. In several residences, it was also noted that activities were initiated only after the Monitoring Team entered the building.

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		• In Pecos, upon entering, the living room no materials were available and individuals were sitting around the room; many were engaged in sleeping or stereotypic behavior. Within three minutes of entry, however, a puzzle had been placed on a table and all individuals escorted from the room. During a later observation at Pecos, staff was observed offering frequent prompts during a meal to use utensils and display appropriate posture. Individuals often appeared confused by the prompts or ignored the prompts. During observations, there were also circumstances where staff failed to respond to inappropriate behavior. • In the living room of Nueces, two individuals were observed engaging in stereotypic behavior. A third individual was biting her hand while a fourth repeatedly pulled her shirt down to expose her breasts. Although staff were in the immediate vicinity of these occurrences, none interrupted the behaviors or offered any intervention Observations did reflect, as well, circumstances in which staff effectively provided active treatment. • During the evening meal at Nueces, staff was observed engaging individuals in social conversation, as well as offering appropriate prompts, numerous choices, and the option of assistance. Individuals responded to these actions in a routine manner, suggesting the observation reflected typical meal events. • In all classrooms, staff was consistently observed in organized, formal teaching. Frequent prompts were offered and individuals consistently were provided with reinforcement for success. All classrooms were well organized and the staff demonstrated skills necessary to meet training needs. Documentation provided by the Facility reflected that the RSSLC staff was provided with diverse training opportunities since the previous site visit. Literally hundreds of pages of documentation were reviewed, including tests, interview reports, observations, and written feedback. Despite the amount of documentation regarding training, however, it was not possible to assess the status of progress on implementation of specific skills. This inability was due to the lack of process or system for compiling training data into summary reports. Although the Facility did provide some tables reflecting training data, these tables lacked the details necessary for assessing training progress. Based upon the observations conducted during the current site visit, the provision of active treatment was modestly improved over previous site visits. There remained, however, substantial room for improvement in regard to both the consistency and extent of active treatment, as well as the ability of the Facility to ensure that staff were well-	

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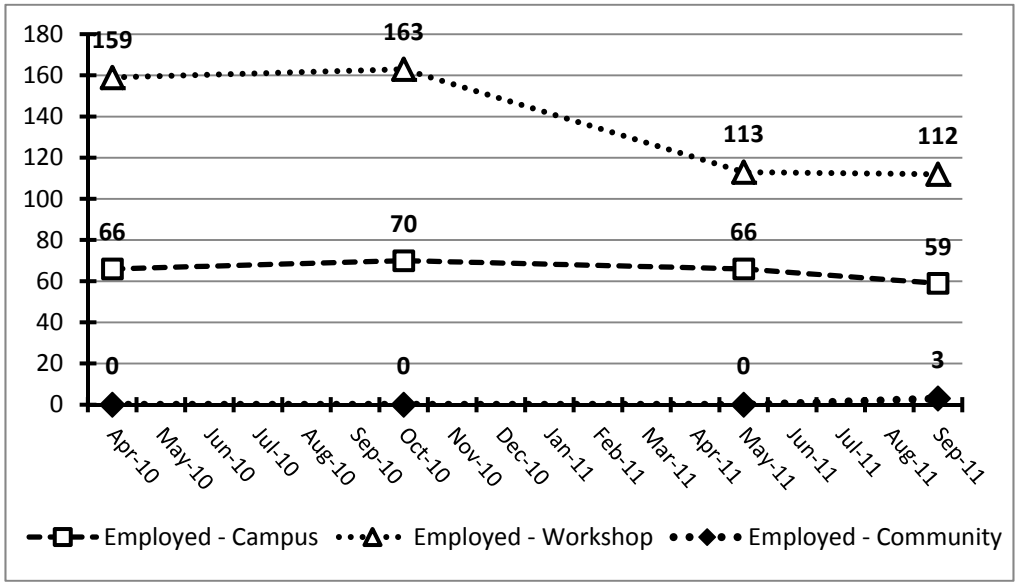
		trained in teaching methods.	
	(b) Include to the degree practicable training opportunities in community settings.	Prior to the last compliance visit, RSSLC had not obtained employment in the community for any individuals living at the Facility. In addition to the lack of community employment, the Facility had provided progressively fewer on-campus employment opportunities. At the time of the current site visit, employment had dropped to 59 individuals employed on campus and 112 in workshops. Since the last site visit, however, three individuals had been provided employment in the community. Although a low number of jobs were available in the community, the Facility had demonstrated progress in this area.  The Facility provided 452 pages of raw data pertaining to community outings. The Facility did not provide any summaries of the community outing information. As a result, the volume of raw data prevented assessment of progress in this area, and there was no evidence the Facility reviewed trends in outings or identified actions to increase outings. The Facility also provided 898 pages of narrative information pertaining to community training, including memos, PSPs, and lists of participants. No training data were provided. Due to the volume of material and the lack of actual data, it was not possible to assess progress in this area, and there was no evidence the Facility reviewed trends in	Noncompliance

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		outings or identified actions to increase training during outings.	

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

1. The continuation of efforts to enhance skill acquisition programs was welcome. In order to ensure that these efforts produce measurable benefits, it is recommended that RSSLC take steps to enhance the ability of staff to implement training programs in all settings, and refine efforts to monitor program implementation. (Provision S3a)
2. Ensure that all training programs reflect an evidence-based 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 inclusion of specific instructions for training preparation and implementation. (Provision S1)
3. Ensure that assessments are conducted as required and are used to produce adequate skill acquisition programs. (Provision S2)
4. Aggressively act to develop and maintain community employment opportunities for individuals living at the Facility. (Provision S3b)

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), updated 10/1/11 2. RSSLC Settlement Agreement Status Update, dated October 2011 3. Section T Presentation Book 4. Draft DADS Policy 018: Most Integrated Setting Practices, undated 5. DADS Policy 004: Personal Focus Assessment, dated 09/01/11 6. RSSLC Policy G.6 Admitting/Moving Individuals: Community Movement, Revised 08/11/11 7. RSSLC Policy G.5 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement, Revised 08/11/11 8. RSSLC Policy G.5 Admitting/Moving Individuals: Community Exposure, Revised 08/11/11 9. RSSLC Policy G.6.1 Admitting/Moving Individuals: Post Move Monitoring, Revised 08/11/11 10. RSSLC Policy G.12 Admitting/Moving Individuals: Alternate Discharge, Revised 10/24/11 11. RSSLC Policy G.8 Withdrawal of Referral for Community Movement 8/11/11 12. RSSLC Policy G.9 Placement/Program Review Team (PRT) 8/11/11 13. Community Integrated Discussion Record, revised 03-2010 14. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 15. Since last on-site review, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge" 16. Since last on-site review, a list of all individuals who have died after moving to community living 17. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 18. A list of 404 individuals who were reported to have been assessed for placement for the period between 9/23/10 and 9/23/11, date of assessment, and resulting recommendation(s) 19. Community Placement Report, dated September 26, 2011 20. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 21. Report Update for Obstacles to Community Transition, dated August 2011 22. Community Placement Obstacles from 5/1/2011 to 9/30/2011, dated September 30, 2011 23. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 24. Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) Worksheets for 28 individuals: Individuals #70, #120, #133, #145, #150, #160, #161, #164, #181, #216, #254, #264, #275, #283, #302, #346, #369, #389, #470, #487, #523, #635, #644, #661, #680, #693, #694, and #745 25. Personal Support Plans (PSPs) and Personal Focus Assessment (PFA) for Individuals #16, #58, #70, #160, #440, #540, #632, #680, #746, and #747

	26. Completed CLDPs for four Individuals #12, #36, #355, and #671 27. Partial CLDPs for four Individuals #290, #531, #662, and #800 28. Pre Move Site Reviews for Individuals #12, #36, #167, #355, #455, #583, and #671 29. MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #36, #355, #583, and #671 30. CLDP Tracking tools used by the Transition Coordinator 31. Completed Post Move Monitoring (PMM) checklists for Individuals #12, #36,#246, #252, #281, #285, #355, #439, #455, #547, #557, #583, #671, and #691 32. Record Reviews for #51, #113, 124, #531, and #579 **People Interviewed:** 1. Cynthia Newton, Transition Coordinator 2. Carol Agu, QDDP Consultant 3. Terri Carter, Post Move Monitor 4. Joan Poenitzsch, Director of Quality Assurance 5. QDDP and Social Worker for Individual #113 6. PST for San Antonio 7. PST for Individual #51 **Meeting Attended/Observations:** 1. PSPs for Individuals #51, #60, and #156 2. PFA for Individual #579 3. CLDP for Individual #124 4. Post-Move Monitoring Visit for Individual #671 5. Human Rights Committee
	Facility Self-Assessment: The Monitoring Team reviewed the RSSLC POI. For the most part, the POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide details as to the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. **For Provision T1**, the Facility indicated it was in compliance with only one component of this Provision, T1h, which requires the issuance of a Community Placement Report. The Monitoring Team concurred with this assessment. 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 this provision. These included revisions of a number of transition related policies and procedures to reflect changes being made to statewide policies; providing ongoing training and information sessions for Facility staff on most integrated setting topics, including training for QDDPs on Living Options; development of tracking by the Transition Coordinator for certain CLDP benchmarks; and development of an annual Obstacles Report. The POI further indicated the Facility had plans to report obstacles data to its QA/QI Council, train staff to use the

	database and develop a Facility plan as needed to address identified obstacles. These latter action steps had not yet been started, but should provide an opportunity for the Facility to effectively use data to guide its POI and measure progress. The POI also stated that identifying barriers to individuals living in the community had been completed for all individuals and action plans were being implemented. The Monitoring Team did not find this to be an accurate assessment, as described below under Provision T1b1, in which examples of the failure to adequately address obstacles are provided. **For Provision T2**, RSSLC stated it was not in compliance with the PMM process and the Monitoring Team concurred. The Facility reported two Action Steps completed since the last Monitoring visit, including development of a back-up plan in the event of the absence of the Post-Move Monitor and weekly meetings between the Transition Coordinator and Post-Move Monitor to review PMM and identify any related issues for follow-up. **For Provision T3**, no rating was required. **For Provision T4**, the Facility indicated no rating was required, as there had been no alternate discharges.
	Summary of Monitor's Assessment: This Section was found to be not in compliance overall. The Monitoring Team found the Transition Coordinator and Post-Move Monitor demonstrated a strong commitment to facilitating the ability of individuals to move to an appropriate integrated setting in a manner that promoted safety and good adjustment. Significant deficits in the Facility's assessment processes continued to hamper these efforts to develop and implement adequate transition planning. This remained a matter of substantial concern to the Monitoring Team. **For Provision T1**, the Facility indicated it was not in full compliance with many of the components for this provision. It did report it had achieved compliance in the issuance of a Community Placement Report under Provision T1h. The Monitoring Team concurred with these assessments. The Facility had continued to focus significant attention on community transitions, and had 27 active referrals at the time of this site visit. There should be consideration given to providing additional staff support to the office of the Transition Coordinator to manage a projected high number of transitions, both in the planning and implementation of the CLDP, but also in the potential increase in the workload of the Post-Move Monitor. The Transition Coordinator had implemented a tracking system for several CLDP and transition-related benchmarks, including the 45-day assessments, trial visits and timeliness of PMM visits, which was a positive step, but the Facility should evaluate whether more than a tracking system is needed in the way of resources to support the requirements to effectively manage this many transitions. RSSLC had recently developed or revised a significant number of policies related to transition; however, the Monitoring Team found many instances in which the requirements of the statewide and local policies were not yet being implemented as required. The Monitoring Team found many instances in which the PST failed to identify in each individual's PSP the protections, services, and supports that needed to be provided

	to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. The Monitoring Team was able to identify some examples of thoughtful PSPs in which the PST adequately addressed supports, services and obstacles and then developed corresponding strategies, and this represented at least a measure of progress. The Monitoring Team also commends the creativity of some of the newer approaches taken by the Facility toward promoting education and awareness of community living options and encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. Overall, RSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness, but there were practices which could significantly enhance awareness for individuals. For example, staff had accompanied individuals to visit friends and ex-roommates who had moved to the community from RSSLC. This was a particularly commendable practice, as it not only promoted the maintenance of relationships, but also presented community living in a context that would be more meaningful to individuals. **For Provision T2**, the Facility reported it was not in compliance with either of the sub-provisions, and the Monitoring Team concurred. The Monitoring Team found that the PMM Checklists were generally being completed in a timely manner. There was also considerable progress noted in the process used to complete the PMM Checklists. In many instances, the Post-Move Monitor had taken actions and maintained a comprehensive record that documented careful follow-up and loop closure. There were still some deficiencies noted in the process, despite the overall diligence and attention to detail. There were some instances in which supports were not adequately documented in the PMM Checklists reviewed, and during the PMM visit observed, the Monitoring Team found it necessary to prompt the Post-Move Monitor to observe for the presence of certain supports, as well as to act with immediacy regarding a situation with potential for harm to the individual. It was reported that DADS State Office personnel would soon begin external validation for the PMM process. The Monitoring Team commends this initiative and looks forward to reviewing its implementation at the next site visit. **For Provision T3**, no rating was required. **For Provision T4**, no rating was completed as the Facility reported it had no alternative discharges during the monitoring period.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for	This provision was found to be not in compliance. The Facility had continued to focus significant attention on community transitions. RSSLC reported seven individuals had	Noncompliance

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	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.	transitioned to the community in the past six months. This was slower pace than the reported 15 placements during the previous six months; however, the Facility also reported 21 new referrals from PSTs since the last monitoring visit, which resulted in 27 active referrals. No one had returned after moving to the community, nor had any deaths occurred for individuals who had moved to community living within the past six months. Two deaths had occurred for individuals who had moved from RSSLC, but both individuals had moved in 2009 and their deaths were reported to be from natural causes that would appear to be unrelated to deficiencies in transition practices. 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 integrated settings appropriate to their needs. Examples included: • The Transition Coordinator provided training to QDDPs on the process for documenting PSPAs for most integrated setting activities such as trial visits, PMM follow-up and the CLDP Summary. • The Transition Coordinator provided training to PST members on most integrated setting and obstacles thereto. • The Facility developed a Community Exposure Committee to develop a more comprehensive approach to community living awareness. • The Facility developed a cross-discipline PSP/PST Committee to address enhancement of the quality of PSPs. • QDDPs attended Q Construction training to enhance their skills as facilitators for PSP meetings and were evaluated for competency. Although all of the current QDDPs had been assessed as competent by the Facility, the Monitoring Team did not find this to be the case. Refer to Provision F1a for further detail and recommendations. The Monitoring Team commends these activities and initiatives. As detailed in the rest of this Section T and in Section F above, however, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 F2ab, and T1b1); education for community awareness (see Provision T1b2); and transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not be said to be effectively assisting and encouraging individuals to move to the most integrated setting yet. As just one example, the Monitoring Team found Individual #113 had expressed a desire to move to the community and be more independent on many occasions. His most recent PFA documented several key statements in this regard. Individual #113 had also had several unauthorized departures from the Facility, including one on 8/12/11, in which	

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		he stated he did not want to live at RSSLC. Following this event, the PST held a team meeting with the individual and guardian. The PSPA stated the guardian agreed to an alternative placement for the individual, and planned to check out options closer to home. The PST was in agreement with this. No referral was generated and no meeting was held with the Designated MRA. The Transition Coordinator was not informed of these developments by the PST. The Monitoring Team interviewed the individual's social worker and QDDP. There was only one documented contact with the guardian since 8/18/11, which took place on 10/21/11, in which the guardian indicated the other family members felt RSSLC was the best living option for the individual at the time. This was a lost opportunity for advocating for the individual to move to the most integrated setting appropriate to his needs. The Monitoring Team encouraged the Social Worker and QDDP to make additional and immediate contact with the guardian and family to pursue the possibilities for further examining community living options and identifying and addressing the specific concerns of the family in advance of the individual's upcoming PSP scheduled for 11/22/11.	
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 provision was found to be not in compliance. RSSLC had recently developed or revised a significant number of policies related to transition, including, RSSLC Policy G.6 Admitting/Moving Individuals: Community Movement; RSSLC Policy G.5 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement; RSSLC Policy G.5 Admitting/Moving Individuals: Community Exposure; RSSLC Policy G.6.1 Admitting/Moving Individuals: Posy Move Monitoring; and RSSLC Policy G.12 Admitting/Moving Individuals: Alternate Discharge. These were reported to have been revised to be consistent with changes being made to statewide policies. As noted in T1a, the Transition Coordinator had also been providing ongoing training to QDDPs and PST members as to the requirements and processes contained in these policies. The Monitoring Team found many instances in which the requirements of the statewide and local policies were not yet being implemented as required, and these are 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	This provision was found to be not in compliance. The Monitoring Team was able to identify some examples of thoughtful PSPs in which the PST adequately addressed supports, services and obstacles and then developed corresponding strategies. For example, for Individual #16, the PST had substantial concerns about the individual's safety in a community living setting due to severe PICA behaviors. These concerns were well documented in the PSP, and the PST decided the individual's appropriate most integrated setting would be RSSLC as a result. The PST then developed a well thought out series of Action Plan strategies to explore whether an appropriate community living	Noncompliance

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	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.	option could be found. The Monitoring Team found many instances in which the PST failed to identify in each individual's PSP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. Several examples follow: • For Individual #632, the PST identified the obstacle to community living was "community awareness of all choices" available to the individual. The Action Plan developed to enhance awareness, to participate in one tour and one provider fair over the course of the year, did not appear to be sufficient to result in much enhancement. There were Action Plans for off-campus activities that might also have been used to promote awareness, but there was no discussion by the PST or specific instruction in the Action Plans as to how these activities might be used for this purpose. In addition, the PST documented the family preferred the individual remain at RSSLC, but did not provide any indication as to the family's level of awareness of community living options or develop any Action Plan to address family awareness. • For Individual #632, the identification of supports and services needed in the most integrated setting was disjointed and not informative. For example, for leisure and recreation, the PSP stated the supports needed were "above stated items are needed," but it was not clear what items were being referenced. For Physical and Nutritional Management, the PSP stated "PNMP should be followed at all times," but the needs and supports for the PNMP were not included anywhere in the PSP discussion. • For Individual #440, the PST identified the limited awareness of community living options of the individual and family to be the only obstacle to community living. The PST then went on to determine the most integrated setting was RSSLC without any further rationale as to why the individual's needs could not be met in a community setting. The PST did develop an Action Plan to increase the individual's level of community awareness, but it was non-specific and not individualized to meet his needs. It did not address the lack of awareness on the part of the family. The Action Plan simply stated that the individual would be provided with opportunity to participate in a variety of activities (e.g. attending provider fairs, group home tours), and on an "as-needed" basis, but with no indication as to what would be needed to enhance his awareness. • For Individual #680, the PST determined, at the PSP meeting on 9/19/11, the best setting for the individual would be a community group home. Although it	

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		acknowledged limited experience of the individual and the mother/LAR, no Action Plans were developed. • For Individual #540, the PST identified the obstacles to community living were the LAR's reluctance for alternate placement and the individual's lack of understanding of community options. The PST did not develop any Action Plan regarding the LAR's reluctance. • For only one of three (33%) PSP meetings attended during the site visit was there a substantial discussion regarding living options.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	This provision was found to be not in compliance. 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 September 2011. Of the 28 CLOIP Worksheets reviewed, only 2 (6%) documented any discernible response. Of the remaining Worksheets, 13 indicated there was no response or that the individual did not seem to comprehend the information. For 13 (46%), the MRA Service Coordinator did not met with the individual due to LAR request or the inability to contact the LAR for permission for the meeting. This would suggest that there should be some consideration given to assessing how the process, materials and/or information should be modified to better meet the needs of the individuals. RSSLC had taken other actions to increase education and awareness about community living options over the past six months for individuals, staff and families. Examples included: • Twelve CLOIP tours of community living options had taken place and at least 35 individuals had taken CLOIP tours; • RSSLC arranged seven additional community exploration trips to community providers, with 16 individuals participating; • Staff accompanied individuals to visit friends and ex-roommates who had moved to the community from RSSLC. This was a particularly commendable practice, as it not only promoted the maintenance of relationships, but also presented community living in a context that would be more meaningful to individuals; • Fifty pre-selection visits to community living options had been made by individuals. • Preparing Facility staff to engage individuals, families and LARs in discussions about community living is another essential ingredient in the provision of adequate education of these options. The Facility also maintained documentation on the participation of staff in tours and visits to community homes, which indicated that approximately 30 staff had participated in either a	Noncompliance

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		community tour or pre-placement visit from the time of the last site visit. • RSSLC held its annual Provider Fair on October 25, 2011. The Facility was experimenting with a new approach in this area and held a Progressive Provider Fair in which provider representatives visited residences and work areas on a rotating basis throughout the morning, meeting with staff to describe their services and answer questions. This facet of the approach was particularly commendable, as it appeared to increase the knowledge and comfort level of facility staff with the viability of services available in the community for the individuals they support. The Monitoring Team commends these efforts and the creativity of some of the newer approaches to promoting education and awareness. Overall, RSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness, as described in Provisions T1, F1 and F2. 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. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision was found to be not in compliance. The Facility reported that the assessment for placement process was the Community Living Options Discussion Record (CLODR) that takes place at least annually as a part of the PSP as described in Texas DADS SSLC Draft Policy 018: Most Integrated Setting Practices, undated. The Facility provided a list of approximately 404 individuals who had been assessed for placement between 9/23/10 and 9/23/11 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 Provisions F1e, T1a, and T1b above, this did not yet appear to be the case. The ability of the PSTs to engage in critical thinking, interdisciplinary assessment and actual person-centered planning was still developing and continued to require considerable investment in staff training and mentoring. The Monitoring Team found there was no formal assessment process that included a substantive interdisciplinary evaluation and discussion.	Noncompliance

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T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	This component was found to be not in compliance overall; however, the Facility was working hard to 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 Draft Policy: Most Integrated Setting Practices 018.1, undated. The Monitoring Team reviewed the Community Placement Report, dated September 26, 2011. Of the six community placements that had occurred since June 2011, four (67%) were completed within the 180 day timeframe. According to Community Placement Report only five of the 29 current active referrals (17%) appeared to have exceeded the 180 days, most by a small margin. Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180 day timeframe will appropriately be exceeded. DAD's policy also acknowledges this and provides an avenue to apply for and receive a waiver when needed. Overall, the Monitoring Team found that timeliness was not a significant concern at this time. This is all the more remarkable given the large number of active referrals. The Monitoring Team expressed some concern as to whether staffing to manage this number of transitions effectively, efficiently and safely both in the planning and implementation of the CLDP, but also in the potential increase in the workload of the Post-Move Monitor. The Facility should consider providing additional staff support to the office of the Transition Coordinator. There were concerns related to the adequacy of the CLDPs that were developed. Some of these concerns were related to adherence to policy, such as the identification of Facility staff to ensure each prescribed support was implemented as required. Other, weightier concerns had to do with the failure by the PSTs to adequately identify the appropriate essential and non essential supports for each individual. These deficiencies are described in more detail in T1c1, T1c2, and T1c3 below.	Noncompliance
	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.	This provision was found to be not in compliance. 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 the PSTs did not demonstrate proficiency in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or the identification during the PSP planning meeting of the supports and services needed and desired in a community setting, as described in Provision T1b, Section F1c and Section F2a. Examination of this element of the	Noncompliance

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		Settlement Agreement will therefore be contingent to some degree on a positive evaluation of these items at some point in the future. The Monitoring Team attended the single CLDP meeting held during the site visit, for Individual #124. Through record review, the Monitoring Team identified significant health concerns and other needs the team had failed to assess prior to the CLDP meeting. As these discrepancies and potential problems were raised by the Monitoring Team, it became necessary for the PST to postpone the CLDP until information could be gathered to ensure adequate supports and services could be identified. Examples of the concerns identified included, but were not limited to: • The individual had a serious spinal condition with nerve impingement that had potential to result in paralysis if a fall were to occur. The individual had had increasing falls and gait deterioration over the past year. The PST did not ensure the provider was sufficiently aware of the potential for harm nor ensure strategies were developed to ensure protection, either at the Facility or for the new living environment. • The PST had not adequately assessed the individual's need for gastroenterology follow-up, as it was not aware of important information contained in the medical record. The individual had a colonoscopy with a tubular adenoma removal and no follow-up had been recommended; however, the individual's physician was unaware there had been a prior colonoscopy in 2009 with multiple polyps removed. It was not clear the recent colonoscopy had been completed with the specialist having knowledge of the previous results which, combined with the more recent results, may put the individual at increased risk for colon cancer. Because the PST was unaware of these circumstances, they were unable to adequately assess the individual's need for treatment while living at the Facility or make appropriate recommendations as to follow-up when the move to the community took place.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	This provision was found to be not in compliance. For zero of four (0%) completed CLDPs reviewed did the Facility consistently identify the Facility staff responsible 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, as the Transition Coordinator could take responsibility for ensuring the completion of essential supports and plans for non-essential supports at the time of the Pre-Move	Noncompliance

#	Provision	Assessment of Status	Compliance
		Site Visit.	
	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.	This provision was found to be not in compliance. The Monitoring Team reviewed four CLDPs that were currently in progress and found there was good documentation of the individual and family participation at times, but this was not consistent. For two of four (50%) the Monitoring Team found adequate documentation was provided to substantiate appropriate involvement of the individual and/or LAR: • For Individual #290, the individual was expected to move to the home of the Aunt/Guardian. Good documentation of involvement of the LAR was found. • Similarly, the Monitoring Team found appropriate documentation of participation by the LAR for Individual #662. There was not adequate documentation provided for the remaining two: • For Individual #531, there was documentation of participation of the individual's mother only in the initial referral process. The mother indicated she wished the individual to move home with her, but the PST identified barriers related to the mother's living environment and developed two strategies to overcome this obstacle. There was no further documentation provided regarding the mother's input even though at least three PSP addendum (PSPA) meetings were held to discuss arrangements for provider visits. It was not clear how the mother's preference or the obstacles may have been resolved in such a way that alternate planning was underway. It was also noted that while documentation was available of PSPA to plan for provider visits, there was not documentation available to indicate the PST had yet met to evaluate the individual's reactions to the visits. • For Individual #800, the individual's mother was reported to be in favor of the referral and hoped for the individual to move closer to her with a provider who could help facilitate contact, but there was no further documentation the mother was informed of or involved in the planning process. There was documentation of PSPA to plan for provider visits, but neither the mother nor the individual were noted to be involved. It was again noted that while documentation was available of PSPA to plan for provider visits, there was not documentation available to indicate the PST had yet met to evaluate the individual's reactions to the visits.	Noncompliance
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	This provision was found to be not in compliance. Obtaining updated assessments from various professionals and ensuring they are current, accurate and available at the CLDP and for the use of the selected provider is an important step. The Facility must ensure the assessments are completed and/or updated within 45 days prior to the individual's move to the community in order to be considered current. The Transition Coordinator had implemented a tracking system for the 45-day assessments, which was a positive	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual's leaving.	step. For the four completed CLDPs reviewed, 36 of 37 (97%) attached assessments, were found to have been updated within 45 days prior to the transition date. Although timeliness of the 45-day assessments had improved, assessments were still not being consistently well integrated into a comprehensive assessment in a manner that allowed for the CLDP to adequately 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. As described in Provision T1c1, the Monitoring Team identified significant health concerns and other needs for Individual #124 the PST had failed to assess prior to the CLDP meeting. The Monitoring Team did not review closed records for other individuals who had moved to the community to ascertain whether assessments completed prior to their moves accurately reflected their needs for supports and services, but the findings for Individual #124 called into question the assessment processes and findings that must form the basis for this required comprehensive 45-day assessment. The Monitoring Team interprets this requirement of comprehensiveness to include that the assessment must accurately reflect needs for supports and services, not simply that assessment documents be produced within 45 days of departure. The Monitoring Team strongly recommends the Facility take action, through policy directive, training and quality monitoring, to assure assessments are being completed in a thorough, accurate and detailed manner.	
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	This provision was found to be not in compliance. The Monitoring Team reviewed four MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan and found that these appeared to have been completed in accordance with policy expectations. RSSLC had also been completing Pre-Move Site Reviews, as required by policy. The Monitoring Team requested copies of all Pre-Move Review Site Reviews for individuals who had moved to a community home since the last monitoring visit. Reviews for seven individuals were provided for Monitor review, which was completed off-site following the monitoring visit. The Monitoring Team would have expected to have received a Pre-Move Site Review for Individual #252, but this was not included in the response to this request for all such visits. The Monitoring Team must therefore assume the Pre-Move Site Review for this individual was not completed as required, resulting in a compliance rate of 85%.	Noncompliance

#	Provision	Assessment of Status	Compliance
	supports shall be obtained by the Facility before the individual's departure from the Facility.	The seven documents reviewed 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 attestation that verified the provider is in good standing with DADS, using the DADS Quality Reporting System website, and to attach the printed verification. These were included for each of the seven (100%). The Pre-Move Site Reviews did not appear to yet be effectively used to thoroughly document the readiness of the provider and/or the new environment to support the individual. In many instances the document listed the evidence to be considered, but did not indicate anywhere whether the evidence was observed. For example: • For Individual #36, the essential supports included a listing of eight health care consultants to be available in the community, as well as that the Primary Care Physician was to be provided with information concerning the individual's medical needs. The evidence included a) CLDP/provider interview and b) letter to the physician. The Pre-Move Site Review did not document in the Comments section or elsewhere as to whether these supports were in place and what evidence was actually observed. In addition, the Pre-Move Site Reviews did not always adequately document necessary follow-up to a support that was not found to be in place. For example: • For Individual #12, the essential supports included staff trained to use the DuraGlide transfer system. The Pre-Move Review documented this support had not yet been completed, but did not provide any additional information as to the plan to ensure the support was put in place prior to the date of the individual's move.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	This provision 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 several CLDP and transition-related benchmarks, including the 45-day assessments, trial visits and timeliness of PMM visits, which was a positive step. The Monitoring Team interviewed the Director of Quality Assurance who reported the Facility had not yet begun to develop quality assurance processes for the CLDP. She noted there had been some lack of clarity about whether the Facility or DADS State Office would be responsible for this and that she would obtain clarification and begin development of quality assurance processes as needed.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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<tr><td>T1g</td><td>Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.</td><td>This provision was found not yet to be in substantial compliance. The Facility issued an Annual Report: Obstacles to Transition Fiscal Year 2011, dated August 2011. It provided an analysis of community placement obstacles, including the following quantitative findings:

<table><tr><th>Obstacle</th><th>Total</th></tr><tr><td>Lack of supports for people with significant challenging behaviors</td><td>44</td></tr><tr><td>Lack of specialized mental health supports</td><td>7</td></tr><tr><td>Ned for services and supports for persons with forensic needs/backgrounds</td><td>2</td></tr><tr><td>Need for environmental modifications to support the individual</td><td>7</td></tr><tr><td>Need for transportation modifications to support the individual</td><td>4</td></tr><tr><td>Lack of availability of specialized medical supports</td><td>10</td></tr><tr><td>Lack of availability of specialized therapy supports</td><td>43</td></tr><tr><td>Lack of availability of specialized educational supports</td><td>4</td></tr><tr><td>Need for meaningful and supported employment</td><td>2</td></tr><tr><td>Lack of funding due to an individual's legal and citizenship status</td><td>9</td></tr><tr><td>Individual's reluctance for alternate placement</td><td>152</td></tr><tr><td>LAR's reluctance for alternate placement</td><td>99</td></tr><tr><td>Other</td><td>40</td></tr></table>
For the largest category, individual's reluctance for alternate placement, the Facility provided some additional analysis which indicated the single largest reason for this reluctance was a lack of understanding of community living options. Center strategies and actions to overcome or reduce this obstacle, or others, were not specific to the obstacle, but rather were a general statement of the PSTs' responsibilities to identify and address obstacles. The Facility should develop or propose specific strategies for those</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		obstacles it considers the most prevalent or most significant. For example, reluctance to consider community living as a result of a lack of understanding of community living options should be addressed with development of an individualized education/awareness strategy for each individual, as recommended in T1b2. The availability of data, and the selection of an issue to analyze, were an indication the Facility is addressing obstacles to movement to more integrated settings. This provision requires DADS to use the information to take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs. Information about such actions was not yet available and provided to the Monitoring Team by the Facility. The Monitoring Team is aware that DADS is addressing this. DADS should ensure that specific strategies related to prioritized obstacles are developed and implemented. Once this information is provided to the Monitoring Team, this provision may be found in substantial compliance for RSSLC.	
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	This provision was found to be in substantial compliance. The Facility issued a Community Placement Report on September 26, 2011, covering the period of 9/1/2010 – 9/26/2011. The report was in the standardized format as prescribed by DADS State Office. It listed: • Seven community placements • Twenty-nine current referrals • Four rescinded referrals • Four individuals who preferred community, not referred-LAR choice • Zero individuals who preferred community, not referred-other reason • Zero individuals for whom the LAR prefers community, not referred. As described in Provision T1a, the Monitoring Team found that there was at least one individual (Individual #113) who the PST had determined community living to be the appropriate most integrated setting, but who had not been referred; the individual was not listed on the Community Placement Report. The Facility needs to develop a means to ensure the accuracy of the information in the Community Placement Report. Nevertheless, the Facility was in substantial compliance with this provision, as it had provided the report and included all categories required.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, 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 provision was found to be not in compliance. The Monitoring Team interviewed the Post-Move Monitor and reviewed the PMM checklists for fourteen 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. There was also considerable progress noted in the process used to complete the PMM Checklists. In many instances, the Post-Move Monitor had taken actions and maintained a comprehensive record that documented careful follow-up and loop closure. While the Monitoring Team found that the Post-Move Monitor was generally diligent in checking supports that were to be provided, there were some instances in which supports were not adequately documented. One example of this was that question 12, which asks if medical and other specialty appointments were kept, consistent with the individual's CLDP, was consistently not completed in the PMM Checklists reviewed. This appeared to be an oversight related to using a pre-filled template. While the use of such a template appeared to be an attempt to ensure follow-up on items from a previous visit, it may be prudent to use a template that does not have the boxes for #3-12 pre-filled. There were some other occasions in which no documentation was entered in a support category. Examples included: • For Individual #547, the 45-Day PMM Checklist on 6/23/11 did not have any entry in the support for Religion, which had also been left blank in the 7-Day Checklist. • For Individual #36, there was no entry by the Post Move Monitor for the essential Health supports.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There were instances found in which the Post Move Monitor noted that a nonessential support was not due or in place at a 7-Day visit and that follow-up would take place at the following 45-Day visit. The Post Move Monitor did not obtain and document the plan for putting those non-essential supports into place. This should be accomplished as a rule, but is particularly important when supports need to be put into place between the 7 and 45-Day visits. An example of this issue may be found in the 7-Day PMM Checklist for Individual #36, which took place on 6/29/11. The individual had social and leisure supports that were to begin on 6/24/11 and be ongoing. The 7-day notation indicated only F/U at 45 day visit with no plan described as to how the supports would be provided in the interim. As described in Provisions F 1c, F1d, F2, and T1c1, there also continued to be some barriers to thorough PMM review as a consequence of the failure of the PSTs to adequately assess the needed supports of individuals either at the Facility or in the community. The PSTs also did not yet provide adequate direction to the Post-Move Monitor as to the evidence required to accurately ensure the presence of essential and non-essential supports. For example, in many instances the PSTs continued to indicate the evidence required to verify essential supports related to training were to be only a training roster. The PST should clearly state the necessity to interview and observe for staff compliance and knowledge in addition to the paper review of a training roster.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	This provision was found to be not in compliance. The Monitoring Team accompanied the Post Move Monitor on a 90-day PMM visit for Individual #671 on 10/27/11. 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. There were still some deficiencies noted in the process, despite the overall attention to detail. During the PMM visit observed, the Monitoring Team found it necessary to prompt the Post-Move Monitor to observe for the presence of certain supports, as well as to act with immediacy regarding a situation with potential harm to the individual. Concerns were evident in both the day program and the residence. The day program was supposed to have a blender to provide ground meats and hard vegetables according to the CLDP. In interview with the day program staff, it was noted that food had been prepared and served that day by day program staff. When the Post-Move Monitor appropriately inquired about whether the diet texture was being followed, the day program staff seemed unaware of the requirement for ground meats and hard vegetables, stating the individual was doing fine with chewing skills. The Post-Move	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitor did not take immediate action at that time to verify the diet status, nor did she request to observe the required blender until the Monitoring Team prompted that this would be necessary. Later in the day, the Post-Move Monitor visited the residence of the individual. When questions were posed to the staff person, who was new since the 45-Day visit and did not seem to be fully aware of the individual's plan, it was revealed she was also not aware of the requirement for ground meats and hard vegetables; further she reported meats were cut into fine pieces. When supervisory provider staff arrived, the Post-Move Monitor appropriately questioned them about the diet texture. The response was that the provider team had met and made a decision to change the texture because the individual seemed to do fine with chewing if she was encouraged to eat slowly. The supervisory staff showed the Post-Move Monitor documentation of the meeting in which this decision was made. There were no team members at the meeting with clinical expertise related to appropriate diet texture nor were any assessments completed by appropriate clinicians to inform this decision. The only health care professional represented was an LVN. The Post-Move Monitor did not at that point engage the supervisory staff in a discussion related to lack of any clinical justification for the change in diet texture or the potential dangers to the individual. Upon leaving the residence, the Monitoring Team asked the Post-Move Monitor what her next actions would be, especially given this was the 90-Day visit. She replied appropriately that she intended to follow-up to ensure the new staff person was fully inserviced on the individual's needs. When questioned as to any further actions she might take, the Post Move Monitor indicated none came immediately to mind but that she would need to think about it. After several moments, the Monitoring Team raised the issue of the diet texture and the Post-Move Monitor indicated she realized this was a significant issue and would plan to contact the appropriate staff at the Facility to follow-up. After allowing several more minutes for the Post-Move Monitor to provide any additional response, the Monitoring Team brought up an awareness that an adverse event had occurred for an individual who had moved from another unnamed facility when provider staff did not provide the correct diet texture. At that point, the Post-Move Monitor staff notified the Transition Coordinator by telephone, who then took immediate and appropriate action to ensure the protection of the individual. As described herein, it was not clear how long it may have taken for the appropriate protective action to be implemented without prompting from the Monitoring Team. It is recommended the Post-Move Monitor *immediately* report to the Transition Coordinator and the PST any deviation from the CLDP by the community provider during the 90 day post move monitoring period, and request guidance. While the Post-Move Monitor cannot be expected to have clinical expertise in all areas, it is essential that all	

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		deviations be evaluated by someone who does have that expertise. Community providers may at times appropriately make changes to supports and services, but should have adequate evaluation and justification. The individual's Facility PST must also serve during the critical 90-Day post-move period to ensure that adequate personal knowledge of the individual is factored in to decisions made by the community provider. It was reported that DADS State Office personnel would soon begin external validation for the PMM process. The Monitoring Team commends this initiative and looks forward to reviewing its implementation at the next site visit.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
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;	This provision was not rated. The Facility reported it had had no alternate discharges during this monitoring period. The Transition Coordinator was working to develop a local policy and procedure on alternate discharges and provided a draft copy for the Monitoring Team to review. This appeared to be consistent with CMS requirements as well as the guidance provided in Draft DADS Policy 018: Most Integrated Setting Practices, undated.	Not Rated

#	Provision	Assessment of Status	Compliance
	(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.		

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

1. 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. (Provision T1b2)
2. Ensure timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Provision T1f. Quality assurance processes should be undertaken focusing on whether an adequate and reasonably intensive exploration and development process is taking place, including the collection of data regarding the number and types of community exploration activities undertaken for each individual on the list of current referrals. (Provisions T1b1, T1d, and T1f)
3. The Facility should consider providing additional staff support to the office of the Transition Coordinator to manage a projected high number of transitions, both in the planning and implementation of the CLDP, but also in the potential increase in the workload of the Post-Move Monitor. (Provision T1c)
4. The Facility should take action, through policy directive, training and quality monitoring, to assure assessments are being completed in a thorough, accurate and detailed manner. (Provision T1b)
5. The Facility should obtain clarification regarding responsibility for quality assurance processes related to the CLDP and begin development of these processes as needed. (Provision T1f)
6. DADS should ensure that specific strategies related to prioritized obstacles are developed and implemented. (Provision T1g)
7. The Facility needs to develop a means to ensure the accuracy of the information in the Community Placement Report. (Provision T1h)
8. The PST should clearly state the necessity to interview and observe for staff compliance and knowledge in addition to the paper review of a training roster during a PMM visit. (Provision T2a)
9. The Post Move Monitor should obtain and document the plan for putting non-essential supports into place at each visit in which the supports are not yet completed or in place. (Provisions T2a and T2b)
10. The Post-Move Monitor should immediately report to the Transition Coordinator and the PST any deviation from the CLDP by the community

provider during the 90 day post move monitoring period, and request guidance. (Provision T2b)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Richmond State Supported Living Center (RSSLC) Plan of Improvement (POI), updated 10/1/11 2. RSSLC Settlement Agreement Status Update, dated October 2011 3. Section U Presentation Book 4. Prioritized list of 404 individuals with guardianship status, date 10/1/11 5. List of three individuals for whom a guardian had been obtained in the last six months 6. DADS draft policies, undated: Guardianship; Advocate; Self-Advocacy; Affirming and Protecting Rights 7. Rights Assessments for Individuals #70, #199, #363, #599, #646, #740, #747 8. Signature sheets for New Employee Orientation for the past six months 9. Minutes of Self-Advocacy meetings held for the past six months **People Interviewed:** 1. Jim North, Human Rights Officer (HRO) **Meeting Attended/Observations:** 1. PSP for Individual #51 2. Human Rights Committee (HRC) Meeting
	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 statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the Settlement Agreement were still pending final issuance and that it was awaiting this final guidance prior to developing local policies. 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, RSSLC reported it continued to update the priority list on a monthly basis as changes occurred, to provide training to new employees during orientation and to support individuals to take part in self-advocacy activities both within the Facility and in concert with community-based groups.
	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. **Provision U1:** This provision was determined to be not in compliance. The Facility maintained a prioritized list of individuals with guardianship status, with the prioritization criteria remaining the same as in the previous visits. The list was currently undergoing a thorough review. The PSTs did not currently

	adequately assess decision-making capacities nor develop appropriate action plans to address deficits. The Facility reported its PSTs did not use 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. Pending statewide policies on Guardianship, Advocacy and Affirming and Protecting Rights, at least in the draft forms made available for review, addressed the assessment and prioritization processes,. In particular, the pending policy on Affirming and Protecting Rights significantly revised the assessment process to be used for determining capacity to give informed consent. This was a positive step. Once this policy is promulgated, Facility PSTs will need training from DADS regarding how the revised assessment should be accomplished and how to use the results to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. DADS may also want to review the somewhat differently worded instructions for prioritization it gives in the draft policy on Guardianship on page 4 under Guardianship list and in number 5 of Exhibit A to ensure a consistent process. The HRO had continued 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. The Facility also continued to provide substantial supports for self advocacy, but is encouraged to engage the members in a more formal and purposeful decision-making curriculum as a next step in promoting their ability to effectively participate in making important decisions about their lives. **Provision U2:** This provision was determined to be not in compliance. Three new guardians had been obtained during the past six months, but little organized effort had been undertaken as the Facility awaited the new policies. The pending policy on Guardianship would designate the HRO as the Facility's Guardianship Coordinator and would establish a Guardianship Committee. This draft of the policy should more clearly state the role of the Committee in assisting individuals to obtain guardians. The HRO reported the Committee would not be established until the final statewide policy was available, but he had engaged in some outreach toward potential members.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking	This provision was found to be not in compliance. It was reported by the Facility that 55% of individuals living at RSSLC had a legal guardian. The Facility provided a prioritized list of individuals with their guardianship status. There were 404 names on the list, and the Facility census was reported to stand at 376, so it would seem there must be some duplicates or perhaps names of individuals who have moved and not yet been removed from the list. The HRO noted that DADS State Office had recently directed the Facility to obtain a current status and clarification of recommended guardianship need from each individual's PST which would be used to further update the list. This process was currently underway. The HRO reported the Facility continued to use the same prioritization criteria as at previous site visits until new statewide policies were	Noncompliance

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	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.	finalized. 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 currently adequately assess decision-making capacities nor develop appropriate action plans to address deficits. The Facility reported its PSTs did not use 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, and the Monitoring Team concurred. For example, Individual #51 was verbally fluent and able in the PSP meeting to clearly express preferences and exhibited at least some capacity to understand consequences and take part in her own treatment. However, when completing the Rights Assessment, the PST responded to each of the seven categories of informed consent by a blanket "needs assistance." There was no discussion about what levels of assistance might be needed or what types of support might be provided to facilitate her participation in the decision-making. A review of six other completed Rights Assessments found none (0%) in which the PST indicated it had carefully assessed each category of informed consent in a discrete manner or with a formal tool for this purpose. RSSLC did not yet 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. There were, however, statewide draft policies and procedures available to review. It was not known when these policies would be finalized, and the Facility was waiting for final policies before localizing the requirements. The statewide drafts included policies on Guardianship, Advocate, Self-Advocacy and Affirming and Protecting Rights. The most relevant of the draft policies to provision of guidance to the PSTs in assessing the decisional capacity of individuals was Affirming and Protecting Rights. This policy included a revised version of the Rights Assessment that had a greatly expanded section on the evaluation of an individual's capacity to give or withdraw informed consent. This was a positive step. Facility PSTs will need training from DADS to prescribe a process for how the assessment should be accomplished and how to use the results to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. The Facility should consider additional resources regarding decisional capacity, which exist nationally, that may further inform and amplify the development of training. A sampling of such resources include:: • *Decisions By and For People with Mental Retardation: Balancing considerations of Autonomy and Protection*, James W Ellis; • *Decision-Making Capacity in Adults: Its Assessment in Clinical Practice, Bellhouse,* et al;	

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		• *Alternatives to Guardianship* on-line training found at maine.gov/guardianship, which provides additional assessment documents; and, • A variety of resources found at guardianship.org In addition, the pending statewide policy on Guardianship provides instructions as to the prioritization criteria to be used in considering the need for guardianship and designating a priority status for each individual. DADS may want to review the somewhat differently worded instructions for prioritization it gives in the draft policy on Guardianship on page 4 under Guardianship list and in number 5 of Exhibit A to ensure a consistent process. The HRO continued to provide training on guardianship and advocacy at New Employee Orientation. This training 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 sensitivity of the PST members to the issues, and the thoughtfulness of deliberations of the PST when they are considering the need for guardianship. Over the course of six months, the training had been provided to approximately 90 new employees. The Facility should consider how it might make this training available to incumbent PST members as well. The Monitoring Team noted RSSLC continued to provide substantial supports for organized self-advocacy, which was to be commended. In addition to providing support for regular meetings at the Facility, individuals from RSSLC also attended the 2011 Texas Advocates Conference in August 2011. The pending statewide Self-Advocacy policy designated the HRO to serve as the Self-Advocacy Coordinator for the Facility. The HRO was already actively engaged in many of the requirements of this pending policy. The Monitoring Team reviewed the minutes of six Self-Advocacy meetings held since the last monitoring visit and recommends that Facility consider obtaining and implementing a formal choice-making/self-advocacy curriculum that would foster the abilities of individuals to participate in meaningful decision-making about their lives. There are many good examples of such curricula for individuals with intellectual disabilities that may be adapted for use by the Facility. For example, the California Department of Developmental Services has developed a number of consumer-friendly publication and workbooks that may be useful. These can be viewed and downloaded at http://www.dds.ca.gov/ConsumerCorner/Publications.cfm.	
U2	Commencing within six months of the Effective Date hereof and with	This provision was determined to be not in compliance. RSSLC had not undertaken any significant actions toward soliciting guardianship for individuals during the past six	Noncompliance

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	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.	months as it awaited the issuance of statewide policies. Since the last monitoring visit, three individuals had obtained new guardians and two of these were successor guardians for individuals who had already been adjudicated incompetent. The draft statewide policy designates the HRO as the Guardianship Coordinator for the Facility. According to the draft statewide Guardianship policy, a Guardianship Committee is also to be developed that is responsible for developing, prioritizing and maintaining a list of individuals who do not have either the functional capacity to make decisions regarding their own health or welfare or an existing LAR to make such a decision. Other responsibilities or requirements found in the Guardianship policy include meeting regularly to discuss guardianship needs at the center and maintain meeting minutes that include: requests for guardianship services, the date of the meeting, members in attendance, items reviewed and decisions made. It was unclear in the body of the policy whether the Guardianship Committee was expected to somehow act on requests for guardianship services, other than in developing and maintaining the prioritized list; however, Exhibit A explicitly stated the Guardianship Committee's role included assisting individuals to obtain guardians. It is recommended the policy more clearly list each of the actual responsibilities of the Guardianship Committee. The HRO reported he has made some outreach to potential participants or this committee, including members of the community with legal and/or guardianship expertise, but did not plan to formally constitute this committee until the pending statewide policy was finalized. 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 as described above in U1. DADS should provide this guidance in the formal promulgation of policy as soon as possible.	

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

1. DADS should provide guidance as to the fulfillment of the requirements for Provision U through the formal promulgation of policies as soon as possible. Once received, RSSLC should quickly develop and implement local policies.
2. The pending statewide policy on Guardianship should more clearly list each of the actual responsibilities of the Guardianship Committee
3. DADS should review the somewhat differently worded instructions for prioritization it gives in the draft policy on Guardianship on page 4 under Guardianship list and in number 5 of Exhibit A to ensure a consistent process.
4. The Facility should make Guardianship training for new employees available to incumbent PST members as well.

The following are offered as additional suggestions to the Facility:

1. The Facility should obtain and implement a formal choice-making/self-advocacy curriculum that would foster the abilities of individuals to participate in meaningful decision-making about their lives. Examples may be found at http://www.dds.ca.gov/ConsumerCorner/Publications.cfm.
2. The Facility should consider additional resources regarding decisional capacity, which exist nationally, that may further inform and amplify the development of training. A sampling of such resources include::
   - *Decisions By and For People with Mental Retardation: Balancing considerations of Autonomy and Protection*, James W Ellis;
   - *Decision-Making Capacity in Adults: Its Assessment in Clinical Practice, Bellhouse,* et al;
   - *Alternatives to Guardianship* on-line training found at maine.gov/guardianship, which provides additional assessment documents; and,
   - A variety of resources found at guardianship.org

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Plan of Improvement (POI) dated 10/10/11 2. RSSLC Status Update presentation dated October 2011 3. RSSLC Presentation Book for Section V 4. List of SSLC Policies 10/11/11 5. List of all new & revised State & Facility policies implemented since the last compliance visit (5/02/11) 6. DADS Policy 020.1 Recordkeeping Practices 3/05/10 7. DADS Policy 010.1 Nursing Services 5/11/11 8. DADS Policy 044.2 Emergency Response 9/7/11 9. DADS Policy 053 Medication Variances 9/23/11 10. RSSLC Policy A.6 Recordkeeping 9/23/11 11. RSSLC Policy A.28 Quality Assurance Plan 10/11/11 12. RSSLC Policy C.01 Incident Management 8/1/11 13. RSSLC Policy C.02 Protection from Harm-Abuse, Neglect, and Exploitation 5/11/11 14. RSSLC Policy G05 Recommending and Choosing a Provider for Community Movement 8/11/11 15. RSSLC Policy G.5 Community Exposure 9/11/11 16. RSSLC Policy G06 Community Movement 8/11/11 17. RSSLC Policy G06.1 Post Move Monitoring 8/11/11 18. RSSLC Policy G08 Withdrawal of Referral for Community Movement 8/11/11 19. RSSLC Policy G09 Placement/Program Review Team (PRT) 8/11/11 20. RSSLC Policy I.00b Nursing Services 9/15/11 21. RSSLC Policy I.00d Psychiatry Services 8/30/11 22. RSSLC Policy I.00e Pharmacy Services 10/10/11 23. RSSLC Policy I.29 Integrated Clinical Meeting undated 24. RSSLC Policy J.1 Use of Restraint 9/29/11 25. RSSLC Policy J.6 Psychological and Behavioral Services 9/29/11 26. Emails notifying staff of policy revisions for RSSLC Policies and procedures A.06, C.01, I.00d, I.18, and I.28, and deletions of several policies 27. RSSLC Active Record Order & Guidelines (AROG) 28. RSSLC Master Record Index/Table of Contents revised 8/2/11 29. RSSLC Individual Notebook Equivalent listing where documents can be found, revised 9/21/11 30. Active Record, Master Record, and Group Notebook for Individual #480 31. Active Records for Individuals #672 and #773 32. Group Data Book including Individuals #315, #531, and #800 33. List of names of individuals selected for validation audits for September 2011 34. Procedure: Monitoring Documentation Done by New Employees after New Employee Training (NET) and On-the-Job Training 8/4/11 35. Curriculum materials used for Recordkeeping training, including example observation notes

	36. Blank record audit tools, including: • Settlement Agreement Cross Referenced with ICF-MR Standards Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 (formats with and without instructions) • RSSLC-Active Record Review • Settlement Agreement Provision V.4-Tool for use of the Record 37. Section V. Recordkeeping process and unit monitoring schedule 38. Unit Random Sample Lists for audits to be conducted in October 2011 39. Section V Trend Analysis Report, Date Range: 5/1/11-8/31/11 40. Outline, power point slides, and sign-in sheets for a Recordkeeping Corrective Action Plan inservice training session held 10/3/11 41. Integrated Program Monitors Work Group Meeting Minutes 5/17/11, 8/3/11, 9/26/11, and10/13/11 42. PSP Discipline's Assessment Tracking Log 5/1/11-9/12/11 43. PSP Disciplines' Assessments Tracking Log for PSPs scheduled for 10/24/11-11/2/11 44. Outline of presentation to Unit Directors and other disciplines at unit Morning Meeting of 5/17/11, 5/19/11, and 5/20/11 describing the Interview Tool for use of the Record 45. Interview Tool for use of the Record for Individuals #248 and #680 46. List of individuals who had been admitted, died, or transitioned to community 5/1/11-10/14/11 **People Interviewed:** 1. Group interview of Wanda Hartensteiner, Medical Records Director, and Unified Records Coordinators (URCs) Tracy Stafford and Susan Steamer 2. Joan Poenitzsch, Director of QA, and Brenda McClendon, Program Auditor 3. Group interview of Program Monitors Suzy Royer, Adelia Pavliska, and Andrea Faniel 4. QDDPs Lenin Mathews and Cornesia Foster 5. Active Treatment Instructor Leon A Classroom 6. Residential Coordinator San Antonio B **Meeting Attended/Observations:** 1. Special risk meetings with PSTs for Individuals #58 and #680 2. QA/QI Council 10/25/11 3. Neches day program and Leon A classroom 4. PSP for Individual #60
	Facility Self-Assessment: The Facility reported it was not yet in compliance with any of the provisions of this Section. The Monitoring Team concurs. The Facility reported a number of action steps taken to lead toward compliance. Review of documents, including the Presentation Book and Unified Records of several individuals confirms that the reported actions had been implemented. With a few exceptions, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide many details as to the Facility's self-assessment processes, but rather listed actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may more fully use its internal quality assurance processes, including the development of

	additional measures, to assess ongoing progress toward completion and the actual outcomes. For example, the Facility had gathered a great deal of data from its audits of records; these data could be used to report on the effectiveness of actions taken to improve the quality of records and of the current status of the Unified Record. The Presentation Book, while also primarily listing actions that had been taken, provided additional detail and included evidence the Facility gathered to confirm completion of steps. This was well organized and useful not only to help the Facility know its status but also to provide information to the Monitoring Team. Actions the Facility had taken included, among many others: • Revised the AROG and adding subtabs • Established a Draft AROG on the share drive that lists new documents added to the record in between changing the hard copies in the Active Record; this was to provide instruction on where these new documents were to be filed • Notified staff of changes and providing training to new and incumbent employees • Implemented corrective action for areas of low compliance found during record monitoring • Developed definitions/criteria to be used during record monitoring in order to increase agreement between internal and external audits • Revised the audit process so clerks monitor records on a unit other than their own • Began review by URCs to check if corrective actions arising from audits were completed
	Summary of Monitor's Assessment: Although the Monitoring Team concurs with the Facility's self-assessment that it does not yet comply with any provision of this section, the Monitoring Team also recognizes the significant improvements that have occurred. Overall, the Facility had made significant progress in meeting the requirements of this Section. The Facility maintained a Unified Record consisting of an Active Record, Master Record, and an individual section in a Group Notebook. However, the Facility also had a number of other books in which documents were kept. Some of these documents could be considered part of a Unified Record, and the Facility needs to identify all components of the Unified Record so they can ensure consistency across components of the records and can include all components in the required random audits. There were still numerous errors and deficiencies in documentation, although there had been improvement. The Facility was addressing these through corrective actions arising from audits, both for specific deficiencies in individual records and systemic actions intended to improve documentation. The Monitoring Team commends the Facility for developing a system to monitor the documentation done by new employees after on-the-job training. The Facility had developed and implemented a robust audit system, although (as indicated above) it was unclear whether all components of the Unified Record were included in the audits. Corrective actions were checked by the URCs for completion; a database had been initiated that may help identify continuing errors

	that may indicate a need for systemic changes. In addition to the audits of the Unified Record, the Facility had established a tracking system to determine whether discipline assessments were posted to the share drive 10 days before annual PSP planning meetings. This system will permit tracking of whether assessments are posted in time to permit PST members to review them for information needed for integrated planning. The Facility had implemented an interview system to evaluate whether staff use the record in making decisions. Information from two sets of facility interviews and from interviews conducted by the Monitoring Team indicate that staff generally report use of records in making decisions. However, there were examples in which the PST members were unaware of information in the record or did not use it in making decisions. Both DADS and the Facility had developed or revised policies needed to meet the requirements of the Settlement Agreement. Other policies still need to be developed; drafts of some have been prepared but not finalized yet into policy. The Facility should develop a process to ensure all affected staff are aware of and understand their responsibilities for newly implemented or revised policies.

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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. The Facility did not have an Individual Notebook. Instead, documents were placed in a number of records. The Individual Notebook Equivalent listed where each document was to be filed (with most documents filed in multiple books). Documents could be filed in a Group Notebook "maintained on the home," a PNMP Notebook in the PNMP Coordinator's office, an Active Treatment Notebook, and a Monthly Flow Notebook "maintained in the aide station on the individual's home." These books included information about individuals, such as the PSP, PNMP, PBSP, data sheets, and instructions to staff. In addition, there were data sheets in dining rooms. It was unclear whether the Facility considered these to be part of the Unified Record. Records that contain information on an individual's status, including data on progress, must be treated as part of the Unified Record and included in audits of the record. The Facility must identify which of these notebooks are part of the Unified Record. 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.	Noncompliance

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		Policy for recordkeeping at the Facility was specified in policy A.6 Recordkeeping, which was revised 9/23/11. 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. At the last compliance visit, the Monitoring Team recommended 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. At that time, 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. To ensure that the record, which could serve as evidence during a review of the death, remained secure, the revised policy now states, "Upon notification of the death of an individual served, Incident Management staff secures all volumes of the individual's Active Record in the Incident management Department for a period of 10 calendar days. The record may be checked out from the Incident Management Department in order to complete required reports but must be returned to the Incident Management Department by the end of the shift of the staff member who checked it out." This was an important revision, and the Monitoring Team appreciates that the Facility implemented a thoughtful and appropriate response. Active Records were filed in two, three (most common), or 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. 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. 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 #480, #672 and #773, as well as the Master Record the Group Notebook for Individual #480. Individual #480 was selected by computerized random selection from among records audited in September 2011, so the Monitoring Team could compare its findings with those from a relatively recent audit. Individual #672 had been admitted since the last compliance visit and could provide information on the timeliness of assessments and on the condition of a record started recently.	

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		Individual #773 was selected from the list of individuals to be audited in October 2011. In addition, the Monitoring Team reviewed the Group Data Book including Individuals #315, #531, and #800. 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 (AROG). 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. The Monitoring Team completed both the review using the AROG and the audit tool titled Settlement Agreement Cross Referenced with ICF-MR Standards for Section V. Although records were generally in order and, for the most part, complete and legible, none of the Active Records reviewed met all the requirements of Appendix D and Facility policy. • For Individual #480, 79% of the documents identified as required by the Monitoring Team were present in the Active Record. The Master Record was available. The Group Notebook included seven of 10 (70%) documents listed on the Individual Notebook Equivalent sheet and relevant for the individual (two missing items from the list were related to communication, which the URCs reported are in the PNMP Notebook as listed on the sheet). Of the items on the audit tool rated by the Monitoring Team (regarding consistency with Appendix D of the SA, and evidence of falsification of records and accuracy of recordkeeping practices), the Monitoring Team identified deficiencies in completeness and consistency with the table of contents (that is, some records were out of order or in the wrong tabs) but otherwise found compliance. • For Individual #672, 83% of the documents identified as required by the Monitoring Team were present in the Active Record. Of the items on the audit tool rated by the Monitoring Team, the Monitoring Team identified deficiencies in accuracy of documents, legibility, completeness, gaps between entries, order of documents, and consistency with the table of contents. • For Individual #773, 84% of the documents identified as required by the Monitoring Team were present in the Active Record. Of the items on the audit tool rated by the Monitoring Team, the Monitoring Team identified deficiencies in legibility, current documents, completeness, gaps between entries, order, and consistency with the table of contents. In reviews throughout the report, the Monitoring Team found both examples of	

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		improvements and of problems. For example, in reviewing nursing documentation, an improvement was that the Facility had added additional tabs in the Active Medical Records for the nursing sections. This made the locating the various nursing related documents easier and more readily accessible. A problem was that several nursing related documents were not in the charts and had to be located and returned to the records. When asked, both an Active Treatment Instructor in a Leon A classroom and a Residential Coordinator in San Antonio were able to show where the group books were and to state and show what information was found in them. These books were readily accessible. On the other hand, the Residential Coordinator stated that data regarding handwashing for an individual would be found in a book in the dining room, and the Self-Administration of Medication data would be with the nurse; in both cases, the information would be accessible to staff who needed to provide and document services but would not be easily available for review. These were not listed in any of the information about contents of the Unified Record that was provided to the Monitoring Team. The Active Treatment Notebook in the Leon A classroom book included data sheets and other important information for several individuals served in that room; most documents listed in the Individual Notebook Equivalent as filed in the Group Notebook, but not communication information, were in this book, and additional information such as the Rights Assessment and Dining Plan were also in this book. Although the AROG and Individual Notebook Equivalent list provide information on where documents should be filed and located, there remained some inconsistency, such as the location of handwashing data. Furthermore, location of some documents did not make them as accessible as needed. As reported in Provision o.4, generally, the PNMP was located in the PNMP notebook that followed the individual on Leon, San Antonio, and Trinity. The PNMPs, however, on Three and Four Rivers were located in group books; therefore there was not a clear method in place to ensure the PNMPs followed individuals if they separated from their groups for activities on and off grounds. The Monitoring Team did not compare copies of data sheets, PNMPs, or other documents found in multiple books to determine whether they all were identical. As noted in Provision V.3, many of these books were not included in the audits of records, and the Monitoring Team was not informed of a process to ensure consistency of information across the locations. The Facility should make sure it has such a process, perhaps including it in the records audit process, and should provide that information to the Monitoring Team at the next compliance visit.	

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		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. Also posted to the Share drive, in addition to the assessments for the PSP, are the quarterly nursing assessment and medical consultations (following review by the physician). The Monitoring Team did not review these but supports the use of this drive to make documents easily accessible to members of the PST. In addition, another valuable use of the Share drive was to make current information available; for example, after a visit to the hospital, a hospital report was scanned into the Share drive in order to make it available to medical providers, nursing staff, and other relevant PST members. Prior to the last compliance visit, the Facility had initiated training new staff during new employee orientation and new nurses during their new nurse orientation. The Monitoring Team recommended 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. The Facility implemented this recommendation. For a sample of 20% of new employees, the URCs reviewed documentation done by the new employees after NET and on-the-job training were completed (approximately eight weeks after hire). The sample reviewed by the time of the compliance visit included five Direct Support Professionals I and one LVN II. Documentation provided to the Monitoring Team included the month of NET, the names, titles, home assignments, supervisors, findings, and actions taken. The Facility also provided an example of an email sent to one employee's supervisor describing the findings and actions, and reminding the supervisor that a follow-up review would be done in two weeks (follow-up reviews were not yet due at the time of the compliance visit, so no documentation of those could be provided). This seems to be an excellent system; the Monitoring Team will be interested in seeing the effectiveness of the system in improving documentation. The limitation of this system is that there will not be follow-up for all new employees. If the system is effective, the Facility might want to develop a process that permits review of documentation by all new employees, perhaps by using Records Clerks to expand the resource available for monitoring. Nevertheless, the Monitoring Team wishes to commend the Facility for implementing this action. The Facility had taken many actions to improve recordkeeping. Deficiencies in documentation still existed. The Monitoring Team recognizes that this process takes time to evolve and to complete improvements that will bring the Facility into compliance with this provision. Given the improvement in records and in the auditing process, the	

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		Monitoring Team expects this provision to come into compliance in the near future.	
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 is 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. Joan Poenitzsch, Director of QA, and Brenda McClendon, Program Auditor, provided information about the process of policy development, revision, and implementation. They identified two processes; the first occurs when State Office (SO) develops policies that much be operationalized locally, and the second occurs when the Facility identifies policies that need development or revision. When SO develops policies, the Facility may add to them and provide detail on specific procedures to implement them at the Facility. For example, the Facility operationalizes the policy by identify specifically who is assigned particular responsibilities. The Facility is now focusing on ensuring the facility policies include everything required in the state policy. Usually, development of new policies at the Facility begins at the department level. Departments can initiate new policies. For example, Community Relations submitted a Volunteer Pet policy. The draft comes to Brenda McClendon, who is the lead person on policy (same for policies coming from SO). She distributes the draft to appropriate staff to get feedback and ensures the feedback is provided to the person who authored the policy draft. The QA Department then edits the policy. Brenda, the Director of Quality Assurance, the Settlement Agreement Coordinator, and the Facility Director review the policy before final approval by the QA Department. The same process is true for revisions, which are usually initiated by a department or as a result of a revision of SO policy. In addition to policy drafts from departments, the Facility might develop or revise policy to address a requirement or recommendation from an external source (such as a finding from a regulatory review or the Settlement Agreement report). In that case, the QA Department QA would initiate the policy development or revision and send it to the appropriate department to take the lead on drafting (so that the experts in an area would gather info and prepare draft), or it could be assigned as part of a CAP. The Facility did not have a process for routine or periodic review of policies. The Monitoring Team recommends that the Facility establish a process of periodic review and updating of policies.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility had developed or revised numerous policies since the last compliance visit. New and revised policies relevant to implementation of this SA included: • A.6 Recordkeeping (revised 9/23/11) • C.01 Incident Management (revision date 8/1/11) and Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (revision date 5/11/11). Several policies related to abuse, neglect, and incident management were merged into these two new policies. This represents a significant improvement in that these policies are now, for the most part, aligned with DADS policies and include provisions that, if carried out effectively and consistently, should lead to substantial compliance with all provisions of Section D of the SA. • A.28 Quality Assurance Plan. The RSSLC QA Department had recently (10/11/11) approved its policy entitled A.28 Quality Assurance Plan. The language in the policy does not directly and specifically address each element of this section of the SA. Nevertheless the policy describes a set of comprehensive procedures that, when viewed in their entirety, would likely lead to compliance with this section of the SA. • G05 Recommending and Choosing a Provider for Community Movement (revised 8/11/11) • I.29 Integrated Clinical Meeting (effective 9/7/11) • J.1 Use of Restraint (revised 9/29/11) • J.02 Psychological and Behavioral Services (revised 9/29/11) • 1.00b Nursing Services (revised 9/15/11) • 044.2 Emergency Response Policy (revised 9/7/2011) • I.00d Psychiatry Services. Psychiatry Policy 1.00d (revised 08/30/2011) now makes clear how integrated care must be provided. • The Facility developed and implemented a new policy to address Pharmacists review of new medication orders, Physician Order Review By A Pharmacist policy, dated 10/20/11. The Policy clearly delineates the necessary activities to facilitate the pharmacist monitoring action of new medications, as outlined by Provision N1. Other policies continue to need development or revision. For example, at the last review it was reported that RSSLC Policy A.27 Quality Assurance/Quality Improvement Council was in draft form. This policy remains in draft form and has the stated purpose of reviewing and overseeing the facility's status in regard to: regulatory/life safety visits; annual peer audits; facility support performance and internal controls audits; and Settlement Agreement monitor visits. Since the last compliance visit to RSSLC, DADS also continued to develop and implement policy. New or revised policies included:	

#	Provision	Assessment of Status	Compliance
		• SSLC Statewide Policy 010.1 Nursing Services (effective 5/11/11) • SSLC Statewide Policy 044.2 Emergency Response (effective 9/7/11) • SSLC Statewide Policy 053 Medication Variances (effective 9/23/11) DADS was also in process of developing policies on Guardianship, Advocate, Self-Advocacy and Affirming and Protecting Rights, as described in Section T. According to the Director of Quality Assurance, to inform staff of new or revised policies, the Facility usually sent an email describing where to find the revised or new policy. When a policy is revised as a response to a plan of correction from Regulatory, per interview, the Facility reported it provided competency based training and maintained evidence of training; it will be working on an internal system of training new policies. The Monitoring Team asked for the following documentation: "For each such policy, 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, and consistent with the description by the Director of Quality Assurance, the Facility provided a number of emails sent in August and September 2011 from the Settlement Agreement Coordinator to specific departments or to a broader group of staff; each of these described a change in policy or stated where a new policy, procedure, or form had been placed (policy manual or share drive). None provided detailed information on the changes that had been made to the policy. In addition, the Facility provided an email from the Director of Medical Records to department heads that described two changes in Policy A.06 Recordkeeping. Although the Facility reported that competency-based training is provided when a policy is revised as a response to a plan of correction for Regulatory survey findings, and that there is evidence documented of this training, no documentation was provided to the Monitoring Team to show that any policy was disseminated through a process that included competency-based training. The Facility should develop a process to ensure all affected staff are aware of and understand their responsibilities for newly implemented or revised policies. It is essential that the Facility document training provided on sensitive or essential policies. To achieve compliance, DADS and the Facility will need to complete policy development, revision, and implementation as necessary to implement all provision of this Settlement Agreement. As part of the implementation of policy, the Facility will need to ensure staff are aware of new and revised policies and have the competence to implement them accurately.	
V3	Commencing within six months of the Effective Date hereof and with	The Facility had a robust process in place to audit five randomly selected records each month. This process had changed since the last compliance visit. At the time of that visit,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	each records clerk audited one Active Record per month from her own unit, but there was now a rotation established so each records clerk audits a different unit each month. Audits by records clerks were called Internal Audits. Three records from each unit were selected randomly by computer each month. During most months, the URCs audited the first and third record on the list for each unit, thus doing a validation review of two-thirds of the audited records (External Audits). Considering only the audits by URCs, that amounted to 10 audits per month. The Facility provided the Monitoring Team with audits by URCs of 10 audits for August 2011. Combined with the audits completed by the Records Clerks but not in the URC validation sample, this exceeds the required five individuals per month. These audits did not include the additional notebooks—the Active Treatment Notebook, PNMP Notebook, or Monthly Flow Notebook. Per report by the Director of Medical Records, the Active Treatment Coordinators reviewed the Active Treatment Notebooks for all individuals monthly for each unit. However, this was not an independent audit, nor did it ensure that documents were consistent across the types of notebooks. Although this provision does not require that audits be independent, having the reviews at least sampled by an independent auditor can determine whether the reviews are accurate. In any case, the information from these reviews was not included as part of the random audits, which, therefore, were not complete audits of the Unified Record. For compliance, the audits must include all components of the Unified Record. For each audit completed by a records clerk or URC, two forms were used. The form titled "Settlement Agreement Cross Referenced with ICF-MR Standards Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4" listed the items to be scored for compliance. The form titled "RSSLC-Active Record Review" served as a source document. This form had a line for each document that was to be in the Active Record; it had columns for the document name, the maintenance guidelines for each document (that is, what was to be in the Active Record and when documents were to be purged), whether the document was present/not present/not applicable, and comments. Information from the audit tools was aggregated for a Trend Analysis report for the period of 5/1/11-8/31/11. This report included: 1. For each record, a spreadsheet of information from internal audits listing each item on the monitoring tool with a tally of yes, no, and N/A responses to each query a along with a percent of Yes or No ratings scored Yes on the monitoring tool. 2. For a given report time period the overall "compliance score" (recorded as a percentage) for each record audited during the time period. Bar graphs of overall percent of compliance were provided separately for internal and external audits for the entire period and by month.	

#	Provision	Assessment of Status	Compliance
		3. A tally of these data by query that resulted in the identification of areas above, and below 80% compliance. These data could be used to identify areas in need of systemic improvement. 4. Data enumerated above were separately recorded for audits done by internal monitors (Records Clerks auditing other units) and external monitors (QA staff). Comparisons of results were displayed in graph form by month 5. Finally, the level of agreement between internal and external monitors, by question on the monitoring tool, and by month, was displayed. The percent of compliance rated in internal audits ranged across the items from a low of 38% for gaps between entries to 100% for having a table of contents, electronic records being protected through security access or pass codes, and provides information adequate for use in routine decision-making. The bar graph for compliance as determined by internal audits showed steady improvement from 73% in May 2011 to 90% in August 2011. However, the bar graph for compliance as determined by external audits showed compliance at 55% in May and June 2011, 65% in July 2011, and 60% in August 2011. This difference raises the likelihood that the definitions followed differ between the Records Clerks and URCs. The Records Clerks and the URCs entered their findings on separate screens; the database then listed, for each item, the finding by each. The URCs reported that the database provided a column for the findings by each auditor, a column with Y/N for agreement, and a calculation of the percent of agreement for the record. The Monitoring Team did not review any of these. There were two issues that could affect inter-rater agreement in the validation audits. First, the checks were done at different times, with the URCs auditing after the Records Clerks had completed audits; therefore, there could not be a true review of agreement. Changes could have been made in the records; corrective actions could have been completed, and documents could have been updated or become out of data in the interim. The potential for corrective actions to have been completed would lead to an expectation the URCs would find higher compliance, but they did not. Second, audits were not independent. One URC usually reviewed the Records Clerk's ratings before completing her own audit. The Monitoring Team recommends that a sample of the audits be done independently before there is an opportunity for corrective actions to occur, to give a better estimate of the agreement between the raters in order to ensure the definitions of the requirements are clear and that compliance is observable. The Monitoring Team audited the record for Individual #480. This record was randomly selected by computer from those that had been audited by the Facility in September 2011. Given the difference in time period between the Facility audit and the Monitoring	

#	Provision	Assessment of Status	Compliance
		Team audit, and the corrective actions that had occurred, this could only be considered a rough estimate of the agreement. Audits had not yet been completed by the URCs for October, and there was no opportunity for the Monitoring Team to do an audit of a record that had not had opportunity for corrective action. Agreement was calculated for all items on the RSSLC-Active Treatment Review that the Monitor, URC, or both found applicable; agreement was 67%. Agreement on the monitoring tool for items rated by the Monitoring Team (items about accessibility, security, and use by staff were not checked) was also 67%. These figures, while only an estimate of agreement, do not support that the definitions of items and criteria for rating were clear and observable. The Facility should review the definitions, attempt to discover why ratings differ across auditors, and revise the definitions to ensure clarity and improve accuracy of audits so the data available are more usable for decision-making by the Facility. As with other sections of the SA, reports prepared by the QA Department were reviewed by the Medical Records Department, the QA Department, and the QA/QI Council. The Facility reported that the URCs send emails to responsible disciplines, unit directors, and unit clerks listing corrections that are needed. The email states the URC will check the record again in 2-3 weeks; they then check the record (a process they began approximately two months before the compliance visit). Then they send out the new list of what is still needed, and they continue to check. The Facility provided samples of such emails. In addition, there was one example of addressing deficiencies in a systemic manner; the Facility provided an outline, power point slides, and sign-in sheets for a training session provided 10/3/11 for all staff who document in the record (the Monitoring Team did not confirm the percentage of those staff who had received training at that time, but sign-in sheets documented over 300 staff trained including direct service staff and clinicians); this training addressed items found deficient in records, including gaps, legibility, signatures, and dates. In addition to the audits by Records Clerks and URCs, a second audit process conducted by program monitors was in place. Each program monitor is assigned certain homes. Program monitors review Chart 1 and the Group Notebook at the home. Program monitors look for a subset of what the URCs look at for Chart 1. Program monitors selected charts to audit by selecting one group notebook and picking the charts from that notebook. The program monitors reported that each audited the group notebook and individual Chart 1s of about 20 individuals per month. The program monitors did not use a random sampling process to identify records to review; instead, each monitor had a chart to show what they have done so they try to cover all notebooks in about a 3-month period and not repeat till they have completed a rotation. Each monitor had a different way of doing this selection; one reviewed a whole home at a time,	

#	Provision	Assessment of Status	Compliance
		whereas the others sampled across homes. Program monitors reported they also do special audits when asked by the Unit Director or Director of Residential Services. Furthermore the program monitor may decide there is a need for additional monitoring in a specific home. It would be advantageous for the program monitors to establish a process for selecting records that is consistent across program monitors; criteria for selection of special audits might also be helpful. The process could include some scheduling that can be coordinated with the URC audits in a way that would provide information for validation of accuracy of audits and assurance of completion of corrective actions. Program auditors reported they find some of the same errors repeated or, for the same record, not corrected. They reported they have changed their corrective action process so that they now ask the unit directors and QDDPs to come up with resolution. Carol Agu, Q Consultant, agreed that QDDPs should have due date for resolution; the next step was for Unit Directors to verify resolution of findings for individual records. Program monitors reported these changes began about two months ago, and they are just trying to get the Unit Directors and QDDPs involved at the individual level now so the individual record deficiencies are resolved. Therefore, they had not yet made recommendations for systemic change. At the last compliance review, the Monitoring Team recommended the Facility consider coordinating the two separate audit processes in order to facilitate decision-making on improvement initiatives and to develop a unified corrective action system. Although the audits still remain separate, the Facility had implemented a database that provides aggregate info on percentage of correct and deficient items on audits and had initiated a workgroup including program monitors, URCs, and different disciplines by invitation (based on which problems they see), the Assistant Director of Programs, the Director of Residential Services, the QDDP Consultant, and (recently) a QDDP and a residential coordinator. This workgroup had begun to meet monthly to look at trends and identify actions to take. For example: • The workgroup saw records were missing a lot of psychology updates, so the workgroup involved a staff psychologist and identified what needed to be done. • Daily schedules were not completed correctly; an excellent sample was identified and provided to QDDPs and Unit Directors to use for training. The workgroup had not followed up to see whether systemic problems were resolved. The database that will provide needed information was implemented in May 2011 and is in process of being populated as audits are completed. The Facility continued to make progress in implementing audits that may be effective in	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>ensuring a useful and accurate Unified Record. To achieve compliance, the Facility will need to audit all components of the Unified Record, will need to ensure audit information is accurate and that auditors can reliably rate each question, and will need to document improvements in the quality of the records.</td><td></td></tr>
<tr><td>V4</td><td>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.</td><td>The Facility had initiated processes to monitor and evaluate how records are being used.

One such useful process is the PSP Discipline's Assessments Tracking Log of assessments due on the Share Drive but not posted. Unless assessments are posted, all PST members cannot review them easily. Although this list did not indicate who had viewed the assessments, it did indicate what was available for viewing and for using in making decisions about care, treatment, and training shows for each individual what assessments are required, dates due, and dates completed; it also has a column for Late (not posted 10 days ahead). There is no column for whether the assessment was posted by time of PSP. The following table provides data from the log for May until September 2011. It shows remarkable consistency in percent of assessments posted timely.

<table>
<tr><th>Month</th><th>Number required</th><th>Number On Time</th><th>% on Time</th></tr>
<tr><td>May</td><td>498</td><td>357</td><td>72%</td></tr>
<tr><td>June</td><td>464</td><td>342</td><td>74%</td></tr>
<tr><td>July</td><td>372</td><td>269</td><td>72%</td></tr>
<tr><td>August</td><td>476</td><td>349</td><td>73%</td></tr>
<tr><td>September*</td><td>141</td><td>109</td><td>77%</td></tr>
</table>
*Partial month

For PSPs due from 10/24/11-11/2/11 the PSP Discipline's Assessments Tracking Log also showed consistent data.
• Number required: 143
• Posted timely: 104 (73%)

These logs document a relatively high but not complete posting of assessments 10 days prior to the annual PSP planning meeting and therefore available to help in integrated decision-making by the PST. The Facility should review these logs to identify any trends (for example, if specific reports are often not timely) and implement actions to increase timeliness of posting to the share drive.

The Facility had also begun an interview process to gather information on use of the</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		record for decision-making. The URCs reported they each pick a person from the random audit list. The URCs make sure they do interviews for different units each month and also select so they are rotating units and homes within the units from month to month. The URC interviews the clinician from each discipline who did one of the reports in the record. Discuss the reports and IPNs as part of asking the questions from V4 tool; incorporate the questions into the discussion. They found this works better than asking the questions one after another as written (e.g., "when you did the audiology report, which parts of the chart were useful to you?" "When you go into a PSP meeting, do you see the chart there; which books are there; who uses them?"). The URC enters onto the form summaries of the responses to each question. The URC rates use of information from the record as "No" if any one person says or the URC interprets one had been reviewing the information but not sharing the information with QA/QI Council or others yet. The Monitoring Team reviewed two interview tools. Both rated all disciplines as using the record to make decisions, except for one discipline for Individual #680; based on the summaries written on the forms, the Monitoring Team would agree. The Monitoring Team also conducted six interviews (involving seven clinicians, clinical department directors, and QDDPs) about use of the record. However, these interviews asked the questions in general rather than specific to an individual. In these interviews, the following was reported: • Six of six (100%) described ways they use the record. • Six of six (100%) described either meetings at which the record is used or content of records that is referred to in meetings. • Two (33%) reported they could find documents in the record, two (33%) reported they could usually find documents in the record, and two (33%) reported problems in finding documents in the record. • Four of six (67%) provided a specific example of using information from another discipline's reports to help plan a treatment or intervention. Nevertheless, the Monitoring Team found examples in which information in the record was not used when making decisions. For example: • As reported in Provision O.4, at no time during any of the observations was staff observed referring to the PNMPs outside of mealtime. • At the CLDP observed by the Monitoring Team, the PST was unaware of a very important medical history issue and was therefore unable to adequately assess the individual's need for treatment while living at the Facility or make appropriate recommendations as to follow-up when the move to the community took place. • As reported in Provision K.4, there were examples in which no action was taken although data suggested undesired behavior was worsening. In some cases,	

#	Provision	Assessment of Status	Compliance
		progress notes reported improvement, although data showed worseining. The Monitoring Team also found examples in which information was presented in meetings and used in planning. For example: • The Facility adequately collected and presented data to physicians, P&T committee, and at Psychiatric Medication and Behavior Management Clinics, on the use of STAT medications, benzodiazapines, anticholinergics and on risk factors for metabolic syndrome. The Facility had made significant progress toward compliance with this provision. To achieve compliance, the Facility needs to ensure that assessments and reports are available so that PSTs can use—and do use--information in planning supports and services, and that information and data are used during planning and review meetings. The Facility must also use the information gathered from interviews, the assessment tracking log, and other processes that may be used; the Facility should identify issues and trends that need to be addressed and implement systemic improvement actions as appropriate.	

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

1. Revise the Individual Notebook Equivalent sheet as needed to ensure accuracy of location of documents. (Provision V.1)
2. A process should be in place to ensure documents filed in several locations are consistent and are all replaced when updated or revised. (Provision V.1)
3. Review and clearly identify which books are considered part of the Unified Record. Any documents that record information about an individual's status, other than clinician working notes and raw data sheets, should be considered part of the Unified Record and must be included in the required random audits. (Provision V.3)
4. Establish a process of periodic review and updating of policies. (Provision V.2)
5. Develop a standardized system to train staff, and ensure staff have the necessary knowledge and skills to implement the new or revised policies. To accomplish this, the Facility should define in policy or procedure the process that will be used to ensure this occurs. In developing such a policy, the following should be considered:
   - It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy.
   - It should identify whether a process to ensure knowledge or competence needs to be established for the specific policy, whether staff in specific job categories need to document knowledge of the policy by signing off, and the list of job categories to whom training should be provided.
   - In addition, for each policy approved, consideration should be given to defining who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g.,

classroom training, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility.

- Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training). (Provision V.2)

6. Implement actions to increase timeliness of posting to the share drive. (Provision V.4)

List of Acronyms

Richmond State Supported Living Center
October, 2011 Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADOP	Assistant Director of Programs
ACP	Acute Care Plan
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AED	Anti-Epileptic Drug/Automated External Defibrillator
AFO	Ankle Foot Orthotic
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BIR	Behavioral Incident Report
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CAP	Corrective Action Plan
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)
CWS	Client Work Station
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
DD	Developmental Disabilities
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DMID	Diagnostic Manual-Intellectual Disability
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRO	Differential Reinforcement of Other Behavior
DRR	Drug Regiment Review
DSHS	Department of State Health Services
DSM/DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DSP	Dental Support Plan
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FAST	Functional Assessment Screening Tool
FBA	Functional Behavior Analysis or Functional Behavior Assessment
FFAD	Face-to-Face Assessment/Debriefing
FSA	Functional Skills 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/HOBE	Head of Bed/Head of Bed Elevation
HRC	Human rights committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy

IBW	Ideal Body Weight
IC	Infection Control
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICF/DD	Intermediate Care Facility for Persons with Developmental Disabilities
ICM	Integrated Clinical Meeting
ID/DD	Intellectual Disability/Developmental Disability
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IMC	Incident Management Committee
IMRT	Incident Management Review Team
IPN	Integrated Progress Note
ISP	Individual Support Plan
i.v./IV	Intravenous
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MAS	Motivational Assessment Scale
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MP	Medication Plan
MR	Mental Retardation
MRA/MHMRA	Mental Retardation Authority/Mental Health and Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
MSP	Medical Support Plan
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan
NDC	Non Direct Care
NEO	New Employee Orientation
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NP	Nurse Practitioner
O2	Oxygen
O2Sat	Oxygen saturation
OCD	Obsessive Compulsive Disorder
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OT/OTR	Occupational Therapist, Registered
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
PFI	Personal Focus Interview
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PMOC	Psychiatric Medication Oversight Committee
PMR	Psychiatric Medication Review
PMT	Psychotropic Medication
PNA	Psychiatric Nursing Assistant
PNM	Physical and Nutritional Management
PNMC/PNMPC	Physical and Nutritional Management Coordinator/ Physical and Nutritional Management Plan Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth, oral intake
POC	Plan of Correction
POI	Plan of Improvement
PRC	Polypharmacy Review Committee
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/Physical Therapist
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMRP/QDDP	Qualified Mental Retardation Professional/Qualified Developmental Disabilities Professional
QPR	Quarterly Psychiatric Review
RC	Restraint Checklist
RD	Registered Dietician
RN	Registered Nurse

r/o	Rule out
ROM	Range of Motion
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SAN	Settlement Agreement for Nursing
SFBA	Structural and Functional Behavior Assessment
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
SSLC	State Supported Living Center
SPCI	Safety Plan Crisis Intervention
SPO	Specific Program Objective
SQRA	Standard of Quality for Risk Assessment
SSLC	State Supported Living Center
SSO	Staff Service Objective/Specific Service Objective
STAT	Immediate
STD	Sexually Transmitted Disease
TB	Tuberculosis
TD	Tardive Dyskinesia
TIVA	Total Intravenous Anesthesia
TO	Training Objective
UA	Urinalysis
UIR	Unusual Incident Review or Unusual Incident Report
UTI	Urinary Tract Infection
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus
x/o	Rule out