United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center
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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 whe$_{n\ the}$ 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 whe$_{n\ the}$ 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.

Substantial Compliance Ratings and Progress

Across the state's 13 facilities, there was variability in the progress being made by each facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation, of the parties who crafted the Settlement Agreement was for there to be systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report for detail regarding the facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity; some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, provision item L.1 addresses the total system of the provision of medical care at the facility. Contrast this with provision item T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

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, especially Tracy Stafford, Susan Steamer, Virginia Mahan, and Gloria Henrichsen. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Too many other staff to mention assisted in numerous ways.

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.

Give$_{\text{n the}}$ 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

Population. Population of the Facility at the beginning of the compliance visit was 364 individuals.

Facility Self-Assessment. RSSLC wrote its self-assessment following new guidelines from DADS. As indicated in each of the sections of the report below, this was a good first step. Overall, the new format should help guide the facility in moving forward and to help managers and clinicians develop the ways in which they assess the quality and depth of the activities in which they and their staff engage to meet the many items of each of the provisions of the Settlement Agreement. The self-assessment described the activities engaged in to assess status, results (in some cases including data on status of processes or on outcomes), and the self-rating and rationale for the rating. The Monitoring Team provides, in this report, many specific reviews of the self-assessments to assist the Facility to select appropriate activities and measures of status and to describe reasons for discrepancies in ratings between this report and the self-assessment. The Facility should consider how it might expand use of its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

In addition, RSSLC provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. This report also provides some comments about the action steps in order to assist the Facility to review its plans and ensure they will lead toward compliance and will provide an organized approach that can coordinate with the self-assessment.

Specific Findings

Following are summaries of specific findings for each Section of the Settlement Agreement:

Restraints

Use of crisis intervention restraint had increased. Restraint was not consistently administered in accordance with policies and procedures. This remains an area to which the Facility must attend, review trends, and identify and implement improvements.

- Positive Practices and Improvements Made
  - No use of prone restraint was identified.
  - The Facility had expanded the Restraint Trend Report to include key data tracked longitudinally.
  - The Facility had initiated a process whereby the Director of Behavioral Services can view video surveillance tapes that had recorded the restraint episode, including the events immediately preceding the restraint and the events immediately following release from restraint.
- Improvements Needed
  - The use of crisis intervention restraint at RSSLC increased significantly since the last review period.
  - Most crisis intervention restraint use at the RSSLC was highly restrictive.

- There was little evidence of continued improvement in restraint documentation noted.
- The Facility practices did not ensure a substantive clinical and administrative review of each restraint episode; the practices 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.

<u>Abuse, Neglect and Incident Management</u>
The Facility and State continued to have many good practices in place but still needed to improve in a number of areas.

- Positive Practices and Improvements Made
  - 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.
  - The Monitoring Team did not find any instances of lack of cooperation betwee$_{n\ the}$ Facility, DFPS, OIG or local law enforcement in its review.
  - All allegations of physical abuse received a law enforcement referral.
  - Reporting procedures for reporting abuse and neglect were prominently displayed throughout the Facility and the Facility had an effective monitoring system to ensure postings remained in place.
  - In every instance where an alleged perpetrator (AP) was know$_{n\ the}$ AP was immediately placed in no contact status.
  - The RSSLC is to be commended for convening periodic joint meetings with DFPS, OIG, and local law enforcement at which any issues of mutual cooperation can be reviewed and resolved.
- Improvements Needed
  - Although training for staff on abuse and incident reporting was in place, and all staff was current in that training, staff knowledge of abuse/neglect reporting requirements needs to improve.
  - The Facility is to be commended for improving the process for review of non-serious discovered injuries; however, the Facility's investigations of non-serious discovered injuries were not always adequate to make a determination that abuse or neglect was not a cause of, or contributing factor to, the injury under review.
  - There continues to be a problem with timely response from DFPS in initiating investigations.

- Timely reporting of allegations was problematic at the RSSLC, as 86% of investigations in the Monitoring Team's sample were not reported to DFPS within one hour of discovery as required.

Quality Assurance

The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of the QA system. QA systems are in place for most sections of the SA. The development of the data system that consolidated data from multiple sources was impressive. However, the Facility had not as yet developed an organized process to use monitoring data to routinely and consistently develop Corrective Action Plans (CAPs) for all requirements of the SA, and identification of systemic issues is extremely limited.

- Positive Practices and Improvements Made
  - The process for inter-rater reliability checks, and generally improving the accuracy of monitoring data was encouraging and seemed to be producing more consistent interpretation of subject matter requirements being monitored.
  - The Monitoring Team commends the Facility for revising trend data to include longitudinal data. There are still additional revisions to longitudinal tracking that should be considered.
  - The Facility is to be commended for its work in creating a data library.
  - CAPs did not clearly articulate the anticipated outcome of each action step and the Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified. The Facility did not appear to have a method to determine the effectiveness of a CAP.
- Improvements Needed.
  - Data items on the monitoring tools have not been weighted, so in preparing overall compliance reports the most critical data item counted the same as the most mundane.
  - The Facility is only beginning a process to develop key indicators as an additional activity to measure organizational performance in fundamental areas of facility operations and outcomes.

Integrated Protections, Services, Treatments and Supports

Overall, the Facility's progress had not been substantial in developing and implementing 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, although some improvements were identified. The Facility had made progress in achieving the expectation for the PFA to be completed and posted 90 days prior to the ISP date, such that all disciplines could incorporate the individual's preferences and individual goals into their assessments and recommendations. It was noted the Facility was beginning to make some attempt to use personal futures planning tools.

- Positive Practices and Improvements Made

    - The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs and IDT members.
    - There were some examples of improved integration observed in planning meetings.
- Improvements Needed
    - IDTs were not yet proficient in identifying the most integrated setting appropriate to an individual's needs.
    - The portion of the directive for each discipline to include recommendations regarding the most integrated setting and supports/services needed in that setting had not yet been fully implemented.
    - ISPs 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.
    - Barriers to living in the most integrated setting always lead to goals, objectives, or service strategies.
    - ISP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner. Staff did not demonstrate competence to implement the ISP programs or provide active treatment on an ongoing basis.

<u>Integrated Clinical Services</u>
The Facility continued to expand steps toward providing clinical services in an integrated manner. Facility policies have been developed or revised to provide direction. Participation of clinical staff in the ISP/IDT process had continued to improve in many areas, but further improvement is needed.

- Positive Practices and Improvements Made
    - The Facility continued to use a consultation form to document review by facility clinicians of medical consultations from non-Facility clinicians.
    - All sampled consultations had documentation of review, and nearly all documented whether there was agreement or disagreement with consultant findings and recommendations.
    - The Facility had developed a process to track upcoming, completed, and missed consultations and to review outcomes of consultations at unit meetings.
- Improvements Needed
    - Evidence of integration and collaboration was not regularly found included within Health Management Plans that needed integration/collaboration with other disciplines.
    - Examples are provided throughout this report of both involvement in the ISP process and lack of involvement.

<u>Minimum Common Elements of Clinical Care</u>
The Facility had taken significant steps to develop clinical indicators and other processes that have great promise. At the same time, assessments continue not to be consistently timely or of adequate quality.

- Positive Practices and Improvements Made
    - Diagnoses were consistent with ICD-9 and DSM IV codes, but there was still a need to complete psychiatric evaluations.
    - The Facility had taken a significant step in addressing chronic medical conditions through the implementation of clinical guidelines and a database that was consistent with those guidelines.
- Improvements Needed
    - Assessments for the ISP were often not completed on a timely basis.
    - Although quality of assessments had improved for some disciplines, such as medical services, there were still areas for which assessments were not comprehensive, such as communication services.
    - Gaps in identification, documenting, and using clinical indicators remained. There were still problems in gathering needed data and analyzing and summarizing the information. These limit the ability of the Facility to respond timely to changes in status, assess and respond to risks, and evaluate progress or decline.

At-Risk Individuals

The statewide risk assessment procedure, with guidelines for rating risk, was in use at the Facility. The Facility policy for implementation of the State directed at risk policy was revised as recently as 5/11/12. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred, yet there were limited examples of accurate interdisciplinary risk identification, thorough assessments, and effective interdisciplinary risk action plans.

- Positive Practices and Improvements Made
    - Staff understanding of risk assessment policies and procedures had improved, and progress in some limited areas had been noted.
    - Since the last review the Facility had taken many proactive steps to assess the efficacy of bedrail use for each individual, safety risks associated with bedrail use for each individual, and the testing of bedrail alternatives, including the purchase of alternative devices where warranted. The Facility is to be commended for the initiative it has taken in this regard.
- Improvements Needed
    - Consistent application of policies and procedures was lacking.
    - It was not clear that IDTs yet were able to accurately assess levels of risk in an interdisciplinary and independent manner.

Psychiatric Care and Services

The Facility made some limited progress: PBSP descriptions of psychiatric care improved, and polypharmacy reviewed were strengthened by the addition of a polypharmacy review board. However, many individuals continued to have multiple (and sometime conflicting) psychiatric diagnoses. In addition, many psychotropic medication treatments were often not linked to symptoms of a psychiatric diagnosis, and treatment response could not be monitored with data on those symptoms. Efforts to minimize the need for pretreatment sedation were at an early stage of development.

- Positive Practices and Improvements Made
  - Reiss Screens were administered to all individuals who required them.
  - The polypharmacy review process was strengthened with the addition of the Polypharmacy Review Group. Monthly reviews were conducted in the psychiatric clinics, for all individuals who were treated with psychiatric polypharmacy. Evidence was presented which showed modest decreases in polypharmacy rates across the campus.
- Improvements Needed
  - Some individuals did not yet have a psychiatric evaluation and there continued to be cases where different diagnoses were cited in the various sections of an individual's clinical record. "Not otherwise specified" (NOS) or "rule out" (R/O) diagnoses remained, and there were cases where cited diagnoses were not linked to specific behavioral characteristics of proposed disorders.
  - There were no medication plans in place. 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.
  - Both staff psychiatrists had resigned and the Facility did not have a sufficient number of psychiatrists to provide the services required by the SA.
  - An adequate process was not in place for Interdisciplinary Teams (IDTs) to select and assign appropriate modalities for the treatment of behavioral disorders, and the treatments individuals received were not properly described in the Positive Behavior Support Plans (PBSPs).
  - 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 individuals who needed screens received them, and results of positive screens did not always get the follow-up that was required.

<u>Psychological services</u>

The Facility demonstrated progress during the current site visit. Areas of noted improvement for the Facility included the completion of Psychological Assessment reports for the majority of people living at the Facility. Although intellectual and adaptive behavior testing was very limited, the Facility had completed several more reports. The Facility also demonstrated improvement in several elements of both the Structural and Functional Assessments and the PBSPs.

- Positive Practices and Improvements Made

- Psychological Assessment reports had been completed for the majority of individuals.
- The Facility also demonstrated improvement in several elements of both the Structural and Functional Assessments and the PBSPs.

- Improvements Needed
  - Although several individuals living at RSSLC were involved in counseling services, none of these individuals was provided with the necessary treatment plans. As a result, counseling interventions did not reflect evidence-based practices.
  - There was little improvement in the data collection and graphing process in comparison with the baseline site visit. In many circumstances, it was not possible to readily identify specific trends in behavior and demonstrate that individuals were benefiting from the PBSPs.
  - Although SFAs had improved, there continued to be little integration between behavioral and psychiatric assessments and interventions.

Medical Care

Medical services continues to make significant improvements, and progress towards compliance. The Facility had developed many progressive initiatives, such as an electronic database to track, and trend core clinical indicators. Physicians had also demonstrated marked improvement with documentation, and follow-up on acute medical conditions. The Facility must continue such efforts, and ensure more assertive assessment of chronic medical conditions.

- Positive Practices and Improvements Made
  - Clinicians were more promptly and comprehensively following up on reported acute medical problems.
  - Annual medical assessments were much more comprehensive.
  - Follow-up to diagnostic studies and consultation reports was also an area of marked improvements. The clinical management of acute seizures was noted to be good.
  - The Facility had taken a progressive approach to developing a medical quality assurance process at the Facility. The development of core indicator databases for diabetes, and osteoporosis will enable close monitoring of these conditions, and improved outcomes, if fully implemented.
  - The Medical follow-up database is also another progressive approach to ensuring that diagnostic tests and consultations are tracked through completion, and that appropriate action plans are developed.
- Improvements Needed
  - Although the Facility has begun to develop clinical guidelines and practices for addressing individuals with chronic conditions, more assertive evaluation and management of chronic conditions, especially neuromotor, musculoskeletal, clinical management of syndromal conditions, aspiration, and aspiration pneumonia.
  - Clinicians must better participate in the IDT process, and ensure that the IDT is well aware of all medical issues.

- The Mortality review process must be more comprehensive and include a review of all potential causes of death, all system issues, and care provided by all disciplines.

Nursing Care

There was improvement in most areas of nursing services, with assessment of risk being the exception.

- Positive Practices and Improvements Made
  - The Nursing Department continued to maintain a highly motivated and stable Nursing Administrative and Management staff. Since the last review, a nurse was reassigned to serve as an Assistant Infection Control Nurse, and another nurse had been reassigned to serve as Nurse Case Manager Supervisor, effective 6/1/12. All nursing positions were filled.
  - The Wound Care Nurse continued to provide excellent wound care management in collaboration with other relevant disciplines. As a result there were only two individuals with pressure ulcers, which is commendable considering the medically complex population that resides at the Facility.
  - The Emergency Response System had continued to make improvements. All of the required emergency equipment had been procured and placed in designated areas located throughout the campus.
  - The Nursing Department had recently made significant progress on developing health care plans that were individualized sufficient to meet individuals' unique needs.
  - The Facility had a comprehensive Medication Variance Database for developing reports on medication variances from which a root cause analysis method can be used in analyzing and trending data.
- Improvements Needed
  - Although the Nursing Department was making steady progress in improving the quality of the Annual and Quarterly Nursing Assessment, the Nurse Case Managers continued to need training to improve summarizing and analyzing raw clinical data into statements that are clear, concise, and meaningful to adequately determine individuals' health status in relation to each of their identified nursing problems/diagnoses.
  - The Nursing Department and Nurse Educators continued to implement and train nurses on new policies, procedures, and protocols. The protocols were laminated onto small cards, placed on a ring, and provided to each nurse to carry at all time for easily reference, a opposed to having to look them up in the nursing manual. The Nurse Educator maintained an excellent tracking system for training to ensure that nurses receive all required and other identified training as needed. The Nurse Educators had trained all the incumbent direct care staff on the State's mandated Observing and Reporting Clinical Indicators for Health Status Change of the Individuals Served and were continuing to provide this training at New Employee Orientation. However, the Nursing Policies, Procedures, Processes, and Protocols have not yet been adequately put into clinical practices sufficient to meet individuals' health status needs.
  - There was no significant improvement in assessing risks.

- Nursing staff administering medications could benefit from receiving enhanced dysphagia training to better understand and carryout safe medication administration strategies.

Pharmacy Services and Safe Medication Practices

Overall, the pharmacy department continues to work towards substantial compliance, and is proactive in addressing areas of noted deficiencies. It maintains a process to address adverse drug reactions, and provides meaningful drug utilization reviews. The Facility continues to improve on developing a more comprehensive approach to quarterly drug regimen reviews, and is working with other departments to ensure that medication variances are carefully reviewed.

- Positive Practices and Improvements Made
  - The Facility has an efficacious mechanism to ensure that the dispensing pharmacist evaluates all new orders for allergies, indication, dosing, drug interaction, and follow-up of physician action plans related to pharmacy recommendations.
  - The Pharmacy also maintained a process whereby the pharmacy checked all necessary diagnostics, when clinically indicated by printing off a copy of the diagnostic report form the laboratory database, or requesting a copy of the diagnostic test result.
  - The Monitoring Team compliments the clinical pharmacists for attending psychiatric, and neurology consultations, and to the physicians for their comprehensive, and well documented review of quarterly drug regimen reviews (QDRRs), and associated recommendations.
- Improvements Needed
  - There were significant deficiencies in the QDRRs reviewed by the Monitoring Team.
  - The Facility has yet to fully develop and implement its medication variance policy.

Physical and Nutritional Management

Overall, improvement has been noted, especially as it related to the PNMT and the PNMT evaluations. The PNMT had improved its core membership with the addition of the Registered Dietitian (RD) and planned addition of a QDDP. The PNMT evaluations also showed great improvement as the evaluations began reflecting actual assessment rather than a summary of previous assessments. Another area of improvement was the PNMPs, which were more comprehensive than in previous visits; however, the PNMPs still lacked consistency in this regard.

Concerns included lack of a timely response to issues associated with PNM. Individuals who were not admitted to the hospital were not consistently reviewed by the IDT or PNMT and individuals who were not identified as "high risk" were not consistently monitored.

- 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 IDT.
- 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 this data to better identify system issues or respond to recurrent issues on a regular basis.
    - A risk process was in place but continued to not consistently identify those individuals who were at an increased 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.
    - Supports and strategies to mitigate risk regarding the areas of oral care, head of bed assessment, bathing positioning, and medication administration were lacking in detail in assessments and were not comprehensively included in the PNMP.
    - Staff was observed not consistently implementing PNMPs and displaying safe practices that minimize the risk of decline in PNM health status.
    - 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.
    - Individuals receiving enteral feeding were not provided with assessments that identified the medical necessity of the tube and pathways to oral intake.

<u>Physical and Occupational Therapy</u>

Overall, as with PNM concerns, there was a lack of problem solving and identification of issues that contributed to decline in mobility, and/or positioning. 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. There were many positives that should be noted as well. These included timely completions of assessments and screenings for new admits and all individuals having 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. The concern as previously noted was the comprehensiveness of the assessment.

- Positive Practices and Improvements Made
    - Assessments were completed in accordance to the schedule set forth by RSSLC.
- Improvements Needed
    - 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.

- 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 ISP.
- Physical and occupational therapy plans were not implemented as written.
- A system did not exist that ensures staff responsible for positioning and transferring high-risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.

Dental Services

The Facility had developed, and is in the process of implementing an oral hygiene program that will incorporate each Individual's oral hygiene needs into a dedicated services plan through a multidisciplinary approach. Importantly, the Monitoring Team noted that the oral hygiene of many of the individuals who reside at the Facility has significantly improved. The Facility maintains an effective emergency dental services process that helps to ensure that individuals who require emergency dental procedures are triaged appropriately. The Facility is in the process of implementing a dental database, which should enable better tracking of dental services. The Monitoring Team noted that dental services was not well represented within the context of the interdisciplinary team process, and it is essential that the ISP clearly delineates all oral hygiene, and oral health care needs.

- Positive Practices and Improvements Made
  - Oral hygiene of many of the individuals who reside at the Facility has significantly improved.
  - The Facility maintains an effective emergency dental services process that helps to ensure that individuals who require emergency dental procedures are triaged appropriately.
- Improvements Needed
  - Dental treatment plans were not comprehensive, and did not demonstrate integration of dental assessments, services needs, and supports into the interdisciplinary team process.
  - Although the Facility has several very useful programs in development, such as the suction toothbrushing program and oral hygiene care plan initiative, the Facility must fully implement these, and assess them for efficacy.
  - There is a lack of integration of dental services into the ISP. The Monitoring Team noted many examples when dental services were not discussed at all by the IDT, nor reflected in the ISP.
  - The dental department did not effectively collaborate with psychology services to develop and implement necessary approaches to assist in mitigating the need for sedation.

Communication

There continued to be little progress as it related to meeting the communication needs of the individuals living at RSSLC. Communication assessments continued to be vague and not provide the in-depth investigation regarding how to increase an individual's communicative functioning. 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.

- Positive Practices and Improvements Made
  - Much work had been done on polices surrounding Communication supports. This included policies K.O6.1 and K.06.2.
  - The majority of assessments identified whether the individual required direct or indirect therapy.

- Improvements Needed
  - RSSLC increased their number of SLPs to four on campus but 1.5 were dedicated to dysphagia and the ratio still exceeded the ratio identified by the Facility as being needed to address all issues.
  - 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.
  - Communication strategies and programs were not consistently integrated into the ISP, and DCPs interviewed were not knowledgeable of the communication programs.
  - Alternative and Augmentative Communication (AAC) devices (individualized as well as common area) were not functional or consistently utilized.

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

- Improvements Needed
  - The site visit revealed instances in which staff demonstrated initiative and utilized solid skills in addressing the needs of individuals living at the Facility. However, in many circumstances, individuals living at the Facility were observed to be without adequate engagement and without adequate educational materials.
  - Skill acquisition programs did not reflect adequate knowledge of each individual's preferences and did not include the use of reinforcers shown to be effective with each individual. Rather, skill acquisition programs were highly similar across individuals and at times reflected the use of templates in which only the name of the individual was changed.
  - Although staff verbally reported familiarity with skill acquisition plans, observed performance and reviewed documentation reflected that skill acquisition plans were often not implemented as intended.

Most Integrated Setting

A summary of noted progress included a renewed emphasis on transitions to community living. There had been 17 such transitions between November 1, 2011 and April 30, 2012, according to the Community Placement Reports and three more had occurred since that report was issued. This was a substantial increase over the seven transitions accomplished in the previous six month period.

- Positive Practices and Improvements Made
  - Over the past six months, RSSLC had devoted additional resources to training on topics related to ISP and CLDP development, including several initiatives by the Transition Coordinator toward improving CLDP assessment quality and ensuring that responsible RSSLC staff were identified for all supports.
  - The Monitoring Team also commended the efforts of the Transition Coordinator toward developing creative approaches for promoting education and awareness.
  - PMM Checklists were being completed in a timely manner, and the PMM visits were documented using the prescribed standardized tool.

- Improvements Needed
  - Additional training continued to be needed on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof.
  - The process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement.
  - 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 IDTs to adequately identify the appropriate essential and nonessential supports for each individual.
  - The processes the Facility implemented to ensure supports were in place and being adequately implemented were still insufficient. The Facility's implementation of the Pre-Move Site Review was not adequately documented.
  - There was insufficient attention to detail exhibited in the PMM process.
  - The Facility did not fully comply with policies on alternate discharges.

Consent

Improvement and progress had occurred in several areas. Issues of identification of need for assistance in making decisions and full development of policy addressing decision-making remained.

- Positive Practices and Improvements Made
    - DADS issues a statewide policy on guardianship and the localization of that policy to RSSLC. The Facility had begun to take some beginning steps toward implementing the requirements of the policy, such as recruitment of members for the Guardianship Committee, and the development of materials to be used for staff training.
    - The Facility demonstrated support for self-advocacy.
    - The Facility demonstrated support for ongoing training of new employees in guardianship and advocacy and had expanded training for incumbent employees.
    -
- Improvements Needed
    - The Monitoring Team remained concerned that the new DADS policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished.
    - The Facility maintained a prioritized 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, but still did not use any standardized process or tool for purposes of making a judgment about such capacity. The list contained some errors, particularly as it reflected a priority status for several individuals who had moved from the Facility more than six months ago, and needed to be updated.
    - There was little activity toward the solicitation of guardians for individuals during this review period. It was reported no guardians had been obtained.

<u>Recordkeeping and General Plan Implementation</u>
RSSLC showed progress in all provisions of this Section. The Facility maintained a unified record for each individual. Since the last compliance visit, the Facility had begun to audit the Group data notebook, in recognition that this notebook is part of the unified record and therefore subject to the audit requirements of Provision V3.

- Positive Practices and Improvements Made
    - The Facility had policy to guide recordkeeping and that included all requirements of the DADS Recordkeeping policy.
    - Records were accessible to staff, and staff could identify where in the records to find documents.
    - Most, but not all, documents that were required to be in the Active Record were present.
    - Legibility had improved, although the Facility had identified legibility as an area of low compliance and had provided training.
    - The Facility had developed or revised a significant number of policies required for implementation of this Settlement Agreement.

- There is a robust records audit system in place. The audit system had been revised to involve interrater reliability audits betwee$_{n\ the}$ Unified Records Coordinators and the program monitors.
- Corrective actions were taken on errors discovered in audits.
- Staff report use of information in the record for making decisions. Monitoring Team interviews and observations noted use of the records.

- Improvements Needed
  - There remained a large enough number of documents not present and of other types of errors so that the Facility had not yet reached substantial compliance.
  - There are still policies that need to be developed or revised at both the DADS and Facility levels. Furthermore, continuing efforts must be made to ensure policies are implemented accurately.
  - Agreement betwee$_{n\ the}$ URC and Monitoring Team on one record showed acceptable agreement on the presence of documents but not on the monitoring tool. The Facility will need to revise the instructions and item definitions as the URC/program monitor reliability checks identify disagreements.
  - Assessments are not posted timely so they can be reviewed by the IDT in advance of ISP annual meetings and used in making planning decisions.
  - Observations of daily services and supports indicated the information in the records is not used to guide the actual services provided in residential and activity settings.

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 Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. RSSLC Section C Presentation Book 4. DADS Policy #001: Use of Restraint 8/31/09 5. DADS Policy #001: Use of Restraint 4/10/12 6. RSSLC Policy J.1: Use of Restraint 10/19/11 7. PMAB Training Curriculum 8. Facility training materials for restraint monitors 9. Restraint Elimination Committee minutes for 11/30/11, 1/4/12, 2/29/12, and 4/23/12 10. Restraint documentation for non-medical restraints: Individuals #600 (2/3 10:36am, 3/21, 3/22, 4/19 6:19am, 12:20pm, and 1:40pm, and 4/22), #267 (12/9 2:15pm), #630 (1/20), #643 (3/5, 3/9, and 4/10), #17 (1/14 and 4/16), #100 (11/14 4:30pm and 5:40pm, and 3/12), #672 (1/27, 1/31 6:40am and 2:25pm, and 4/12), #165 (2/29 5:22pm), #142 (2/14 and 3/28), #513 (2/5), #448 (4/20), #25 (2/9), #315 (2/18 and 2/20 and 11:35am), 306 (3/6 10:41am), #113 (12/15 8:00am), #137 (4/19), and #773 (2/1) 11. Restraint documentation for medical restraints (dental): Individuals #694 (2/14), #555 (4/4), #483 (2/15), #207 (1/10), #239 (4/9), #268 (11/30), #57 (12/14), #479 (3/21), #403 (2/27), #40 (3/29), #442 (3/7), #115 (1/3), #405 (4/10), #375 (12/6), #353 (12/15), #232 (11/28), #771 (4/11), #220 (11/18), #413 (4/4), #498 (2/14), and #585 (11/8) 12. Restraint documentation for protective mechanical restraints: Individuals #44, #502, and #540 13. For Individuals #600, #672, #643, #267, #630, #17, #165, #100. #757, and #142, the individual's ISP 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" 4/1/12 15. Restraint related monitoring/QA forms and reports 16. List of individuals with mechanical restraints for protective reasons 4/19/12 17. List of individuals with a Safety Plan (undated) 18. List of individuals injured during restraint (undated) 19. Crisis Intervention Restraint log 11/1/11 to 4/27/12 20. Medical Restraint Log 4/18/12 21. Medical and Dental Support Plans and implementation documentation for Individuals #584, #56, #789, #25, #452, #718, #358, #160, and #86 22. Facility Restraint Trend Analysis for period ending 4/30/12 23. QA Department Trend Analysis Report 4/30/12 24. Incident Management Team minutes for 2/3/12, 2/10/12,2/17/12, 2/24/12, 3/9/12, 3/16/12,

	3/23/12, 3/30/12, 4/6/12, and 4/13/12 25. List of staff approved as Restraint Monitors (undated-document request II.26) 26. Restraint Monitors training transcripts (14) 27. Direct Care Professional (DCP) training transcript (26) **People Interviewed:** 1. Bobby Buckner, Director of Behavioral Services 2. Pat Newell, Psychology Assistant 3. Shalla Parker, Unit Director 4. Tranika Jefferson, Associate Psychologist 5. Claudette Bonner, Psychology Tech 6. Reuben Muhammad, Incident Management Coordinator **Meetings Attended/Observations:** 1. Incident Management Team (IMRT) 5/16/12 **2.** Four Rivers Unit Morning Meeting 5/16/12 **3.** Quality Assurance/Quality Improvement (QA/QI) Council 5/15/12 4. Administrative Review Team 5/16/12 5. Restraint Elimination Committee 5/16/12
	Facility Self-Assessment: The Facility self-assessment relied primarily on a review of existing policies and on Monitoring Tool data collected over the last six-months. 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. The self-assessment reported substantial compliance with Provision C.2 and noncompliance with the other seven Provisions in Section C. The Facility's Action Plan that accompanies the self-assessment included steps to improve processes that would lead to compliance with the Settlement Agreement. Additional action steps will need to be developed to address issues identified by the Monitoring Team which are not sufficiently addressed in the current Facility Action Plan.
	Summary of Monitor's Assessment: The RSSLC's self-assessment reported that the Facility was 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 Monitoring Team did not concur because of the lack of documentation of restraint review by the Unit teams and the Incident Management Review Team (IMRT). These reviews are necessary to ensure sufficient oversight to any determination that a restraint was terminated as soon as the individual was no longer a danger to him/herself or others. The use of crisis intervention restraint at RSSLC increased significantly since the last review period. RSSLC did not consistently administer restraint in accordance with applicable written policies, procedures,

	and plans governing restraint use. The State office released a new restraint policy in April which included several significant changes in procedure and documentation requirements. The Facility reported that it had attended training on this policy and had begu$_{n\ the}$ process of training Facility staff on the new State policy on restraint. Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records, restraint elimination committee minutes, and minutes of the Incident Management Team (IMRT), no use of prone restraint was identified. Since the last review the Facility had expanded the Restraint Trend Report to include key data tracked longitudinally. Crisis intervention restraint use at RSSLC was primarily the result of Individuals being aggressive towards staff. Most crisis intervention restraint use at the RSSLC was highly restrictive. Data related to staff training are sufficient to demonstrate substantial compliance with the training component of Provision C.3. In its last report the Monitoring Team noted that the Facility had made significant improvement in its documentation of crisis intervention restraint. There was little evidence of continued improvement in restraint documentation noted in this review. The restraint monitoring process at the Facility is deficient in a number of important areas. 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 Facility had initiated a process whereby the Director of Behavioral Services can view video surveillance tapes that had recorded the restraint episode, including the events immediately preceding the restraint and the events immediately following release from restraint. 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 after release in accordance with policy.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment:	Noncompliance

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	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.	1. Reviewed current RSSLC Restraint Policy to determine if policy prohibits prone restraint. 2. Reviewed the restraint trend analysis for 4/1/11 to 3/31/12 to determine if any prone restraint had been used. 3. Reviewed most recent Section C QA/QI Audit results which included audits of 100% (119 of 119) of restraints (9/1/11 to 2/29/12). 4. Reviewed Restraint Monitor training records to determine if all monitors have been trained. From its self-assessment the Facility determined that: 1. Current RSSLC Restraint Policies governed the use of restraints in accordance with this provision. 2. The trend analysis indicated that no restraints were used that are prohibited by RSSLC Restraint Policy. 3. Most recent Section C audit results indicated that documentation did not indicate in 100% of restraints that the restraint was not used for the convenience of staff or after a graduated range of less restrictive measures had been exhausted. 4. All staff designated as restraint monitors have completed the training required of restraint monitors as described in the RSSLC Restraint Policy. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because Section C audit results did not clearly demonstrate that restraint was not used for the convenience of staff or after a graduated range of less restrictive measures had been exhausted. Additionally, the self-assessment did not address the Settlement Agreement (SA) requirement that restraint use occurs "in accordance with applicable, written policies, procedures, and plans governing restraint use. Monitoring Team note: Provision C.1 includes requirements that were not addressed in the Facility self-assessment. For example, the self-assessment did not address restraint use as an alternative to treatment. In addition, the Facility self-assessment did not address the Settlement Agreement (SA) requirement that restraint use be administered (i.e. implemented) "in accordance with applicable, written policies, procedures, and plans governing restraint use". Future self-assessments should address each requirement in the Provision. <u>Monitoring Team findings</u> RSSLC did not consistently administer restraint in accordance with applicable, written policies, procedures, and plans governing restraint use. Documentation prepared by the Facility for a sample of 17 crisis intervention restraints did not contain information required by policy; for example, none of the 17 documentation files contained the	

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		"Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint" and only three contained documentation that the Incident Management Review Team (IMRT) reviewed the restraint episode. None of the 17 Restraint Checklists (RCs) and Face-to-Face Assessment Debriefings (FFADs) reviewed contained complete and accurate information. Documentation related to medical restraint was also problematic. There did not appear to be sufficient data and internal controls to ensure the use of medical restraint occurred within the parameter of defined policy and procedure. For example, the Facility was unable to produce an accurate listing of medical restraint used for medical procedures. The Facility reported that it had begu$_{n\ the}$ process of training staff on the new State policy on restraint. This policy was effective 4/10/12 and the training provided to facilities on policy implementation encouraged facilities to convert restraint practices to the new policy requirements in an orderly manner as staff received training. Because of this the restraints reviewed by the Monitoring Team did not include any that were expected to comply with the requirements of the new policy. Per interview, the Facility acknowledged that it had not yet converted restraint practices to be compliant with the new policy but was looking forward to doing so in the near future as several aspects of the new policy were expected to facilitate improved record-keeping, restraint practices, and associated documentation, particularly in the areas of use of protective mechanical restraint and use of medical restraint. The Facility has experienced difficulty in establishing and following administrative procedures necessary to adhere to the existing State restraint policy. For example, at the last review it was noted that the Facility had finally started using consistently the State-required Restraint Checklist and Face-to-Face Assessment Debriefing documents. As noted above, the use of these documents to consistently and accurately record information associated with each restraint episode has been problematic. The Monitoring Team encourages the Facility to use the training associated with rolling out the new State policy as an opportunity to reinforce essential elements of restraint documentation requirements. The use of crisis intervention restraint at RSSLC increased significantly since the last review period. The RSSLC Trend Report indicated the use of crisis intervention restraint 165 times in the five months since the last review (November, 2011 through April, 2012). In the five months prior to the last review (May, 2011 through October, 2011) restraint was used 115 times. This 43% increase was reported to be primarily attributable to issues presented by several new admissions. Since the last review the Facility had expanded the Restraint Trend Report to include key data tracked longitudinally. As a result, the Monitoring Team was able to review six-	

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		month trends and note the following: • Crisis intervention restraint use at RSSLC was primarily the result of Individuals being aggressive towards staff. This was the case with 74% of crisis intervention restraints. Most restraints occurred between noon and 5:00pm. Aggression towards staff can occur for many reasons; including deficient active treatment and/or positive behavior support plan. Ordinary staff interaction with Individuals as well as an Individual's ability to communicate wants and needs can also be a factor. • Most crisis intervention restraint use at the RSSLC was highly restrictive. In reviewing restraint trends the Monitoring Team determined that over the last six months the horizontal /side lying technique (i.e. a restraint technique that includes multiple staff restraining the individual on the floor) was used in 55% of restraints; there was no indication in the trend reports of whether individuals sat down or whether staff moved them to the floor. The basket-hold technique was used in 24% of restraints. Mechanical or chemical restraint was used in 6% of restraints. These highly restrictive techniques were used in 85% of the restraints over the six-month period. This pattern of use of highly restrictive restraint techniques was also noted in the last compliance report. The narrative analysis that accompanies the Trend Analysis reports did not identify or address either of the above subjects. The Monitoring Team would hope that in the future this analysis would identify and probe key areas of inquiry such as these. This should include interdisciplinary review and discussion. As noted above, many aspects of daily life at the Facility can contribute positively, or negatively, towards behavior that resulted in the need for restraint use. Documentation review and interviews by the Monitoring Team suggest that staff involved in the use of medical restraint did not implement restraint policy correctly. For example, policy requires that the Restraint Checklist (RC) and Face-to Face Assessment/Debriefing (FFAD) be used in all instances of restraint use. Policy (both State and RSSLC) does not exclude medical restraint 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 medical restraint episodes for which the Facility was asked to produce documentation. The Director of Behavioral Services reported that certain requirements in the new State restraint policy, specifically unique checklists for medical restraint, should make it easier to track and monitor use of medical restraint in the future. The Monitoring Team assembled three samples of restraint use at the RSSCLC. The source document used for these samples was the listing of restraints used since the last review that was provided in response to the monitoring team's pre-visit document	

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		request. The Facility was unable to produce an accurate list of medical restraints used for medical procedures. Consequently, the medical restraint sample is limited to dental procedures. These samples were: 1. Restraint documentation for crisis intervention restraints (Sample C.1): Individuals #600 (2/3 10:36am, 3/21, 3/22, 4/19 6:19am, 12:20pm, and 1:40pm, and 4/22), #267 (12/9 2:15pm), #630 (1/20), #643 (3/5, 3/9, and 4/10), #17 (1/14 and 4/16), #100 (11/14 4:30pm and 5:40pm, and 3/12), #672 (1/27, 1/31 6:40am and 2:25pm, and 4/12), #165 (2/29 5:22pm), #142 (2/14 and 3/28), #513 (2/5), #448 (4/20), #25 (2/9), #315 (2/18) and 2/20 (11:35am), 306 (3/6 10:41am), #113 (12/15 8:00am), #137 (4/19), and #773 (2/1). This sample consisted of 20% of crisis intervention restraints. Many of these restraints and Individuals will be discussed in Provision C.7 because of the high frequency of restraint. As a result, this sample was reduced in size to include only one restraint for each of the Individuals reviewed in Provision C.7, resulting in a sample of 20% of the Individuals who experienced crisis intervention restraint. The sample included restraint use for each of the Individuals frequently restrained (and discussed in detail in Provision C.7) and other restraints selected to ensure each type of restraint and various durations of restraint was represented. 2. Restraint documentation for medical restraints (Sample C.2): Individuals #694 (2/14), #555 (4/4), #483 (2/15), #207 (1/10), #239 (4/9), #268 (11/30), #57 (12/14), #479 (3/21), #403 (2/27), #40 (3/29), #442 (3/7), #115 (1/3), #405 (4/10), #375 (12/6), #353 (12/15), #232 (11/28), #771 (4/11), #220 (11/18), #413 (4/4), #498 (2/14), and #585 (11/8). This sample consisted of 20% of those Individuals who had received pre-treatment sedation for dental procedures. 3. Restraint documentation for protective mechanical restraints (Sample C.3): Individuals #44, #502, and #540. This sample consisted of 20% of those Individuals who had protective mechanical restraint. 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>	

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		Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records, restraint elimination 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. Fifty-five percent of crisis intervention restraints at the RSSLC used the horizontal side-lying technique which can create a situation where an Individual ends up, inadvertently and momentarily, in a prone or supine position. The Facility should ensure its restraint review activity considers this in its review. Because of the frequency of use of this type of restraint (and the long duration of many) at the RSSLC the Monitoring Team recommends that restraint review specifically document that the Individuals subject to horizontal side-lying restraint were, or were not, in a prone or supine position during the restraint. <u>Other Restraint Requirements</u> 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 Sample C.1 (crisis intervention restraints) the following are the results of this review: • Sixteen of 17 records (94%) 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?" In each case the response was "yes." The data on the FFAD was corroborated by narrative information on the Restraint Checklist (RC). The Facility was unable to produce a RC and FFAD for Individual #600 (Note: this will affect compliance scores throughout Section C). • Sixteen of 17 records (94%) included documentation showing that the restraint monitor could 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. • There were instances where documentation on the RC and FFAD raised questions as to if restraint occurred for the appropriate reason. For example, restraint use for two individuals (Individuals #142 and #448) who had Safety Plans (now called Crisis Intervention Plans) did not document that Safety Plans were followed. Failure to implement Safety Plans may indicate that restraint occurred before absolutely	

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		necessary, raising the question if restraint was used as an alternative to clinically directed behavior program implementation, i.e. for the convenience of staff. As reported in Section K the Monitoring Team observed only occasional implementation of positive behavior support plans. 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 document that the plans had been implemented, nor did the Facility have data to identify whether the plans were effective in minimizing use of restraint. • Sixteen of 17 records (94%) included documentation showing that preventative strategies and interventions were attempted prior to restraint. • Only six of 17 (35%) restraint records included documentation that the Interdisciplinary Team (IDT) reviewed the restraint episode. Those that did not were restraints for Individuals #600, #630, #17, #100, #672, #615, #513, #448, #25, #315, and #113. • Only nine of 17 (53%) records included documentation validating Unit Morning Meeting review of the restraint episode. Those that did not were restraints for Individuals #600, #630, #142, #448, #315, #306, #137, and #113. • Only five of 17 (29%) records included documentation validating IMRT Meeting review of the restraint episode. Those that did not were restraints for Individuals #600, #630, #142, #315, #306, #137, #267, #643, #17, #672, #25, and #113. Protective mechanical restraints were in use for eight individuals living at the RSSLC. Three were selected for the sample for this review. A seatbelt for Individual #540 was used because of the individual's self-injurious behavior (SIB). Padded sleeves for Individual #502 were used because of the individual's SIB. A helmet for Individual #44 was used because of the individual's SIB. RSSLC policy requires that the use of protective mechanical restraint be specified in a Safety Plan and must include plans to systematically decrease and eliminate the need for the protective restraint device. No Safety Plan was provided to the Monitoring Team for Individuals #540 and #502. Safety Plans are required by policy. A Safety Plan was provided for Individual #44 but it did not include plans to systematically decrease and eliminate the need for the protective restraint device. Additionally, the Facility did not provide, in the documentation files prepared for the Monitoring Team, the Individual Support Plan (ISP), Individual Support Plan Addendums (ISPAs), or Positive Behavior Support Plans (PBSPs) for any of the three Individuals. As a result the Monitoring Team is unable to assess the efficacy of the use of protective mechanical restraint at the RSSLC. <u>Medical Restraint:</u> In the Self-Assessment, the Facility reported that all individuals who	

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		had pretreatment sedation had had a Medical or Dental Support Plan. The Facility Action Plan had three steps. The first was to develop the needed medical and dental support plans; that step was reported to have been accomplished. The second action step was to monitor progress related to the medical and dental support plans, and the third action step was to revise the support plans when progress was not noted. The Facility acknowledged that it had not started to implement the latter two steps. Rates of use of pre-treatment sedation: The dental clinic provided data that showed that between October 2011 and March 2012, the number of sedations varied between a low of 26 (March 2012) and a high of 55 procedures (Jan 2012). The monthly average number of procedures was 44. General anesthesia was used on average for 3% of procedures, and oral pretreatment sedation was used for about 7.7% of procedures. These figures were similar to what was reported for the prior six months. Data was not provided by the Facility for rates of medical pre-treatment sedation. Monitoring for safety when pre- treatment sedation was used: The Monitoring Team reviewed records for eight uses of dental oral pre-treatment sedation, and for four cases of TIVA (Sample J3). Selection of the samples is described as part of Section C of this report. Results were as follows: • Oral pre-treatment sedation for dental procedures: Medical orders were provided for the day of the procedure. Ativan was used, and the maximum dose was four mg. Medical monitoring for safety was guided by nursing sedation protocol and was documented on the Medical Monitoring Form. The Monitoring Team requested, but was not provided, with the details of the medical monitoring. • TIVA sedation: The full protocol for TIVA sedation was detailed in previous reports of the Monitoring Team. The Monitoring Team was provided with vital sign and REACT score reports from the dental suite, from the infirmary, and from the home. The Monitoring Team verified that monitoring was done. In one exception, information from the infirmary was not received, for Individual #694. The failure to consistently administer restraint in accordance with applicable, written policies, procedures, and plans governing restraint use, including 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 Provision J.4 of this report. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	

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C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Facility self-assessment The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed most recent Section C QA/QI Audit results which included audits of 100% of restraints (9/1/11 to 2/29/12) to determine if all restraints were terminated as soon as the individual was no longer a danger to him/herself or others. From its self-assessment the Facility determined that: 1. Section C audit results (9/1/11 to 2/29/12) indicated that four of 119 (3%) audits found that restraint documentation did not clearly indicate that restraint was terminated as soon as the individual was no longer a danger to him/herself or others. Based on the findings of this self-assessment, the Facility determined that this provision is in substantial compliance because there is a process that identifies and alerts the facility when a restraint is not terminated as soon as the individual is no longer a danger to him/herself or others. Monitoring Team findings 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 crisis intervention restraints were included in Sample C.1. Sixteen (94%) appropriately documented release as occurring whe$_{n\ the}$ Individual was no longer a danger to themselves or others. Therefore, this provision is found in substantial compliance. Nevertheless, the Monitoring Team has the following observation about review of restraint use: The lack of documentation of restraint review described in Provision C.1 by the Unit Team (47% of the time) and the IMRT (71% of the time) indicates an issue the Facility should address. One purpose of these reviews is to ensure that data recorded on the RC and the FFAD is accurate. This would occur through interdisciplinary discussion of the circumstances of the restraint episode and should typically include a staff person with personal knowledge of the restraint episode such as the Restraint Monitor. This is a necessary procedural step to validate that restraint release occurred according to policy and as described on the RC and FFAD.	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	Facility self-assessment The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed current restraint policies and procedures to determine if the policy	Noncompliance

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	one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	requirements of this provision are met. 2. Reviewed most recent Section C audit results (9/1/11 to 2/29/12). 3. Reviewed the restraint trend analysis for 4/1/11 to 3/31/12. From its self-assessment the Facility determined that: 1. All elements required by this provision were included in current restraint policies and procedures. 2. Section C audit results (09/01/2011 to 02/29/2012) indicated that 2 of 119 audits found that staffs applying the restraint were not in compliance with the training requirements described by this provision. 3. The trend analysis of the Section C monitoring tool indicated that no restraints were used that are prohibited by RSSLC Restraint Policy. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance due to no documented evidence that the training and other issues have been addressed. However, the facility is moving towards compliance as the Section C monitoring tool identifies instances whe_{n the} facility fails to comply with the provision. Monitoring Team note: The Facility self-assessment did not address all requirements of this Provision, most notably the requirement that the "Facility shall develop <u>and implement</u> policies governing the use of restraints." Future self-assessments should also identify and address policy implementation issues. <u>Monitoring Team findings</u> Multiple examples of issues with policy implementation were presented in Provision 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. Training Requirements: Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint • Approved verbal and redirection techniques • Approved restraint techniques • 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 26 staff training records (selected by picking the second name of a direct care	

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		professional on each printout page of the list of employees) to validate completion of the following courses: • RES0105 Restraint: Prevention and Rules for Use at MR Facilities • RES0110 Applying Restraint Devices • PMA0320 – PMAB Basic • PMA0400- PMAB Restraint • PMA0700 –PMAB Prevention • PBS0100 – Positive Behavior Support The Monitoring Team used this sample of 26 direct care staff, referred throughout the report as Sample C.4, to determine the following: • For training class RES0105 Restraint: Prevention and Rules for Use at MR Facilities all 26 (100%) had completed the training within the last 12 months. • For training class RES0110 Applying Restraint Devices 25 of the 26 (96%) had completed the training within the last 12 months. • For training class PMA0320 – PMAB Basic all 26 (100%) had completed the training within the last 12 months. • For training class PMA0400 – PMAB Restraint all 26 (100%) had completed the training within the last 12 months. • For training class PMA0700 – PMAB Prevention all 26 (100%) had completed the training within the last 12 months. • For training class PBS0100 – Positive Behavior Support all 25 of the 26 (96%) had completed the training within the last 12 months. The Monitoring Team also reviewed a State report "Percent of All Employees Completing Courses of Training Program." This report indicated the following completion rates for RSSLC employees: • 100% RES0105 Restraint: Prevention and Rules for Use at MR Facilities • 100% RES0110 Applying Restraint Devices • 99% PMA0320 – PMAB Basic • 100% PMA0400- PMAB Restraint • 100% PMA0700 –PMAB Prevention • 100% PBS0100 – Positive Behavior Support 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.	

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		The Monitoring Team concurs with the Facility's self-assessment of noncompliance 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.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed most recent Section C audit results (9/1/11 to 2/29/12). 2. Reviewed a random sample of Medical and Dental Support Plans to determine the quality of the plans. From its self-assessment the Facility determined that: 1. Section C audits indicated that the documentation was not clear in 100% of cases that the restraint was used as a crisis intervention and was not prohibited by medical orders. 2. All individuals needing a Medical or Dental Support Plan had one; however, Dental Support Plans did not always have measurable objectives against which to monitor progress. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance due to the results of the Section C audits not indicating compliance in 100% of cases and the lack of documentation related to the effectiveness of Dental Support Plans. <u>Monitoring Team findings</u> Based on a review of 17 crisis intervention restraints (Sample C.1), in 16 (94%) there was evidence documenting that restraint was used as a crisis intervention. The Facility was unable to provide a RC or FFAD for one Individual (#600) in the sample. The Facility presented to the Monitoring Team a RSSLC form titled "Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint." This form was intended to address the SA requirement that restraint not be used that is prohibited by the individual's medical orders. This intended use was verified by the Director of Behavioral Services. This form was not present in any of the 17 documentation files prepared for the Monitoring Team. The Monitoring Team reviewed the Annual Physician Summary for several of the 17 Individuals and conditions noted on the active problems list of the physician's summary suggested that many Individuals had medical conditions (e.g. overweight, underweight, high blood pressure, seizure disorders, abnormal EKG, degenerative back disease, etc.) that should have been assessed and considered in determining any restrictions on the use of restraint. No documentation was provided that would address the additional requirement that	Noncompliance

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		prohibitions against restraint, other than medical considerations, were assessed, considered, and noted in an Individual's ISP. Documentation in the files prepared by the RSSLC did not allow the Monitoring Team to adequately determine if physicians and the IDT regularly assess whether restraint should be limited or prohibited prior to implementation for each individual who is restrained. It is essential that the IDT and staff providing supports and services have all information needed to make decisions about restraint use. Safety considerations with respect to restraint use should include thoughtful interdisciplinary discussion and should be documented in each ISP. Medical and dental support plans had been developed for many individuals; however, a review of documentation led the Monitoring Team to conclude implementation did not always occur as planned. For example, from the documentation presented to the Monitoring Team only one of five (20%) dental support plans reviewed was implemented in a timely manner (Individual #584). For three, a significant time gap (at least seven months) elapsed between plan development and initial implementation (Individuals # 56, #452 and #789). For the fifth person (Individual #25) the time gap between plan development and implementation was two months. The review of five medical support plans showed three plans that were developed in 2011 with no evidence presented to the Monitoring Team that they were ever implemented (Individuals #718, # 358, and #25) and two that were implemented well after plan development (Individuals #86 and #160). 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 ISP 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. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
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	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed most recent Section C audit results (9/1/11 to 2/29/12). From its self-assessment the Facility determined that: 1. The audits indicated that a face-to-face assessment was conducted within 15 minutes	Noncompliance

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	soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed 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.	in 73% of audits. The audits indicated that vitals were monitored every 30 minutes in 69% of cases. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance due to response time lines not being consistently met. Monitoring Team note: the Facility self-assessment did not address training requirements for staff serving as Restraint Monitors and should in the future. <u>Monitoring Team findings</u> 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 140 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 are required for someone to serve as a restraint monitor, and conduct FFADs. • ABU0100 Abuse and Neglect • PMA0320 PMAB Basic • PMA0400 PMAB4: Restraint • PMA0700 PMAB7: Prevention • CPR0100 CPR Basic • RES0105 Restraint: Prevention and Rules for Use at MR Facilities • RES0110 Applying Restraint Devices • RIG0100 Rights of Consumers • PBS0100 Positive Behavior Support • Facility developed FFAD training The training records of 14 staff designated as restraint monitors were selected for review. These were the Restraint Monitors for the 17 crisis intervention restraints in Sample C.1. The Facility was asked to identify the Restraint Monitor names from the RCs in Sample C.1 and provide the training transcript for each of them. The Facility only provided training transcripts for 10 of the 14 staff. Nine of the ten showed all required training had been completed. The other transcript showed none of the required training was completed. As a result, the Monitoring Team has concluded that nine of 14 (64%) staff serving as Restraint Monitors had been adequately trained. 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.	

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		Based on a review of 17 restraint records for restraints that occurred at the Facility (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 10 (59%) of the instance of restraint. Those that did not included: o Individual #165: 12/7/11 at 9:50 a.m. and 12/25/11 at 6:08 p.m. o Individual #600: 3/22/12 at 4:45 a.m. and 4/19/12 at 6:19 a.m. o Individual #100: 11/14/11 at 4:30 p.m. and 11/14/11 at 5:40 p.m. o Individual #672: 1/31/12 at 2:25 p.m. ▪ Monitored and documented vital signs as required by policy in 15 (88%). Records that did not contain documentation of this included: o Individual #600: 4/19/12 at 6:19 a.m. o Individual #100: 11/14/11 at 4:30 p.m. o Although the nurses attempted to take vital signs on Individuals # 643 on 3/5/12 at 1:45 p.m. and #672 on 1/27/12 at 12:55 p.m., there was documentation that the individuals refused to allow them to be taken but no documentation of observations that could be made (e.g., mental status). o Vital signs were taken later than 30 minutes after restraints were applied on Individuals: #100 on 11/14/11 at 5:40 p.m., #165 on 12/25/11 at 6:08 p.m., and #165 on 12/27/11 at 9:50 a.m.. This delay in completing the mental status later than 30 minutes after the restraints were applied violated the Restraint Policy. The Nursing staff should be re-trained on the policy to ensure monitoring occurs within 30 minutes of the application of the restraints. ▪ Monitored and documented mental status as required by policy in 16 (94%). Records that did not contain documentation of this included: o Individual #100: 11/14/11 at 4:30 p.m. o Mental status assessments were completed later than 30 minutes after restraints were applied on Individuals: #100 on 11/14/11 at 5:40 p.m., #165 on 12/25/11 at 6:08 p.m., and #165 on 12/27/11 at 9:50 a.m. This delay in completing the mental status later than 30 minutes after the restraints were applied violated the Restraint Policy. The Nursing staff should be re-trained on the policy to ensure monitoring occurs within 30 minutes of the application of the restraints. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
C6	Effective immediately, every individual in restraint shall: be	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-	Noncompliance

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	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.	assessment: 1. Reviewed most recent Section C audit results (9/1/11 to 2/29/12). From its self-assessment the Facility determined that: 1. The audits indicated that: a) the individual was checked for restraint related injury in 89% (100 of 112) of audits, b) opportunity to exercise limbs was provided in 20% (1 of 5) of audits, c) food was offered in 0% (0 of 3) of audits, d) fluids were offered in 0% (0 of 4) of audits, the opportunity to toilet was offered in 43% (3 of 7) of audits, and e) supervision was provided as indicated by this provision in 99% (115 of 116) audits. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance due to audits not demonstrating sufficient consistency in individual being checked for restraint related injury, that opportunity to exercise limbs was provided, that food was offered, that opportunity to toilet was offered, and that supervision was provided as indicated. <u>Monitoring Team findings</u> A sample (Sample C.1) of 17 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The Facility was unable to produce a RC for one Individual (#600) in the sample. The following compliance rates were identified for each of the required elements: • In 16 of 17 (94%), continuous one-to-one supervision was documented. • In 16 of 17 (94%), the date and time restraint was begun was documented. • In 16 of 17 (94%), the location of the restraint was documented. • In 16 of 17 (94%), information about what happened before, including the change in the behavior that led to the use of restraint, was documented. • In 14 of 17 (82%), 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 always indicate that interventions in the Safety Plan were attempted. • In 16 of 17 (94%), the specific reasons for the use of the restraint were documented. • In 16 of 17 (94%), the method and type (e.g., medical, dental, crisis intervention) of restraint were indicated on the restraint checklist. • In 16 of 17 (94%), the names of staff involved in the restraint episode were indicated on the restraint checklist. Eleven (65%) of the restraints in the sample included use of the horizontal side-lying technique. In all 11 at least two staff were listed as applying the restraint. • The Restraint Checklist documented observations of the individual and actions	

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		taken by staff while the individual was in restraint. Observations every 15 minutes were either not taken, or not recorded on the RC, as required by policy. . For example, Individual #306 was restrained for 27 minutes and 18 minutes elapsed without an action code recorded on the RC. Individuals #113 and #165 were restrained 19 minutes and 18 minutes respectively with the only recorded action codes being the start and release of restraint. Individual #315 was in mechanical restraint (arm splints) for an hour and 50 minutes and went an hour and 25 minutes with no action code recorded on the RC. • In 16 of 17 (94%), the specific behaviors of the individual that required continuing restraint were noted. • Nine of the 17 restraints (53%) reviewed were 15 minutes or longer. Two mechanical restraints exceeded 1.5 hours in length and there was insufficient documentation on the RC to determine if opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bedpan occurred or were necessary. • In 16 of 17 (94%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. • In 16 of 17 (94%), the date and time the individual was released from restraint was recorded on the restraint checklist. • 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 #600 and #165. Restraint monitors were not always present within the required 15 minutes. This was the case with three (18%) of the 17 restraints in the sample, for Individuals #113, #513 and #600. None of the 17 crisis intervention restraint records in the sample had an alternative physician-ordered monitoring schedule. In its last report the Monitoring Team noted that the Facility had made significant improvement in its documentation of crisis intervention restraint. There was little evidence of continued improvement in restraint documentation noted in this review. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
C7	Within six months of the Effective Date hereof, for any individual	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-	Noncompliance

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	placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	assessment: 1. Reviewed records of individuals identified as having more than 3 restraints in any 30 day period to determine if there was an IDT review through an Individual Support Plan Addendum (ISPA). 2. Reviewed ISPAs to determine if the content and analysis requirements of this provision were met. From its self-assessment the Facility determined that: 1. ISPAs were inconsistently held when an individual had been restrained more than three times in a rolling 30-day period. 2. ISPAs did not consistently identify the information described in this provision. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance due to the ISPAs not being completed. <u>Monitoring Team findings</u> According to Facility documentation provided in response to the document request, during the six-month period prior to the on-site review, a total of 10 individuals were placed in restraint more than three times in any rolling thirty-day period. A sample of nine of these individuals (90%) was selected for review to determine if the requirements of the Settlement Agreement were met. The tenth individual in document TX-RI-1205-II.6 was excluded from the sample as the individual had been discharged from the Facility. The following documents were reviewed, if available. • Document TX-RI-1205-II.6 • PSPs • PSP addenda • PBSPs • PBSP progress notes • Safety Plans • 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. A problem with the information provided by RSSLC regarding restraint was the failure by the Facility to ensure that restraint records were consistent and coherent. For each of the	

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		individuals included in the review, documentation from at least one source at the Facility was not in agreement with information from other sources at the Facility. In many circumstances, applications of restraint included in document TX-RI-1205-II.6 of the document request were not reflected in available Restraint Checklists, reviews by the Interdisciplinary Team, or PBSP progress notes. • For Individual #100, two Restraint Checklists were in the chart. The checklists were dated 11/16/2011 and 3/12/2012. Document TX-RI-1205-II.6 reflected restraint applications on 11/14/2011 (4), 11/15/2011 (2), 11/16/2011, and 3/12/2012. No PSP addenda reflecting a review of restraints were in the chart. • For Individual #142, document TX-RI-1205-II.6 reflected six applications of restraint in the previous six months: 2/14/2012, 3/2/2012, 3/27/2012, 3/28/2012, 4/16/2012, 4/20/2012. Restraint Checklist in the individual's chart reflected restraint applications on 2/3/2012, 2/9/2012, 2/10/2012, 2/12/2012, 2/13/2012, and 2/14/2012. The Psychology Progress Notes from the same period reflected no applications of restraint. • For Individual #600, Restraint Checklists in the chart reflected 12 applications of restraint in the previous six months. The Facility-wide list of individuals with restraints and the dates and times of those restraints provided as Document TX-RI-1205-II.6 reflected 35 applications of restraint during the previous six months. • For Individual #643, Restraint Checklists reflected restraint applications on 1/25/2012 (3) and 2/21/2012. Document TX-RI-1205-II.6 reflected restraint applications on 11/2/2011, 11/7/2011, 1/25/2012 (3), 2/21/2012, 3/5/2012, 3/9/2012, 3/14/2012, and 4/10/2012. The conflicting information the Facility regarding use of restraint brought into question whether the Facility could accurately track the use of restraints and ensure that the required Facility actions were taken whenever an individual experienced more than three restraints in a rolling 30-day period. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For none of the individuals/instances reviewed (0%), did documentation reflect that the IDT met as required to review applications of restraint according to accepted practice and the stipulations of the Settlement Agreement. Although documentation reflected that the IDT for some individuals met to discuss restraint, in none of the records provided did any individual's IDT meet for all stipulated applications of restraint. • For Individual #630, document TX-RI-1205-II.6 reflected that restraints were applied on 11/13/2011, 11/26/2011 (2), 11/27/2011, 12/19/2011,	Noncompliance

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		1/19/2012, 1/20/2012, 1/22/2012, and 3/17/2012 (2). Additional information made available by the Facility included no PSP addenda, indicating that the IDT had never met to discuss restraint applications during the previous six months. • For Individual #267, document TX-RI-1205-II.6 reflected that restraints were applied on 11/2/2011, 11/26/2011 (2), 11/28/2011, 12/7/2011 (2), 12/9/2011 (2), 12/10/2011, 1/26/2012, 1/27/2012 (2), 2/5/2012 (3), 2/7/2012, 2/15/2012 (3), 2/16/2012, 2/17/2012, 2/21/2012 (2), 2/24/2012, 3/3/2012, 3/16/2012, and 3/21/2012 (2). PSP addenda reflected that the IDT met to review restraints only twice: on 12/1/2011 and 12/20/2011. When documentation provided by the Facility reflected that the IDT had met to review restraint, that documentation typically reflected a failure to provide an adequate review of the restraint application and factors contributing to the use of restraint. • For Individual #267, the PSP addendum from 12/1/2011 included no specific information regarding the number of restraints or factors contributing to restraint. The PSP addendum dated 12/20/2011 included only a cursory review, stated that the individual "had some medical issues going on", and offered no recommendations. • For Individual #600, the PSP addendum from 3/21/2012 described an event in which interactions with staff and peers contributed to the behavior that ultimately required the application of restraint. The PSP addendum, however, went on to state that no psychosocial factors contributed to the use of restraint. For nine of the individuals/instances reviewed (100%), IDTs had not reviewed the individual's adaptive skills. For nine of the individuals/instances reviewed (100%), individuals' teams failed to review the biological, medical and psychosocial factors. The following are examples of where teams failed to do this adequately: • For Individual #267, the PSP addendum dated 12/20/2011 included only a cursory review, and stated only that the individual "had some medical issues going on."	
	(b) review possibly contributing environmental conditions;	For nine of the individuals/instances reviewed (100%), individuals' teams failed to review the possibly contributing environmental conditions.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For nine of the individuals/instances reviewed (100%), individuals' teams failed to review or provide assessments of the behavior provoking restraints. The records of some individuals included Structural and Functional Assessments (SFAs). Due to the poor	Noncompliance

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		quality of PSP addenda and other documentation, it was not possible to identify when, if at all, SFAs were completed or reviewed in response to the application of restraint.	
	(d) review or perform functional assessments of the behavior provoking restraints;	For nine of the individuals/instances reviewed (100%), individuals' teams failed to review or provide assessments of the behavior provoking restraints. The records of some individuals included Structural and Functional Assessments (SFAs). Due to the poor quality of PSP addenda and other documentation, it was not possible to identify when, if at all, SFAs were completed or reviewed in response to the application of restraint.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	For eight of the individuals reviewed (89%), the individual had a PBSP. Although copies of PBSPs and Safety Plans were requested from the Facility, for most of the individuals these documents were either not provided or were substantially outdated. This presented a substantial impediment to the process of determining the adequacy of interventions. • For Individual #142, the most recent PBSP was dated 3/28/2011. There was no indication of revisions to the PBSP because of restraint or other circumstances. • For Individual #643, no SFA, PBSP, or Safety Plan was provided by the Facility. • For Individual #672, no SFA was provided by the Facility. Similarly, behavior data for the individuals experiencing restraint were not fully made available by the Facility. Of the nine individuals experiencing more than three applications of restraint in any rolling 30-day period, the Facility provided behavior data for only three individuals. For these three individuals, Individual #142, #600, and #672, the data were often incomplete, again limiting the evaluation process. • For Individual #142, the provided data ended on April 1, 2012. These data suggested that self-injury was improving up to that point. A review of the available records, however, had indicated a considerable under-reporting of restraint applications in the behavior data in comparison with the number of Restraint Checklists. Due to these data issues, it was not possible to formulate conclusions about treatment efficacy for this individual. • For Individual #600, the provided data ended on March 26, 2012. These data suggested a substantial drop in physical aggression during March. The lack of more recent data prevented the determination of whether the decrease continued. Available Restraint Checklists indicated that multiple applications of restraint were required in both February and March, suggesting that the behavior necessitating restraint had not improved. • For Individual #672, the provided data ended on March 18, 2012. These data reflected that last displays of aggression and self-injury were on February 20, 2012. Without more recent data, it was not possible to determine if these trends continued.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based upon the lack of behavior data, as well as missing or outdated PBSPs and Safety Plans, it was not possible to determine the adequacy of behavior interventions in relation to the use of restraint.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	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.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	In none of the records reviewed (0%), was there adequate documentation to determine that the individual's PBSP had been revised as appropriate. • For Individual #142, the most recent PBSP was dated 3/28/2011. • The most recent PBSP for Individual #267 was dated 1/24/2011. • The most recent PBSP for Individual #630 was dated 2/14/2011. • For Individual #643, no SFA, PBSP, or Safety Plan was provided by the Facility.	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.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed most recent Section C audit results (9/1/11 to 2/29/12). From its self-assessment the Facility determined that: 1. 95% of audits (110 of 116) indicated that the restraint was reviewed within 3 business days; 0% (0 of 2) ISPs were revised when indicated. Based on the findings of the self-assessment, the Facility determined that this provision was not in substantial compliance because the required IDT reviews and subsequent ISP revisions did not consistently occur. <u>Monitoring Team findings</u> RSSLC policy for the review of crisis intervention restraints requires that the IDT meet and review each use of restraint as a crisis intervention that is not authorized by a Safety Plan within one working day of the restraint. The review is to be summarized in an ISP addendum. 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 is to be	Noncompliance

#	Provision	Assessment of Status	Compliance
		reviewed at the Unit Meeting and at the Incident Management Meeting. Restraint Checklists are to be reviewed at Unit Meetings to ensure completeness, with the Unit Director or designee assigning responsibility for corrections needed. The restraint monitoring process at the Facility is deficient in a number of important areas. First, the data on the Restraint Checklist (RC) and the Face-to-Face Debriefing documents (FFAD) cannot be considered necessarily reliable because, as noted in Provision C.5, five of 14 (36%) restraint monitors in Sample C.1 were not adequately trained. Second, in the documentation files prepared for the Monitoring Team, as noted in Provision C.1, only six of 17 (35%) restraint files in Sample C.1 included documentation that the Interdisciplinary Team (IDT) reviewed the restraint episode; only nine (53%) included documentation validating Unit Morning Meeting review of the restraint episode; and, only five (29%) included documentation validating IMRT review of the restraint episode. Finally, the Facility had staff from the Behavioral Services Department review each restraint using the Monitoring Tool. This review consisted primarily of checking the data on the RC and the FFAD. This is not required by policy but was initiated to ensure each restraint receives review from the Behavioral Services Department which is outside the chain of command of the residential units conducting unit reviews. These optional reviews often did not occur until weeks after the restraint episode. The Facility may want to consider doing these paperwork checks on a sample basis and use the time of the psychology staff to review the circumstances associated with a restraint episode with staff involved as soon after the restraint episode as possible. The Unit review and the IMRT review of restraints are also problematic whe$_{n\ the}$y do occur. The Monitoring Team observed a review of restraints during this visit. In each case the basic facts associated with the restraint was presented. Limited discussion occurred. In order to ascertain the circumstances under which restraint was used (the SA requirement) the Monitoring Team would expect more substantive discussion including a review of recent relevant data and interdisciplinary discussion. Facility policy requires that restraint reviews determine if each application of restraint was justified, if each restraint was applied correctly, and a determination of factors that exist, if modified, might prevent the future use of restraint. The restraint review meetings observed by the Monitoring Team did not do this. On a positive note, the Facility had initiated a process whereby the Director of Behavioral	

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		Services can view video surveillance tapes that had recorded the restraint episode, including the events immediately preceding the restraint and the events immediately following release from restraint. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of 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. (Provisions C1, C.2 & C.3)
2. Implement a process to ensure restraint restrictions designated by the physician or IDT are adequately documented and communicated to staff working with individuals who have such restrictions. (Provision C.4)
3. Ensure that medical and dental support plans are implemented timely and consistently. 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 ISP 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 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. Restraint review should specifically document that the Individuals subject to horizontal side-lying restraint were, or were not, in a prone or supine position during the restraint. (Provision C.8)
6. The narrative analysis that accompanies the Trend Analysis reports should identify and address topics emerging from review of longitudinal data. (Provision C.1)

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.
3. Use the training associated with rolling out the new State policy as an opportunity to reinforce essential elements of restraint documentation requirements.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment 5/1/12 2. RSSLC Action Plans 4/27/12 3. RSSLC Section D Presentation Book 4. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 5/11/11 5. DADS Policy 02.3 Incident Management 1/31/11 6. RSSLC Policy A.25 Securing Evidence 7/17/09 7. RSSLC Policy B.15 Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation 8/1/07 8. RSSLC Policy B.26 Placing an Employee on Investigative Leave 6/30/10 9. RSSLC Policy C.0 Video Surveillance 8/10/11 10. RSSLC Policy C.01 Incident Management 8/1/11 11. RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 12/20/11 12. RSSLC Policy D.8 Completing/Routing Client Injury Report 3/10/11 13. RSSLC Policy E.10 Participating in Unit Morning Meeting 3/10/11 14. RSSLC Policy E.17 Completing Incident Information Reports 3/15/12 15. Unusual incidents log 11/1/11 to 4/23/12 16. Log of serious injuries 11/1/11 to 4/23/12 17. Log of serious incidents 11/1/11 to 4/23/12 18. Log of witnessed Injuries 11/1/11 to 4/23/12 19. Log of discovered Injuries 11/1/11 to 4/23/12 20. Log of peer to peer injuries 11/1/11 to 4/23/12 21. CMS 2567's surveys since the last review 22. Incident management meeting minutes for 2/3/12, 2/10/12,2/17/12, 2/24/12, 3/9/12, 3/16/12, 3/23/12, 3/30/12, 4/6/12, and 4/13/12 23. Individual training records for RSSLC investigators 24. Individual training records for DFPS investigators 25. Documentation of volunteer background checks 26. Documentation of employee background checks 27. RSSLC Criminal Background Checks report 4/9/12 28. Training curriculum for Abuse, Neglect, and Exploitation 29. Acknowledgement of Reporting signed forms for 25 randomly selected employees 30. DFPS document labeled "Commencement of DFPS Investigation" undated 31. Log of Department of Family Protective Services (DFPS) cases 11/1/11 to 4/23/12 32. DFPS investigation reports and related documentation for cases 41036898, 41247616, 60941300, 41324412, 41484134, 41512212, 41545604, 41633499, and 4127712 (sample D.1) 33. DFPS investigation administrative referrals 41164916, 40799736, 40473556, 40460817, 41164916,

	41170838, 41172596, 41178148, 41178138, 41194006, 41211341, 41582172, and 41463252 34. Other DFPS investigation reports and related documents for cases 41087971, 41324412, 41512212, and 41710373 35. Office of Inspector General (OIG) investigation reports 08398-12, 08283-12, 08439-12, and 08507-12 36. DFPS/OIG/RSSLC coordination meeting minutes 2/15/12 37. FY11 OIG case log 11/1/11 to 4/11/12 38. Document prepared by RSSLC describing the audit process to detect underreporting of injuries 39. Materials used to educate individuals, LARs, and family members on Abuse, Neglect, and Exploitation 40. DADS report MHMR0102 Percent of All Employees Completing Course of Training 4/1/12 41. Incident Information Report (E.17) and related documents for Individuals #17, #152, #399, #612, and #686 (sample D.3) 42. RSSLC investigations of serious injuries UIRs 122, 128, 118, 065, and 139 (sample D.2) 43. List of employees/dates placed in No Direct Contact status (undated) 44. Staff Training Records (25 randomly selected employees) 45. State report "Percent of All Employees Completing Courses of Training Program." 4/1/12 46. Self-Advocate meeting minutes from 11/1/11 to 4/30/12 47. Employee roster 4/9/12 48. RSSLC Trend Reports 4/30/11 **People interviewed:** 1. Jane Purcell, Assistant Director of Programs 2. Joan Poenitzsch, Director of Quality Assurance 3. Reuben Muhammad, Incident Management Coordinator 4. Adam McCain, Facility Investigator 5. Robert Muhammad, Facility Investigator 6. Tim Weatherby, Assistant Director of Administration 7. Al Barrera, Facility Director 8. Shannon Steele, Director of Residential Services 9. Six Direct Care Professionals **Meetings attended/Observations:** 1. Incident Management Team Meeting (IMRT) 5/16/12 2. Four Rivers Unit Morning Meeting 5/16/12 3. Quality Assurance/Quality Improvement (QA/QI) Council 5/15/12 4. Administrative Review Team 5/16/12 5. Individual Support Plan (ISP) annual meetings for Individuals #462 and #508
	Facility Self-Assessment: There are 22 Provisions or components of Provisions in Section D of the SA. The RSSLC self-assessment reported substantial compliance with 19. The Monitoring Team determined substantial compliance with only 13. Provision D.1 (which addressed the Facility's commitment not to tolerate abuse), Provision D.4 (which addressed tracking and trending of data), and Provision D.5 (which addressed required background checks of employees and volunteers) were found to be in substantial compliance.

	The Facility's self-assessment process was overly general. For example, many sections did not address each element of each Provision or component of a Provision. Future self-assessments should be more descriptive. For example, this self-assessment often described a task such as "reviewed 25 reports" but did not specify how the review was done, how the 25 reports were selected for review, who conducted the review, or how the review results were documented; and, whether or not QA monitoring data was also used to determine the status of compliance, and consideration of other relevant data. The Facility's Action Plan that accompanies the self-assessment included steps to improve processes that were intended to lead to compliance with the Settlement Agreement. Similar to the Self-assessment, the Action Plan also lacked detail and comprehensiveness and was overly general. For example, an Action Step was described as "continue weekly training classes on A/N/E." This describes a regular and routine activity at the Facility. Action steps should reflect intended actions to correct an identified problem, or a set of intended actions that when viewed together are intended to correct an identified problem. Additional action steps will need to be developed to address issues identified by the Monitoring Team which are not sufficiently addressed in the current Facility Action Plan.
	Summary of Monitor's Assessment: 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. The Monitoring Team did not find any instances of lack of cooperation betwee$_{n\ the}$ Facility, DFPS, OIG or local law enforcement in its review. Training for staff on abuse and incident reporting was in place, and all staff was current in that training; however, staff knowledge of abuse/neglect reporting requirements needs to improve. All allegations of physical abuse received a law enforcement referral. The Facility is to be commended for improving the process for review of non-serious discovered injuries; however, the Facility's investigations of non-serious discovered injuries were not always adequate to make a determination that abuse or neglect was not a cause of, or contributing factor to, the injury under review. There continues to be a problem with timely response from DFPS in initiating investigations. Reporting procedures for reporting abuse and neglect were prominently displayed throughout the Facility and the Facility had an effective monitoring system to ensure postings remained in place.

	In every instance where an alleged perpetrator (AP) was know$_{n \text{ the}}$ AP was immediately placed in no contact status. Timely reporting of allegations was problematic at the RSSLC, as 86% of investigations in the Monitoring Team's sample were not reported to DFPS within one hour of discovery as required. Employee and volunteer background checks were completed timely. The RSSLC is to be commended for convening periodic joint meetings with DFPS, OIG, and local law enforcement at which any issues of mutual cooperation can be reviewed and resolved.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed local policies that address Abuse, Neglect and Exploitation (ANE) to determine if zero tolerance commitment and staff reporting responsibilities were included. From its self-assessment the Facility determined that: 1. The policy that addresses ANE included the commitment to zero tolerance. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because the local policies address the commitment of zero tolerance of ANE. Monitoring Team note: Provision D.1 includes requirements that were not addressed in the Facility self-assessment. For example, the self-assessment did not address Facility practices that demonstrate zero tolerance to abuse nor did it address policy implementation, especially with respect to reporting requirements. Future self-assessments should address each requirement in the Provision. <u>Monitoring Team findings</u> 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, and Exploitation (12/20/11) requires 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Reporting procedures for reporting abuse and neglect were prominently displayed throughout the Facility and the Facility had an effective monitoring system to ensure postings remained in place. 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. Staff training requirements for abuse/neglect training were 100% current, and completion of the form staff sign annually acknowledging their reporting responsibilities was 100% current. All the above demonstrate that the Facility does not tolerate abuse or neglect and that staff are to report. Therefore, this provision is found in substantial compliance. Nevertheless, there are concerns that the Facility needs to address, as indicated below. To test staff knowledge of abuse/neglect reporting responsibilities the Monitoring Team met with three staff from the morning shift and three staff from the afternoon shift. All were give$_{\text{n the}}$ same competency test used in annual refresher training. Only one staff answered all five questions correctly. Four staff failed to answer correctly the multiple choice question "If I witness or suspect that an Individual served has been neglected, abused or exploited, I must do the following:" Staff knowledge of abuse/neglect reporting requirements needs to improve. All the above demonstrate that the Facility does not tolerate abuse or neglect and that staff are to report. Therefore, this provision is found in substantial compliance. Nevertheless, there are concerns that the Facility needs to address, as indicated below. Timely reporting of allegations was problematic at the RSSLC. As noted above, the Facility self-assessment did not address the implementation requirements for reporting included in this provision. The sample of DFPS cases (Sample D.1) included seven cases where the date and time of the incident being reported was noted. In six (86%) the allegation was not reported within the one hour required timeframe. The Monitoring Team requested a list of incidents of late reporting in the pre-visit document request. The list that was provided, which reported one instance of late reporting, did not include any of the six instances discovered in the sample reviewed by the Monitoring Team. Additionally, in January, 2011 the Facility received a regulatory deficiency related to timely reporting of allegations of mistreatment, neglect, or abuse.	

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		The Monitoring Team reviewed Facility follow-up actions in instances where DFPS returned a confirmed finding of abuse and neglect. In one case (41247616) an employee who was the subject of a confirmed finding of physical abuse was not terminated from employment. An additional measure of a facility's commitment to zero tolerance is its review and 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 an injury. The Facility had experienced 980 non-serious discovered injuries between 11/1/11 and 5/14/12. The Facility's investigation of non-serious discovered injuries were not always adequate to make a determination that abuse and neglect could be ruled out as a cause, or a contributing factor, of the injury. Please refer to Provision D.2.a for additional discussion of this topic. While Facility policy requires that staff report (and report timely) allegations of abuse, neglect, and other serious incidents, consistent implementation of timely reporting needs to be addressed. The frequency of untimely reporting is unacceptable and does not demonstrate sufficient commitment to no toleration of abuse and neglect. The Monitoring Team has determined that the RSSLC was not in substantial compliance with this provision of the SA. The Facility had received a compliance rating of substantial compliance in the last review. During this visit, additional factors that would demonstrate commitment to zero tolerance, such as the frequency of timely reporting, administrative follow-up to confirmed findings, and the process for review of discovered injuries, were reviewed and considered by the Monitoring Team in determining SA compliance status. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-	Noncompliance

#	Provision	Assessment of Status	Compliance
	not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	assessment: 1. Reviewed 25 of 99 (included ANE and serious incidents) from November 2011 to March 2012 Unusual Incident Reports (UIRs) to determine if they were reported to the facility director or designee according to policy. 2. Reviewed Incident Management Minutes to determine if every UIR of ANE and Serious Incidents were reviewed and discussed during Incident Management Meeting to address any reporting problems or concerns. From its self-assessment the Facility determined that: 1. 25 of 25 (100%) UIRs were reported to the facility director per policy. 2. 100% of every UIR of ANE and Serious Incidents were reviewed and discussed during Incident Management Meeting and addressed any reporting problems or concern. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance as staff report 100% of deaths, ANE and other serious incidents using a standardized process. <u>Monitoring Team findings</u> RSSLC Policy's C.01 Incident Management (8/1/11), C.02 Protection From Harm – Abuse, Neglect, and Exploitation (12/20/11), and D.8 Completing/Routing Client Injury Report address this provision of the SA. These policies included most reporting requirements necessary to comply with this component of the SA. In the last review the Monitoring Team noted that one significant omission in these policies was the absence of language that directs staff to report serious injuries immediately, within one hour, to the Facility Director/designee. This policy omission had not been corrected. The Facility provided data to the Monitoring Team for a six month reporting period of 10/1/11 through 3/31/12. During this six month period allegations reported to DFPS were as follows: • 100 abuse allegations. The disposition by DFPS of these 100 allegations was: Eight were substantiated, 34 were unconfirmed, 19 were inconclusive, 35 were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. Four were listed as disposition pending. • 47 Neglect allegations. The disposition by DFPS of these 47 allegations was: Seven were substantiated, 20 were unconfirmed, eight were inconclusive and 11 were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. One was listed as disposition pending. • No exploitation allegations.	

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		Note: The above data represented individuals who were alleged to have been abused or neglected. It does not represent the number of DFPS cases as a case may have multiple alleged victims. The Monitoring Team was concerned that a significant number of allegations of abuse had been referred back to the Facility because the nature of the allegation did not meet the DFPS definition of abuse. The Monitoring Team reviewed four of these administrative referrals (41170838, 40473556, 40799736, and 41463252). In each case the information contained in the referral consisted of, in effect, a mini investigation, ranging from two to four pages in length. The investigator reviewed considerable information, including in each case conducting staff interviews, before reaching the conclusion that the allegation was, as stated in one referral, "more of an administrative issue." These mini investigations took as long as nine days (in one case) for the investigator to make the determination. In each case reviewed by the Monitoring Team the determination made by the investigator appeared to be appropriate. In reporting allegations the Facility used a standardized reporting system. Two samples of investigations were selected for review. These included: • Sample D.1 of nine DFPS investigations of abuse, neglect, and/or exploitation between 11/1/11 and 4/15/12. This sample included the following DFPS investigation reports: 41036898, 41247616, 60941300, 41324412, 41484134, 41512212, 41545604, 41633499, and 4127712. This represented a 20% sample of 45 cases included in the log provided in response to the Monitoring Teams document request.. The sample was selected by working back from the most recent investigation and selecting one case of confirmed physical abuse, one case of confirmed neglect, two cases of unconfirmed physical abuse, one case of unconfirmed neglect, two cases with inconclusive findings (one an allegation of neglect and the other an allegation of verbal abuse) and two allegations of neglect referred back to the Facility (one an allegation of verbal abuse and one an allegation of neglect). • Sample D.2 of three facility investigations of serious injuries. RSSLC provided a report entitled Serious Injury Report, which listed serious injuries to individuals from 11/1/11 to 4/23/12. From this report the Monitoring Team was able to determine the RSSLC had 15 serious injuries during this time period. From these 15, three (20%) were selected for Sample D.2 to assess the adequacy of the facility investigation process. All three were noted on the Facility log as discovered injuries. In reviewing Sample D.1 (DFPS case reports) seven of the nine investigations (77%) noted a date and time the incident occurred (the other two noted the time of the incident	

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		as unknown). Six of the seven (86%) investigations that noted the date and time an incident occurred were not reported to DFPS within one hour of discovery as required by policy. Those that did not were cases 41036898, 60941300, 41324412, 41484134, 41545604, and 4127712. In reviewing Sample D.2 (serious injuries) all three were reported immediately (within one hour) to the Facility Director/designee. 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 Facility had revised its policy directed at investigations of non-serious discovered injuries in March, 2012. The policy revisions now require that an investigation be conducted by a Facility Investigator if the nature of the injury meets defined criteria primarily related to the type of injury (e.g. lacerations or punctures) or the location of the injury (e.g. bruises to the face, back, or abdomen). The criteria also calls for an investigation to be done by a Facility Investigator if the individual with the non-serious discovered injury was on 1:1 level of supervision. Investigations of non-serious discovered injuries conducted by a Facility Investigator are reported to, and reviewed by, the Facility's IMRT. The policy revision also requires that all other non-serious discovered injury investigations (conducted by unit staff) are reported to, and reviewed by, the IDT at the unit morning meeting. In both circumstances these reviews are documented in meeting minutes. The Facility is to be commended for improving the process for review of non-serious discovered injuries in order to ensure that abuse or neglect was not a cause of, or contributing factor, of the injury. The Monitoring Team reviewed three non-serious discovered injuries investigated after the new policy was in effect. The investigation of an injury to Individual #17 (4/17/12) followed the established criteria and included an investigation report by the Facility Investigator and review by the unit IDT. The investigation and the review were thorough and complete. The investigation of an injury to Individual #152 (4/24/12) also followed the established criteria and included an investigation report by the Facility Investigator and review by the unit IDT. In this case the investigation was not thorough and complete. The injury was noted to be a bruise and the probable cause "rubbing." The Individual had 1:1 level of supervision and there was no indication staff was interviewed. Unit staff reported the Individual "bruises very easily." This statement was accepted on its face without interviewing medical staff to validate its accuracy.	

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		The investigation of an injury to Individual #399 (4/29/12) was not investigated by a Facility Investigator and should have been because the Individual had 1:1 level of supervision. Additionally, the review of this injury conducted at the unit morning meeting concluded that bruises to the inner thigh were likely the result of "sitting on a hard bench for a long period of time." It does not seem probable that sitting on a bench would result in bruises to the inner thigh. The Facility needs to take steps to ensure investigations of non-serious discovered injuries are completed in accordance with the current policy, and that staff who review these investigations ensure investigations are thorough and complete. It is of concern that two of the three investigations reviewed by the Monitoring Team, which had presumably been reviewed by the Administrative Review Team (ART), were insufficiently thorough and/or were incomplete. 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. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA.	
	(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.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed Alleged Perpetrator (AP) reassignment sign-in sheet from 11/1/12 to 3/31/12 to determine if all APs were not assigned to direct contact with individuals until the investigation and any subsequent personnel action or training with the AP was completed. 2. Reviewed the AP sign-in sheet to ensure that an investigator from the facility initialed a formal release for that AP to return to duty if applicable 3. Documented the immediate and appropriate action that was taken to protect the individual(s) involved in the UIR in the Incident Management Meeting (IMM) minutes. From its self-assessment the Facility determined that: 1. The AP reassignment sign-in sheet verified that 100% of alleged perpetrators were removed from direct contact with individuals until the investigation process was completed and appropriate action and/or training was completed.	Substantial Compliance

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		2. The AP reassignment sign-in sheet revealed that an investigator from the facility initialed a formal release for that AP to return to duty (if applicable) in 100% of the allegations. 3. 100% of the immediate protective action that was taken to protect the individual(s) was documented in the IMM minutes. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because RSSLC staff takes immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, until the investigation is finished. <u>Monitoring Team findings</u> Based on a review of the nine investigation reports included in Sample D.1, in every instance where an alleged perpetrator (AP) was know$_{n\ the}$ AP was immediately placed in no direct contact (NDC) status. Additionally, the Monitoring Team was provided with a log of employees who had been reassigned since 11/1/11. The log included the applicable UIR number, the date of reassignment, the outcome of the investigation, and the date the employee was returned to work if the employee was not discharged or had not resigned. The Facility should understand the relationship between late reporting (refer to Provisions D.1 and D.2.a) and this SA requirement. When late reporting occurs this can impact the Facility's ability to immediately remove alleged perpetrators from direct care responsibilities and as a result place Individuals at unnecessary risk. Each instance of late reporting detected by the Facility's internal review processes should assess this potential with respect to compliance with this Provision. Review of nine investigation files included in Sample D.1 showed there were no instances where staff that had been removed from direct contact had been subsequently reinstated prior to completion of the investigation. This conclusion was reached by reviewing the UIR that accompanied each DFPS investigation. Based on a review of the nine investigation files in Sample D.1, it was documented that adequate additional action was taken to protect individuals in each case. For example: nursing assessments were done and treatment rendered as appropriate, alleged perpetrators were put in NDC status, and emotional assessments of victim trauma were conducted by psychology staff. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	

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	(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.	Facility self-assessment The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the training compliance report for ANE from Competency Training & Development (CTD) from 11/1/11 to 3/1/12. From its self-assessment the Facility determined that: 1. Reviewed the staff training compliance report from CTD and the results were: • 11/ 2011 – 99% • 12/ 2011 – 99% • 01/ 2012 – 100% • 02/2012 – 100% • 03/ 2012 – 99% Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because of the percentages for the above months listed reflecting compliance rate of 99% -100%. Monitoring Team findings RSSLC Policy C.02 requires that all staff complete class ABU0100 Abuse and Neglect, and Policy C.01 requires that all staff complete class UNU0100 Unusual Incidents at least yearly. These two classes are sufficient to demonstrate compliance with the SA. A review of the training curricula related to abuse and neglect was carried out for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: In relation to the requirement that training is competency-based, the material reviewed included provisions for trainees to demonstrate their understanding of what constituted 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 26 staff training transcripts (Sample C.2) showed that all 26 (100%) had completed competency-based training on abuse and neglect within the last 12 months and 25 of 26 (96%) had completed competency-based training on unusual incidents within the last 12 months. Additionally, the Monitoring Team reviewed the DADS report MHMR0102 Percent of All Employees Completing Course of Training (4/1/12) which reported a 99% compliance	Substantial Compliance

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		rate for staff completion within the last 12 months of ABU0100 and a 100% compliance rate for UNU0100. To test staff knowledge of abuse/neglect reporting responsibilities (and to gauge the effectiveness of the training) the Monitoring Team met with three staff from the morning shift and three staff from the afternoon shift. All were give$_{n\ the}$ same competency test used in annual refresher training. Only one staff answered all five questions correctly. Four staff failed to answer correctly the multiple choice question "If I witness or suspect that an Individual served has been neglected, abused or exploited, I must do the following:" Staff knowledge of abuse/neglect reporting requirements needs to improve. In consideration of the frequency of late reporting noted in Provision D.1 and D.2.a, and the lack of staff knowledge noted above, the Monitoring Team has determined that staff training on the requirements of abuse and neglect reporting has not been effective. While the presentation of the curricula was competency-based, the learning, at least with the small sample of six, had not been retained. The Facility needs to take aggressive actions to ensure staff retains knowledge from completing staff development classes. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of the SA. This is because this Provision requires that the training be competency-based, that staff complete the training, and that documentation of training completion is maintained. Nevertheless, the Facility should take additional steps to ensure the retention of knowledge and that staff implement the knowledge provided in the training.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed 20 random employees from the home staff assignment sheets (including employees working less that 3 months) Acknowledgment of Responsibility for Reporting Abuse, Neglect and Exploitation forms kept in the Competency Training Development Department. 2. Reviewed video surveillance tapes as requested by OIG and DFPS and determined that additional staffs were negligent in mandatory reporting. From its self-assessment the Facility determined that: 1. 20 of 20 were signed and acknowledged by the staff person selected. 2. A current process has been identified to address mandatory reporters who fail to report. Based on the findings of this self-assessment, the Facility determined that this provision	Noncompliance

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	neglect.	was in substantial compliance because 100% of staff has signed Acknowledgement forms. The Center continues to be proactive in addressing mandatory reporters who fail to report. Note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA, for example a review of investigation report data to determine if any mandatory reporter failed to report, and if so, whether appropriate personnel action was taken. <u>Monitoring Team findings</u> The Monitoring Team asked for copies of the DADS Form 1020 Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation (7/09) for staff hired in March and April, 2012, and, for a random sample of 26 employees. Form 1020 is required by State policy. The 44 new hires all (100%) had completed and signed the Form 1020. Eighteen of the 26 incumbent staff (69%) in the sample had not completed and signed the Form 1020. The Facility presented an alternative Facility form for the other eight. This form did not contain data equivalent to that which is noted on Form 1020 and cannot be considered as an adequate substitute for Form 1020. Through document review and interview the Monitoring Team did not discover any instance of a mandatory reporter failing to report abuse or neglect. Several instances of late reporting were noted in Provisions D.1 and D.2.a of this report. These were not identified by the Facility through its investigation report review process. Consequently, no personnel action was taken. While this component of the SA relates to failure to report (as opposed to late reporting) it is important that the Facility identify instances of late reporting and follow-up accordingly. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA. This provision had previously been rated as in substantial compliance. This rating of noncompliance is because of the high rate (31%) of non-use of Form 1020. This may be a contributing factor to the high rate of late reporting, and staff lack of knowledge, described in Provisions D.1 and D.2.a.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the Individual Service Planning Meetings from 11/1/11 to 3/31/12 for a formal discussion on assisting family members in reporting ANE.	Noncompliance

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	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.	From its self-assessment the Facility determined that: 1. The reviews of the Annual Planning Meetings from 11/1/11 to 3/31/12 for a formal discussion on assisting family members in reporting ANE indicated that 0 out of 10 listed a discussion on steps for reporting ANE with the individual/family member present. Based on the findings of this self-assessment, the Facility determined that this provision was not in compliance because the discussion on the steps of reporting ANE is not documented in the Annual Individual Service Plan Meetings with the individual/family member present. <u>Monitoring Team findings</u> ISP meetings attended by the Monitoring Team did not include any presentation of information, or discussion, of abuse and neglect identification and reporting procedures. ISP documents reviewed by the Monitoring Team did not include any information with respect to abuse and neglect identification and reporting procedures. The Facility reported that 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 ISP meeting presents an opportunity to reinforce with the individual and his/her family/LAR (and staff attending the ISP meeting) abuse/neglect identification and reporting procedures, and to reinforce to each individual their right to feel safe while living at the Facility. 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 most meetings that addressed abuse, neglect, exploitation, or rights material. 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. The Facility expectation for discussion of this topic at ISP meetings is an appropriate method to accomplish this. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	

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	(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.	Facility self-assessment The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed audits from 1/1/12 to 3/31/12 campus investigators to determine whether the individual's rights and ANE posters were posted in all living areas and program areas. From its self-assessment the Facility determined that: 1. 18 of 18 (100%) audits reflected that the individual's rights poster and reporting ANE posters were posted and in good condition. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because 100% of the posters were visible in each living unit and program area. Monitors note: The Facility self-assessment references audits conducted by campus investigators. The Facility presented a document to the Monitoring Team describing its monitoring process for ensuring compliance with this Provision. This process, as described on that document, relied on Facility social workers and the Human Rights Officer, to do monthly inspections and document that posters are in place. In the future, the self-assessment document should more clearly describe processes in place to demonstrate compliance with this provision. Monitoring Team findings 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. This process was managed by the Human Rights Officer and relied on social worker inspections. Results of these audits presented to the Monitoring Team were consistent in application and demonstrated compliance with this provision. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Facility self-assessment The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed 25 cases from 11/1/11 to 3/31/12 to ensure law enforcement and/or the Office of Inspector General (OIG) had been notified accordingly for cases of ANE. From its self-assessment the Facility determined that: 1. 25 out of 25 cases reflected that law enforcement and/or OIG were notified in all ANE cases reviewed. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because all cases had law enforcement and/or OIG notification as applicable. Monitoring Team findings To be in substantial compliance with this component of the SA there should be evidence that at least all allegations of physical abuse receive a law enforcement referral. All allegations of physical abuse, if substantiated, may represent some form of assault or battery that could result in the perpetrator being criminally charged. Therefore, it is important that all allegations of physical abuse receive law enforcement referral. In all allegations of Physical Abuse in Sample D.1 (100%) law enforcement notification occurred. Based on a review of three investigations completed by the Facility (Sample D.2), 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 investigation. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of 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	Facility self-assessment The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed 25 cases (random sample) from 11/1/11 to 3/01/12 for potential retaliation. From its self-assessment the Facility determined that: 1. Review indicated that 24 of 25 cases did not have retaliation reported. In the one case, when retaliation was reported, the AP was placed on Emergency Leave	Substantial Compliance

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	appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	throughout the investigation (DFPS and OIG) and the employee who retaliated was terminated as per policy. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance as action was taken when retaliation was reported. <u>Monitoring Team findings</u> Based on interviews with 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 Facility had created a "Reporting Retaliation" poster that was displayed prominently throughout the Facility. Based on a review of investigation records (Sample D.1 and Sample D.2), there were no concerns noted related to potential retaliation. As reported in the Facility self-assessment one instance of retaliation was reported and the Facility responded in an appropriate and decisive manner, resulting in termination of the offending employee. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the Campus Coordinator Log and Home Shift Log for auditing purposes to verify all discovered injuries were reported, documented and investigated. 2. Reviewed the audit reports by the Facility Investigators of the home shift logs to determine whether injuries to individuals are reported for investigation. From its self-assessment the Facility determined that: 1. The audit reports of the Campus Coordinator Log and Home Shift Log from 1/1/11 to 3/1/12 were: • 12/ 2011 – 95% • 01/2012 – 90% • 02/2012 – 100% • 03/2012 – 100% 2. The audit reports completed by the Campus Investigators' for reporting injuries to individuals for the period of 1/1/12 to 3/31/12 were:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 01/2012 – 100% • 02/ 2012 – 100% • 03/2012 – 100% Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because the percentage averages above for the listed months reflect over 90% or better for each month. Monitoring Team note: the Facility self-assessment does not describe what documents are reviewed and any methodology for determining whether or not unreported injuries were discovered, and if they were, whether or not they were subsequently reported for investigation. <u>Monitoring Team findings</u> The documentation provided to the Monitoring Team was insufficient to determine if essential elements of this Provision had been met. The Monitoring Team asked for a written description of the review activity associated with this Provision, if sampling occurred, who conducted the review activity, and how the review activity was documented. The materials provided in response to this document request did not address these topics. Additionally, as noted above, the description of the self-assessment activities undertaken by the Facility was insufficiently detailed to assess its adequacy in demonstrating compliance with this Provision. An additional purpose of a semi-annual audit of injuries would be to ensure that patterns of non-serious injuries that could raise suspicion of abuse or neglect are identified and subject to investigation. This would require review and analysis of Facility data. Such a review might analyze six-months of injury data and identify individuals with large numbers of non-serious injuries that could raise suspicion, such as falls, or peer caused injuries. Data analysis could determine if a significant number of these injuries occur when a certain staff person is on duty, or they occur at a certain location, or any other variable determined to be potentially significant. This type of data analysis (i.e. a semi-annual audit) could determine that a formal investigation should have been initiated. This type of data analysis could also point to systemic issues that might need to be explored in more detail, perhaps using root cause analysis methodologies. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA.	

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D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed Incident Management (IM) staff training records to determine all required training was completed by staff conducting investigations per state and local policy. From its self-assessment the Facility determined that: 1. On 3/29/12, review of the IM staff training records indicated all staff (100%) that conducted investigations had completed training by Labor Relations Alternatives on serious injury investigations. The Chief Nurse Executive who completes UIRs on all deaths is scheduled for investigator training provided by Labor Relations Alternatives the week of 4/23/12. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because all IM staff that conducts investigations received the training required by state and local policy. Monitoring Team note: Provision D.3.a includes requirements that were not addressed in the Facility self-assessment. For example, training requirements of DFPS investigators were not addressed nor was the issue of investigators not being in the chain of command of those being investigated. Future self-assessments should address each requirement in the Provision. <u>Monitoring Team findings</u> The RSSLC policy C.01 Incident Management included specific operational descriptions providing for the conduct of investigations. DFPS has similar descriptions and related training. The Monitoring Team review of facility policy found it described the conduct of investigations and required that investigators be qualified. The policy specifies that	Substantial Compliance

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		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 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 the Monitoring Team is of the opinion that this training is competency-based. 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	

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		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 – (this class is apparently no longer offered. Per interview with the IMC the LRA course noted below has been deemed as the appropriate alternative although this was not able to be corroborated by DADS Central Office when asked during the compliance visit.) 4. MEN0300 People with Mental Retardation 5. LRA training Fundamentals of Investigations and Conducting Serious Investigations (INV0100) 6. Training in Root Cause Analysis. DFPS had eight investigators assigned to work RSSLC cases. The training records for these investigators were reviewed. All eight (100%) completed the requirements for investigations training. RSSLC had seven staff designated as investigators. The training records for these staff were reviewed. All seven (100%) had completed the requirements for investigations training. Three had not completed CITO100 which apparently has not been offered for some time and INV0100 had been deemed an acceptable equivalent, although this was not able to be corroborated by DADS Central Office when asked during the compliance visit. 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 concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed 25 cases from 11/1/11 to 3/1/12 to determine if staff cooperated with outside entities during investigations. 2. Reviewed potential issues between facility, DFPS, OIG, and Ft. Bend County Sheriff's Dept. during quarterly meeting on 2/15/2012.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		From its self-assessment the Facility determined that: 1. Review of 25 cases indicates 25 of 25 (100%) showed that staff cooperated with outside entities during ANE investigations. 2. No issues were identified. The Facility was commended for cooperating with the investigations by scheduling appointments, securing evidence and identifying factors that may contribute to the case. (Note that the Facility did not report, and the Monitoring Team did not determine, who commended the Facility for cooperating.) Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because there were no instances of staff not cooperating with outside entities during investigations. <u>Monitoring Team findings</u> The Monitoring Team did not find any instances of lack of cooperation in its review of the nine DFPS investigations in Sample D.1 or with the OIG cases which were reviewed. 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 2/15/12. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed 25 cases from 11/1/2011 to 3/1/12 (random sample) to determine that if there were any interference with investigations by other entities during investigations by law enforcement. From its self-assessment the Facility determined that: 1. 25 of 25 (100%) cases indicated that there were no interferences with investigations by other entities during investigations by law enforcement. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because all of the reviewed cases were coordinated appropriately. <u>Monitor Team findings</u>	Substantial Compliance

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		The Monitoring Team did not find any issues with lack of coordination with law enforcement agencies. 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 nine of nine (100%) investigation records from DFPS (Sample D.1) no evidence of interference by one agency or the other was identified. Of the three investigation records from the Facility (Samples D.2.), there was no suspicion of abuse or neglect, and therefore would not be appropriate for reporting to DFPS or law enforcement. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	
	(d) Provide for the safeguarding of evidence.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed local policy to ensure it supported the safeguarding of evidence. From its self-assessment the Facility determined that: 1. According to policy, evidence was being secured in a cabinet inside the IMC office and only the IMC and 2 (Day Time) Facility Investigators have access to the keys locked in the IMC office. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because evidence is safeguarded as per policy.	Substantial Compliance

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		Monitoring Team findings In previous reviews, the Monitoring Team observed the area the Facility uses for safeguarding physical evidence as well as actual evidence secured in a locked file cabinet in the locked office of the Incident Manager's office. The IMC reported this same space is still used to store and protect physical evidence. Based on a review of the investigations completed by DFPS (Sample D.1) and the Facility (Sample D.2) any physical evidence that needed to be safeguarded was. Additionally the Facility had 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. The Monitoring Team has a concern with the protection of testimonial evidence. Collateral witnesses and APs are usually not interviewed until several days after the incident occurred or was reported. This can diminish the accuracy of testimonial evidence. In fact, the training curriculum DFPS uses in training its investigators (Module 7 of DFPS Facility Investigations ILSD training, page 7-2) states "Interviews should be done as soon after the incident as possible, while witness' memories are still fresh. (Research has established that memory decays rapidly over the first 24 hours after an event, followed by a more gradual decline.)" The Facility had very limited mechanisms to prevent the potential contamination of testimonial evidence. The formal curriculum used by the Facility for training on abuse and neglect that all employees must complete did not include subject matter addressing this topic, although the RSSLC staff instructor reported this topic is covered in training. The Facility's Abuse and Neglect policy did not address this topic. When an alleged perpetrator (AP) is placed on No Direct Contact (NDC) status he/she signs a letter acknowledging that they are not to contact co-workers during or after work hours; however, there does not appear to be any mechanism to attempt to monitor compliance with this requirement. In reviewing interview statements in DFPS case files investigators typically did not query the AP or collateral witnesses as to if they had been in communication with anyone regarding the incident under investigation. Conclusions in DFPS cases reviewed by the Monitoring Team, when video surveillance evidence is not available, were based almost entirely on testimonial evidence. If the integrity and efficacy of testimonial evidence can be questioned (both the truthfulness and the accuracy of recollection of events) then conclusions reached through the investigatory process can also be questioned. RSSLC, along with DFPS, need to establish a methodology that can reasonably protect testimonial evidence.	

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		Although the Monitoring Team raises this significant concern, based on criteria used in prior reviews of this and other facilities, it finds that safeguarding of physical evidence is adequate to result in a finding of substantial compliance with this provision. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of 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 a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed of a random of 25 sample cases from 11/1/11 to 3/1/12 to determine if all investigations of incidents commenced within 24 hours. From its self-assessment the Facility determined that: 1. Review indicated that 19 out 25 cases (76%) commenced within 24 hours. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance because 76% were in compliance. Monitoring Team note: Provision D.3.e includes requirements that were not addressed in the Facility self-assessment for example, investigations being completed within 10 days. Future self-assessments should address each requirement in the Provision. <u>Monitoring Team findings</u> The Monitoring Team reviewed the DFPS document intended to provide guidance to investigators as to what constitutes substantive investigatory activity that would confirm an investigation commenced within 24 hours of an incident being reported. DFPS guidelines did not require DFPS presence at the Facility within 24 hours of an incident being reported except in instances of Class 1 physical abuse and sexual abuse allegations. DFPS did require that enough information be obtained from the Facility to enable DFPS to "develop an initial plan for the investigation" within 24 hours. These procedures required DFPS to instruct the Facility to "protect physical evidence." These procedures do not address the protection of testimonial evidence from witnesses and any alleged perpetrators. Almost always testimonial evidence is the primary evidence used in DFPS investigations and used to reach investigation conclusions. For the Facility to protect this evidence, measures would need to be taken, including potentially the need to isolate staff witnesses from one another in order to not contaminate testimony until witness interviews have occurred (which is the primary reason that DFPS should begin interviewing staff as soon after the reported incident as possible). DFPS investigator training highlights the importance of timely interviewing noting "Interviews should be done as soon after the incident as possible, while witness' memories are still fresh.	Noncompliance

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		(Research has established that memory decays rapidly over the first 24 hours after an event, followed by a more gradual decline.)." 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 (Sample D.1)</u> The following summarizes the results of the review of the nine DFPS investigations in the sample: Seven of nine (78%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information 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 adequate documentation was not present to validate that substantive investigatory activity occurred within the first 24 hours or sooner: • Investigation 41484134: there was no documentation of any investigatory activity occurring within the first 24 hours. The first substantive activity documented in the case report occurred three days after the report of the incident whe_{n the} investigator attempted to interview the alleged victim. This was a case of unconfirmed physical abuse. • Investigation 41545604: the only investigatory activity that occurred within the first 24 hours was a phone call informing local law enforcement of the incident and a phone call betwee_{n the} DFPS investigator and a Facility investigator. The Facility investigator described what her understanding of the incident was. The DFPS investigator did not confirm that the AP was removed from client contact. No other investigatory activity is documented in the case report. The Facility places alleged perpetrators (AP) in non-direct care status immediately after an allegation and ensures they are closely supervised while on shift. Eight of nine (89%) investigations were completed within 10 calendar days of the incident or required time extensions were requested by the investigator and approved by the supervisor. Case 41545604 was completed in 11 days. All nine (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 stated for the	

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		investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In all nine (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: All three (100%) 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. None of the three (0%) were completed within 10 calendar days of the incident, including sign-off by the supervisor (IMC). All three (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 stated for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. All three (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. Additionally, investigations must be completed within 10 days unless an extension has been requested and approved. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment:	Noncompliance

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	sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	1. Reviewed 25 cases (random sample) from 11/1/11 to 3/1/2012 to determine if all cases provided a clear basis for conclusion. 2. Reviewed 25 sampled cases from 11/1/11 to 3/1/12 to determine if all potential witnesses have been identified. From its self-assessment the Facility determined that: 1. Review indicated that 25 out of 25 (100%) provided a clear basis for the conclusion. 2. Review indicated that 25 out of 25 (100%) all potential witnesses were identified. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because 100% of all cases reviewed provided a clear basis for the conclusion and 100% of all witnesses have been identified. Monitoring Team note: Provision D.3.f includes requirements that were not addressed in the Facility self-assessment, for example, determining whether or not "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" was documented. Future self-assessments should address each requirement in the Provision. <u>Monitoring Team findings</u> 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> Contents of investigation reports reviewed were sufficient to provide a clear basis for conclusions. The reports utilized a standardized format that sets forth explicitly and separately: • Each serious incident or allegations of wrongdoing; • The name(s) of all witnesses; • The name(s) of all alleged victims and perpetrators; • The names of all persons interviewed during the investigation; • For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; • All documents reviewed during the investigation; • All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the	

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		investigating agency; • The investigator's findings; and • The investigator's reasons for his/her conclusions. The following summarizes the results of the review of DFPS investigations: • In all nine (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 nine (100%), each serious incident or allegations of wrongdoing; o In nine (100%), the name(s) of all witnesses; o In nine (100%), the name(s) of all alleged victims and perpetrators; o In nine (100%), the names of all persons interviewed during the investigation; o In nine (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 nine (100%), all documents reviewed during the investigation; o In nine (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 nine (100%), the investigator's findings; and o In nine (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> 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. The following summarizes the results of the review of Facility investigations: • In all three investigations reviewed (100%) the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: o In three (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	

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		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 three (100%), the name(s) of all alleged victims and perpetrators. o In three (100%), the names of all persons interviewed during the investigation. o In none (0%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. o In three (100%), all documents reviewed during the investigation. o In three (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. Section 8 of the UIR would typically be used to record information related to previous incidents. o In three (100%), the investigator's findings. o In three (100%), the investigator's reasons for his/her conclusions. The Facility needs to establish work processes that establish the method by which all 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, will be required to achieve compliance with this component of the SA. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed 25 UIRs from 11/1/11 to 3/1/12 to determine if review by QA Auditors and IMC was completed, and if needed, corrections were made.	Noncompliance

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	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.	From its self-assessment the Facility determined that: 1. Review of cases indicated that 25 out of 25 cases were reviewed by the QA Auditors and the IMC to ensure that cases were accurate, answered questions and provided corrections needed. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because adequate supervisory review is occurring for all cases reviewed. Monitoring Team note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA, for example no methodological information was provided to explain how determinations of accuracy, completeness, and coherency were determined. <u>Monitoring Team findings</u> 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 three investigation files reviewed there was evidence that IMC (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 Provision 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	

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		report is accurate, complete and coherent and that any further inquiries or deficiencies (necessary to address requirements of the SA) are addressed promptly. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed 25 cases from 11/1/11 to 3/1/12 to determine that each case has a written report per the provisions of subparagraph in D3g. From its self-assessment the Facility determined that: 1. Review indicated that 25 out of 25 cases (100%) had written reports. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because all cases contain a written report. Monitoring Team note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA; for example, for the written report to be subject to the provisions of subparagraph g it must adequately identify the type of issues identified in subparagraph g. This was not assessed by the Facility. <u>Monitoring Team findings</u> RSSLC used the IMRT process to review the DFPS reports already reviewed by the IMC. This process was intended to ensure senior management of the Facility was involved in the review of each case. The IMRT members who would review each DFPS report included the Director of Residential Services, the IMC, the Rights Protection Officer, a Unit Director, the Assistant Director of Programs, and the Facility Director. Each was expected to independently review the DFPS case report to prepare for discussion at the subsequent meeting. RSSLC used a form "DFPS Investigation Cover Sheet Allegation and Final Report", dated 2/6/12, 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 nine (100%) cases. The information contained in the DFPS Investigation Cover Sheet Allegation and Final Report served to document the occurrence of the reviews. The report that results from this review activity should document that the investigation was thorough and complete and that the report was accurate, complete and coherent. In instances where this was not the case these reports should document actions taken by the Facility to correct	Noncompliance

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		deficiencies. The DFPS Investigation Cover Sheet Allegation and Final Reports provided to the Monitoring Team did not contain sufficient information to document that the detailed requirements contained in Provision D.3.g had been considered in the review process. The Facility had received a compliance rating of substantial compliance in the last review based on the presence of reports. The Monitoring Team does not believe the presence of a report, by itself, is sufficient to achieve compliance with the SA requirements associated with this Provision. Reports produced pursuant to this provision must address the requirements in Provision D.3.g of the SA. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA.	
	(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.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed UIR Tracking Log and actual UIR Folder (18 out of 25) to ensure that disciplinary and/or programmatic actions were documented and/or provided. From its self-assessment the Facility determined that: 1. Reviewed cases from 11/1/11 to 3/1/12 (random sample indicated that 18 out of 25 cases (72%) had all disciplinary and/or programmatic actions documented and included. Based on the findings of this self-assessment, the Facility determined that this provision was not in compliance because all disciplinary and/or programmatic actions are not tracked and documented with corresponding outcomes. Monitoring Team note: the Facility's self-assessment was incomplete as it did not address all required elements of the SA; for example, the outcomes of corrective actions intended to assess recurrence of similar events was not assessed. <u>Monitoring Team findings</u> Follow-up actions, persons responsible, and target dates, relative to DFPS and Facility investigations are noted in each UIR. The Facility did not have an organized and detailed system to track implementation of planned actions. The systems in place at the Facility to achieve compliance with this Provision were also deficient in meeting an important element of this component of the SA: assessing if the	Noncompliance

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		outcomes of disciplinary or programmatic actions corrected a situation and/or prevented recurrence. For example, staff training was often a recommendation. The Monitoring Team was unable to determine if the Facility engaged in any administrative review activity to determine if training and retraining (related to specific subject matters) had resulted in a change (decrease or increase) in the problem(s) the training was intended to address. 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. Case files reviewed in Sample D.1 included copies of all relevant disciplinary action taken in response to investigation findings. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
	(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.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Evaluated the facility's records and record area for easy accessibility. From its self-assessment the Facility determined that: 1. After evaluation of record area, it was concluded that the current area/system is efficient and meets the requirements of every investigation being maintained that permits investigators and others to easily access every investigation involving a particular staff member or individual. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because the system allows investigators and other appropriate personnel to easily access every investigation involving a particular staff member or staff. <u>Monitoring Team findings</u> Data systems at the RSSLC enable an investigator to quickly identify individuals and staff who have bee$_{n \text{ the}}$ subject of prior investigations. File storage in the IMC's office was organized and up-to-date. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	Substantial Compliance
D4	Commencing within six months of	<u>Facility self-assessment</u>	Substantial

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	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.	The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed revised Trend Reports to ensure that all unusual incidents were tracked by incident, staff alleged, individuals involved, location, date and time of incident and cause outcomes of incidents; in addition they include a comparison from 12 months prior for each month and a 90 day data review. From its self-assessment the Facility determined that: 1. The Trend reports from November 2011 to March 2012 reflected the above data changes and information. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because the trend reports include longitudinal data. Monitoring Team note: the self-assessment did not address all requirements of this provision, For example, the tracking of outcomes of investigations was not included in the self-assessment. <u>Monitoring Team findings</u> Since the last review the Facility had made improvements in its Trend Report, most notably in tracking data longitudinally. An area still in need of improvement is tracking data on the results and outcomes of incidents and investigations, by type (e.g. Physical abuse Class I, Class II, Neglect, etc.), including data that can tell the Facility, for example, if the frequency of confirmed and/or inconclusive findings is increasing or decreasing. For example, (hypothetically) if data comparing six-month periods showed that confirmed finding of physical abuse increased from 2% of allegations made to 4% of allegations made one would expect executive level discussion looking more in-depth at the confirmed investigation reports. Similarly, significant changes in the percentage of cases with inconclusive findings should cause more in-depth review and analysis. This observation was made by the Monitoring Team at the last review. Trend data should be presented in a manner that lends itself to useful discussion and decision-making. The Facility's tracking and trending of unusual incidents could be improved if the results of investigations of incidents and allegations presented data in a manner that lended itself to thoughtful discussion and decision-making. For example, in reviewing longitudinal trend data the Monitoring Team observed: • Over the last 12 months 22% of abuse and neglect allegations were confirmed and 22% were returned with an inconclusive finding. The Monitoring Team did not find any identification of these important data, or discussion of it, in the narrative section of the monthly trend reports. • Over the last six months (compared to the previous six months) the number of	Compliance

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		injuries had decreased by 30% and the number of serious injuries had decreased by 120%. The Monitoring Team did not find any identification of these important data, or discussion of it, in the narrative section of the monthly trend reports. Significant data trends should be identified, reviewed, analyzed, and discussed to try and determine possible causation. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	
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 whe$_{n\ the}$y are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Initial and annual checks with Employee Misconduct Registry, the Nurse Aide Registry, the Client Abuse and Neglect Reporting System, and the Federal Bureau of Investigation for employee fingerprints are conducted for 100% of applicants, employees, and volunteers. This occurs during the initial involvement with the SSLC and annually thereafter. From its self-assessment the Facility determined that: 1. All of the 1,357 current employees and volunteers do not have, as a result of any of the checks performed, any permanent bars to employment. Since the last monitoring review, there have been none (0%) of people who had discretionary bars to employment. The Director has exercised a decision making process to determine if they may continue with employment or volunteering. Based on the findings of this self-assessment, the Facility determined that this provision was in substantial compliance because 100% of the current employees and volunteers do not have a criminal history that would preclude them from working or volunteering in an SSLC. <u>Monitoring Team findings</u> 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	Substantial Compliance

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		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 check of 30 employees confirmed that required background checks were completed. A random sample of six volunteers who regularly work with individuals living at the RSSLC confirmed that required background checks were completed. 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 concurs with the Facility's self-assessment of substantial compliance with this provision of the SA.	

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

1. 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)
2. Improvement in timely reporting of incidents is needed. (Provision D.2.a)
3. Improvement in timely initiation of investigations is needed. (Provision D.3.e)
4. Improvement in review of non-serious discovered injuries is needed. (Provision D.2.a)
5. Additional steps to educate individuals and guardians regarding abuse/neglect identification and reporting need to be initiated. (Provision D.2.e)
6. The audit process to determine under-reporting of injuries and other incidents needs improvement. (Provision D.2.i)
7. Ensure Facility investigations of serious incidents include all components necessary to demonstrate compliance with Provision D.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)
8. Aggressively pursue strategies to ensure staff retains knowledge after completing Abuse and Neglect training. (Provision D.1)

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 Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. RSSLC Section E Presentation Book 4. DADS Policy 003.1-Quality Assurance 1/26/12 5. RSSLC Policy A.28 Quality Assurance Plan 3/13/12 6. RSSLC Quality Assurance Plan 4/12 7. RSSLC Corrective Action Plan Process 5/11/12 8. Restraint Trend Report 4/30/12 9. Unusual Incidents Trend Report 4/30/12 10. Allegations Trend Report 4/30/12 11. Injury Trend Report 4/30/12 12. QA Monitoring tools for each provision of the SA 13. QA/QI Council Meeting Minutes for 11/8/11, 11/21/11, 12/6/11,12/19/11, 1/3/12, 1/17/12, 1/31/12, 2/14/12, 2/28/12, 3/13/12, 3/27/12, 4/3/12, and 4/17/12 **People interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Alice Ramirez, Data Analyst **Meetings attended/Observations:** 1. Incident Management Team Meeting (IMRT) 5/16/12 2. Four Rivers Unit Morning Meeting 5/16/12 3. Quality Assurance/Quality Improvement (QA/QI) Council 5/15/12 4. Administrative Review Team 5/16/12 5. Restraint Reduction Committee 5/16/12
	Facility Self-Assessment: The Facility self-assessment 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 Monitoring Team observed continued improvement in the development of the administrative processes associated with QA activity. The RSSLC was 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 its data system that supports the QA processes. This includes the preparation of reports that integrate the monitoring completed (and data) at the discipline department level with that completed by the QA Department. The Monitoring Team was able to review evidence of this process. The Action Plan that accompanied the Facility self-assessment identified a series of planned activities directed at compliance with the SA.

	Summary of Monitor's Assessment: DADS had issued a revised QA policy in January, 2012 and the Facility had revised its QA policy accordingly. The Monitoring Team was able to determine that QA systems are in place for most sections of the SA. The development of the data system that consolidated data from multiple sources was impressive. The process for inter-rater reliability checks, and generally improving the accuracy of monitoring data was encouraging and seemed to be producing more consistent interpretation of subject matter requirements being monitored. Data are tracked and trended using two primary systems. The first was 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 was a Facility implemented system using SA monitoring tools. The Monitoring Team commends the Facility for revising trend data to include longitudinal data. There are still additional revisions to longitudinal tracking that should be considered. The Facility's quality assurance activity was focused on improving the level of agreement with inter-rater reliability. The Facility needs to ensure that future quality assurance activity also focuses on improving the quality of services, supports, and outcomes for the Individuals. The QA program at the Facility had not as yet developed an organized process to use monitoring data to routinely and consistently develop Corrective Action Plans (CAPs) for all requirements of the SA. Data items on the monitoring tools have not been weighted, so in preparing overall compliance reports the most critical data item counted the same as the most mundane. The QA activity in place at RSSLC directed at the identification of systemic issues is extremely limited. The Facility is to be commended for its work in creating a data library. The Facility QA process did not appear to be using available data to identify individuals with concerns across multiple areas (e.g., injuries, incidents, hospitalizations or ER visits, restraints, etc.), and use these data to identify possible systemic issues. CAPs did not clearly articulate the anticipated outcome of each action step and the Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified. The Facility did not appear to have a method to determine the effectiveness of a CAP. The Facility reported it is beginning a process to develop key indicators as an additional activity to measure organizational performance in fundamental areas of facility operations and outcomes.

	The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of the 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.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed longitudinal data in trend reports. 2. Reviewed the Quality Assurance/Quality Improvement (QA/QI) Council minutes to determine frequency of meetings. 3. Reviewed the QA/QI Council minutes to determine frequency of restraint data review. 4. Reviewed the QA/QI Council minutes to determine frequency of POI section monitoring review. 5. Reviewed the QA/QI Council minutes to determine if corrective actions are needed and/or identified. 6. Reviewed of the QA Plan to determine that it accurately reflects ongoing monitoring. 7. Reviewed Quality Indicators to determine that monthly data is collected timely and shared with the QA/QI Council quarterly. From its self-assessment the Facility determined that: 1. The longitudinal data has been expanded to include a rolling 12 month period. 2. Since the 11/2011 court monitor visit the QA/QI Council met twice in November, December, February and March. In January the Council met three times thus meeting the requirement for meetings to be held at least monthly. 3. The QA/QI Council minutes indicate the Council is reviewing the restraint data at least quarterly. 4. Since the October court monitor visit the QA/QI Council reviewed the following POI monitoring: • 11/8/11 – Sections M (Documentation, Acute Illness & Injury Annual Nursing Assessment, Annual Nursing Care Plan) • 11/21/11 – Sections Q, D • 12/6/11 – Sections C, M (Urgent Care, Skin Integrity, Pain Management, Chronic Respiratory) • 12/19/11 – Sections K,S • 1/3/12 – Discussed narrative summary with data presentation for each QA/QI Council meeting. • 1/17/12 – Sections G,H,L,I,M (Seizure Management, Infection Control, Medical Administration & Documentation, Prevention) • 1/31/12 – Sections F,U	Noncompliance

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		• 2/14/12 – Sections V,M (Acute Illness & Injury, Annual Nursing Assessment, Annual Nursing Care Plans, Documentation) • 2/28/12 – Sections C,N,P,R • 3/13/12 – Sections O,T • 3/27/12 – Sections D, E,M (Nursing Care, Medication variance) • 4/3/12 – Sections F,J,S,E The current schedule for quarterly review is being followed to ensure all sections are reviewed at least quarterly. 6. Since the October court monitor visit the QA/QI Council has reviewed corrective action plans submitted at the time of each the QA/QI Council meeting. (The external QA monitors continued to meet with the Section Leads and internal monitors to review data, discuss monitoring results, determine corrective action plans, and/or discuss the need for modifications to corrective action plans.) 7. The Quality Assurance Plan is comprehensive and contains required elements. 8. Since the work on the key indicators began early 2/12 and development ensued they are in the process of being refined and defined. Once these tasks are complete, data collection will begin. Based on the findings of this self-assessment, the Facility determined that this provision was not in compliance because the QA/QI Meetings continue to change and become more focused on trends, data analysis, and discussion of how corrective action plans can improve services but additional time is needed to ensure QA/QI meetings remain focused on improved content. While progress is being made, RSSLC QA/QI Council meetings continually grow and change with each meeting and stability has not been attained. Key/quality indicators are in the development stage. <u>Monitoring Team findings</u> DADS Policy 003.1 - Quality Assurance was reviewed and found to be consistent with the requirements of the Settlement Agreement (SA). This policy was updated in January, 2012. The policy now provides specific direction to SSLCs with respect to the organization and administration of a Quality Assurance (QA) program. The policy addresses the interdisciplinary nature of the QA process and requires that the QA/QI Council receives routine reports and updates from quality assurance-related committees including but not limited to: □ Restraint Reduction Committee; □ Client Injury or Safety Committee; □ Physical Nutritional Management Team; □ Incident Management Team; □ Behavior Support Committee;	

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		Pharmacy and Therapeutics Committee; Infection Control Committee; Skin Integrity Committee; and Performance Improvement/Evaluation Teams. These requirements should result in the tracking of data across multiple disciplines and this should facilitate interdisciplinary review, analysis, and decision-making. The State policy reinforces the function of the QA department as one of coordination and implementation of quality assurance activities and requires that corrective action plans are developed and implemented to address problems identified through analysis of data and program monitoring. The role of QA within discipline departments is also specified more clearly, requiring QA activity within each discipline department which is validated through inter-rater reliability checks completed by the QA department. The Facility revised its QA policy (A.28) to incorporate the new requirements associated with the revised State policy. The RSSLC engaged in two primary sets of activity which 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 Monitoring Team had noted in its last report that the trend analysis reports required by DADS were deficient primarily because of the lack of longitudinal data. The Monitoring Team commends the Facility for revising trend data to include longitudinal data. There are still additional revisions to longitudinal tracking that should be considered. For example, the Allegations Trend Report reports the day of the week, shift, and hour of the day for allegations for the report month. It may be useful to track these data over an extended period of time as it could have implications for staffing, supervision, and activity levels of individuals. For example, if allegations are disproportionally represented on certain days of the week, certain shifts, or in clearly delineated time windows, it's conceivable that activity schedules, staffing ratios, or supervisory presence may need to be examined. At a minimum these data, when reviewed longitudinally, can give clues as to administrative and programmatic processes that may contribute to outcomes, positively or negatively. The second set of reports, labeled Trend Analysis Report, presented data gathered from monitoring reports administered by both the QA Department and the discipline department under review. These reports provided information regarding inter-rater	

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		reliability and displayed data by each question on the monitoring tool. The Facility had placed a great deal of emphasis on improving the level of agreement between monitoring conducted by discipline departments and monitoring done by QA staff (inter-rater reliability). The Facility's quality assurance activity was focused on improving the level of agreement with inter-rater reliability. This was a necessary step to ensure data collected through QA activity and used for decision-making was accurate as possible. The Facility needs to use these data to ensure that future quality assurance activity focuses on improving the quality of services, supports, and outcomes for the Individuals. . The QA process, including all the monitoring and auditing tools, and all the QA related committees and work groups should ensure that its primary focus is on improving outcomes for Individuals. Compliance with SA requirements will be a logical outcome flowing from improved outcomes for Individuals living at the Facility. The RSSLC had a Quality Assurance/Quality Improvement Council in place. The Monitoring Team reviewed the minutes and report packages used for each of the monthly primary QA/QI Council meetings held since the last review. This review confirmed that a report is prepared for presentation at the QA/QI Council meeting that includes quantitative monitoring data on several provisions of the SA. These reports were generated from Monitoring Tool data. The work of the QA/QI Council is organized so each provision of the SA is reviewed at least quarterly. This group meets every other week. Currently QA reports result from the activity associated with use of the monitoring tools; however, in its self-assessment the Facility reported it is beginning a process to develop key indicators as an additional activity to measure organizational performance in fundamental areas of facility operations and outcomes. Such key indicators might include things like overall fill (staff) rates, overall turnover (staff) rates, training compliance, deaths, aspiration related deaths, rates of aspiration pneumonia, restraint trends, budget variances, engagement (active treatment) rates, engagement rates by living area, serious injuries, non-serious injuries, abuse/neglect/exploitation confirmations, medication errors, oral hygiene, environmental conditions, community referrals, and community placements. The Monitoring Team looks forward to reviewing progress in the development of key indicators at its next review. As noted in previous reports, the Monitoring Team believes a Quality Assurance (QA) and Corrective Action Planning (CAP)process should include two 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 staff in the QA Department.	

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		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, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; 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. In its last report the Monitoring Team noted that QA activity at RSSLC consisted largely of work effort directed at the first of these two strategies. This continued to be the case. Activity directed at the second strategy was limited and needs to expand. In the last review the Monitoring Team had suggested to the RSSLC QA Director that the Facility may want to consider coding CAPs in a way that allows CAPs that target similar types of problems to be summarized in separate reports. This could facilitate a process where CAP data associated with similar types of problems could be reviewed looking for systemic issues needing attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified. The Facility acted on this suggestion and has coded CAPs so that those that are generated in response to a particular section of the SA are coded accordingly. Additional refinement of CAP coding is recommended. CAPs from one section can address a very similar problem to CAPs in one or more other sections. It is important that a data system be able to place all CAPs that address a similar issue together in a report for review and analysis. An obvious example would be staff training. Often, "additional training" might be the activity a CAP is targeting. Reviewing all CAPs that include additional or different types of training may point to a systemic problem associated with the design, content, and type of training offered at the Facility. Trending of allegations of abuse and neglect, unusual incidents, and restraints provide examples of the current status of the Facility's processes to track and trend information. RSSLC produced a monthly Allegations Trend Report, a monthly Unusual Incidents Trend Report, and a monthly Restraint Trend Analysis. The Facility also produced a multitude of reports related to the use of SA Monitoring Tools. 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	

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		refinement of these processes in its next review. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed each of the following for relevant information regarding development of corrective action plans: 1. Reviewed Quality Assurance plan. 2. Reviewed corrective action plan status report. 3. Reviewed tracking, trending and data analysis of data presented in the QA/QI reports for 11/11, 12/11, 1/12, 2/12, 3/12, and 4/12. 4. Reviewed inter-rater reliability data 5. Reviewed QA/QI minutes for 11/12, 12/11, 1/12, 2/12, 3/12, and 4/12. From its self-assessment the Facility determined that: 1. QA Plan is being revised to include a data library, (refers to content and services that foster use of collections of numeric data in one central location.). 2. Of the 18 corrective action plans implemented and reflected on the CAP Status Report several needed components were not available on the CAP Status Report: • Date of Dissemination of CAP to responsible person(s) for implementation. • CAP due date. • Date CAP completed. 3. The QA/QI minutes included what sections were discussed and corrective action plans developed. 4. Inter-rater reliability data has not been presented to QA/QI as of yet and is insufficient due to all sections not having an inter-rater reliability check at this time (currently done in Section V.) 5. On 1/3/12, the Quality Assurance Director presented a sample of a narrative summary to Section Leads to utilize when analyzing and trending data for reports to QA/QI Council. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance because additional work needs to occur on the Corrective Action Plan Process; The CAP Status Report needs expanding and Inter- Rater reliability needs to occur in all sections of the Settlement Agreement.	Noncompliance

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		Monitoring Team findings Please refer to Provision E.1 for a description of data collection and analysis processes in use at the RSSLC. The Facility self-assessment referred to a data library. This was created by collecting information from each discipline department and determining what type of data they collect, the frequency of data collection, the purpose of data collection, and the intended use. This is summarized in one document and serves as a reference tool for the QA department. In the last review the Monitoring Team reported that the Facility had begun to develop an organized process 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. Limited progress in this area was noted during this review. Most CAPs relate to the Nursing section of the SA. CAPs reviewed did not clearly articulate the anticipated outcome of each action step. As reported in the Facility self-assessment the CAP status reports (necessary for the tracking of CAPs) did not include the date of dissemination to the responsible person(s) for implementation, the CAP due date, or the CAP completion date. Please refer to Provision E.1 for additional information that effects compliance with this Provision. The Facility QA process did not appear to be using available data to identify individuals with concerns across multiple areas (e.g., injuries, incidents, hospitalizations or ER visits, restraints, etc.), and use these data to identify possible systemic issues. To the extent such review takes place it appropriately occurs through the IDT and risk assessment process; however, in order to facilitate organizational performance improvement such data needs to be reviewed and analyzed from a facility-wide perspective. 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 Facility's QA process should be able to demonstrate a capability of 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	

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		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. For the Facility to be in compliance with this provision, a system will need to be in place that identifies many components of protections, supports, and services. In addition to collecting and reviewing monitoring data, and making certain those data are reliable and tracking corrective actions, the Facility will need to continue to refine its outcome measures. This activity should be reflected in discussions at the QA/QI Council. The Council meeting observed by the Monitoring Team consisted primarily of presentations of data related to specific sections of the SA. There was very little discussion or questions directed at the presenters. There was no discussion that could be considered interdisciplinary in nature. Simple analysis that "we're trending up" or "we're trending down" is not sufficient. Data analysis also needs to be sufficiently robust to enable the Facility to proactively identify homes, day/vocational programs, and/or departments that require improvement, as well as to identify an array of potential systemic issues requiring attention. The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of the QA system. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Established and reviewed Corrective Action Plan (CAP) database. 2. Conducted observations at ten QA/QI for development of corrective action plans. 3. Reviewed 18 corrective action plans implemented and reflected on CAP Status Report for defining responsible parties for their implementation. From its self-assessment the Facility determined that: 1. Established CAP database on 11/15/11 and reviewed the CAP database which revealed the CAP Status Report does not clearly identify dissemination of CAPs to all parties responsible for their implementation. 2. Observations of QA/QI meeting revealed development of CAP by members but did not clearly identify dissemination process of CAP to responsible parties. 3. QA/QI minutes revealed CAPs are developed at QA/QI to address problems identified through the Quality Assurance process.	Noncompliance

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		Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance because the Corrective Action Plans are not clearly disseminated to all responsible parties. (They appear to be working but the process remains unclear for dissemination). Monitoring Team findings As explained to the Monitoring Team, the Facility relied on review of its CAP Tracking System to validate that corrective action plans were disseminated to all entities responsible for their implementation. The "assigned to" data entry was intended to confirm dissemination. There were instances where the entry in this data field was for groups of staff such as "nurse managers" or "QA nurses." Dissemination should be to specific individuals to ensure accountability for completion. Data presented on the CAP Tracking Log was insufficient to provide the Monitoring Team with assurance that CAPs were disseminated to all parties responsible for their implementation, including development of CAP actions to be implemented, measurement of effectiveness of CAP actions, and reporting. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	Facility self-assessment The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed monitoring needed on corrective action plan database. 2. Conducted observations at ten QA/QI meeting for corrective action plans implementation. 3. Interviewed five Section Leaders on knowledge of corrective action plans. From its self-assessment the Facility determined that: 1. The corrective action plan database listed areas where monitoring was needed but did not provide information on whether or not the desired outcome was met. Corrective action plan tracking tool needs to be implemented and the basics of when to use a CAP must be understood by Section Leaders. Evidence must be submitted to QA to support CAPs. 2. Observations during QA/QI found no deliberation or discussion involving current or completed CAPs. 3. Clear that section leaders did not have specific knowledge of CAP process. Not all evidence for corrective action plans has been received by the QAD.	Noncompliance

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		Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance because the corrective action plan data base could not identify whether or not a completed corrective action plan has met the desired outcome in a timely manner. Monitoring Team findings The Facility was asked if the database used to track CAPs could produce a list of all open CAPs and all closed CAPs, and, if these reports could be produced by subject matter or other delineations such as the Department assigned responsibility for implementation. CAPs were produced by SA section. For example, all Section M CAPs were presented together. It did not appear that CAP reports could be generated by responsible party or by common subject matter as described in Provision E.1. The Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified. To achieve compliance, the Facility must ensure most CAPs are completed within assigned timeframes or that there is documentation of status reports, and gather and report information (including data when appropriate) to evaluate whether the CAP (or a set of related CAPs) was effective in remedying or reducing the problems originally identified and is revised if not effective. From this review the Monitoring Team was 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. A document prepared by the Director of Quality Assurance titled "RSSLC Corrective Action Plan Process 5/11/12" was intended to address this. At the time of the review it was unclear as to the extent of dissemination of this document. The monitoring, and associated documentation, of CAP implementation will need to be addressed once systemic CAPs become a regular outcome of the QA process. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Facility self-assessment The Facility reported it had engaged in the following activities in conducting its self-assessment:	Noncompliance

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		1. Reviewed follow up needed on corrective action plan data base/status report. 2. Reviewed evidence submitted for corrective action plans to ensure the implementation of the corrective action plans and to review for effectiveness. 3. Conducted observations at three QA/QI meetings for indication that CAPs are modified for effectiveness. From its self-assessment the Facility determined that: 1. The corrective action plan data base and status report needed revisions to include when monitoring was needed, dissemination of CAP data, due date and date CAP completed. 2. Evidence was not submitted to the Quality Assurance Director if corrective action plans were modified. 3. Observations during QA/QI indicated not all members are familiar with the process of modifying corrective action plans. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance, because staff responsible for monitoring the effectiveness of corrective action plans could not identify their monitoring process and when revisions are necessary. <u>Monitoring Team findings</u> As described above, the Facility did not appear to have a method to determine the effectiveness of a CAP. Without an evaluative methodology to determine the effectiveness of a CAP it is unlikely a determination could be made that a CAP requires modification. To achieve compliance with this provision, the Facility will need to provide evidence that effectiveness of CAPs is monitored, and that CAPs are revised as needed. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. Continue to refine the type of data tracked and trended longitudinally (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. Richmond State Supported Living Center (RSSLC) Self-Assessment, updated 05/01/2012 2. RSSLC Status Update May 2012 Visit 3. Richmond State Supported Living Center Action Plans, updated 04/27/2012 4. Section T Presentation Book materials 5. Draft DADS Policy 018: Most Integrated Setting Practices, undated 6. DADS Policy 004 Personal Support Plan Instructions, dated 7/30/10 7. DADS Policy 004: Personal Focus Assessment, dated 09/01/11 8. RSSLC Policy F.04 Personal Support Plan Process 12/30/10 9. RSSLC Policy F.5: Completing Personal Support Plan Meeting Documentation, revised 11/17/11 10. RSSLC Policy F.13: Implementing & Documenting Active Treatment Programs, revised 03/09/2011 11. RSSLC Policy F.5: Completing Personal Focus Assessment, effective 09/23/11 12. PSP Assessment Tracking Log, 11/1/2011-4/13/2012 13. Annual Assessments Filed Within 10 Days, for meeting dates of 2/1/2012-2/20/2012 14. List of PSPs and Attendance Tracking, Meeting Dates of 11/1/2011-4/13/2012 15. 30-Day Individual Support Plans (ISPs), Assessments, Skill Acquisition Programs (SAPs), and Quarterly Reviews for Individuals #19, #81, #82, #278, #306, #546, #600, #626, #689, and #799 16. ISP Assessments for Individuals #7, #17, #212, #296, #306, #330, 462, #508, #714, and #789 17. Sample of recent Individual Support Plans/Personal Support Plans (ISPs/PSPs) and Personal Focus Assessment (PFA) and Quarterly Reviews for Individuals #29, #51, #165, #268, #388, #641, #775, and #776 **People Interviewed:** 1. Carol Agu, QDDP Consultant 2. Cynthia Fannin, Director of Education and Training 3. Joan Poenitzsch, Director of Quality Assurance 4. David Savage, QA Auditor 5. QDDP for Individual #51 6. Cynthia Newton, Transition Coordinator **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #17, #387, #462, and #508 2. PFA for Individual #429 3. Post-Move Monitoring Visit for Individual #353 4. Human Rights Committee
	Facility Self-Assessment: The Monitoring Team reviewed the RSSLC Self-Assessment and Action Steps. The current Self-Assessment

	reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment and finally provided a self-rating stating why or why not it believed compliance had been achieved. RSSLC reported it was not in compliance with any of the provisions, or the components within each provision, of this section of the SA. The Monitoring Team concurs. The Facility had begun in some instances to attempt to couple the self-assessment with its internal quality assurance processes to assess ongoing progress toward completion and the actual outcomes, in that it reviewed the results of internal Section F Monitoring Tools as a part of its self-assessment processes. However, these data were based on limited samples thus far and the Facility noted concerns with inter-rater reliability, so it was not yet likely this information provided a sound basis for evaluation. In the Action Plans, dated 04/27/2012, the Facility indicated it intended to further implement the Section F monitoring tool, track and trend for effectiveness of the tool, develop data analysis or review at the QA/QI Council and develop corrective action as necessary. The Monitoring Team recommends the Facility also develop an overall QA plan involving monitoring tools, QDDP audit tools, active treatment tools and any other applicable tools. The Monitoring Team recommends this be considered a priority towards compliance with this Section.
	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. Overall, the Facility's progress had not been substantial in developing and implementing 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, although some improvements were identified. A summary of progress included observation of one ISP, for Individual #462, that was well-organized and carefully guided by the QDDP. The Facility had made progress in achieving the expectation for the PFA to be completed and posted 90 days prior to the ISP date, such that all disciplines could incorporate the individual's preferences and individual goals into their assessments and recommendations. It was noted the Facility was beginning to make some attempt to use personal futures planning tools such as have been recommended by the Monitoring Team at the annual meetings, but it should be cautioned these will be of limited use if they are not the result of an ongoing exploration of choices, both large and small, by and with the individual. In addition to the progress noted, specific findings as to each provision are as follows: **Provision F1:** The Facility continued to implement the "Supporting Visions" ISP process, which was intended to reinforce the concept that planning is intended to support the individuals' vision for the future. There was still no meaningful preparation provided to ensure the PFA and/or ISP processes were conducted in a manner that facilitated real participation by the individuals. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs and IDT members. The Monitoring Team commends these efforts, but continued to find that staff did not consistently take personal responsibility for obtaining current information at all times, including for IDT planning meetings. For example, the Monitoring Team continued to find evidence of a concerning and continuing trend in IDT members being unaware of assessment information. On the whole, the Monitoring Team also found IDTs were not yet proficient in identifying the most integrated setting appropriate to an individual's needs. The

	portion of the directive for each discipline to include recommendations regarding the most integrated setting and supports/services needed in that setting had not yet been fully implemented at RSSLC. **Provision F2:** The Monitoring Team found there were some examples of improved integration observed in planning meetings. Overall, however, ISPs lacked many of the criteria specified in the SA for this Provision. ISPs 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. The Monitoring Team also found ISP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner. Staff did not demonstrate competence to implement the ISP programs or provide active treatment on an ongoing basis. There also appeared to be a significant incidence of failure to provide timely development and implementation of an ISP for each individual.

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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.	The Qualified Developmental Disabilities Professional (QDDP) was the one person assigned to each individual to facilitate the work of each IDT. The Facility reported that it currently had 19 QDDPs, with one vacant position, a QDDP Coordinator and a newly hired QDDP Educator. RSSLC reported that 14 QDDPs had been deemed competent at the time of the last visit to facilitate ISP meetings, but that the Facility was reviewing competency for all of them due to the finding of the Monitoring Team at that time. As was the case in the last monitoring site visit, the Monitoring Team found there were varying levels of competency in facilitation displayed among the QDDPs. For example, three of four ISPs (75%) attended during this visit were found to be disorganized, nonresponsive to assessment information and lacking in integration. On a positive note however, the Monitoring Team did observe one ISP, for Individual #462, that was well-organized and carefully guided by the QDDP. The assigned QDDP also remained responsible for ensuring the monitoring and revision of 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 Provisions F2a6	Noncompliance

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		and F2d. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, as described in F2e below, an effort the Monitoring Team commends; however, the outcome of producing competent facilitators had not yet been achieved. <u>Conclusion:</u> This provision was found to be not in compliance.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	<u>Composition and Participation of IDT:</u> The Facility tracked the attendance of IDT members at annual ISP meetings. According to a document provided for review, entitled List of PSPs and Attendance Tracking, Meeting Dates of 11/1/2011-4/13/2012, the overall compliance for attendance by the required disciplines during this period was 95.2%. Participation ranged from 55% to 100%. For those ISPs in which participation was relatively low, there was no indication of the disciplines that failed to participate as required. The QA Department should consider analyzing the data to determine if there are any trends that need to be addressed. In addition, the Monitoring Team found that attendance was not always an adequate measure of participation. Overall, participation of IDT members appeared to be increasing, but this was variable. Of note was the lack of consistent participation by speech therapy. As reported in Section R, only three of 26 records reviewed (11%) indicated the SLP consistently participated as a member of the IDT. In two of four ISPs held during this monitoring visit, as described in Provision F2a1, lack of participation by a Speech Therapist at the ISP resulted in goals that were not relevant or inadequate to meet the needs of the individuals. <u>Extent of Individual participation in ISP:</u> Meaningful participation by Individuals in the ISP continued to be very limited. This finding was consistent with the Facility's own self-rating in the Self-Assessment. 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	Noncompliance

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		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 IDT to explore the PFA areas with the individual. The portfolio could then be revised for the ISP meeting based on the PFA results. This would make the ISP a much more comprehensible, participatory and positive experience. It was noted the Facility was beginning to make some attempt to use tools such as these at the annual meetings, but they will be of limited use if they are not the result of an ongoing exploration of choices, both large and small, by and with the individual. <u>Conclusion:</u> This provision was found to be not in compliance.	
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.	<u>Extent to which assessments are conducted routinely:</u> Assessments for the ISP were still not consistently completed on a timely basis. The expectation, per policy, had been that assessments were to be posted no later than ten days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. This expectation had recently been changed to 15 days prior to the meeting. The Monitoring Team found that even for the ISPs held during the week of the compliance visit, not all assessments were available. The Monitoring Team also reviewed the assessments available on the shared drive for a sample of ISPs upcoming over the next ten days. Zero of ten (0%) had all required assessments available and/or posted by the required date. This consistent tardiness in the completion of ISP assessments was confirmed by the Facility's own tracking data. The Monitoring Team reviewed two documents, including the PSP Assessment Tracking Log, 11/1/2011-4/13/2012 and the Annual Assessments Filed Within 10 Days, for meeting dates of 2/1/2012-2/20/2012. The former tracked assessments by individual and the latter tracked assessments by residence. While there was significant variability among and within the disciplines as to timeliness, one that stood out as frequently being submitted late was the Nursing Summary. Coupled with a finding in Provision F2d that Nursing Quarterly Assessments were not being consistently completed, the Facility may need to place a focus on corrective action in this area. It was also noted that DADS policy calls for the PFA to be completed and posted 90 days prior to the ISP date, such that all disciplines could incorporate the individual's preferences and individual goals into their assessments and recommendations. The Facility had made progress in achieving this expectation. <u>Extent to which assessments are conducted in response to significant changes:</u> There were still many instances in which assessments were not updated whe$_{\text{n the}}$ need arose. Examples included: • As reported in Provision O2, two of six (33%) individuals who were diagnosed	Noncompliance

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		and/or hospitalized with a PNM issue were appropriately assessed and followed by the PNMT or IDT in a timely manner. • Individual #689 had skin breakdown, poor posture, and a history of recurrent pneumonias and emesis. This would be an ideal person for the PNMT to provide a comprehensive assessment but the PNMT was not planning to initiate a referral. • As reported in Provision O3, RSSLC continued to provide Head of Bed (HOB) assessments but these were not consistently provided as indicated by a need of the individual or a change in status. <u>Extent to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs:</u> There were some improvements noted in some of the assessment processes at RSSLC. Examples include: • As reported in Provision K5, documentation provided by the Facility revealed that 360 individuals (99%) had a Psychological Evaluation report in the record. Of those 360 individuals, 324 (89%) had a Psychological Evaluation report completed within the past year. None of these evaluation reports was shown to include current intellectual or adaptive assessment results, but the provision of Psychological Evaluation reports reflected progress. In addition, the functional assessments completed by the psychology staff were considerably improved over previous site visits. Overall, assessments were still not routinely of sufficient quality to reliably identify the individual's strengths, preferences and needs. The Monitoring Team found there were significant limitations in the current processes. In particular, the Monitoring Team found that the PFA was not effectively providing a basis for describing an optimistic living vision as originally intended, nor even being implemented in a careful and thoughtful manner. Examples included: • The Summary Section was intended to synthesize the findings of the PFA such that they could be used to provide the team with guidance and insight in the development of the ISP. Only two of ten (20%) of the PFAs reviewed included a summary section that was more than a few words; some were essentially blank. The section was only used routinely to document a list of preferences without any synthesis as to how the team might use them to support the individual's future. • In zero of ten (0%) PFAs, did the IDT document any meaningful community integration opportunities, in spite of being prompted to discuss opportunities to join clubs or to explore having relationships with others living in the community. • Very few PFAs devoted any attention to work exploration or opportunities. In one example, the PFA answered the individual "does not work" to each of eleven	

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		work-related questions; in another, the IDT documented "NA" to all of the questions. Other examples of failures to adequately identify strengths, needs and preferences in discipline specific assessments included: • The Integrated Risk Review (IRR) process continued to need improvement. It was not clear that IDTs yet were able to accurately assess levels of risk in an interdisciplinary and independent manner. There was still a tendency to rely strictly on the guidelines for each risk category without factoring in how the various risk factors may compound one another. For example, Individual #387 was recently admitted to the Facility for a PICA safe environment and a recent history of having foreign objects such as paper clips found in his gastrointestinal tract during a colonoscopy. The individual was being served in a PICA safe home and a PICA safe work area. The IDT was prepared to document a low rating for bowel obstruction and a medium rating for challenging behaviors despite this recent history and the restrictive environment that had been prescribed. The Monitoring Team questioned the IDT as to whether these factors would merit a higher rating in terms of the actual risk and they agreed after considering the combination of factors. • As reported in Provision R2, zero of 30 records reviewed (0%) revealed individuals' assessments included how the determined goal was meaningful to the individual, and zero of 26 records reviewed (0%) revealed individuals' assessments included how strategies/interventions/programs could be utilized throughout the day. • As reported in Provision O2, three of 19 Individuals (15%) 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. <u>Conclusion:</u> This provision was found to be not in compliance.	
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.	<u>Extent to which assessment results are used to develop ISPs:</u> 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, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for IDT members to review each other's assessments prior to the ISP meeting, nor were assessments completed with sufficient thoroughness. Even whe_{n the} results of this	Noncompliance

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		flawed assessment process were used in the development of the ISP, the IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary. For example, as reported in Provision S1, based upon a sample of 26 ISPs and corresponding SAPs, there was no indication that assessment information was used in the development of skill acquisition programs. None of the ISPs in the sample included information specific to the SAPs, such as assessment findings or documentation that IDT discussions had encompassed skills targeted by the SAPs. In addition, for none of the ISPs or SAPs (0%) reviewed were there Functional Skills Assessment (FSA) findings discussed in the ISP that corresponded with the specific skills targeted by the SAPS. Another example of the failure to ensure assessments were used to develop appropriate ISP strategies was a concerning and continuing trend in IDT members being unaware of assessment information. For example: • For Individual #387, IDT members were not aware of the results of the individual's audiological exam, which was a factor in that there was a question as to whether a hearing deficit may have impacted communication. The Monitoring Team had requested a copy of all assessments for this 30-day ISP and was in possession of the information, but no IDT member was aware of it. • Also for Individual #387, the nurse case manager reported the individual had had no seizure activity since 2010. In reviewing the record, the Monitoring Team found evidence of possible seizure activity had been recorded in November 2011. • For Individual #429, the Nurse Case Manager reported in the third Quarterly meeting on 5/14/12 that no medication changes had been made, but this was in error. In addition, she reported that an EKG had been ordered, but no results were yet available. The results had actually been received on 5/11/12. She stated that her report was dated 4/25/12 and that was why she did not have the most current information. <u>Conclusion:</u> This provision was found to be not in compliance. It is essential that all staff take personal responsibility for obtaining current information at all times, but particularly for IDT planning meetings.	
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	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 IDT as a whole and the members individually serve as the state's qualified professionals for this purpose. While DADS policy and the SA explicitly state that the decision of the LAR regarding community placement is to be honored, team members at RSSLC had been provided clarification and	Noncompliance

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	(1999).	training as to their individual responsibilities to make a recommendation about the most integrated setting both in their individual assessments as well as during the ISP discussion of living options. The State Office had provided a directive that each SSLC team member must include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need. In addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the ISP. The professionals' recommendation should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. On the whole, the Monitoring Team found IDTs were not yet proficient in identifying the most integrated setting appropriate to an individual's needs. The portion of the directive for each discipline to include recommendations regarding the most integrated setting and supports/services needed in that setting had not yet been fully implemented at RSSLC. The Monitoring Team reviewed seven recent ISPs, including the assessment packets, and attended four ISPs to evaluate compliance with this provision. Overall, each team member did not consistently include a determination in his/her assessment as to most integrated setting as required. The Monitoring Team was provided with 47 discipline specific assessments related to the seven ISPs reviewed. Of these only five (11%) provided such a determination. In the ISPs observed, the individual disciplines were generally asked to provide their respective professional findings and opinions in this regard. There was no integrated discussion held to attempt to reconcile various opinions or to discuss how needs identified as obstacles might be met in a community setting. For the most part, it appeared the IDTs and individual members were complying with a requirement to complete certain sections without a real understanding of the intent. IDT 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. For example, the QDDP for Individual #387, the QDDP stated somewhat apologetically at the beginning of the Living Options discussion that "we are required to go over this living option." The IDT for Individual #462, on the other hand, seemed much more capable of and comfortable with discussing possible living options with reluctant LARs, and developed an appropriate plan in which IDT members would arrange for and accompany the family	

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		to visit a specific option. The Monitoring Team saw this meeting as a sign of progress, but reiterates that living options exploration and discussion must go on throughout the year. It is unreasonable to expect that LARs who are fearful or reluctant about community living will be influenced by the discussion at the annual ISP meeting; in fact, the opposite is usually the case. Families and LARs often come to the meeting feeling in a defensive posture about this subject, which is not conducive to a discussion that might highlight the potential advantages of community living. <u>Conclusion:</u> This provision was found to be not in compliance.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	<u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u> The ISP process relies heavily on the PFA process to identify preferences and strengths. As described further in Provision S1, the PFA lacked an evidence base and standardized administration such that the weaknesses associated with anecdotal assessment were likely to be more pronounced with this process, and as a result, there was only limited information to suggest that SAPs were based upon the preferences of the individuals or used reinforcers selected through structured assessment. This was further exacerbated by the finding that the PFA was not thoughtfully implemented, as further described in Provision F1c. <u>Extent to which ISP provides an explanation for any need or barrier that is not addressed:</u> IDTs did not consistently provide an explanation for any need or barrier that was not addressed. In none of the seven recent ISPs reviewed (0%) were barriers clearly identified and addressed. For example: • For Individual #429, most members of the IDT indicated they believed the most integrated setting appropriate to the individual's needs was in the community.	Noncompliance

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		The psychologist stated the individual should be better able to express wants and needs without any self-injurious behavior before making such a move. The IDT did not discuss any specific strategies in this regard, nor set any target criteria to know whe$_{n\ the}$ individual would demonstrate "readiness." The speech therapist was not at the meeting and therefore could not provide information about the individual's current communication status or recommendations for strategies to enable the individual to express wants and needs. The Monitoring Team reviewed the individual's current programs and found the functional communication strategies in the PBSP were limited to the following: o General Teaching Strategies: teach to engage in functional communication; and o Replacement behaviors: staff should provide communication training to the individual. The only speech therapy involvement documented was in February 2012 in which she noted she had observed the individual for a possible speech facilitation device and for an update. No speech or communication assessments or recommendations were found to address these barriers. <u>Extent to which ISP encourages community participation:</u> The Monitoring Team found that ISPs did not provide adequate strategies to encourage meaningful community participation. In a review of seven recent ISPs, zero of seven (0%) evidenced any meaningful community integration strategies. Instead, these were typically limited to stating the individual would have opportunities to participate in various community outings. For many of these individuals, community awareness and participation had been identified as obstacles to living in the most integrated setting, but IDTs did little to develop community integration strategies that would address these obstacles. Also, as reported under Provision S3(b), during the current site visit no further community employment opportunities had been created beyond the three individuals documented during the previous site visit, while on-campus employment had dropped from 59 to 40 individuals, and on-campus workshop employment had increased substantially to 151 individuals. <u>Conclusion:</u> This provision was found to be not in compliance.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies	<u>Extent to which ISP 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:</u> As described in Provision F2a4 and further in Section S, ISP programs did not contain the	Noncompliance

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	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;	requisite essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions. Extent to which ISP identifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to overcome identified barriers to living in the most integrated setting: Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. The ISP 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. As reported in Section T, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of seven (0%) recent ISPs reviewed evidenced proficiency in this regard. Also see Provision F1e above. Conclusion: This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions: This provision requires that all protections, services and supports, treatment plans, clinical care plans, and other interventions are delivered in a manner that forms a unified approach to meeting an individual's needs and supporting his/her aspirations and preferences. In such an approach, one would expect to see, for example, training in independent living skills to also have components that might include communication skills development, strategies for use of the skills in community settings, incorporation of positive behavior support techniques, risk action plans, etc. So, a training program to improve dining skills might include techniques to encourage eating at a reasonable pace for both social and risk prevention purposes; use of a graphic menu to assist the individual to identify preferences, lear$_{n\ the}$ names of foods and make choices; incorporation of reinforcement for safe dining behaviors and/or replacement behaviors; and might describe both formal and informal opportunities for community dining. The Monitoring Team found that, although teams were trying to identify and incorporate individuals' preferences and work in a more integrated manner, the resulting ISPs still did not show an integrated plan that set forth the full array of protections, supports, and services individuals required. Additional and extensive training was likely to be needed to prepare teams to think creatively about the needs and preferences of individuals and how to address them on a person-by-person basis in a way that involves collaborative planning and recognition of the possible contributions of several disciplines to a single area of needs and preferences.	Noncompliance

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		For seven recent ISPs, zero (0%) reflected an integrated approach to the so-called Integrated Discussion section. In most cases, this section was actually separated into discipline specific segments with headings identifying them as such. The Facility had not yet begun to use the new ISP template, so it remained to be seen whether the new template, once introduced, would be used effectively as a tool to assist the IDTs to achieve such integrated plans, or whether teams would simply use the new format without also adjusting their thought processes and problem-solving techniques. Too often, the Monitoring Team has seen the IDTs merely adapt old processes such that they fit into the new tool. The Monitoring Team looks forward to reviewing the implementation of this process at its next visit. Other examples that demonstrated that ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual included: • Individual #511 had a Positive Behavior Support Plan, but the ISP did not provide any discussion of the Functional Analysis related to the target behaviors. The individual's LAR indicated she believed the behaviors were related to a lack of coping skills to process grief over a parent's death and that this was holding the individual back from referral for community living. The IDT did not document any discussion as to how these factors could be addressed in an integrated fashion, and the issue of grief counseling was not addressed at all. • As reported in Provision M1, the Monitoring Team found that the Acute Care Plans (ACPs) for Skin Integrity for Individuals #276 and #259 did not consistently integrate all of the treatments and interventions that were being carried out by the Wound Care Nurse and other disciplines. • As reported in Provision O3, PNMPs were not formally developed with input from the IDT. In zero of 19 records reviewed (0%), were PNMPs clearly developed with input from the IDT with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the ISPs that the PNMPs were included, but there was no evidence of discussion or input from other team members or integration. • As reported in Provision R2, zero of three (0%) identified potential connections between behaviors and difficulties with communication and zero of three records reviewed (0%) revealed integration of Communication programs into the PBSP. • As reported in Section R, rationales and descriptions of interventions regarding use and benefit from AAC, EC, and/or other communication programs were not clearly integrated into the ISP <u>Conclusion:</u> This provision was found to be not in compliance.	

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	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Extent to which ISP identifies: • Methods for implementation: As reported in Provision S1, the Facility had demonstrated some progress in this area. In addition, as reported in Section K, there were improvements in certain components of Positive Behavior Support Plans (PBSPs), including strategies that include the teaching of desired replacement behaviors and use of positive reinforcement sufficient for strengthening desired behavior. Despite these improvements, RSSLC had failed to improve or had regressed in several areas. Methods for implementation were fund to be lacking in many key components necessary to effectively promote learning, including: o As also reported in Section K, and despite the improvements in PBSPs cited above the Monitoring Team found that clear, simple, precise interventions for responding to the behavior when it occurred had decreased from 100% to just 11%, since the last review. o In all of the SAPs provided at RSSLC, instructions included either general statements of what the individual being taught was expected to do or generic instructions to follow the prompting hierarchy in relation to the step of the training program. There was no indication of specific, individualized instructions for any SAP. o In all skill acquisition programs reviewed included in the sample, there was no indication that sufficient trials were provided or that the individual's progress or lack thereof in relation to the SAP was considered in relation to the number of trials offered. o For training to be effective there must also be a consequence for an incorrect response. It is accepted practice to either prevent an incorrect response or to follow an incorrect response with an attempt to correct the response. The SAPs at RSSLC did not include such instructions. In most SAPs, the consequence for an incorrect response was described in general terms, such as to provide assistance. o None of the SAPs provided by the Facility included provisions for generalizing acquired skills to new settings or for maintaining acquired skills once formal training was completed. • Timeframes for completion: The SAPs at RSSLC often included a time frame for completion, but it was also found, that individuals were frequently required to demonstrate mastery for extended durations. In the ISPs reviewed, the Action Plans noted a Completion Date, but this was typically given as a one year time frame and did not appear to be individualized based on the nature of the activity to be implemented. • Responsible Staff:	Noncompliance

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		This provision speaks to both the development and implementation of the ISP, and effective implementation will require identification of the staff responsible for implementation. The Monitoring Team reviewed the ISP as well as various means by which the Facility implements the ISP, such as the SAPs and Health Management Plans (HMPs), to determine whether these requirements were met in any of the documents and/or mechanisms used in the overall process of developing and implementing the ISP. The Monitoring Team findings indicated this was not being done consistently in the ISP. The ISP Action Plans identified responsibility by position to an extent, but not by specific name, nor did they clearly delineate the specific responsibility of each position. The SAP format in use at RSSLC did not include a section in which the person(s) responsible for implementation could be identified and did not provide for the specific identification of either a person by name or a position as the individual responsible for implementation. It is up to the Facility to determine how it will ensure the responsible parties for implementation will be identified as a part of the overall ISP process to ensure effective implementation, but this information must be readily accessible and comprehensible to staff who may be designated with these responsibilities. <u>Conclusion:</u> This provision was found to be not in compliance.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	<u>Extent to which interventions, strategies, and supports are practical and functional</u>: In many instances, the interventions, strategies, and supports prescribed in the ISP were not practical or functional in the Facility nor in a community setting. Many interventions, strategies, and supports were provided on a very intermittent and even random basis, which would render them to be not of any practical function in an individual's life. Many examples of the interventions, strategies, and supports that were not practical or functional may be found in Section S. In another example: • Individual #641 had a training objective that required a response of "I am doing fine" when asked "How are you doing?" It was impractical to expect that this would always be an accurate response, nor was it functional in terms of providing the individual with appropriate means to communicate various states of being. <u>Conclusion:</u> This provision was found to be not in compliance.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the	<u>Extent to which ISP identifies data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress:</u> Neither the ISP nor the other documents by which the Facility implements the ISP consistently identified the data or frequency of data collection. For example, the majority	Noncompliance

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	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.	of SAPs provided no instructions for data collection other than the code to use for recording a prompt level. It was also common to discover SAPs that provided only a schedule for data collection. In addition, as reported in Provision M1, Health Management Plans did not consistently specify the frequency nursing interventions were to be carried out or where to document. Extent to which ISP identifies the persons responsible for the data collection and the persons responsible for data review: As noted above in Provision F2a4, this was not being done consistently in the ISP. The ISP Action Plans identified responsibility by position to an extent, but not by specific name, nor did they clearly delineate the specific responsibility for data collection. The SAP format in use at RSSLC did not include a section in which the person(s) responsible for data collection could be identified. Likewise, the SAP format did not provide for the specific identification of either a person by name or a position as the individual responsible for program review. The majority of SAPs provided no instructions for data collection other than the code to use for recording a prompt level. It was also common to discover SAPs that provided only a schedule for data collection. In addition, as reported in Provision M1, Health Management Plans did not consistently specify the frequency nursing interventions were to be carried out or where to document. It is up to the Facility to determine how it will ensure the responsible parties for data collection and review will be identified as a part of the overall ISP process to ensure effective implementation and review, but this information must be readily accessible and comprehensible to staff who may be designated with these responsibilities. Conclusion: This provision was found to be not in compliance.	
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.	Extent to which goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP: This provision requires that disciplines work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. The Monitoring Team found there were some examples of progress toward coordination among staff. For example, as reported in Provision J8, individual #210 had been doing well on Clozaril but had developed a cardiac arrhythmia. The nurse manager reviewed the reasons that Clozaril was stopped after a screening EKG ordered by the PCP had showed an arrhythmia, and a different medication was substituted, but without much efficacy. Further consultation was sought with an arrhythmia specialist and the upcoming appointment with the specialist was reviewed. The psychologist planned to attend the upcoming appointment and to review the question about the safety or resumption of Clozaril use. The QDDP shared information from the family regarding a strong preference to resume Clozaril treatment if at all possible. The Monitoring team	Noncompliance

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		learned the following day that the consultation took place and the psychologist assured that the question of whether the arrhythmia precluded further use of Clozaril was addressed. It was, and the arrhythmia specialist provided advised that Clozaril could be resumed. The Monitoring Team found that the IDT had been conscientious is obtaining the screening, family preferences were brought to the table, appropriate consultation was obtained, and the process was well guided by the psychologist and QDDP. Overall, however, there was a lack of coordination observed in the coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP, as described throughout this Section F. <u>Conclusion:</u> This provision was found to be not in compliance.	
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.	<u>Extent to which ISP is accessible to staff:</u> Staff generally reported that the ISP was accessible. The ISP was placed in the individual's section of the Group Notebook. As reported in Section O, however, PNMPs located at the Infirmary were of such poor quality as to make staff unable to clearly view the positioning photos. This would negatively impact accessibility. <u>Extent to which ISP is comprehensible to staff:</u> Observations and review of program data indicated that, in terms of outcomes, the ISP 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 ISP or did not implement them as called for in the ISP. Examples included: • As reported in Section O, 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. • As reported in Provision S1, during the current site visit, observations reflected that only 9% of locations involved functional engagement by more than 50% of the individuals present in that location. Furthermore, only approximately 23% of the individuals observed were engaged in some type of formal or informal functional activity. This was less than half of the functional engagement level of 50% noted during the previous site visit. It follows that a lack of engagement by staff also indicates they were not engaged in implementing any ISP related activities such as SAPs, Service Objectives or generalization strategies, as these all require engagement as a prerequisite. As reported in provision S1, although staff verbally reported familiarity with skill acquisition plans, observed performance and reviewed documentation reflected that skill acquisition plans were often not implemented as intended.	Noncompliance

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		Conclusion: This provision was found to be not in compliance.	
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.	Monthly review of progress: Overall, the IDTs did not consistently ensure assessment of progress was noted in that 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 not consistently completed in a way that provided for meaningful evaluation of progress or program revision. In addition, other examples of failure to assess progress or take appropriate action included: • The Monitoring Team found several instances in which Nursing Quarterlies had not been completed. For example, for Individual #51, the last Quarterly Nursing Assessment was dated 10/16/11. When questioned, the QDDP stated this was not out of the ordinary. • As reported in Provision M1, 27 of 44 (61%) Health Management Plans were reviewed and/or revised annually and/or quarterly. • As reported in Provision O7, the PNM Team or IDT did not document progress of individual strategies 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. • As reported in Provision P1, , there was not a consistent assessment or comprehensive review for 4 of 8 individuals (50%) as indicated by a change in the individual's status or as dictated by monitoring results. • As reported in Provisions R1 and R3, SLPs did not consistently participate in the monitoring of programs to ensure they remain effective and relevant to the individual. Zero of 26 records reviewed (0%) indicated an SLP reviewed/ monitored the implementation and effectiveness of goals at a minimum monthly if direct and quarterly if indirect. Extent to which ISPs are modified as appropriate: The failure to complete timely reviews obviously produced a concomitant negative outcome in terms of appropriate modification. Many individuals remained on the same programs with very little progress noted and very little modification made for many months. For example, for Individual #51, the Monitoring Team attended the ISP during the previous monitoring visit and found that the IDT had developed some creative and integrated strategies; however, very few of these had been implemented. The Individual had expressed a strong desire to obtain a passport and the IDT developed a plan to assist her to achieve this. As of this monitoring visit, six months later, no progress had been made on this objective.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Conclusion: This provision was found to be not in compliance	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training whe$_{n\ the}$ plans are revised.	Extent and adequacy of competency-based training for staff responsible for development of ISPs: As documented in previous reports, training on ISPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. In addition, QDDPs were trained in facilitation skills using the Q Construction curriculum. Additional training sessions and resources had been initiated, including on the topics of: • Role of the IDT during the ISP meeting • Progress notes • functional Assessment Update • Assessment Tracking • Revised Functional Assessment Summary • Section F Monitoring Tool Extent and adequacy of competency-based training for staff responsible for implementation of ISPs: The Monitoring Team found staff were not adequately provided with competency-based training. This finding was made by the lack of active treatment and engagement observed and by the lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record. Examples included: • Numerous SAPs and related documentation reviewed during the site visit did not suggest that staff were competent in implementing SAPs. In many instances, SAP data sheets reflected that SAPs were not implemented as frequently as required by the implementation instructions. During observations in several residences, staff were observed to be unaware of programmatic schedules and did not implement SAPs according to those schedules. • As reported in Provision O4, when DCS were asked if they had been trained to implement an individual's plan, only 60% answered in the affirmative. • Also as reported in Provision O4, 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. Conclusion: This provision was found to be not in compliance.	Noncompliance
F2f	Commencing within six months of	Extent to which ISPs are developed within 30 days of admission: RSSLC reported 17	Noncompliance

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	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.	admissions in the last six months. The Monitoring Team reviewed a sample of ten of these and found deficiencies in several areas: • For two of the ten (20%), documentation indicated the ISP meeting was not held within 30 days of admission. • For Individual #546, the ISP should have been held no later than 4/25/12, but the document was not included in the information provided. • For Individual #689, who was admitted on March 17, 2012, the initial ISP had not yet been held. No rationale was provided other than to say the individual was participating in informal programming. • Individual #387 had a 30 day ISP during the monitoring visit. The monitoring team requested all assessments prepared for the meeting, but no medical or social assessments or PFA were provided for review. . <u>Extent to which ISPs are revised annually and as needed:</u> The Monitoring Team reviewed a list of ISP dates provided by the Facility. A sample of 72 entries (pages 3-4) indicated that there was only one that had a current ISP date that exceeded the 365 day requirement. <u>Extent to which ISPs are put into effect within thirty days of preparation:</u> RSSLC Policy F.5: Completing Personal Support Plan Meeting Documentation, revised 11/17/11, required the ISP be filed within 30 days of the ISP meeting. Despite an apparent overall compliance with annual meeting dates, the Facility did not actually consistently implement ISPs within 30 days of preparation. The Facility's own data indicated that eight (11%) had not been "completed" within 30 days. Of these, five were delayed well beyond the 30 day requirement, ranging from almost two months to more than five months. <u>Conclusion:</u> This provision was found to be not in compliance. There appeared to be a significant incidence of failure to provide timely development and implementation of an ISP for each individual.	
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	The Facility had begun a process of internal monitoring of the ISP related functions using the Section F and Section S monitoring tools. Each QDDP was expected to complete tools as assigned by QA on a random basis and to include only individuals for whom the QDDP was not assigned. This was followed by an external validation of a random sample of three to five of the completed tools by a QA Auditor. This process had been ongoing since November 2011. The Facility tracked annual assessments filed within the 10 or, more recently, 15 day requirement, using the PSP Assessment Tracking Log, 11/1/2011-4/13/2012 and the	Noncompliance

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	provisions of this section.	Annual Assessments Filed Within 10 Days, for meeting dates of 2/1/2012-2/20/2012. The former tracked assessments by individual and the latter tracked assessments by residence. The Facility also tracked attendance data, but as described under Provision F1b above, these data could did not necessarily present an accurate or reliable picture of meaningful participation by IDT members. The Facility should prioritize the development of an overall QA plan involving monitoring tools, QDDP audit tools, active treatment tools and any other applicable tools as described in the Action Plans, dated 03/08/2012. The Facility had just received confirmation that they could individualize the use of the Settlement Agreement Monitoring Tools and was considering how they might do so. Conclusion: This provision was found to be not in compliance.	

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

1. The Facility should prioritize the development of an overall QA plan involving monitoring tools, QDDP audit tools, active treatment tools and any other applicable tools as described in the Action Plans, dated 03/08/2012. (Self-Assessment and F2g)
2. The Facility should evaluate its training for QDDPs and redouble its efforts to develop competency among the QDDPs, both the currently certified and those yet to be deemed competent. (Provision F1a)
3. In order to make the ISP a much more comprehensible, participatory and positive experience for individuals, 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. (Provision F1b)
4. The QA Department should consider analyzing ISP attendance data to determine if there are any trends that need to be addressed. (Provision F1b)
5. The Facility may need to place a focus on corrective action in the area of Nursing Annual and Quarterly Assessments. (F1c)
6. Additional training should be provided on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. (Provision F2e)

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 Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. RSSLC Presentation Book for Section G 4. DADS Draft Policy Minimum and Integrated Clinical Services 1/12/10 5. RSSLC Policy I.12 Routing of Off Campus Consultations 1/6/11 6. RSSLC Policy I.13 Routing of On Campus Consultations 1/6/11 7. RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 3/19/12 8. RSSLC Policy I.29 Integrated Clinical Meeting 9/7/11 9. RSSLC Integrated Neurology Clinic Policy (no number) 4/17/12 10. RSSLC Patient Polypharmacy Review Policy undated 11. RSSLC Policy F.5 Person Directed Planning & Active Treatment: Completing Personal Support plan Meeting Documentation 11/17/11 12. RSSLC Policy I.08 At Risk Individuals 2/18/11 13. Consultation Report blank form 8529 dated June 2011 14. Integrated Meeting minutes with attachments • 2/15/12 regarding Individual #500 o Integrated Progress Notes (IPN) of 2/15/12 o Physician's Orders of 1/3/12-2/16/12 • 3/14/12 regarding Individual #649 o 3/14/12 o Physician's Orders of 3/9/12-3/14/12 • 4/4/12 regarding Individual #328 with Physician's Orders sheets for 2/22/12-4/5/12 15. Description—What our Clinical Pharmacists do here at RSSLC 16. In-service attendance sheets for Medical Follow Up Database and Policy Training 17. Consultation reports for Individuals #41, #95, #142, #165, #248, #296, #412, #424, #501, #555, #712, #726, and #728 **People Interviewed:** 1. Tran Quan, D.O, Medical Director, and Raj Thakur 2. Group interview of Tran Quan D.O, Medical Director, Raj Thakur, Anto Parambil R.Ph, Pharmacy Director, Michael Shatz D.Ph., Clinical Pharmacist, Carol Heath DDS, Reneda Simmons RN, Infection Control Nurse, Antonio Crascini RN, Assistant Infection Control Nurse, and Ping Law OTR, Director of Habilitation **Meeting Attended/Observations:** 1. Integrated Support Services Meeting 5/15/12 2. Medical Integrated Meeting 5/16/12 3. Medical Morning Meeting 5/17/12

	4. Individual Support Plan annual planning meetings for Individuals #462 and #508 5. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: RSSLC had made considerable revisions to its Self-Assessment, previously called the Plan of Improvement (POI). In the new format, the Facility described, for each provision item, the activities the Facility engaged in to conduct the Self-Assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance, along with a rationale. That was an improvement in the Facility self- assessment activity. Nevertheless, the activities listed for Provision G1 were a number of separate and distinct activities related to a number of requirements in several sections of the report rather than a set of activities that were sequential and aimed at developing systems for clinical integration. Admittedly, even if there were a systematic set of steps to implement and maintain integrated clinical services, there would still be some very specific tasks to be assessed. Many of these would best be included as part of the Facility's overall quality assurance process. The information about some actions as presented for this section did not match the information provided in another section or in documents provided by the Facility. For example, regarding use of suction toothbrushing, the Self-Assessment for Section G stated "132 individuals were identified to benefit from suction tooth brushing and 100% are receiving suction tooth brushing" whereas the Self-Assessment for Section Q (Dental Services) stated "100% of the individuals with defined need (3 individuals) were enrolled in suction toothbrush protocol." Furthermore, issues of quality of the actions need to be assessed when relevant to integrated clinical services. For provision G1, the Facility reported it reviewed the risk rating database to monitor that all individuals have a current risk rating. Although having risk ratings completed and current is essential, a central issue for this section is whether the risk ratings reflect integrated and collaborative clinical assessment of risk, which was not assessed and was found lacking in observations by the Monitoring Team. Interestingly, the Self-Assessment for Section I (At Risk Individuals) did not track or report the percent of individuals who had risk ratings. The Monitoring Team encourages the Facility to assess progress toward establishing processes to develop and maintain integrated clinical services as well as specific actions to address recommendations and other specific needs, and to ensure that information on actions addressing the same issues is consistent across the Self-Assessment. The Facility also provided an Action Plan intended to move toward compliance with provisions of this Section. The Action Steps, while general in nature, do provide an outline for development of a tracking system to ensure individuals receive appropriate clinical treatment and to integrate multiple disciplines. This addresses the concerns expressed about the Self-Assessment but will require more detail. However, the first three Action Steps, which were listed as "Completed," were not assessed in the Self-Assessment.

	RSSLC assessed that it was not in compliance with Provision G1, and the Monitoring Team concurs. The Facility reported being in substantial compliance with Provision G2, but the Monitoring Team does not concur, although it recognizes the significant improvements that have been put into place.
	Summary of Monitor's Assessment: The Facility continued to expand steps toward providing clinical services in an integrated manner. Facility policies have been developed or revised to provide direction. Participation of clinical staff in the ISP/IDT process had continued to improve in many areas, but further improvement is needed. For example, evidence of integration and collaboration was not regularly found included within Health Management Plans that needed integration/collaboration with other disciplines. Examples are provided throughout this report of both involvement in the ISP process and lack of involvement. The Facility continued to use a consultation form to document review by facility clinicians of medical consultations from non-Facility clinicians. Although there were not always Integrated Progress Notes documenting the clinicians' review, all sampled consultations had documentation of review, and nearly all documented whether there was agreement or disagreement with consultant findings and recommendations. In addition, the Facility had developed a process to track upcoming, completed, and missed consultations and to review outcomes of consultations at unit meetings.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility has continued to expand steps toward providing clinical services in an integrated manner. In response to a document request for a copy of any State or Facility policy or procedure guiding integrated clinical services, the Facility provided the following policies: • RSSLC Policy I.29 Integrated Clinical Meeting 9/7/11 • RSSLC Integrated Neurology Clinic Policy (no number) 4/17/12 • RSSLC Patient Polypharmacy Review Policy undated • RSSLC Policy F.5 Person Directed Planning & Active Treatment: Completing Personal Support plan Meeting Documentation 11/17/11 A draft DADS statewide policy had also been available for over a year. 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 repeated 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.	Noncompliance

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		Participation of clinical staff in the ISP/IDT process had continued to improve in many areas, but further improvement is needed. Examples of improvement included: • There was evidence of greater integration of psychiatry services into interdisciplinary planning. As reported in Provision J8, observation of a Psychiatric and Behavior Management Clinic (PBMC) showed evidence of integrated care. As reported in Provision J2, the PBMC involved several IDT members, including the QDDP, psychologist /behavior analyst, nurse case manager, clinical pharmacist, and selected DSPs who knew the individual well. Also, the Psychiatry Department started a process to improve PBMC diagnoses. Several IDT members completed a form that contained a variety of psychiatric symptoms for individuals being reviewed was completed by various IDT members. Following discussion and, when appropriate, broader IDT meetings, PBMC diagnoses were revised. Also, in the case of Individual #210 there was a well-integrated discussion about treatment with Clozaril. The individual had been doing well on Clozaril but had developed a cardiac arrhythmia. The nurse manager reviewed the reasons that Clozaril was stopped after a screening EKG ordered by the PCP had showed an arrhythmia, and a different medication (Zyprexa) was substituted, but without much efficacy. Further consultation was sought with an arrhythmia specialist and the upcoming appointment with the specialist was reviewed. The psychologist planned to attend the upcoming appointment and to review the question about the safety or resumption of Clozaril use. The QDDP shared information from the family regarding a strong preference to resume Clozaril treatment if at all possible. The Monitoring team learned the following day that the consultation took place and the psychologist assured that the question of whether the arrhythmia precluded further use of Clozaril was addressed. It was, and the arrhythmia specialist provided advised that Clozaril could be resumed. The Monitoring Team found that the IDT had been conscientious in obtaining the screening, family preferences were brought to the table, appropriate consultation was obtained, and the process was well guided by the psychologist and QDDP. • PNMT evaluations for Individuals #251 and #661 included assessment by the OT, PT, SLP, RN, and RD. The outcome reflected a comprehensive strategy to mitigate risk. • The Monitoring Team attended the Skin Integrity Meeting on 5/16/12, which demonstrated that the meeting was integrated with relevant disciplines. The Skin Integrity membership included: Medical Director, Physicians, Dietitian, Habilitation therapist, Clinical Pharmacist, Chief Nurse Executive, Nurse Educator, Quality Assurance Nurse, Nurse Managers, Infection Control Nurse, and Nurse Managers.	

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		However, there were also examples in which planning and assessment did not evidence an integrated approach. For example: • As reported in Provision L1, the Monitoring Team observed Individual #398 at the living area, while being provided physical therapy by physical therapy aides. The Monitoring Team assessed that the Individual was in severe distress during the treatment. The Individual was seen in 1996 by an orthopedic specialist, who recommended "regular follow-up" for "vast degenerative arthritis changes" of the spine. An x-ray of the spine, dated 7/14/10 demonstrated severe arthritis of the spine, and also subluxation of the lower spine. Interdisciplinary planning of integrated services should have included assessment of these conditions prior to beginning physical therapy. • As reported in Provision M3, evidence of integration and collaboration was not regularly found included within Health Management Plans that needed integration/collaboration with other disciplines. For example: o As reported in Provision M1, it was documented that Individual #193 was found to have a fracture of the left fifth metacarpal (little finger) following an incident of hitting a shelf and a sanitizer dispenser. An Acute Care Plan was initiated which was individualized sufficiently to meet Individual #193's needs from the nursing standpoint. However, there was no documentation in the Integrated Progress Notes that the nurses collaborated with the habilitation therapist regarding the fracture and casting. Any plan of the Habilitation therapist should have been integrated into the Acute Care Plan due to the mobility issues related to the use and proper healing of the fracture. o Individual #112 pointed to his right foot, removed his shoe and showed the nurse his foot. The nurse assessed the foot and found abrasions on the right ankle, fifth toe and bottom of the foot. The physician said to keep the foot dry and he was referred to sick call in the morning for impaired skin integrity. The Wound Care Nurse was also notified of the abrasions. An Acute Care Plan was initiated for Impaired Skin Integrity Related to Abrasions on Right Foot as related to nursing care. There was no documentation that the habilitation therapists were contacted. They are the discipline best qualified to evaluate the shoe for proper fit. The Acute Care Plan should have been developed in collaboration with the Habilitation therapist. • Individuals' Acute Care Plans (ACPs) for Skin Integrity did not consistently integrate all of the treatments and interventions that were being carried out by the Wound Care Nurse and other disciplines. However, the ACPs for Skin Integrity were adequately individualized for the actions/interventions the nursing staff were carrying out. Although the Wound Care Nurse had been conducting weekly reviews	

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		of new Acute Care Plans and Health Management Plans, he had not considered the inclusion of all pertinent care interventions related to other relevant disciplines' into the plans developed by the Nurse Case Managers. • As reported in Provision O3, PNMPs were not clearly developed with input from all members of the IDT or reviewed consistently by the IDT. • As reported in Provision R1, there was no consistent evidence of active collaboration betwee_{n the} SLP and Psychology (Sample #5) as evidenced by: o Zero of three records reviewed (0%) revealed problem behaviors were integrated into assessment. o Zero of three records reviewed (0%) revealed integration of Communication programs into the PBSP. o Zero of three (0%) identified potential connections between behaviors and difficulties with communication. o Seven of 23 Behavior Support Committee (BSC) minutes (30%) reviewed indicated SLP membership and participation in the Positive Behavior Support Committee. o For Individual #429, most members of the IDT indicated they believed the most integrated setting appropriate to the individual's needs was in the community. The psychologist stated the individual should be better able to express wants and needs without any self-injurious behavior before making such a move. The speech therapist was not at the meeting and therefore could not provide information about the individual's current communication status or recommendations for strategies to enable the individual to express wants and needs. The primary system for integrated clinical planning lies within the ISP process. Examples are provided throughout this report of both involvement in the ISP process and lack of involvement. • Habilitation therapies were not actively participating in the development of the ISP as evidence by lack of documented discussion or presence at the annual ISP planning meeting. Three of 26 records reviewed (11%) for SLP involvement indicated the SLP consistently participated as a member of the IDT. Without SLP involvement, issues of communication for individuals with communication skill deficits and needs may be incomplete, and valuable information regarding safe dining may not be presented. For example: o No Communications therapy staff were present at the ISP annual planning meeting for Individual #508, who required a modified food texture and specialized techniques, and who had very limited language skills but no action plans in her current ISP related to communication; the current ISP had an action plan to socially interact with preferred staff, and this would	

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		have been a good opportunity for an SLP at the meeting to discuss how to integrate communication into social interaction. o As noted above, there was no speech therapist at the ISP annual planning meeting for Individual #429 who could assist in planning for development of means to express wants and needs. There were other processes and venues that had developed for integrated clinical planning. Examples include the following: • After a visit by the Hospital Liaison Nurse 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 nursing and medical meetings and reported on hospitalized individuals. He maintained communication with the Nurse Case managers, Unit Directors, Qualified Mental Retardation Professionals (QDDPs), Wound Care Nurse, Occupational and/or Physical Therapist, and other IDT members as necessary. The IDT members were notified as soon as pending discharges were known in order to discuss any necessary training or equipment needed on discharge. Since the last review, it was positive to find that the Hospital Liaison Nurse had begun attending Integrated Support Plan (IDT) and IDT Addendum meetings for individuals who were hospitalized or in LTAC facilities. The Hospital Liaison Nurse's attendance at the post discharge meeting provided the IDT with valuable firsthand knowledge of the individual's health status at the time of discharge in order to be able to identify whe$_{n\ the}$re were significant changes in status that would require revising their risk assessment ratings. • As reported in Provision M6, it was positive to learn from the Unit Nurse Manager for Leon that they collaborated with Habilitation therapy and had initiated a pilot project, 5/1/12, for the use of adaptive equipment and positioning for medication administration. • The Medical Morning meetings had expanded clinician involvement. A positive practice that continued to be noted was participation by PNMT (usually the designated PNMT nurse) in the medical morning meetings as well as grand rounds thus allowing for the increased sharing of issues between multiple committees. The Monitoring Team observed one Medical Morning meeting. The meeting began with report from the on-call physician and the hospital and infirmary reports and continued to two discussions of specific cases. There is still work to be done to reflect active collaboration betwee$_{n\ the}$ physicians and the PNMT regarding their caseload (and, as noted above, to increase involvement of needed disciplines in HMPs). The Facility had, through this process, developed a means to improve integration but still needs to ensure the outcome of integrated and collaborative planning occurs and is evident.	

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		• The Facility continued its weekly Integrated Meeting that reviews one individual with complex issues most weeks. The Monitoring Team observed the meeting held during the compliance visit. There were 19 clinical staff in attendance, including physicians/ARNPs, nurses (including the Skin Integrity and Wound Care nurses), the clinical pharmacist, the QDDP, OT representing the PNMT, and dietitian, among others. Discussion was integrated, with different disciplines providing information including status and progress on several medical issues, a report on the individual's daily activity, and status of enteral feeding and hydration. Both medical and non-medical recommendations were developed and summarized. Furthermore, the Monitoring Team reviewed minutes of three other such meetings for Individuals #328, #500, and #649. Attendance was similar at all three meetings. For Individual #649, the focus issue was self-injurious behaviors, and the Behavior Analyst attended. • The Facility had initiated an Integrated Support Services quarterly meeting. Although this focused on support services, many agenda items related to projects in which support services needed to provide services needed by clinical disciplines to ensure delivery of supports. This has led to changes in the way Support Services carries out its work. For example, maintenance staff were assigned to specific buildings for quicker response. Residential and vocational/activity areas do not have to wait for work orders to ensure attention to needed maintenance, including safety issues. The Risk Management director took responsibility for emergency medical equipment and had worked closely with Nursing staff, as reported in Section M. Housekeeping, working with Nursing and residential staff, replaced an aerosol with a non-aerosol safer for individuals with respiratory problems. More space was provided for counseling services. Support services worked closely with Residential Services, Habilitation therapy, and Nursing to address bedrails and seek alternatives. This was a significant step in responding to concern in the last compliance report about lack of collaboration across disciplines and was evidence of creative and effective planning to address that concern. • An Integrated Behavior Case Review process had been initiated. The Monitoring Team observed one meeting. This meeting involved a variety of staff, including the person's psychologist as well as other psychologists, teachers, the QDDP, SLPs, vocational instructors, and direct care staff. Although not "clinical" in the sense of being a data driven process, the meeting did reflect an opportunity for staff from a diversity of disciplines to share perspectives and ideas. The general guidelines for the meeting were that any ideas were open for presentation and no one was to attempt to disregard or invalidate the ideas. This information was then to be compiled by psychology staff and included in the behavior assessment process. All input was truly welcomed and staff appeared very comfortable with the format. Ideas were shared that did not seem to have been considered before, and everyone	

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		looked eager to build upon the meeting outcomes. <u>Conclusion</u> This provision is not in compliance. There are many missed opportunities for integrated planning and collaborative services. At the same time, the Facility has initiated a number of procedures that involve collaboration and should help pave the way for clinical disciplines to work together on a routine basis.	
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.	In response to a request for any Facility policy that guides Facility clinicians in performing and document reviews of recommendations from non-Facility clinicians, the Facility provided the following policies: • RSSLC Policy I.12 Routing of Off Campus Consultations 1/6/11 • RSSLC Policy I.13 Routing of On Campus Consultations 1/6/11 • RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 3/19/12 Policies I.12 and I.13 provide steps to be taken for routing off-campus and on-campus consultations. For off campus consultations, the policy begins at the point of delivery of the consultation documents to the medical coordinator, who is to send the original to the Primary Care Physician (PCP) and a copy to the unit case manager and is to flag any needed follow up appointments, lab work, and medical studies for the unit case manager. The medical coordinator is to schedule follow up appointments and send notices to the unit case manager. The PCP is to document "whether to accept, reject, or other on the back of the consultation form" (see next paragraph for description of this form: and sign, then return it to the Unit Nurse Manager (the policy used both "unit case manager" and "Unit Nurse Manager" terminology, but these appeared to be the same position) to present to the unit morning meeting that "contains most members of the PST and will determine if a formal PST is needed based on the consultation." For all medical consultations, the Facility required use of a Consultation Report form that included information from the consultation, including consultant findings and recommendations; this form was an attachment to the policy on routing of off campus consultations. Page 2 of the form had check boxes for noting whether the recommendations were accepted, rejected, or other. It also included a number of lines for "Explanation (Plan of Care)" and a place for the Primary Care Physician (PCP) to sign and date. For on-campus specialty clinics, the process for routing was somewhat different, but the process for review by the PCP and for presentation by the Unit Nurse Manager to the "PST" was the same as for off-campus consultations. One addition was a process for	Noncompliance

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		reporting any suspected abuse, neglect, or sexual activity between individuals. Although not directly required by the requirements of this provision, the Facility provided information on the related issue of determining that appointments are kept. Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies provided a process for entering information into, and using, a consultation database. This policy included quality assurance activity to ensure missed appointments are rescheduled and presentation to the IDT if an individual missed two consecutive consultation appointments for the same referral. The Facility provided, in the Presentation Book, a report of Pending Medical Consultation Appointments from May 12, 2012. This listed upcoming appointment dates (most of which had not yet been reached) and rescheduled appointment dates for missed appointments for one unit. This procedure, if followed, should minimize missed appointments and ensure follow up. Directly relevant to this provision, the database included sections to be completed by the PCP acknowledging consultant recommendations and the PCP's response, and the Unit Case Manager marking that the IDT reviewed the PCP's acknowledgment of consultation; this information should also minimize any missed actions by PCPs and unit case managers. The Monitoring Team reviewed a sample of 17 medical and MBSS consultations for 13 individuals. Of those, all 17 (100%) had documentation of clinician review on the consultation form. Eleven of 17 (65% had documentation entered into the Integrated Progress Notes (IPN). Fifteen of seventeen (88%) indicated agreement with consultant findings and recommendations, with one disagreement and one not checked. In one instance, for Individual #296, a recommendation was accepted by the physician although it contained confusing and conflicting information, but this was cleared up in discussion with the IDT, which is a positive finding. The Facility did not provide, and the Monitoring Team did not identify, any ISPAs to document IDT review and action. Recognizing that only some consultations will require IDT review and action, the Monitoring Team still needs evidence that IDT action beyond review at the Morning Meeting occurs. <u>Conclusion</u> This provision shows improvement and is near to substantial compliance. To achieve compliance, documentation must consistently be entered into the IPN. Furthermore, the Facility should have a process to ensure the IDT takes action whenever appropriate; it will be important that evidence is available to document such action. Although that was not presented, the incident in which a confusing consultation report was cleared up through IDT discussion was a positive finding that indicates substantive review of	

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		consultations by the IDT.	

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

1. Assess progress toward establishing processes to develop and maintain integrated clinical services as well as specific actions to address recommendations and other specific needs, and to ensure that information on actions addressing the same issues is consistent across the Self-Assessment. (Self-Assessment)
2. Complete development and implementation of statewide and local policies to provide direction and clarify responsibilities for integrated planning and service delivery. (Provision G1)
3. 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 ISPs and the active record. (Provision G1)

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 Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. RSSLC Presentation Book for Section H 4. DADS Draft Policy Minimum and Integrated Clinical Services 1/12/10 5. RSSLC Policy I.29 Integrated Clinical Meeting 9/7/11 6. RSSLC Integrated Neurology Clinic Policy (no number) 4/17/12 7. RSSLC Patient Polypharmacy Review Policy undated 8. RSSLC Policy F.5 Person Directed Planning & Active Treatment: Completing Personal Support plan Meeting Documentation 11/17/11 9. RSSLC Policy I.08 At Risk Individuals 2/18/11 10. RSSLC Policy K.01 Physical Nutritional Management (1/31/11) 11. RSSLC Habilitation therapies Policy K.04 (Developing PNMPs) (2/23/12) 12. RSSLC Habilitation therapies Policy K.07 (Universal Monitoring) (3/1/12) 13. RSSLC Habilitation therapies Policy K.05.1 (Staffing Effectiveness-Occupational Therapy / Physical Therapy) (4.1.12) 14. RSSLC Habilitation therapies Policy K.05.2 (Occupational Therapy / Physical Therapy Services) (4/1/12) 15. RSSLC Habilitation therapies Policy K.06.1 (Staffing Effectiveness-Speech Therapy) (2/1/12) 16. RSSLC Policy I.26 Physician Quarterly Review 2/18/11 17. RSSLC Policy I.31 Chronic Clinical Indicators 10/12/11 18. RSSLC Medical Policy DSM and ICD Medical and Psychiatric Diagnosis Update Policy 1/12/12 19. RSSLC Medical Policy Physician Order Flag Policy 1/12/12 and sample flag sheet with Axis Info 20. Format for Annual Medical Summary (undated) 21. Active records for Individuals #232, #306, and #508 22. Database screen shots from the following: a. Integrated Risk Rating database entry page b. Axis Information search page c. Report screens for Diabetes I/II and Osteoporosis 23. Sample report pages from database a. Axis III Hepatitis search list of individuals b. Axis Info on Individual(s) page for Individual #16 24. ICD-10 Orientation—RSSLC Physicians Sign-in Sheet (5/9/12) and training materials 25. Sample Sick Call Logs for four units and related Integrated Progress Notes (IPNs) 26. Weekend Sick Call Log and related IPNs 27. Clinical Indicators guidelines, databases, and trend analysis reports for diabetes and osteoporosis a. Graphs of Hbg A1C Averages for All Individuals with Diabetes I/II, Diabetes I/II Complications, and Diabetes I/II Medications

	b. List of individuals with osteoporosis with calcium supplement less than 1000 c. Sample report for Individual #148 including Dexa date and score, CA date and level, VitD date and level, and whether there was osteonecrosis of jaw, dental consult, and rheumatology consult d. Osteoporosis Trend Analysis report of 5/13/12 with summary/analysis of findings and actions to be taken **People Interviewed:** 1. Tran Quan, D.O, Medical Director, and Raj Thakur 2. Group interview of Tran Quan D.O, Medical Director, Raj Thakur, Anto Parambil R.Ph, Pharmacy Director, Michael Shatz D.Ph., Clinical Pharmacist, Carol Heath DDS, Reneda Simmons RN, Infection Control Nurse, Antonio Crascini RN, Assistant Infection Control Nurse, and Ping Law OTR, Director of Habilitation **Meeting Attended/Observations:** 1. Medical Integrated Meeting 5/16/12 3. Medical Morning Meeting 5/17/12 4. Individual Support Plan annual planning meetings for Individuals #462 and #508 5. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: RSSLC had made considerable revisions to its Self- Assessment, previously called the Plan of Improvement (POI). In the new format, the Facility described, for each provision item, the activities the Facility engaged in to conduct the Self-Assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance, along with a rationale. That was an improvement in the Facility self- assessment activity. Nevertheless, the activities listed for Section H did not constitute a comprehensive review of processes or outcomes that would be adequate to reach and maintain compliance. Although this Section contains requirements for minimum common elements of "clinical care," the Self-Assessment activities focused exclusively on medical care and pharmacy. For Provision H1, monitoring was done of Physician Quarterly Reviews, Quarterly Drug Regimen Reviews (QDRRs), Annual Medical Summaries, and the sick call log, but not of assessments done by other clinicians such as psychologists, psychiatrists, nurses, speech and language pathologists (SLPs), occupational therapists (OTs), physical therapists (PTs), the dentist, or dietitians. That focus was consistent throughout the Self-Assessment. The Facility assessed that no provisions of this section were in compliance. The Monitoring Team concurs but assessed evidence related to actions of a wide range of clinical disciplines. The Facility also provided an Action Plan intended to move toward compliance with provisions of this Section. The Action Steps, while general in nature, do provide some sequential Action Steps. The general nature of the Action Steps may be seen in Provisions H5 and H6, for which the first Action Step states that a step to develop a system to track and trend clinical indicators for multiple chronic diseases is in process; this is accurate, but the database has been completed and is being used for some diseases, so it would be

	useful to describe further what actions are planned for continuing development. Furthermore, all Action Steps relate to medical care with no actions aimed at compliance by other clinical disciplines.
	Summary of Monitor's Assessment: The Facility had taken significant steps to develop clinical indicators and other processes that have great promise. At the same time, assessments continue not to be consistently timely or of adequate quality. The Facility will need to work assertively to turn potential into actual improvement in services. There had been improvements in both timeliness and comprehensiveness of some assessments, but problems remained regarding adequacy of assessments and evaluations, and provision of evaluations in response to changes in an individual's status. Assessments for the ISP were often not completed on a timely basis. Although quality of assessments had improved for some disciplines, such as medical services, there were still areas for which assessments were not comprehensive, such as communication services. Diagnoses were consistent with ICD-9 and DSM IV codes, but there was still a need to complete psychiatric evaluations. The Facility had taken a significant step in addressing chronic medical conditions through the implementation of clinical guidelines and a database that was consistent with those guidelines. This database, at the time of the compliance visit, covered diabetes and osteoporosis care. Expansion of this database should provide the Facility with an ability to track outcomes of care, provision of labs and other evaluations, and whether treatments and interventions are modified in response to changes in status. Gaps in identification, documenting, and using clinical indicators remained. There were still problems in gathering needed data and analyzing and summarizing the information. These limit the ability of the Facility to respond timely to changes in status, assess and respond to risks, and evaluate progress or decline. Although no provisions of this Section were yet in substantial compliance, several of the actions that had been implemented could lead toward compliance if the Facility takes assertive action to ensure that information is used thoughtfully to make decisions for both individual treatment and systemic action, and areas of systemic deficiency identified by the information gathered are addressed and improved.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to	Although there had been improvements in both timeliness and comprehensiveness of some assessments, problems remained regarding adequacy of assessments and evaluations, and provision of evaluations in response to changes in an individual's status. Assessments for the ISP were often not completed on a timely basis. <u>Timeliness of regular assessments and evaluations</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	developments or changes in an individual's status to ensure the timely detection of individuals' needs.	As reported in Provision F1c, assessments for the ISP were often not completed on a timely basis. The expectations remained that assessments would be posted to the share drive no later than ten days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. The Monitoring Team found that even for the ISPs held during the week of the compliance visit, not all assessments were available. For Individual #789, the Assessments Tracking Worksheet for this individual showed that as of 10 days prior to the ISP annual planning meeting, no required assessments had been posted, and notifications had been sent out requesting these. On the day of this individual's ISP annual planning meeting, several assessments were present, as reported in Provision V1. However, other assessments were reportedly completed but were filed in a "To be filed" folder on the drive, and a speech/communication assessment was outdated. Furthermore, review of assessments available on the shared drive for a sample of ISPs upcoming over the next ten days found zero of ten (0%) had all required assessments available and/or posted by the required date. Assessments for newly admitted individuals were generally completed timely. Psychological assessments were provided timely, as were physical and occupational therapy assessments and communication screenings or assessments. However, as reported in Provision J2, psychiatric evaluations for new admissions were not completed timely. Other observations regarding timeliness of assessments include: • At the time of the last compliance tour, the Facility informed the Monitoring Team that it would begin to conduct annual psychiatric updates. Due to staffing shortages, the psychiatric updates were not yet in place. • Active Records for Individual #232, #306, and #508 had several missing assessments. Examples of assessments that were not found in the record included: o For Individual #232, the psychological evaluation o For Individual #306, the Positive Assessment of Living Skills (PALS) Summary, psychiatric assessment, and self-medication assessment o For Individual #508, the psychological evaluation and psychiatric assessment Quality of assessments had improved for some disciplines but not in others. • Annual medical assessments were much more comprehensive. RSSLC had established a specific format for the annual medical summary, so that physicians would follow a consistent order and cover all required areas. Per report of the Medical Director, this format had been revised to make information more	

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		accessible and standardized. Nevertheless, assessments for some syndromal or chronic conditions did not include all needed evaluations. For example, individuals with Down syndrome were not regularly assessed for common, and serious, conditions that are known to occur in Down syndrome. • The Nursing Department was making steady progress in improving the quality of the Annual and Quarterly Nursing Assessment. There was a need to continue improvement, especially in summarizing assessment findings. • As reported in Provision R2, communication assessments were not comprehensive. • The Facility had failed to integrate the use of assessments into the planning process for skill acquisition programs. The Facility, however, had not demonstrated that the necessary assessments had been utilized to appropriately identify skills to be increased. Neither was there evidence to indicate that teaching strategies and SAP components were based upon formal assessments. <u>Assessments and evaluations in response to changes in status</u> There remained difficulties in ensuring assessments and evaluations were performed in response to changes in status. Following are a few examples: • Two of six (33%) individuals who were diagnosed and/or hospitalized with a PNM issue (sample #1) were appropriately assessed and followed by the PNMT or IDT in a timely manner. For example: o Individual #30 was diagnosed with pneumonia and has a significant history of aspiration pneumonia but did not receive PNMT or IDT review/assessment upon identification of diagnosis. o Individual #16 was diagnosed with aspiration pneumonia on 12/7/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the IDT 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. o Individual #661 was diagnosed with aspiration pneumonia on 1/20/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was eventually made on 1/30/12 but the PNMT did not complete the assessment until 4/5/12 resulting in an unnecessary delay of getting the needed services to mitigate risk. o Individual #251 was diagnosed with aspiration pneumonia on 2/15/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was made on 2/21/12 but the PNMT did not complete the assessment until 5/1/12 resulting in an unnecessary delay of getting the needed services to mitigate risk.	

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		• As reported in Section P, occupational and physical therapy 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. • As reported in Provision C7, it was not possible to determine whether Structural and Functional Assessments (SFAs) were reviewed when individuals experienced repeated restraints. • The quarterly Comprehensive Nursing Assessments were not updated whe$_{n\ the}$re was a significant change in health status. <u>Relationship of Policies to Assessments</u> The Facility provided a number of policies in the Presentation Book to provide information about habilitation evaluations. It is positive that the Facility had developed or revised these policies to provide clarity about how referrals are to be made, when assessments are to be done, and what actions should occur as an outcome of those evaluations. The Monitoring Team noted a few issues that the Facility might consider addressing: • There is variation among the policies regarding involvement of the IDT. IDT involvement is clearly required by Policy K.01 (Physical and Nutritional Management) but is not addressed in Policy K.2 (Providing Mechanical Supports) or K.3 ((Providing Adaptive Equipment), except for following up with the QDDP if any issues are reported. The IDT should become involved to review any proposals for supports or services so members can assure that all relevant issues have been addressed and that the supports and services are included in the ISP. • Policies K.2 and K.3 state that the Habilitation therapist will assess the individual "in response to a request(.)" Although this is appropriate, there should be recognition that additional assessment related to providing mechanical supports and adaptive equipment may also arise from screening or evaluation routinely done by the Habilitation therapist, who would then bring the issues to the attention of the IDT. Also, the policies should provide timelines following the request within which assessments should be done.	
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	The Self-Assessment reported that approximately 90% of 360 medical records reviewed by PCPs required updating for accuracy of medical diagnoses, and that these updates had been made. The Monitoring Team reviewed many medical, psychiatric, and nursing documents to assess compliance. Psychiatric diagnoses were in the DSM IV format, and medical diagnoses were consistent with the current version of ICD. During the last six months,	Noncompliance

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	Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	the Facility Medical Department had additionally introduced a new electronic database that was linked to the physician orders section of the record, and that tracked the DSM diagnosis of record. However, as reported in Provision J2, there were some differences in diagnoses betwee$_{n\ the}$ diagnoses in the database and on the Active Problem Lists. Nonetheless, the new process should result in diagnoses that all are consistent with current versions of the ICD and DSM. The Facility provided a sign-in sheet and CMS training materials for an ICD-10 orientation for physicians. This information demonstrated a proactive approach to ensuring physicians are aware of current and upcoming practices in ICD coding. The Medical department policy on DSM and ICD diagnosis update requires such training on DSM and ICD at least annually. Not only must diagnoses be consistent with the current version of the DSM or ICD, but diagnoses must clinically fit corresponding assessments or evaluations. For the most part, this was the case. However, there were examples in which diagnoses may not have fit or been supported by assessments or evaluations. • In addition to observations made during the PBMC clinic, the Monitoring Team assessed diagnostic practices for the 16 individuals selected for record reviews (Sample J1). CPEs were in place for seven of the 16 individuals (44%), and each contained DSM diagnoses. The Monitoring Team examined the seven evaluations to determine if the psychiatrist had explained how the individual met the DSM requirements for the diagnoses. Adequate explanations were in place in only two of the seven CPEs (29%).	
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 had initiated processes to ensure medical procedures were initiated timely but not that other treatments and procedures were implemented timely. The processes for medical procedures included use of a database including chronic diseases and the indicators to monitor, implementation of a physician orders flag, and Medical Morning meeting that includes On-call reports so PCPs are aware of any changes in health status. The Facility provided four sample Sick Call Logs (one per PCP) and related IPNs to show a process in which each person seen at sick call is responded to timely for routine, acute, and preventative issues, and also a sample weekend Sick Call Log. The IPNs were written in SOAP format (refer to Section M for additional information) and therefore included a plan of care. In addition, the Morning Medical meeting included reports of all overnight calls to ensure PCPs were aware of any emergent issues and could provide follow-up. The database process and reports, including clinical guidelines, appeared to be an exemplary process that led to the ability to analyze and act on trends. As it expands to additional medical conditions, it should make it possible to track individuals for changes	Noncompliance

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		in conditions and appropriate treatments as well as to identify areas for systemic improvements in health care. The Monitoring Team looks forward to reviewing both the expansion of this process and the outcomes achieved. Related to this process is the establishment of statewide guidelines for medical conditions. The Facility and DADS will need to work together to ensure consistency of these Facility and statewide guidelines and to build on the work each is doing. Nevertheless, there were still some area in which interventions were not timely, as the following examples document: • Review of PSP Training Objective Progress Notes in the Active Record for Individual #232 showed no progress, as checked by the QDDP on the form for the reporting period 3/15/12-4/14/12 and including data beginning 9/15/11-10/14/11) for two of five training objectives (although the Monitoring Team, based on review of the graphs, determined no progress for none of the five training objectives), but all were checked "Continue in program" with no comments or recommendations noted. For one other training objective (a vocational objective), the number of trials had been increased based on completion of an objective during the prior month. Therefore, the record demonstrated timely change in an objective when met, but no timely change whe$_{n\ the}$re was no progress. • At the time of the current visit, the Facility provided annual Reiss Screens for all individuals who lived at the Facility. Since the last visit, fourteen individuals had scores that exceeded the clinical cutoffs. This number did not include the new admissions, for whom psychiatric assessments were not timely. Follow-up for these fourteen individuals had not yet been provided, and the Monitoring Team will inquire with the Facility during the next visit about the supports provided for these individuals. In addition, fifty-one individuals had Reiss screen scores that reached or exceeded the designated cutoffs and had also received psychiatric evaluations. Forty-nine of these individuals (96%) received routine psychiatric care via PBMC. Individuals #216 and #302 did not receive ongoing psychiatric care. The evaluations for Individuals #216 and #302 were reviewed during the current visit by the Monitoring Team. In each case the psychiatrist suggested psychiatric treatment. The Facility should assure that these individuals receive the care that was recommended. • As reported in Provision P1, in many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. <u>Conclusion</u> The Facility has made strides toward the ability to ensure that medical treatments and	

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		interventions are implemented timely through the use of a database and daily reporting procedures. No development of similar actions for other clinical areas was reported to or noted by the Monitoring Team. This progress in developing such monitoring should expand to all areas of clinical care to ensure interventions are timely and appropriate based on assessments. The Facility should use the peer review processes that address other Sections of the SA to ensure treatments are clinically appropriate.	
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.	RSSLC had initiated processes to identify and track clinical indicators of the efficacy of medical treatments and interventions. The Facility had developed a database that identified clinical indicators of chronic health conditions and Policy I.31 Chronic Clinical Indicators that defined a process to expand and use this database. At the time of the visit, the database included osteoporosis and diabetes. For each of these, the Facility provided the Monitoring Team with treatment guidelines that included a listing of labs to be assessed, recommended medications, and information specific to treatment of those conditions. The guidelines for diabetes also included clinical indicators to be tracked, and the database reports for both conditions included clinical indicators to be tracked for individuals and for facility trends. Some actions were taken to identify clinical indicators for other areas of care, including the following: • The Aspiration Trigger Data Sheet was implemented for the individuals who had an aspiration event in the past year 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. Several issue with the existing Data sheet included: o Lack of individualized triggers o Lack of consistent and detailed documentation surrounding the occurrence of triggers (e.g., activity in which trigger occurred, positioning of the individual) o Lack of consistent completion by staff (missing data points) o Lack of implementation for all individuals who were identified as being "high risk" Nevertheless, gaps in identification, documenting, and using clinical indicators remained. • While PNMPs were reviewed at the ISP annual planning meeting, 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).	Noncompliance

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		• As reported in Section K, there were significant problems with gathering and analysis of data to evaluate progress of behavioral interventions. • As reported in Provision M2, only marginal improvement was noted in the analyses and summaries of clinical data. The quality of the nursing summaries varied from Unit to Unit and Nurse Case Manager to Nurse Case Manager. • As reported in Provision I3, no sampled records included the clinical indicators to be monitored and the frequency of monitoring related to increased risks. Summary: The Facility had made progress in establishing a database and process to track and analyze clinical indicators of health care, beginning with two chronic conditions. There remained gaps in identifying and using clinical indicators of efficacy of other treatments and interventions.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The database described in Provision H4 holds promise, as it expands, to be an excellent tool for monitoring health status of individuals. Reports generated by the system provide easily accessible information to assist physicians and other IDT members to track clinical indicators, medications, and lab values that can be analyzed and used in assessing health status. This is still at an early stage. According to the Medical Director, this database will include indicators of health status for both acute and chronic conditions. In addition, the Monitoring Team notes the Risk Level assessment and monitoring process and also that the SA requires monthly reviews by the appropriate IDT member and quarterly reviews by the QDDP. Although these have the potential to be effective systems to monitor health status, information in several sections of this report indicate that these continue to need improvement before they will be effective. As noted in several sections, lack of progress or change in status that should have been identified in a monthly review by a clinician was not always identified, or there was no evidence of review. For example: • The Active Record for Individual #232 did not include any quarterly QDDP reviews, which should summarize health status and/or need to involve the IDT in determining any needed changes to services and supports based on review of monitoring by clinicians. • As reported in Provision O6, two of six (33%) individuals who were diagnosed and/or hospitalized with a PNM issue (sample #1) were appropriately assessed and followed by the PNMT or IDT in a timely manner. • As reported in Provision P2, individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	This section will require demonstration of a functional system that is both integrated and ensures all clinical services make decisions on treatments and interventions timely in response to clinical indicators. The development of clinical indicators and a database at the Facility level to track and provide the clinicians with needed information could provide a means to identify when modifications are needed and to give clinicians objective and useful information. The various protocols developed by the State Office represent an initial framework, but there needs to be evidence these are put into action, support and are supported by appropriate clinical indicators, and lead to treatment that reflects that interventions and changes in interventions are based on identified clinical indicators and criteria that are appropriate for the individual. The clinical guidelines being developed by the Facility should be coordinated with the statewide protocols; these clinical guidelines are matched to the database, which has to potential to make it easier to review treatments and interventions to ensure they are modified in response to clinical indicators. Both the statewide protocols and the Facility's initial clinical guidelines were too new to have been used for the purpose of such review. As noted in Provision H3, there were examples in which treatments and interventions were not modified in response to clinical indicators. The Facility will need to ensure that systems are in place to identify such examples and determine whether there are trends or problematic areas for which systemic improvement actions should be considered.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	A draft DADS state policy addressed provisions G and H together. The policy was not yet completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the facility with some guidance and direction. In response to a request for any State or Facility policy or procedure guiding integrated clinical services, the Facility provided policies for the Integrated Clinical Meeting, Polypharmacy Committee Meeting, Person Directed Planning and Active Treatment: Completing Personal Support plan Meeting Documentation, Risk Assessment, and Integrated Neurology Clinic. All these include components requiring integration of clinical services. However, none brings together definitions and requirements of integrated services, nor was there policy that provided the framework and included the organizational structure or practices to ensure all the requirements of Section H are met. The Facility should develop policy that provides such a framework and organizational structure and ensures that all other relevant policies address, as appropriate, the requirements of this Section. Such a policy must address all clinical care, not only medical and health care. It must also address means to ensure these required elements and other requirements of policy are implemented accurately, including timely and	Noncompliance

#	Provision	Assessment of Status	Compliance
		comprehensive assessments (both routinely scheduled and in response to changes in an individual's status), diagnoses that are supported by and consistent with the assessments, and the development and use of clinical indicators. Finally, as the DADS policy is finalized, local policy will need to be revised as needed for consistency with that policy.	

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

1. All aspects of this section need to address all clinical disciplines. (Self-Assessment and all provisions)
2. Review the processes to track assessments, diagnoses, and diagnostic updates to ensure assessments and evaluations are done regularly as required by policy and in response to changes in an individual's status. Where tracking indicates assessments and evaluations are not completed timely, the Facility must develop systemic improvement actions to improve timeliness. (Provision H1)
3. Expand the database to encompass clinical indicators of more conditions and include in the related guidelines relevant treatment to be provided through disciplines other than physicians. (Provision H4)
4. The Facility and DADS will need to work together to ensure consistency of Facility and statewide guidelines for health care conditions and to build on the work each is doing to establish guidelines and clinical indicators. (Provision H4)
5. Develop policy that provides a framework and organizational structure to address minimum common elements of clinical care and ensures that all other relevant policies address, as appropriate, the requirements of this Section. (Provision H7)

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 Section I Self-assessment 5/1/12 2. RSSLC Section I Action Plan 4/27/12 3. RSSLC Section I Presentation Book (5/14/12) 4. DADS At Risk Policy 006.1 (1/1/11) 5. RSSLC Policy I.08 At-Risk Individuals (5/11/12) 6. RSSLC Policy D.23 Using Bed Rails (4/17/12) 7. Record reviews: Section O Sample #1: Individuals #16, #30, #31, #251, #402 and #661; Section O Sample #2: Individuals #109, #192, #248, #275, #284, #324, #330, #377, #477, #535 #542, #603, #701 and #718; Section O Sample #3: Individuals #40, #84, #99, #169, #219, #330, #388, #585, #632, #724, and #765; Section O Sample #4: Individuals #2, #7, #29, #30, #73, #95, #106, #159, #174, #184, #193, #207, #219, #227, #259, #265, #296, #308, #426, #471, #484, #518, #525, #535, #553, #569, #585, #618, #641, #649, #675, #676, #711, #725, and #765; and, Section O Sample #5: Individuals #41, #296, #412 #649, #712, and #726 8. Records reviews for Individuals #142, #300, #484, #175, #91, #544, #256, #570, #148, #60, #459, #593, #354, #729, #300, and #388. 9. List of all Individuals using bedrails and associated documentation **People Interviewed:** 1. Al Barrera, Facility Director 2. Ping Law OTR, Habilitation Services Director 3. Charlene McCurry, RN, Chief Nurse Executive 4. Robyn Partridge, RN 5. David Taylor OTR PNM Lead 6. Sally Martinez PNMT RN 7. Brandie Rabe PNMT SLP 8. Jean Cuevo PNMT PT 9. Ten DCPs (San Antonio, Trinity, Leon, Lavaca, Sabine, Infirmary and San Jacinto) **Meetings Attended/Observations:** 1. PNMT 5/15/12 and 5/17/12 2. Observations (San Antonio, Trinity, Leon, Lavaca, Sabine, Infirmary and San Jacinto) 3. ISP Annual Meeting for Individuals #17, #462 and #508
	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). This self-assessment was based on a review of policy and data associated with Section I monitoring. 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 86%. Monitoring done by the QA Department reported an overall compliance rate of 39%. The review completed

	by the Monitoring Team suggests that the QA Department monitoring is more reflective of actual performance than the monitoring done by others. These compliance ratings were an improvement from that noted in the previous report, particularly with regard to QA Department monitoring where the average compliance score improved from 2% to 39%. The Facility also presented an Action Plan that outlined action steps, with projected completion dates, that are in the process of being implemented to move the Facility closer to compliance with this section of the SA. 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, was in use at the Facility. The Facility policy for implementation of the State directed at risk policy was revised as recently as 5/11/12. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred, yet there were limited examples of accurate interdisciplinary risk identification, thorough assessments, and effective interdisciplinary risk action plans. Staff understanding of risk assessment policies and procedures had improved, and progress in some limited areas had been noted, but consistent application of policies and procedures was lacking. It was not clear that IDTs yet were able to accurately assess levels of risk in an interdisciplinary and independent manner. At the last review the Monitoring Team noted that the Facility's risk assessment process did not assess risk associated with the use of bedrails. This was noted as important because nearly 50% of the individuals living at the RSSLC used bedrails and the potential for entrapment presents an inherent risk to Individuals. Since the last review the Facility had taken many proactive steps to assess the efficacy of bedrail use for each individual, safety risks associated with bedrail use for each individual, and the testing of bedrail alternatives, including the purchase of alternative devices where warranted. The Facility is to be commended for the initiative it has taken in this regard.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed the local Policy I.08 At Risk Individuals on the risk screening, assessment and management process to determine if the policy addresses the provisions. Reviewed official list of individuals with pneumonia. Reviewed 59 Section I Monitoring Tool audits from 1/1/12 through 3/31/12. Reviewed Interdisciplinary Team (IDT) competency based training to ensure Section I action plans were addressed.	Noncompliance

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		From its self-assessment the Facility determined that: Current policy revealed a process of screening, assessment on individuals with health risk. Drafted revision on the Policy I.08 has not been approved or implemented. One official list of individuals with pneumonia was identified. The system also has database on individuals at various risks. There is no change in risk assessment system since last settlement agreement monitors visit. There was still concern that individuals are assessed at lower risk tha$_{n\ the}$y should be. The Section I Monitoring Tool audit revealed the level of compliance as the following: Internal audits – 86% External audits – 39% The facility QA is in the process of assessing competency gap through inter-rater monitoring. No outcome identified at this time. The IDT competency based training did incorporate elements of Section I action plans. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance because a system was recently modified to assess regular risk screening, assessment and management system that identifies individuals whose health or well-being is at risk. <u>Monitoring Team findings</u> The statewide risk assessment procedure, with guidelines for rating risk, was in use at the Facility. The Facility policy for implementation of the State directed at risk policy was revised as recently as 5/11/12. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred, yet, as reported in Provisions I.2 and I.3, there were only limited examples of accurate risk identification, thorough assessments, and effective risk action plans. In the last report the Monitoring Team noted that policies and procedures appeared to be misunderstood by many staff responsible for implementation. Staff understanding of risk assessment policies and procedures had improved, and progress in some limited areas had been noted, but consistent application of policies and procedures was lacking. For example, monitoring done by staff external to the QA Department reported an overall compliance rate of 86%. The majority of this monitoring was done by staff directly responsible for implementing the at-risk policies and procedures. Monitoring done by the QA Department reported a compliance rate of 39%. The review completed by the Monitoring Team suggests that the QA Department monitoring is likely more reflective of actual performance tha$_{n\ the}$ monitoring done by others. Risk screening was reviewed annually at the ISP planning meeting. It was not clear that IDTs yet were able to accurately assess levels of risk in an interdisciplinary and independent manner. There was still a tendency to rely strictly on the guidelines for each	

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		risk category without factoring in how the various risk factors may compound one another. Furthermore, there appeared to be some inherent difficulties in conceptualizing risk assessment screening and expanding the extent of the risk assessment process beyond strict application of the State guidelines. For example, different disciplines applied varying levels of clinical judgment in assessing risk and presenting information to the IDT for interdisciplinary review, discussion, and decision-making. It is essential that at risk issues not be limited to those outlined in the policy, and clinicians must recognize that guidelines are only to be used as examples, and that good clinical judgment must be used when identifying risks, and developing risk levels, and action plans for high risk conditions. Examples of concerns about risk level screening that occurred at ISP annual planning meetings include: • Individual #387 was recently admitted to the Facility for a PICA safe environment and a recent history of having foreign objects such as paper clips found in his gastrointestinal tract during a colonoscopy. The individual was being served in a PICA safe home and a PICA safe work area. The IDT was prepared to document a low rating for bowel obstruction and a medium rating for challenging behaviors despite this recent history and the restrictive environment that had been prescribed. The Monitoring Team questioned the IDT as to whether these factors would merit a higher rating in terms of the actual risk and they agreed after considering the combination of factors. • For Individual #508, the IDT was using the state guidelines literally without discussion of other issues that might affect risk. The IDT initially established a risk rating of low for weight, because the individual was within 10% of the desired weight range. However, the individual had been significantly overweight and had lost weight while on a 1200 calorie diet (an extremely restricted diet for someone who is at low risk of overweight, indicating the IDT either continued to have considerable concern about the individual's weight or did not select the diet with consideration of assessment of risk. Also, the IDT considered each risk category in isolation from others. The individual was reported to have had reports of food stealing, but there was no consideration of the relationship of food stealing to risk of weight gain or of the diet to food stealing, Furthermore, the initial rating for fractures was low (until the Monitoring Team commented) on the basis of no prior fractures and with no other discussion, although the individual was newly diagnosed with osteopenia. Action plans were not discussed or summarized during the ISP annual planning meeting for Individual #508. • The risk discussion at the ISP for Individual #17 did reflect input from the IDT members. Other than some assessment information from Dietary/Nutrition, there was very little discussion that was based upon data. Furthermore, there was an overall lack of cross-discipline discussion. For example, psychotropic	

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		medication was not discussed during the review of risk relating to constipation, choking, swallowing or gait. Very little of the discussion was about the individual. Instead, discussion focused upon the criteria in the risk tool and whether those criteria had been met. As noted in Provision M2 of this report, nurses did not always develop Health Management Plans for individuals at increased levels of risk. As reported in Provision M5, there was not evidence that all issues with increased risk had accompanying Risk Action Plans. At the last review the Monitoring Team noted that the Facility's risk assessment process did not assess risk associated with the use of bedrails. This was noted as important because nearly 50% of the individuals living at the RSSLC used bedrails and the potential for entrapment presents an inherent risk to Individuals. Since the last review the Facility had taken many proactive steps to assess the efficacy of bedrail use for each individual, safety risks associated with bedrail use for each individual, and the testing of bedrail alternatives, including the purchase of alternative devices where warranted. During residential tours the Monitoring Team observed many instances where safe use of bedrails or the use of alternative (and safer) devices was in place. The Facility also revised its bed rail policy as of 4/17/12. The Facility is to be commended for the initiative it has taken in this regard. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
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.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed the Section I Monitoring Tool audit report to determine if assessments were initiated within five working days of the individual being identified as at risk. Reviewed Section I action plan for this provision. From its self-assessment the Facility determined that: The Section I Monitoring Tool audit was for the time period from 1/1/12 through 3/31/12. There were total of 59 audits. Level of Compliance: Internal audits – 86% External audits – 39% Level of Agreement: 42% The facility determined that action plan is ready to be implemented.	Noncompliance

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		Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance because the 5 working days is not being met. The IDT continues to rate the individual at a lower level of risk rating due to lack of critical thinking. <u>Monitoring Team findings</u> Review of 12 records for individuals initially determined by the PST to be at risk (Individuals #99, #152, #161, #175, #251, #296, #315, #353, #477, #484, #570, and #661) showed there was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual initially being identified as at risk for none of the 12 Individuals. The records of these 12 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 IDT 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 12, an at-risk condition for eight (67%) individuals had changed since the initial identification of risk and assessment that followed. The assessment process related to the change in circumstance was not initiated within 5 days for all eight. This was for Individuals #152, #251, #296, #315, #477, #484, #570, and #661. Based on a review of records of a sample of three individuals (Individuals #175, #484, and #570) for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. The risk assessments and risk plans for all three Individuals were not thorough, did not reflect interdisciplinary review and discussion, and did not include sufficient data that could have led to productive review, discussion, and decision-making. In all three cases the assessments 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 three individuals (Individuals #251, #477, and #661) for whom assessments had been completed to address the individuals' at risk conditions, two (67%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan.	

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		Based on a review of records of six individuals (Individuals #99, #152, #161, #296, #315, and #353) 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 with the risk assessment and risk action plan processes. Examples of concerns are noted below. Only two of six (33%) individuals who were diagnosed and/or hospitalized with a Physical Nutrition Management (PNM) issue (Section O Sample 1) were appropriately assessed and followed by the Physical Nutritional Management Team (PNMT) or IDT in a timely manner. For example: • Individual #30 was diagnosed with pneumonia and has a significant history of aspiration pneumonia but did not receive PNMT or IDT review/assessment upon identification of diagnosis. • Individual #16 was diagnosed with aspiration pneumonia on 12/7/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the IDT 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. • Individual #661 was diagnosed with aspiration pneumonia on 1/20/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was eventually made on 1/30/12 but the PNMT did not complete the assessment until 4/5/12 resulting in an unnecessary delay of getting the needed services to mitigate risk. • Individual #251 was diagnosed with aspiration pneumonia on 2/15/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was made on 2/21/12 but the PNMT did not complete the assessment until 5/1/12 resulting in an unnecessary delay of getting the needed services to mitigate risk. Based on a review of six (Section O Sample 1) records of Individuals who experienced an aspiration event, only two of five (40%) 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: Individuals #31, #661 and #402 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.	

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		The IDT had the ability to lower the risk; however, there was no evidence as to why the guidelines were not followed by the team or other rationale provided that would address the conclusion reached by the IDT for a lower risk rating. Another issue 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. The Monitoring Team noted that health risk screenings did not always address the importance of orthopedic conditions. For example: • Individual #142 - this individual was noted to have serious degenerative spine disease and subluxation of the spine, which are serious medical conditions that must be assertively addressed. The individual was sent to a rheumatologist for evaluation of these conditions, who in turn recommended follow-up with a surgeon, on 2/10/12. As of the date of this review, the Individual had not been scheduled to follow-up with a surgeon. The health risk screening did not address the importance of these orthopedic conditions. • Individual #300 - this Individual was noted to have severe, bilateral degenerative joint disease of the hips, and progressive worsening of spine disease. The clinical record indicated that the Individual was evaluated in the past by an orthopedic surgeon, specific to the hip condition, who recommended conservative treatment, unless the IDT considered bilateral hip replacement. There was no meaningful documentation demonstrating that this issue was addressed by the team, and the Individual was not provided with hip replacement. Importantly, the Individual was not followed by the primary care physician assertively for this issue. In addition, the individual was noted on an x-ray of the spine, dated 10/12/10, as having "progressive worsening" of the cervical spine, and there was no evidence demonstrating appropriate consultation with specialists, or assertive follow-up by the clinician. Both conditions are known to cause significant pain, and although the Individual has been provided a standard dose of Motrin, twice per day, there were no regular measures to assess (and treat) pain on a daily basis. • Similar concerns were noted for Individuals #544 and #256. As reported in Section M of this report, a review of 12 recently completed Integrated Risk Ratings for Individuals: #484, #570, #175, #148, #91, #60, #459, #354, #388, #593, #729, and #300 revealed the following trends that address issues with both Risk Assessments and subsequent Action Plans.:	

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		• Two of 12 (17%) individuals' Integrated Risk Rating Forms contained clinical data in the Rationale Column for each of the Risk Rating Categories. Even if the individuals' risk rating categories were rated low, there should have been clinical data documented in the Rationale Column to support sound clinical judgment for low risk ratings. • Zero of 12 (0%) individuals' Integrated Risk Rating Forms, where clinical data were documented in the Rationale Columns, consistently contained adequate clinical data for all risk categories to support the risk rating categories. However, three of 12 (25%) contained somewhat adequate clinical data in the Rationale Columns for a few of the Risk Rating Categories, while the Rationale Columns were left blanks for other Risk Rating Categories. The clinical data documented in the Rationale Columns primarily consisted of medical diagnoses, history of medical problems, medications/treatments prescribed, and/or a statement of "no problem" related to specific risk rating categories whe$_{n\ the}$ risk was rated low. • Zero of 12 (0%) individuals' Integrated Risk Rating Forms demonstrated risk ratings based the interrelationship with other related risk rating categories. The IDT appeared to consistently rely on the Risk Guidelines to determine risk ratings for the various categories and failed to exercise critical thinking in correlating the interrelationship of the risk categories. • Three of 12 (25%) included BRADEN scores for the skin integrity risk rating categories. • Zero of 12 (0%) Integrated Risk Assessment Attendance Sheets were included with the document request. From a review to the 12 Integrated Risk Assessments, it did not appear that all relevant clinical disciplines contributed substantive clinical data for their respective areas of expertise. In general the individuals' Integrated Risk Ratings varied in the quality of substantive clinical data to support the various risk rating categories with the different IDTs. Examples included: • Individual #354's Integrated Risk Assessment Rating, 3/21/12, included the following documentation for risk rating rationales: High risk rating for Seizures rationale stated, "VNS used". High risk rating for Osteoporosis rationale stated, "Diagnosed with Osteoporosis". Medium risk rating for Constipation rationale stated, "Medications". Medium risk rating for Gastrointestinal Problems rationale stated, "GERD". Medium risk rating for fractures did not include rationale documentation. All of the remaining risks rating category rationales were equally as inadequate as those described above. • Individual #484's Integrated Risk Assessment Rating, 2/29/12, included the following documentation for risk rating rationales: High risk rating for	

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		Respiratory Compromise rationale stated, "Allergic to many things. Will continue to take Neb treatments". Individual #484 had a history of severe reactive airway disease with numerous hospitalizations. The rationale should have contained substantive clinical data related to her severe reactive air way disease to support the high risk rating. The only risk rating categories assessed were for Respiratory Compromise, Osteoporosis, and Polypharmacy. The remaining risk rating categories were not assessed. • Individual #148's Integrated Risk Assessment Rating, 3/21/12, included the following documentation for risk rating rationales: High risk rating rationale for Aspiration rationale stated, "GERD". High risk rating rationale for Cardiac Disease stated, "Bradiacardia – ICU". High risk rating rationale for Osteoporosis stated, "Osteogenosis, imperfect, Recasts." High risk rating rationale for fractures stated, "Osteogenic". High risk rating rationale for dental stated, "TIVA." Medium risk rating for Choking, Respiratory Compromise, Weight, Gastrointestinal Problem, Infections, Polypharmacy, did not include rationales to support the these risk ratings. • Individual #91's Integrated Risk Assessment Rating. 3/6/12, included the following documentation for risk ratings rationales: High risk rating for Circulatory rationale stated, "Uses DVT". This was a misstatement because DVT stands for Deep Vein Thrombosis and it is a diagnosis not a treatment to be used. Eight of the 12 (67%) individuals who had accompanying Risk Action Plans included Individuals #354, #60, #484, #570, #175, #148, #91, and #459. It could not be determined whether Individuals #300, #729, #593, and #388, simply did not have Risk Actions Plans or if they were not included in the document request. A review of the Risk Action Plans revealed the following trends: • Zero of eight (0%) Risk Action Plans were adequate to sufficiently meet individuals' needs related to individuals' high and medium risk ratings. The Risk Action Plans did not consistently include plans for all identified high and medium risk ratings. For the plans which did address some of the high and medium risk ratings, they contained some basic action steps, but failed to include all relevant action steps to adequately address the risk ratings, nor were all relevant disciplines included in the action steps. For high and medium risk ratings the Risk Action Plans, they should have had nursing Health Management Plans (HMPs), but they were rarely, if ever, referred to in the plans, nor were other relevant disciplines specific plans referred to. Therefore, the Risk Action Plans were not adequately integrated. • Zero of eight (0%) Risk Action Plans adequately reflected the identified risk factors. • Zero of eight (0%) Risk action Plans included preventative interventions	

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		sufficient to minimize the condition of risk. • Zero of eight Risk Action Plans contained appropriate functional and measurable objectives incorporated into the PSPs/PSPA s to measure the efficacy of the plans • Zero of eight (0%) Risk Action Plans adequately identified appropriate clinical indicators to be monitored and frequency of monitoring. Additional findings and comments regarding risk assessment can be found in Section M of this report. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
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 whe$_{n\ the}$ 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.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed the Section I Monitoring Tool audit report. Reviewed Section I action plan. From its self-assessment the Facility determined that: The Section I Monitoring Tool external audit revealed compliance of 39%. The facility determined that the action plan if (sic) ready to be implemented. Based on the findings of this self-assessment, the Facility determined that this provision was not in substantial compliance because the system was recently modified and action plans are not being implemented within 14 days. <u>Monitoring Team findings</u> Based on a review of 12 records for individuals determined to be at risk (Individuals #99, #152, #161, #175, #251, #296, #315, #353, #477, #484, #570, and #661), there was documentation that the Facility: • Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate, in two (17%)) cases. Records that contained documentation of this included: Individuals #175 and #484. • Implemented a plan that met the needs identified by the IDT assessment in three (25%) cases. Records that contained documentation of this included Individuals #251, #570, and #661. • Included preventative interventions in the plan to minimize the condition of risk in two (17%) cases. Records that contained documentation of this included Individuals #251 and 661. • Whe$_{n\ the}$ risk to the individual warranted, took immediate action in two (100%)	Noncompliance

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		cases. Records that contained documentation of this included Individuals #251 and #661. • Integrated the plans into the PSPs in one (8%) case. Records that contained documentation of this included Individuals #175. • In two (17%), the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. Records that contained documentation of this included Individuals #251 and #661. • In none (0%) appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. • Included the clinical indicators to be monitored and the frequency of monitoring in zero (0%) cases. None of the risk plans reviewed by the Monitoring Team were adequate to meet the Individual's needs. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	

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

1. The Facility should assure all IDTs are provided with continued training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the ISP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the ISP process. (Provisions I.1, I.2, and I.3)
2. Ensure that appropriate and timely assessment and revision of the ISP 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)

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 Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. 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 4. DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11) 5. DADS Policy 001.1 Use of Restraint (04/10/12) 6. RSSLC Policy I.00d Psychiatry Services (08/30/11) 7. RSSLC Patient Polypharmacy Review Policy (undated) 8. RSSLC DSM and ICD Medical and Psychiatric Diagnosis Update Policy (01/12/12) 9. 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 10. 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) 11. 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 12. Lists of individuals prescribed intra-class polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 13. A list and copy of all forms used by the psychiatrists 14. A description of administrative support offered to the psychiatrists (secretarial, administrative scheduling of psychiatric consultation, etc.) 15. A list of continuing medical education activities attended by psychiatry staff for the past 6 months 16. A list of individuals diagnosed with tardive dyskinesia 17. Facility spreadsheets for the Monitoring of Side Effects (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) evaluations 18. Sample J1: Case reviews for individuals who were newly admitted, had new medications, had new diagnoses, or who had an ISP meeting during the compliance visit. These wereIndividuals #17, #19, #68, #81, #113, #165, #278, #306, #314, #387, #530, #546, #600, #624, #626, and #799. Materials included the individual's social history, most recent Individual Support Plan (ISP), 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 (ISP addenda), medical and/or dental plans to increase cooperation/participation (hygiene, desensitization, etc), most recent Positive Behavior Support Plan (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 Comprehensive Psychiatric Evaluation (CPE), all Psychiatric and Behavior Management Committee (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 clinic consultation 19. Sample J2: Individuals who experienced medical restraint. For dental procedures done under intravenous (TIVA) sedation, Individuals # 115 (01/24/12), #148 (02/22/12), #232, (01/25/12) and #694 (02/23/12). For medical procedures done under oral pre-treatment sedation, Individuals #40 (03/29), #57 (12/14/11, #207 (01/12/12), #403 (02/27/12), #479 (03/21/12), #483 (02/15/12), #555 (04/14/12), and #691(02/14/12). Materials reviewed included medical orders for sedation, physician specified monitoring schedule, standard Facility protocol for medical monitoring during the relevant type of restraint, ISP 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 20. Sample J3: Individuals # 68, #314, #316, #530, #546, #714, and #799. These were individuals treated with Polypharmacy. Materials reviewed were the most recent QDDR and PBMC notes, Integrated Progress Notes (IPNs), and Polypharmacy Review Panel reviews 21. Sample J4: Individuals #113, #429, #615, #630, and #746. These were individuals who were seen in the neurology clinic and were treated with anticonvulsant medications for both seizures and behavioral difficulties, and/or were treated for both neurological and psychiatric problems for which coordination betwee$_{n\ the}$ psychiatrist and neurologist was deemed necessary. Materials reviewed included recent neurology and PBMC notes. 22. Sample J5 Comprehensive Psychiatric Evaluations (CPEs) for Individuals #17, #68, #113, #165, #216, #239, #302, #529, #530, #600, #746, #757, and #799 23. Sample J6: Individuals #44, #91, #99, #179, #210, #212, #239, #623, and #626. These were individuals seen during PBMC on 05/15/12. Materials reviewed were the two most recent PBMC notes and informed consent forms for the medication they received 24. Sample J7: Informed consent forms and Human Rights Committee (HRC) approvals for psychotropic medications approved during the last six months, for Individuals #137, #142, #306, #379, #542, #555, #623, #643 (three medications), #630, #728 (two medications), #672, and #526 25. Sample J8: Individuals #17, #29, #39, #86, #142, #180, #219, #242, #322, #328, #424, #459, #498, #503, #523, #561, #579, #598, #615, #630, #672, #714, #728, and #746. These were individuals who had a change of diagnosis over the past six months. Information/materials reviewed included 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) **People Interviewed:** 1. Bobby Buckner, BCBA, Chief Psychologist 2. Damola Olatoregun, Acting Section J Lead 3. Franca Uzuejbu, RN, Case Manager 4. Michael Shatz, PhD, Pharm D., MBA, Clinical Pharmacist 5. Tran Quan, DO, Medical Director **Meeting Attended/Observations:** 1. Psychiatric and Behavior Management Clinic (PBMC), 05/15/12

	2. ISP for Individual #17 05/15/12 3. Quality Assurance /Quality Improvement (QA/QI) Council meeting 05/15/12 4. Integrated Clinical Meeting 05/16/12 5. Behavior Support Committee (BSC) 05/17/12 6. Pharmacy and Therapeutics Committee (P&TC), 05/17/12
	Facility Self-Assessment: RSSLC had made considerable revisions to its Self- Assessment, previously called the Plan of Improvement (POI). In the new format, the Facility described, for each provision item, the activities the Facility engaged in to conduct the Self-Assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance, along with a rationale. That was an improvement in the Facility self- assessment activity. Mr. Damola Olatoregun, Acting Psychiatry Lead, completed the psychiatry section of the self- assessments. To complete the self-assessments, clinical records and documents related to the care of individuals followed by psychiatry were reviewed to see if they contained elements needed to comply with the requirements of the SA as follows: • Records for 151 individuals who received psychotropic medications were reviewed to determine if all had been evaluated and diagnosed, in a clinically justifiable manner, via a completed CPE. • PBMC notes were reviewed, to determine the appropriateness of the psychiatric diagnosis for individuals receiving psychotropic medications. • PBMC notes were reviewed, to determine if individuals who used psychotropic medications have a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis. • Interdisciplinary Team (IDT) minutes were reviewed to determine if psychotropic medications were used as a substitute for a treatment program or for the convenience of staff or as punishment. • Reviewed list of Dental and Medical Support Plans (DSPs and MSPs) and compared list to those individuals who have used pre-treatment sedation. The Facility self-rated for substantial compliance on Provisions J1, J11, J12, and J14, and for noncompliance on the remainder. The Monitoring Team differed with the Facility only for Provisions J12 and J14. For those provisions the Monitoring Team found that additional work was needed.
	Summary of Monitor's Assessment: The Facility made some limited progress: PBSP descriptions of psychiatric care improved, and polypharmacy reviewed were strengthened by the addition of a polypharmacy review board. However, many individuals continued to have multiple (and sometime conflicting) psychiatric diagnoses. In addition, many psychotropic medication treatments were often not linked to symptoms of a psychiatric diagnosis, and treatment response could not be monitored with data on those symptoms. Efforts to minimize the need for pretreatment sedation were at an early stage of development.

	For Provision J1: The provision remained in substantial compliance: The Facility employed two contract psychiatrists. Dr. Hermant Patel was a long-standing contract psychiatrist who was board certified in psychiatry and forensic psychiatry who worked on a part time basis. Dr. Min Zhoung was a contract psychiatrist who was board eligible in psychiatry and who worked on a full time basis. Drs. Patel and Zhoung had adequate experience in the psychiatric care of individuals with intellectual disabilities, and both were qualified to provide the services required by the SA. **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 and there continued to be cases where different diagnoses were cited in the various sections of an individual's clinical record. "Not otherwise specified" (NOS) or "rule out" (R/O) diagnoses remained, and there were cases 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. 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. Many individuals had Medical and Dental Support Plans, but the planned program to review the technical adequacy of newly developed support plans had just started, 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. Both staff psychiatrists had resigned and the Facility did not have a sufficient number of psychiatrists to provide the services required by the SA. **For Provision J6:** The provision was determined to be not in compliance. Evaluations did not provide the justifications needed to substantiate the diagnoses that were made, and bio-psycho-social formulations needed improvement. **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 Interdisciplinary Teams (IDTs) to select and assign appropriate modalities for the treatment of behavioral disorders, and the treatments individuals received were not properly described in the Positive Behavior Support Plans (PBSPs). **For Provision J10:** The provision was determined to be not in compliance. Improvements were still needed regarding discussions of potential benefits and treatment alternatives (including no medication), 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. The review process was strengthened with the addition of the Polypharmacy Review Group. Monthly reviews were conducted in the psychiatric clinics, for all individuals who were treated with psychiatric polypharmacy. Evidence was presented which showed modest 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 individuals who needed screens received them, and results of positive screens did not always get the follow-up that was required. 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:** The provision was determined to be not in compliance. Informed consent for psychotropic medication had improved, but discussions of risk/benefit and alternatives to medication were not complete. **For Provision J15:** The provision was determined to be not in compliance. The contract psychiatrists were unable to participate in the neurology clinics.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	There were a number of changes in the psychiatric staffing at the Facility. Dr. Elizabeth Ohiku had bee$_{n\ the}$ Lead Psychiatrist for the Facility at the time of the last compliance visit. However, she resigned her position, effective 04/09/12. Dr. Madhu Rao began working at the Facility after the last visit, but she too resigned her position. Drs. Rafael Guerrero and Dominic Joseph, both contractors, were no longer employed at the Facility. At the time of the compliance visit, there were two contract psychiatrists who worked at the Facility. Dr. Hermant Patel was board certified in general psychiatry and forensic psychiatry. His credentials were reviewed in previous Monitoring Team reports. Dr. Patel's licensure was reviewed, and it remained current. Dr. Patel worked for the Facility on weekends. Dr. Min Zhong was a board eligible psychiatrist. At the time of the	Substantial Compliance

		compliance visit he had begun his work as a full-time contractor for the Facility. Dr. Zhong completed his medical education at the Shanghai Second Medical University in 1988, and he completed his psychiatry residency at the Griffin Memorial Hospital in Norman Oklahoma, between 2007 and 2011. Drs. Patel and Zhong had adequate experience with individuals with intellectual disabilities to provide the psychiatric services required by the Settlement Agreement (SA), and their credentials qualify them to do so. Assignments for the psychiatrists were reviewed with the Acting Lead for Section J. The Monitoring Team was informed that Dr. Patel had provided clinic services on Saturdays and Sundays, but with the hiring of Dr. Zhong, he would return to performing CPEs. Dr. Zhong will be at the clinic on a full time basis, Monday – Friday.	
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> Since the last monitoring tour, the Facility developed two spreadsheets with key psychiatric data. One of these was a list of all individuals who received psychiatric care and their psychiatric diagnoses. All of those individuals took psychotropic medications. The second spreadsheet listed the psychotropic medications that were given to individuals followed by psychiatry. The printout provided to the Monitoring Team had 153 names, but it did not include the two individuals admitted on 04/16/12. Including those two individuals, 155/363 (43%) of individuals who lived at the Facility received psychiatric care. <u>The process in place for evaluation and diagnosis:</u> There were two processes in place for evaluation and diagnosis: 1. RSSLC has a long-standing psychiatric clinic known as PBMC. The clinic served individuals who received ongoing psychiatric services. All individuals supported by psychiatry were seen at least quarterly, individuals who had polypharmacy were seen monthly, and individuals in crisis or in need of more frequent follow-up were scheduled on the basis of clinical needs. PBMC participation included the individual and psychiatrist, and also key members of the IDT. These were typically the psychologist, the nurse case manager, clinical pharmacist, qualified developmental disability professional (QDDP), social worker, direct support professionals (DSPs), and habilitation therapists. Psychiatrists also examined individuals in the context of other scheduled IDT functions such as ISP meetings, and whe$_{\text{n the}}$ need arose, through non-scheduled events like crisis management. At the end of each PBMC appointment, the psychiatrist dictated a detailed note that included a mental status examination, an update for what had transpired during the clinic appointment, information about laboratory data and side effects screening. The PBMC did not provide CPEs, but clinical diagnoses were provided by PBMC	Noncompliance

		psychiatrists. These were tracked by the IDT psychologist and were the basis of the Facility diagnosis of record. Any time a change was made during the PBMC clinic, a form (called DG1) was filed so that the PCP would update the APL at the time of the annual medical evaluation. In addition, a hand written correction to the APL was made by the psychiatrist, whenever the diagnosis was updated/changed. 2. In response to the requirements of the SA, the Facility started to provide CPEs to both existing and new referrals to the psychiatry service. Over the past three years, CPEs have been provided to 113 individuals. Drs. Patel and Joseph completed most of these, and Dr. Ohiku completed some. Per information provided to the Monitoring Team, there remained 42 individuals who received PBMC services but who not yet had a CPE. In addition, CPEs needed to be done for individuals who were not followed by psychiatry, but who had Reiss Screen scores that were above the clinical cut-offs. There were 17 such individuals, who had not yet received the required psychiatric evaluation. The CPEs done in the Appendix B format are the focus of Provision J6, and the reader is referred there for further discussion. <u>Observations made during PBMC clinic that related to diagnosis:</u> The Monitoring Team observed a PBMC clinic held by Dr. Zhoung, on 05/15/12. Nine individuals were reviewed (Sample J6). The appointments were attended by several IDT 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 some lasted about 45 minutes. At the beginning of each appointment the individual's psychologist or behavior analyst (BA) provided a several page summary that included details of the individual's progress since the last appointment. Information reviewed included the individual's DSM IV diagnoses, psychotropic medications, and the psychiatric symptoms. For several individuals, questions regarding the diagnosis were broached. For example, there was an excellent discussion about, whether Individual #623 was properly diagnosed with mood disorder secondary to head injury. The discussion was inconclusive and the PTR participants properly decided not to make changes to the diagnosis at that time. Further comments about the PBMC clinic are included under Provision J3. In addition to observations made during the PBMC clinic, the Monitoring Team assessed diagnostic practices for the 16 individuals selected for record reviews (Sample J1). CPEs were in place for seven of the 16 individuals (44%), and each contained DSM diagnoses. The Monitoring Team examined the seven evaluations to determine if the psychiatrist had explained how the individual met the DSM requirements for the diagnoses. Adequate explanations were in place in only two of the seven CPEs (29%). <u>Facility efforts to resolve differences between CPE and PBMC diagnoses, and efforts to</u>	

		resolve R/O and NOS diagnoses: Over the past year, the Facility initiated two processes to address these issues: 1. On 06/01/2011, the Psychiatry Department started a process to improve PBMC diagnoses. The process was described to the Monitoring Team during the current visit. A form which contained a variety of psychiatric symptoms for individuals being reviewed was completed by various IDT members. These forms were reviewed by the psychiatrist, who made her/his observations and conducted a mental status examination. Following discussion and, when appropriate, broader IDT meetings, PBMC diagnoses were revised. In total, changes in diagnoses were made for 24 individuals (Sample J7). The Monitoring Team reviewed each. Several of the changes were examples of elimination of unnecessary diagnoses. For example: • Individual #459 had been diagnosed with both Autism and Obsessive Compulsive Disorder (OCD). In a PBMC note that supported the change, the psychiatrist wrote that he "recommended discontinuing OCD as a diagnosis, since most of his compulsive behaviors are not in excess of what would be expected for an individual with autism." • Individual (#29) who was diagnosed with OCD and with Bipolar Disorder was found not to need the diagnosis of OCD, since "the symptoms that had been attributed to OCD in the past were actually part of his manic symptoms." In other cases, efforts were made to update the diagnosis on the basis of the data presented by staff familiar with the individual. For example: • Individual #322: "He has a psychiatric history of cyclothymia and mental retardation. There were medication changes during the last psychiatric clinic. However, there was discussion of whether the patient met criteria for ADHD and whether he would benefit from psychotropic medication. According to the Conners rating Scale, the patient displays significant impulsivity, hyperactivity and inattentive symptoms where a diagnosis of ADHD is very likely. According to the staff the patient is very impatient." The psychiatrist also noted that there were no medical problems, and MOSES and DISCUS scores and sleep data were also cited. After interdisciplinary discussion with several professionals the diagnosis was changed, ratings were established with Conners rating scales (and other measures such as sleep), and Intuniv was proposed to treat the ADHD. In the above case, the Monitoring Team found that the evidence cited provided adequate clinical justification for the new diagnosis. In other cases, however, the efforts fell short of what was required. For example: • Individual #714 was diagnosed with psychotic disorder NOS. The psychiatrist wrote: "The diagnosis of psychotic disorder NOS seems inappropriate for this patient based on the symptoms that we have observed for the past 60 days and the current pharmacotherapy. Depakote has been very good in re-establishing	

		his mood. He has a past history of psychosis that has been stabilized on Thioridazine and Olanzapine. Reports show that he gets severely psychotic when those meds are reduced. We now see a strong mood component that seems stabilized by Depakote. We saw mood lability and depression/withdrawal and other symptoms reported in prior notes. At this time the diagnosis is changed to Schizoaffective Disorder Bipolar Type and r/o Bipolar Disorder Mixed with Psychotic Features. Diagnostic clarity will be established with time since this patient is not verbal." The problem in this case (and many others) was that while the psychiatrist established that the psychiatric symptoms were consistent with the diagnosis that was offered, the DSM requires more than that to establish the diagnosis. The psychiatrist should have reviewed the diagnostic criteria necessary to make the diagnosis of Schizoaffective Disorder, for example the requirement to establish an uninterrupted period of illness during which all criteria for the relevant affective episode (mania, depression, mixed) were met, and assurance that symptoms met four of the relevant criteria for schizophrenia. In the case that the requirements for the diagnosis could not be made, less demanding diagnoses were available that could account for the symptoms. Overall, the Monitoring Team found that in 11 of 24 (45%) of the cases, the diagnosis change could be justified on the basis of the supporting documentation that was provided. 2. At the time of the last compliance tour, the Facility informed the Monitoring Team that it would begin to conduct annual psychiatric updates. Such updates will follow the Appendix B format. Static and unchanging information (for example, family, developmental and social histories) will be carried forward from year to year. Issues that arose during the year, including resolution of different diagnoses and "rule out" diagnoses, will be recorded in the annual update. Due to staffing shortages, the psychiatric updates were not yet in place. <u>The target symptoms for psychotropic medications:</u> Psychiatric evaluations contained behavioral characteristics/symptoms of the diagnosed disorders. The 16 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, and were located in 12 of 16 (75%) records. The Monitoring Team then compared the cited psychiatric symptoms with the challenging behaviors that were the focus of the behavior plan. This analysis was conducted, since it is important that medications should be used for the treatment of psychiatric disorders, not for non-specific behavior control.	

		For five of 16 (31 %) individuals, the symptoms for psychiatric treatment overlapped with the targets of the behavioral treatment. For the remainder (69%), there was no overlap. This is an improvement over the results of a similar analysis done during the last compliance visit. Further progress is needed, however, to assure that psychiatric symptoms are the focus of psychiatric treatments. The 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. <u>Adequacy of the process to track diagnoses and diagnostic updates.</u> Per the discussion earlier in this provision, until differences between the CPE and PBMC diagnoses are resolved, it is inevitable that there will be differences between the APL diagnosis and other parts of the record, for example the CPE. During the last six months, the Facility Medical Department had additionally introduced a new electronic database that was linked to the physician orders section of the record, and that tracked the DSM diagnosis of record (see RSSLC Medical and Psychiatric Diagnosis Update). However, the APL system was still in place, and the Psychiatry and Psychology Departments were still using the DG-1 forms that linked to the APL. A formal comparison of APL and medical database records was not done. However, the Monitoring Team and the Acting Facility Lead for Section J informally compared APLs with medical database diagnoses in about fifteen records that were available, since they were being reviewed for a variety of other analyses. Differences between APL and medical database diagnoses were noted in three of the records. <u>Conclusions regarding the diagnostic processes in place:</u> • The process of providing a single psychiatric diagnosis was still at an early stage. As described in the Facility Self Assessment, the focus of the work had been on updating PBMC diagnoses. The additional steps of reconciling differences between CPE diagnoses and PBMC diagnoses had not yet begun, and the process of recording the results of all of these efforts in an annual psychiatric update had been delayed due to staffing problems. • R/O and NOS diagnoses remained unresolved, contrary to the specific guidance provided as part of the guidelines for Appendix B. • Problems remained with many of the diagnostic justifications that were in place. It was not sufficient for the symptoms cited to be <u>consistent</u> with the diagnosis offered; the symptoms and other clinical information provided needed to be <u>sufficient</u> to fully support the requirements of the DSM for that diagnosis. The SA requires that psychiatric medications must be provided for valid psychiatric diagnoses, not for behavior control. To make sure that this was the case, the psychiatric diagnoses	

		needed to be fully justified, on the basis of the Diagnostic and Statistical Manual (DSM) or Diagnostic Manual for Intellectual Disabilities (DMID) criteria. • Although there has been an improvement, in many cases the symptoms cited for mental illness are the same as the challenging behaviors that are the focus of the behavior plan, typically aggression and/or self-injurious behavior (SIB). These symptoms cannot be the sole basis of any DSM diagnosis, and clarification is needed, whenever there is a full overlap of symptoms. • Evaluations for new admissions needed to be done in a more timely manner. There were no psychiatric evaluations for nine individuals (Individuals #19, #81, #278, #306, #314, #376, #546, #624, and #626). Some of the admissions were quite recent (Individuals #376 and #624 were admitted on 04/16/12) but a psychiatric evaluation of some sort - even a preliminary evaluation - should have been in place, at least for Individuals #81 and #306, who had lived at the Facility for three months, and Individual #19, who had lived at the Facility for five months. Psychology had responded to the need to have a timely plan in plan by the use of a preliminary Behavioral Assessment Program (BAP). The BAP was generated soon after the admission, and it was then later developed into a full PBSP. Psychiatry could consider a similar process. • The Facility is commended for developing the new ICD and DSM Medical and Diagnosis update, but the same information should be listed in that problem list and the APL. Per the Acting Lead for Section J, efforts have been made to make sure that information in the records for APL information and the new medical database corresponded. However, based on the information reviewed by the Monitoring Team, further progress is needed in this area. Perhaps the two systems could be merged, to avoid the confusion of different problems lists for a given individual. • The Facility had not yet put in place the planned annual psychiatric evaluations. In their absence, there is a risk that the record of some solid clinical work done to address the above issues will in time be lost.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	<u>Presence of a behavior treatment program:</u> At the Facility, behavioral treatment programs were contained in PBSPs and Structural and Functional Behavioral Assessments (SFBAs), or for newly admitted individuals, in Behavioral Assessment Plans (BAPs). The Monitoring Team reviewed a list of all individuals who had behavior treatment programs; all individuals who were prescribed medication via the PBMC were listed as having a behavioral treatment program. The Monitoring Team examined the 16 records for the individuals in Sample J1. All had behavioral treatment programs. <u>Behavioral Treatment Plan description of psychiatric pathology (psychiatric diagnosis or specific behavioral-pharmacological process):</u> At the last compliance visit the Monitoring Team examined PBSP records to assess routine medication practices, and found many examples where the psychiatric diagnosis was absent, or the medications were described without meaningful linkage to a psychiatric diagnosis. Examination of	Noncompliance

		the records of individuals in Sample J1 showed that there has been significant improvement. In the format now in place at the Facility, SFAs provided background information about the psychiatric problems the individual experienced. Many of the individuals in Sample J1 were new admissions who had preliminary BAPs. Four of the records contained a full SFA/PBSP and each described the psychiatric understanding of the individual. For example: • Individual #530: "She was hospitalized at (psychiatric hospital named) in 2002 for "nervous breakdown" and was again hospitalized for two weeks in October 2008 at the (psychiatric hospital named) with symptoms of "agitation anxiety, flight of ideas and delusions". While living in a nursing home (the Individual) also received brief psychiatric treatment at (facility named). According to her sister, she had a history of wandering the neighborhood, seeing things on the walls, pacing aimlessly, stealing from others, being manipulative, asking to borrow things that she does not return, being delusional, irrational, anxious fearful and over talkative…Her diagnosis of Schizoaffective Disorder, Bipolar Type has been identified as being related to depressed mood and psychotic behavior…" • Individual #68: "The individual had a long history of psychiatric problems including auditory hallucinations, talking to himself, laughing for no apparent reason, showing little interest in activities, delusional thinking, uncooperative, withdrawn/inattentive… he was observed to talk to himself daily and he reported that he heard voices… (the individual) experienced problems with hallucinations, delusions, verbal and physical aggression and temper outbursts." • Individual #165: "(the individual) has a diagnosis of Bipolar Disorder, mixed without psychotic features. Her symptoms of this illness include agitation, excessive sleeping and labile mood… she has a history of mood swings. She has history of depression. She has a diagnosis of Posttraumatic Stress Disorder. Her symptoms of this illness include affect instability, history of intense and unstable relationships characterized by alternating extremes of idealization and devaluation, impulsivity, parasuicidal behavior and suicidal thoughts…" The inclusion of the above information helped provide the general background that was needed, to understand the psychiatric interventions that were part of the behavioral treatment program. <u>Behavior treatment plan descriptions of key psychiatric symptoms that supported the psychiatric diagnosis, and were the focus of medication treatments:</u> In previous reports, 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. This was due largely to the absence of information about the psychiatric symptoms.	

To assess progress in these areas, the Monitoring Team examined the behavior treatment program records of individuals in Sample J1, to see which symptoms/ behavioral characteristics were tracked. Information in the PBSP could be found in two places. First, PBSPs contained tables that described details of psychotropic medication treatment. The text of the PBSP provided descriptions of the treatments, including medications. However, the information in the two sources was at times different, occasionally in a significant manner (for example, see Individual #68 below).

In addition, since the ongoing psychiatric treatment and tracking of psychiatric symptoms was provided via PBMC clinics, the Monitoring Team also examined PBMC descriptions of symptoms to be tracked for medication treatment response:

For example:

- Individual #530: The PBSP identified the diagnosis (Schizoaffective Disorder/ Bipolar Type, and Pervasive Developmental Disorder). Medications, and behavioral characteristics/symptoms were identified as aggression to self, psychotic behavior, and depressed mood (hours of night sleep and meal refusal).

  Information of symptoms tracked for each medication in the PBSP and PMBC notes:

Medication	PBSP	PBMC
Seroquel	for schizoaffective disorder aggression to self, labile mood/depressed mood and psychosis	Aggression to self, psychosis depressed mood
Klonopin	for schizoaffective disorder and aggression to self	Hours of sleep
Effexor	for schizoaffective disorder, aggression to self, and depressed mood	Aggression to self and depressed mood (indicators are meal refusal and hours of sleep)
Risperdal	schizoaffective Disorder, aggression to self and depressed mood	Aggression to self and depressed mood, psychosis
Lamictal	for seizure disorder	Refer to report

  Numerical data was reported on the identified symptoms and there was a graph that displayed some of the items, but not others. It is not clear why aggression to

self was relevant for the diagnoses in question, and there were no definitions of how the numerical counts for data were constructed (the graph only said "count"). There was no definition for what constituted psychosis, and the graphs presented for PBMC provided no information on medication doses. These would have allowed the reader to better interpret changes in data. It is not clear why the PBSP format combined information on diagnosis and symptoms into a single entry. It was also not clear why the PBSP format presented a seizure medicine that is not prescribed for behavioral indications.

- Individual #68: The PBSP identified the diagnosis of schizophrenia, and symptoms to be monitored were hallucinations/delusions – "talking to people who are not there, reports hearing voices when people are not present, reports seeing things that others cannot see."

Medication	PBSP	PBMC
Seroquel	Schizophrenia, aggression to others	Aggression, talking to self
Cogentin	Side effects	Side effects
Trazodone	insomnia	sleep
Invega	Schizophrenia, aggression to others	Aggression, leaving without informing staff

Here too, it was not clear why the PBSP listed diagnosis and symptoms in the same entry. For Seroquel, the symptoms listed in the PBSP table were different tha$_{n\ the}$ symptoms reported in the PBSP text, and different than those listed in the PBMC. The same issues apply for Invega. For that medication, neither the symptoms listed in the PBSP table or the PBMC table were appropriate for the medication or diagnosis. Numerical data in the PBMC graphs on hallucinations and delusions did not correspond to tables presented in PBSP, and there was no explanation as to what the numerical ratings for hallucinations meant. Similar to the first example, no information on medication dose was provided on the PBMC graph. This information would have allowed the reader to better understand relationships between medication dose and symptom intensity.

- Individual #165: The PBSP provided the diagnosis of Bipolar Disorder, and identified behavioral symptoms to be monitored as agitation, excessive sleep, labile mood (increased or decreased sleep).

Medication	PBSP	PBMC
Zyprexa	Bipolar disorder - agitation and excessive sleep	psychosis
Trileptal	Labile mood –	Sleep

		increased/decreased sleep	
	Inderal	Hand tremors	Hand tremor

A graph in the PBMC report presented data on aggression, false allegations and work refusals, but did not report information on either the symptoms identified by the PBSP table or the PBMC table, and presented no information on medication doses over time.

Were medications used for staff convenience? The Monitoring Team addressed this question by examination of the records, by observations made during PBMCs and BSC meetings, and 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 for medications continued to be disruptive behaviors that were not directly linked to any psychiatric diagnosis. Although some of these behaviors were severe, including self-injury and aggression, there was no indication of how they related to a psychiatric diagnosis for which medication would be prescribed. Although some of these behaviors were severe, including self-injury and aggression, there was no indication of how they related to a psychiatric diagnosis for which medication would be prescribed. Since it was not clear for what psychiatric pathology the medications were prescribed, it was not possible to rule out the possibility that medication were used for staff convenience.

Were medications used for punishment? The Monitoring Team considered observations made during the tour, and examined the records of the 16 individuals in Sample J1. There was no evidence that medications were used for punishment.

In summary, the Monitoring Team found that progress had been made in the area of appropriate use of medications. There was no evidence that medications were used for staff convenience or for punishment, and there was evidence that a treatment plan was in place for the majority of individuals. Also, treatment plans and psychiatric clinic reviews have started to address the issue of monitoring psychiatric treatments for efficacy. However, many details need to be addressed, in order to establish credible monitoring of psychiatric symptoms. At present, the PBSPs contain conflicting information on what symptoms the medications are supposed to treat, PBSP information conflicts with information in the PBMC, data collected is not defined, and the symptoms monitored are sometimes not appropriate for the medication and/or diagnosis. Due to these issues it was not possible in many cases to determine whether psychotropic medications were providing any benefit to the individual. On these matters please also consult Provision K4 for the current and the previous compliance reports.

J4	Commencing within six months of the Effective Date hereof and with	Background: In the Self Assessment, the Facility reported that all individuals who had pretreatment sedation had a Medical or Dental Support Plan. The Facility Action Plan	Noncompliance

	full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	had three Action Steps (AS). The first was to develop the needed medical and dental support plans; that step was reported to have been accomplished. The second AS was to monitor progress related to the medical and dental support plans, and the third AS was to revise the support plans when progress was not noted. The Facility acknowledged that it had not started to implement the latter two steps. Rates of use of pre-treatment sedation: The dental clinic provided data that showed that between October 2011 and March 2012, the number of sedations varied between a low of 26 (March 2012) and a high of 55 procedures (Jan 2012). The monthly average number of procedures was 44. General anesthesia was used on average for 3% of procedures, and oral pretreatment sedation was used for about 7.7% of procedures. These figures were similar to what was reported for the prior six months. Data was not provided by the Facility for rates of medical pre-treatment sedation. Monitoring for safety when pre-treatment sedation was used: The Monitoring Team reviewed records for eight uses of dental oral pre-treatment sedation, and for four cases of TIVA (Sample J2). Selection of the samples is described as part of Section C of this report. Results were as follows: • Oral pre-treatment sedation for dental procedures: Medical orders were provided for the day of the procedure. Ativan was used in all cases, and the maximum dose was four mg. Medical monitoring for safety was guided by nursing sedation protocol and was documented on the Medical Monitoring Form. The Monitoring Team requested, but was not provided, the details of the medical monitoring. • TIVA sedation: The full protocol for TIVA sedation was detailed in previous reports of the Monitoring Team. The Monitoring Team was provided with vital signs and REACT score reports from the dental suite, from the infirmary, and from the home. The Monitoring Team verified that monitoring was done. In one exception, information from the infirmary was not received, for Individual #694. Status of development plans to minimize the need for pre-sedation: Dental support plans were not provided for the individuals who underwent TIVA procedures. The Monitoring Team reviewed the Dental Support Plans (DSPs) for the eight cases of oral pre-treatment sedation. In seven of the cases, the plan was for tooth brushing. In one case (Individual #555) the plan was to increase ability to participate in routine dental procedures. This was done by encouraging the Individual to spend short amounts of time sitting in the dental chair. Data sheets confirmed that training sessions had taken place. In the Self Assessment, the Facility stated that the provision was not in substantial compliance due to the inability to evaluate progress on Dental and Medical Support Plans. Please see additional comments on medical restraint practices, under section C.	

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-five individuals received psychotropic medication. This group represented 43% of the 363 individuals who lived at the Facility. Staffing at the Facility continued with the two psychiatrists, Drs. Patel and Zhoung. The two psychiatrists provided a combined level of effort of 52 hours per week or 1.3 full time equivalents (FTEs). Psychiatric support was provided by three assistants: • Mr. Damola Olatoregum supported the psychiatrists in the following areas: Gathering information for writing psychiatric evaluations, paperwork preparation for clinics (past clinic notes, medication profile, problem list and symptom checklists); assembling QDRRs, MOSES and DISCUS reviews for review during the clinic; tracking changes decided upon during the clinic for data entry into Department of Psychiatry databases; maintenance of Department of Psychiatry database for diagnoses and for psychotropic medications; polypharmacy meeting attendance and minute-taking; morning medical meeting attendance. • Ms. Denese Daniels was responsible for scheduling psychiatric consultations. • Mr. Rajesh Thakur was responsible for transcribing the psychiatric summaries and other dictations; compiling reports submitted by behavior analyst's nurse case managers, QDDPs and social workers; and maintaining automated forms with individual's demographics for daily use by the psychiatry department. In the Self Assessment, the Facility acknowledged that the current level of psychiatric staffing was not adequate to provide needed services, and the Facility acknowledged that it was not in compliance with the requirements of the provision. The Action Steps noted by the Facility to remedy the situation were to advertise, interview, and select appropriate candidates for the psychiatry positions. The position was posted. At the time of the last interview 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 was due at the current review. It could not be provided due to Dr. Ohiku's departure, and it will be needed in the future.	Noncompliance
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop	The Monitoring Team reviewed 13 Appendix B evaluations. The sample consisted of all CPEs done on individuals from Sample J5 and CPEs for Individuals #216 and #302, who had psychiatric evaluations since their Reiss screens scores were above the clinical cutoffs (see Provision J7).	Noncompliance

	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 Appendix B evaluations reviewed were all informative and detailed. The length of the evaluations ranged from six to eleven single typed pages. With a few exceptions, the format of the evaluations followed the required format. The level of detail in the evaluation was impressive, and showed that the psychiatrists had carefully studied the available historical records. There was detailed information about treatment provided over the years, and in the case of a more recent admission, a careful delineation of information presented at the time of admission. Note, however, that the CPEs for new admissions were often not done in a timely manner (see Provision J2). One of the recommendations made by the Monitoring Team in earlier reports was that the psychiatrists should focus on providing details of the psychiatric symptoms that supported the proposed psychiatric diagnosis, if one was made. This was not always easy to do, since much of the past documentation focused on behavioral, rather than psychiatric interventions. However, a review made by the Monitoring Team in 2010 showed that even though documentation did not favor psychiatric symptoms, it was possible, with some diligence, to find a sufficient number of references to psychiatric symptoms, to allow a construction of psychiatric formulations and diagnoses. In the records reviewed, it was evident that an effort had been made to respond to the suggestions. For example in the evaluation for Individual #529 the psychiatrist carefully documented disturbances in mood, and laid out the case to support the speculation that the individual had experienced an acute psychotic episode several days prior to the examination. The psychiatrist cited evidence from staff observations that supported the conclusion that the individual had been responding to auditory and visual hallucinations. In the end the psychiatrist convincingly presented a case for some form of psychotic disorder (Bipolar Disorder, Mixed Type with Psychotic Features was proposed, and both Mood Disorder due to a General Medical Condition and Paranoid Schizophrenia were listed as "rule out" diagnoses). Although improvements were noted, several areas of challenges remained: First, the bio-psycho-social case formulations (Sections XIII) needed improvement. The Appendix B guidelines were specific on what was required for these formulations (see Appendix B in the SA, and Exhibit A to DADS Psychiatry Policy): *"Case formulation consists of the following sequential tasks undertaken to channel distinct disciplinary assessments into the creation of an integrated treatment plan (starting with) (a) review and integration of information from the disciplinary assessments."* This was rarely done. In five of 13 individuals (38%) the bio-psycho-social case presentation was replaced with something else. For Individuals #17, #216 and #529 there was a section named "summary and psychiatric formulation." For Individuals #68 and #302, the section was titled "summary of findings." In none of the evaluations did the psychiatrist make it clear	

		that he/she had, for example, studied the most recent psychological assessment. Second, diagnostic justification needs to improve. This point was also discussed under Provision J2. While there has been an improvement in the citation of psychiatric symptoms for the individual, it was not sufficient to provide a diagnosis that was consistent with the symptoms. The psychiatrist needed to show how the diagnostic requirements for the diagnosis had been met. Third, there remained cases of unresolved "not otherwise specified diagnoses" (e.g., Individuals #239, #529, #600, #746) and cases where the Appendix B diagnosis differed from the diagnosis cited in the APL, PBMC note, or departmental database (Individuals #113, #239, #529, and #530). As discussed with Facility staff during the visit, one possibility was to initiate the annual psychiatric reviews planned by Dr Ohiku. Such psychiatric reviews could provide the justification of changes in diagnosis. When an annual review is initiated, static and non-changing elements of the psychiatric evaluation (for example family history) would be brought forward from the prior to the current year, matters needing resolution should be addressed, and information regarding the Individual's clinical state should be included. Fourth, in many cases the appendix B evaluations provided many recommendations for possible treatment that had not been implemented and that remained unaddressed by the psychiatrist providing treatment in the psychiatric clinic.	
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	At the time of the last compliance visit, the Monitoring Team confirmed that Reiss Screens had been completed for all individuals who lived at the Facility at that time. 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-nine of these individuals received routine psychiatric care via PBMC. Individuals #216 and #302 did not receive ongoing psychiatric care. The Monitoring Team reviewed the evaluations for Individuals #216 and #302 during the current visit. In each case the psychiatrist suggested psychiatric treatment. The Facility should make sure that the IDT reviewed these evaluations and that these Individuals received the care that was recommended. At the time of the last compliance tour there were twenty-nine individuals who had Reiss screen scores that reached or exceeded the designated cutoffs, but had not yet received	Noncompliance

	psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	psychiatric evaluations. Twelve of these individuals received routine psychiatric care from Facility psychiatrists. Seventeen other individuals did not receive psychiatric care. At the time of the current compliance visit, twenty-two of these twenty nine individuals (76%) had not yet received the needed psychiatric evaluations. • The Facility reported that there were eleven new admissions since the last visit. The Monitoring Team was given Reiss Screens for four of these individuals. Two of those individuals (Individuals #81 and #165) did not exceed the clinical cutoffs. The other two (Individuals #306 and #19) exceeded the cutoffs. Psychiatric Evaluations had not yet been done for those individuals. Reiss Screens were not provided for Individuals #278, #376, #546, #624, #626, #799, and #996. The Monitoring Team asked the Facility about the use of the Reiss Screen when individuals had a change of their clinical status and had an onset of new behavioral difficulties. The Facility had no set policy on this matter, and there were no new referrals to psychiatry since the last compliance visit for any individuals who live at the Facility. At the time of the current visit, the Facility provided annual Reiss Screens for all individuals who lived at the Facility. Since the last visit, fourteen individuals had scores that exceeded the clinical cutoffs. This number did not include the new admissions, discussed above. Follow-up for these fourteen individuals had not yet been provided, and the Monitoring Team will inquire with the Facility during the next visit about the supports provided for these individuals.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	RSSLC Psychiatry Policy 1.00d (revised 08/30/2011) made 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 was 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."* During the last compliance visit, the Monitoring Team discussed difficulties with integrated care with the Lead Psychiatrist. The Facility had committed to several improvements, which were: • A decision was made that PBMC clinics would be scheduled for at least 30 minutes per person, and integrated care would be emphasized at those meetings. During the current visit the Monitoring Team observed a PBMC clinic and saw good evidence for integrated care. For example, in the case of Individual #210 there was a well-integrated discussion about treatment with Clozaril. It emerged that the individual had been doing well on Clozaril but had developed a cardiac arrhythmia.	Noncompliance

		The nurse manager reviewed the reasons that Clozaril was stopped after a screening EKG ordered by the PCP had showed an arrhythmia, and a different medication (Zyprexa) was substituted, but without much efficacy. Further consultation was sought with an arrhythmia specialist and the upcoming appointment with the specialist was reviewed. The psychologist planned to attend the upcoming appointment and to review the question about the safety or resumption of Clozaril use. The QDDP shared information from the family regarding a strong preference to resume Clozaril treatment if at all possible. The Monitoring Team learned the following day that the consultation took place and the psychologist assured that the question of whether the arrhythmia precluded further use of Clozaril was addressed. It was, and the arrhythmia specialist advised that Clozaril could be resumed. The Monitoring Team found that the IDT had been conscientious in obtaining the screening, family preferences were brought to the table, appropriate consultation was obtained, and the process was well guided by the psychologist and QDDP. • The Habilitation Department was invited to contribute recommendations for therapeutic services in the areas of speech and language, OT/PT etc, whe$_{n\ the}$se were appropriate. No new information was received about this matter. • The Facility committed to improved education about case formulations. As reported in the current Self Assessment, the Facility provided an in-service to behavior analysts about case formulations. • One of the components of the Appendix B format was a case formulation. The Facility indicated at the time of the last compliance visit that psychiatrists would include case formulations as part of the Appendix B format, and that these would be incorporated - and as needed expanded - in the SBFA/PBSP documents that describe the overall behavioral healthcare provided. As described under provision J2 of this report, there had been improvements in the SBFA/PBSP documents, where information about the psychiatric component of the behavioral treatment is presented alongside information about behavioral interventions. However, as described under provision J6 of this report, improvements need to be made in the case formulation section of the psychiatric evaluations.	
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	The Monitoring Team reviewed PBSPs and related record material, for evidence of each of the three components of the provision. <u>The IDT should determine the least intrusive and most positive interventions.</u> The records of the individuals included as Sample J1 were reviewed for the presence of statements (in the PBSP or elsewhere) that the IDT had considered the proposed treatment program and made efforts to assure the program used the least intrusive and most positive interventions. Such reviews were located for nine of 16 (56%) individuals. Examples were as follows:	Noncompliance

	individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	PBSPs reviewed did contain statements that the IDT tried to use less restrictive practices. For example: • The PBSP for Individual #68 stated: "Members of the Individual's Personal Support Team evaluate his response to drugs for behavior management at least monthly. Consideration is given to reducing or discontinuing psychotropic medications whenever aggression to others and symptoms of schizophrenia decrease to 1 or less episodes for 12 consecutive months….The following drug changes occurred during the past year: on 6/24/11 Seroquel was discontinued, (medication change) symptoms of schizophrenia decreased (behavioral response)." • The PBSP for Individual #530 stated: "Members of the Individual's PST will evaluate her response to drugs for behavior management at least monthly. Consideration will be given to reducing or discontinuing the medications whenever target behaviors decreases to 0 episodes per month for 12 consecutive months….4/6/11 Effexor decreased (medication change)… continues to maintain zero incidents of aggression to self." • The PBSP for Individual #165 stated "Members of the Individual's Interdisciplinary Team will evaluate her response to drugs for behavior management at least monthly. Consideration will be given to reducing or discontinuing the medications whenever target behaviors decreases to 0 episodes per month." <u>The IDT 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: • Individual #68: "The Positive Behavioral Support Plan does not include highly restrictive procedures or rights modifications. The Individual receives psychotropic medications. This program is in adjunct to the psychotropic medication regimen that is in place to treat his psychiatric condition. …..The support plan is designed to reduce the likelihood of psychiatric symptoms and off task behaviors which limit his opportunities to learn and develop new skills." • Individual #530 "Achievement of effective choice making skills will be a lengthy process but will provide the Individual with a more efficient method to have contact with more preferred activities…..The program is in adjunct to the psychotropic medication regimen that is in place to treat the Individual's psychiatric condition." <u>If the IDT concludes that the individual is best served through psychotropic medication, the ISP must also specify non- pharmacological treatments to minimize the need for medication:</u> ISPs 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. During the last compliance visit the Monitoring Team reviewed with the Lead Psychiatrist how the requirements of the provision were met in the daily practice at the Facility. The Monitoring Team was informed that discussions about new medications typically took place at the PBMC that was attended by key members of the IDT such as the psychologist, nurse case manager, clinical pharmacist and QDDP. Available treatments, alternatives, risk and benefits were considered. For all medications newly approved during the past six months, the Monitoring Team reviewed information for the clinical records that documented the details of these discussions. In addition to the PBMC notes, integrated progress notes, and ISPAs that were pertinent to the medication were also reviewed. A total of 18 medications were reviewed (Sample J7). Information about risk vs. risk and treatment alternatives was included in the newest version of the medication consent that was used for eight of 15 proposed medications. In the remaining seven of 15 medication consents, the newer format was not used and information was not presented about risk vs. risk, or about treatment alternatives. PBMC notes did not contain information on these two issues. Review of the thirteen consents that used the form which included information about risk vs. risk and treatment alternatives showed the following: IDT (including PCP and nurse) determination of whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of the psychotropic medication: Many consent forms contained information about common and most serious side effects of the proposed medications, and the consent forms included the following statement: *<u>Side Effects/Risk vs. Risk:</u> In the case of serious side effects, the medication will be stopped promptly. The medication will be stopped if the personal support team and the LAR determine that, despite adequate dosing for adequate duration, the medication is not effective or if the risks from the side effects outweigh (1) the risks of not taking the medication (2) the benefit of taking the medication.* The Monitoring Team found that while information was contained in the above that was relevant to the risk/risk information required by the provision, it was not sufficient. What was needed was an individualized statement identifying the harmful effects of the mental illness, and an acknowledgment that the IDT compared these to the possible side effects of the medication and found that the risk of the untreated mental illness were	Noncompliance

		greater. In addition, the Monitoring Team did not find evidence that documented PCP participation in the decision making. Unlike the nurse, the PCP was not a participant in the PBMC where the new medication was discussed, and there was no evidence for subsequent consultation betwee$_{n\ the}$ psychiatrist and PCP about the medication being proposed. That was needed. IDT discussion of whether reasonable alternative treatments (including no medication) are less likely to be effective or potentially more dangerous that the medications: The new consent form had a section titled "Other possible choices for (symptom included) medications," that listed alternative medicines. For example: • Individual #643: "Other possible choices of anxiety treatment medications include but not limited to trial of another antianxiety medication." • Individual #728: "possible choices of anticonvulsant treatment medications include but not limited to another anticonvulsant medication. • Individual #630, "Other possible choices of antipsychotics: Patient already taking maximum dose of Abilify." Even when such a statement was included, they did not consider reasonable alternative treatments other than medication. 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 pharmacy provided the Monitoring Team with a description of polypharmacy reviews as follows: At the time of the visit there were four tiers of review: Level 1: A clinical pharmacist attended all relevant IDT processes. Level2: QDDR consultation on a quarterly basis. Level 3: The clinical pharmacists participate in all psychiatry and neurology clinics. Level 4: Three Polypharmacy/Medication Review panels have been held so far in 2012. <u>Pharmacy Activity in clinical meetings:</u> The pharmacy participated in each psychiatry and neurology clinic, as above. The Monitoring Team observed the process by attending the PBMC clinic on 05/15/12, during which nine individuals were reviewed. A clinical pharmacist attended each of the reviews. For each individual reviewed, the pharmacist provided a detailed report regarding labs, possible drug interactions and related metabolic issues. For individuals for whom a QDRR was due, that document was reviewed with the participants. For others, an update was provided. In all cases, the review was detailed and substantive. The clinic included reviews for Individuals (#210, #623, #626), who were treated with polypharmacy. For those individuals, the clinical pharmacist also provided comments and details related to	Substantial Compliance

		the polypharmacy. For example: • For Individual #623 there was a detailed discussion about whether the prescription for Depakote was needed. It was listed in the PBMC notes as a psychotropic medication, but the origin of the prescription had been in the neurology clinic, and it appeared that the prescription was for seizure prophylaxis in the setting of a remote head injury. Following extensive discussion the IDT determined that the use of Depakote was not for behavioral indications. A related question is the duration for which seizure prophylaxis is needed, absent clinical seizures. That issue was deferred to the neurology clinic, but it is possible that there will not be a need for the medication. The clinical pharmacist was a key part of the discussion about the need for Depakote, and the IDT benefited from his knowledge about the Individual's neurological needs, which in turn were helped by the clinical pharmacists' attendance at the neurology clinic. <u>Pharmacy tracking of campus-wide information about polypharmacy:</u> The pharmacy provided a breakdown of polypharmacy information across the campus. There had been reductions in polypharmacy since the last visit, however they were modest. In December 2012 there were 52 individuals with psychiatric polypharmacy, out of the 151 individuals who received psychotropic medications (34%). In April 2012 there had been a reduction to 48 out of 155 individuals who received psychotropic medications (31%). In discussion with the Monitoring Team, Dr. Shatz pointed out that there have been many recent admissions, a large majority of whom (15 of 17, 88%) were admitted on polypharmacy regimens. To maintain clarity on efforts the Facility has made to reduce unnecessary polypharmacy, Dr. Shatz suggested that in the future, he will report not only on the overall numbers of individuals who have polypharmacy, but also the number of medications that have been discontinued since they were not needed. <u>Facility levels reviews:</u> These took place in the P&TC meetings, Polypharmacy/Medication Review Panels and QA/QI meetings. The May 2012 meetings of the P&TC and QA/QI Committee took place during the visit. In each setting there was a review of polypharmacy data. In the P&TC meeting the issue was how best to capture information about whether efforts to reduce unnecessary polypharmacy were successful. A decision was made to also report not only the number of individuals treated with polypharmacy, but also the total number of medications discontinued as unnecessary. One of the reasons to do so was the recognition that reports of the overall numbers of individuals treated with polypharmacy might not reflect positive facility practices over time. This could happen, for example, if over a reporting period many individuals admitted had polypharmacy, while individuals discharged did not. Individual reviews: Per the pharmacy there were seven individuals who took more than	

		one antipsychotic medication. These were Individuals #68, #314, #316, # 530, #546, #714, and #799. Of the seven individuals, three (Individuals #799, #546, and #314) were newly admitted to RSSLC. The records of the remaining four individuals were reviewed for documentation regarding the need for the polypharmacy. Individuals #68, #316, and #714 all had plans in place for continued medication reductions. Individual #530 had a recent reduction in Lamictal. The psychiatrist opined that one of the two antipsychotics might be reduced in the future, but she did not think it wise to do too many changes at one time. Conclusions: Facility monitoring for polypharmacy remains strong. However, when psychiatrists assess that polypharmacy is clinically necessary, there needs to be a statement from the treating psychiatrist as to why that is so. The statement needs to be supported by data, and it needs to be part of a document that will be readily accessible, such as an annual psychiatric update. Additional reviews, such as those that are now conducted by the Polypharmacy/Medication Review Panels are an excellent addition, but they cannot replace work that must be done by the treating psychiatrist.	
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 15 individuals in Sample J1. All evaluations were signed by the psychiatrist or (in the case of MOSES) the PCP. The Monitoring Team reviewed campus-wide tracking of monitoring of side effects. These included: • 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. • Listings for individuals diagnosed with dyskinesia. • A listing of all DISCUS screens done over the past year that were rated five or higher. Adequacy of Screening with MOSES and DISCUS: Review of the Facility of side effect screening dates showed that many individuals had timely exams, but not all. Based on the list provided to the Monitoring Team (updated 04/21/12), 54 individuals did not have MOSES at least one of the required quarterly evaluations during the past six months. Review of the screens that were completed for individuals in Samples J1 showed that in most cases, the administrations were done well and the reviewer's comments were thoughtful. Scoring was not flawless, however. For example, Individual # 157 had no conclusion on the most recent MOSES, Individual # 502 had no score, and Individual #149 had no evaluation, or conclusions.	Noncompliance

		Tracking for Dyskinesia: The Facility reported that there were no individuals diagnosed with tardive dyskinesia. Individuals #119, #144, and #574 were reported to have DISCUS scores of 5 or higher. Individual #574 had a rating of 14 on the DISCUS on 2/24/12. Per the PBMC the psychiatrist diagnosed tardive dyskinesia and the individual was started on vitamin E for that indication. The Individual was seen in Neurology Clinic on 09/13/11. Dr Croft reviewed the records and confirmed that the individual has been known to have dyskinesia for many years. He also confirmed that she had already been seen by Dr. Jankovic, a highly regarded specialist in the area of movement disorders. The diagnosis should be added to the APL. Individual #119 had a score of 5 on 3/16/12; the previous score was 9. The psychiatrist noted that there were other conditions that could account for the movement but did not name the condition. Individual #144 had a DISCUS score of 7 on his most recently reported DISCUS and a score on 7 on the prior exam. He was reported to have constant mouth movements; no medical conditions that could explain the movement were noted, but he was not diagnosed with dyskinesia. None of the individuals were seen in neurology clinic to further evaluate the movements, during 2012 or 2011. In each of these cases more follow-up to determine whether or not the individual had dyskinesia was needed but there was no evidence it was obtained. Additional administrations of MOSES and DISCUS screens following medications dose changes: The Monitoring Team inquired as to whether additional MOSES and DISCUS exams are done when the dose of medication was changed. The Monitoring Team was informed that Facility policy does not require that, but it is done as a clinically sound action, at the discretion of the clinical team. At the next visit the Monitoring Team will ask for examples of cases where additional administrations of side effect screens were done, to better understand Facility practice.	
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	The language of the provision detailed what was required for psychotropic medication plans, and the same requirements were also cited in Facility Policy 1.00d *Psychiatry Services* (revised 08/30/2011.) During the previous visit the Lead Psychiatrist had informed the Monitoring Team that she planned to have psychiatrists complete treatment plans for new medications, but that it had been difficult to do so given the staffing shortage. That staffing shortage has now become more severe, with the departure of both full time psychiatrists. At the time of the tour such medication plans were not in place and the provision remains in noncompliance.	Noncompliance

	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.	Although psychotropic medication plans were not in place, the improved medication consent forms that the Facility had developed and that were in use at the time of the compliance visit included many of key elements required by Provision J13, (e.g., diagnosis, expected timeline, and objective symptoms to be monitored) for medication plans. The new format did not include some key items, for example the details of how the identified key symptoms would be monitored. During the visit there was a productive discussion between the Monitoring Team and the Chief Psychologist regarding the options available for the Facility to move forward with the development of the required medication plans. One of the available options is for the Facility to expand the current medication consents to provide all required elements for treatment plans. Under Provision J3 above, the Monitoring Team reported that the tracking of medication response – essentially the core of the medication plan implementation - was different in the PBSP documentation and in the PBMC presentations. That led to the question of whether the instructions for symptom monitoring contained in the medication consent was being followed by PBMC, where medication monitoring took place. The Monitoring Team had attended a PBMC clinic held on 05-15-12 by Dr. Zhoung for Individuals #44, #91, #99, #179, #210, #212, #239, #623, and #626 and notes from the clinic were examined to explore this issue. The overall quality of the clinical process during the clinic was good. IDT attendance at the clinics was extensive. It typically included the individual, the QDDP, nurse case manager, psychologist, DCPs, and the clinical pharmacist. Each discipline presented information relevant to their area of expertise. Nurse case managers presented side effect screens, psychologists reviewed data (and DCPs provided additional information from their observations), and the clinical pharmacist reviewed QDRR information including labs, drug interactions and FDA guidance on the use of the medications. In some cases staff from Habilitation Services participated and provided information from their area. Clinical discussion typically lasted for 30 minutes or more. Because treatment plans had not been completed, the Monitoring Team next examined the medication consent forms for the psychotropic medications prescribed for each individual (a total of 16 medications for nine individuals) to determine whether they contained the components required by this provision. The Monitoring Team found that none of the consent forms named appropriate symptoms with which to monitor the medication in question. This problem alone was sufficient to explain the lack of consistency in how monitoring was done.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year,	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 Human	Noncompliance

	each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Rights Committee (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 Self-Assessment, 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. As described under Provision J13 above, none of the consents for the medications reviewed in the PBMC used the most recent consent form. However the consents in question were mostly renewals of consent forms written some time ago, and may not have represented current Facility practice. To examine current practice, the Monitoring Team reviewed medications approved in December 2011 and January 2012, and which used the most recent medication consent form that does specify the target symptoms. The dates of approval were chosen to see what later transpired in the PBMC follow-up once the medication was started. Two appropriate medications were located - Abilify for Individual #137 and Zyprexa for Individual #379. As above, in the case of Individual #137 only some of the designated symptoms were monitored. In the case of Individual #379 the consent guidelines were not followed. Accordingly, it appeared that at present, monitoring for symptoms was not being determined by the contents of the informed consent form. This problem should be addressed promptly. Psychologists and psychiatrists should consult at the time a medication is started or the	

		Consent	PBMC
Individual #137	Abilify	Delusional speech, high energy, mood lability	Delusional speech
Individual #379	Zyprexa	Fidgeting, obsession over tidiness, compulsive cleaning	Irritability

		consent renewed. They should jointly determine the details for data tracking for psychiatric symptoms, and that should be carried over to both the PBMC and the Behavioral Treatment Program documents. The Monitoring Team reviewed the informed consents for 15 psychotropic medications approved by the HRC during the past six months (Sample J7) and found the following: • LAR/Guardian consent: In all cases consent was obtained by the psychiatrist from the LAR or guardian. Information provided to the Guardian about the medication was as follows: o Diagnosis: Eight of 15 (53%) medication consents requested listed the DSM diagnosis of the individual o Name of the medication: listed in 15 of 15 (100%) cases o Target symptoms: Psychiatric symptoms/behavioral symptoms to be measured to determine effect were noted in six of 15 (40%) of the medications. o Expected benefits of treatment: In many cases, the expected benefits were related to the target symptoms for the individual. For example, for Individual #728, the medication was proposed to treat symptoms of hypomania and (related) sexual inappropriateness. The expected results were "*eventual remission of the hypomania and hypersexual symptoms, and eventual elimination or reduction in rates of inappropriate sexual behaviors."* The symptoms were stated and could be related to the diagnosis. In other cases, however, standardized and broad language was used for expected results that did not seem related to the diagnosis or medication. For example, Individual #643 was diagnosed with bipolar disorder and treatment with Zyprexa was proposed. The expected results however were: "*Expected benefits for treatment include but are not limited to: remission of rates of aggression to others and replacement with socially acceptable behaviors, improved learning of new skills increased participation in scheduled treatment programs and leisure activities, and access to less restrictive settings."* For this individual, the connection between the diagnosis and target symptoms and the expected results were not clear. The discussion of the expected results should have been more focused and specific. Another example was Individual # 379, who was diagnosed with psychosis, and treatment with an antipsychotic drug (Zyprexa) was proposed for symptoms of hallucinations and delusions. However, the expected results of treatment were cited as*: "Expected benefits of treatment include but are not limited to remission of symptoms, elimination or reductions in rates of aggression to others and replacement with socially acceptable and adaptive behaviors, improved learning of new skills, increased participation in scheduled treatment programs and leisure activities and access to less restrictive settings."* Here too, the description of the results expected of treatment should have been more focused and specific. o *Starting and maximum dose range for the medication:* The newer consent form was used for thirteen of the medications. In all cases the maximum approved	

		dose was stated, but in most cases the initial dose was not. Many medications contained standard language that stated: "*Dosage will be titrated up to minimum dose necessary (within the FDA approved maximum dosing) to achieve full remission and eventual recovery without significant side effect".* For all individuals the starting dose of the medication should have been cited. For five of 15 (33%) individuals, there was no information about the starting or maximum dose of the medication. o Risk vs. Risk information: Sufficient information was not provided, per discussion under Provision J10. o Side effect information for the medication: This was provided in all cases. • HRC review: All medications were reviewed by HRC. In a few cases, a new version of the consent form was used (example: Individual #728, for Depakote; Individual #643, for Haldol). The new form contained information on diagnosis, target symptoms, reasons for addition of the medication, less intrusive approached previously used, and risk vs. risk analysis and dosing information. However, the remainder of cases either used either an older form that did not ask for the above-listed items, or the new form was used but information on one or more of the items was not provided.	
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, whe$_{n\ the}$y are prescribed to treat both seizures and a mental health disorder.	The Monitoring Team reviewed individuals from Sample J4. 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."* At the time of the last compliance tour the Lead Psychiatrist had initiated a Facility practice for psychiatrists employed by the Facility to consult with Dr. Croft during his neurology clinic. The intent was for psychiatrists to do so for individuals who were prescribed medications for both seizures and mental health disorders, and also for other individuals with both mental health and neurological illness. Dr. Ohiku attended neurology clinics until her departure; Dr. Patel was not able to do so since he works for the Facility only on the weekends. There was no current participation by psychiatry in the neurology clinic. A positive development has been the decision of the clinical pharmacists to attend the neurology clinic. The addition will be particularly helpful, regarding efforts to minimize unnecessary polypharmacy. For example: • Individual #630 had been maintained on Zonisamide and Depakote for epilepsy, but had not had any seizures since 1999. The individual also took 30 mg daily (the maximum dose) of Abilify for psychosis. The individual was seen in neurology clinic on 01/24/12, and the neurologist decided to taper and	Noncompliance

		discontinue Zonisamide. The neurologist was uncertain as to whether or not the Individual was also taking Depakote as a dual purpose medication for psychiatric indications (he was). The neurologist decided to taper and discontinue the Zonisamide, but in the ensuing period of time the psychologist noted an increase in symptoms of psychosis, eventually requiring the addition of a second antipsychotic medication to control those symptoms. • Individual #615 was seen in the neurology clinic on 02/02/2010, and had not had any seizures in over a year. He was treated with two anticonvulsant medications (Tegretol and Depakote). The neurologist noted that the Depakote level was very low, and in this case too, he was uncertain as to whether the Depakote was needed for psychiatric management. The neurologist opted at that time not to change the Depakote, but it was eventually discontinued on 12/29/11. Per the PBMC note from 02/21/12, during the following three weeks the Individual's aggressive behaviors worsened and his sleep decreased significantly. As a result, on 01/27/12 the dose of Risperdal, an antipsychotic medication, was increased. There was a subsequent reduction of symptoms. These two cases illustrate the complex nature of psychiatry-neurology interactions and the many clinical decisions in which it is helpful for the psychiatrist, neurologist, and clinical pharmacist to work together. For example in the second case, one strategy to avoid an increase in antipsychotic dose might have been to resume the use of Depakote as a dual purpose medication. Had it then emerged that Depakote was effective for the psychiatric symptoms and the seizure type allowed, it might have been possible to then attempt to taper Tegretol, and to rely on Depakote monotherapy for epilepsy. Other cases of individuals seen in the neurology clinic that had both neurological and psychiatric needs and reviewed by the Monitoring Team were: • Individual # 746 was an individual who had both seizures and mood difficulties. Since there appeared to be a temporal relationship between the seizures and the mood disturbance, the individual was diagnosed with the DSM diagnosis of mood disorder secondary to epilepsy. He was followed in both the psychiatry and neurology clinics. In the PBMC clinic of 02/10/12 the psychiatrist noted that she will review that diagnosis, however, since the individual had not had seizures in more than a year and the mood symptoms might well be related to a different psychiatric diagnosis. • Individual #429 was treated with Depakote for seizures and was followed in the neurology clinic. In the PBMC note from 02/17/2012 the psychiatrist stated that past reports had suggested that Depakote had also helped stabilize the individual's self-injurious behaviors. Per the neurology clinic note of 01/10/12 the drug level of Depakote was low, but sufficient to maintain the individual seizure free. Self-injurious behavior was also treated with an antipsychotic agent, Zyprexa, at a high dose of 30 mg per day. The separate discussions in the	

		psychiatry and neurology clinics raised the possibility that a higher dose of Depakote as a dual purpose medication might be effective for both the neurological and psychiatric condition, and might make possible a reduction in the dose of the antipsychotic medication. The case has not had further review due to the departure of the psychiatrist, but the discussion about further care and possible re-designation of Depakote as a dual purpose medication should take place. The above cases demonstrate the value of participation by psychiatry in the neurology clinic appointment for some individuals, and support the decision of the pharmacy to do so as well. Although some good initial work is evident regarding psychiatry-neurology collaboration, the progress has been interrupted by the psychiatry staffing difficulties and the provision is currently in noncompliance.	

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

1. Differences between CPE diagnoses and PBMC diagnoses should be resolved (Provisions J2 and J6).
2. Differences in diagnoses between APLs and the new Medical and Psychiatric problem list in the medical orders section of record should be resolved. See also the related recommendation #6 that follows (Provisions J2 and J6).
3. R/O and NOS diagnoses that have been in place for more than six months should be resolved, per the guidelines for Appendix B (Provisions J2 and J6).
4. Psychiatric evaluations for new admissions should be done in a timely manner (Provisions J2 and J6).
5. The case formulations for CPEs need to improve (Provision J6).
6. Risk vs. Risk assessment for medication should include treatment alternatives, including no medication treatment (Provision J10).
7. In cases when psychiatrists assess that polypharmacy is clinically necessary, that conclusion should be supported by data, and the information should be included in a document that will be readily accessible, such as an annual psychiatric update (J11).
8. Symptom tracking for medication response should correspond to the symptoms or behavioral characteristics named in the medication consent form (J13).
9. Medication consents should use the most recent version of the form (Provision J14).
10. Medication consents should cite the initial, as well as the maximal, doses of the medication (Provision J14).

The following are offered as additional suggestions to the Facility:

1. The Facility should consider the use of annual psychiatric updates.
2. The Facility should consider the consolidation of APLs and the new Medical and Psychiatric problem lists, into a single entity.
1. The Facility should consider the use of the same format for table of information about psychotropic medications (related DSM diagnosis, related behavioral characteristics/symptoms, etc) in both PBSPs and PBMCs.

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 Self-Assessment and Action Plans – 5/12/2012 2. RSSLC Presentation Book for Section K 3. Positive Behavior Support Committee meeting minutes - 9/7/2011 – 2/22/2012 (24 meetings) 4. Behavior Service departmental meetings minutes – 10/3/2011 and 2/27/2012 5. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), 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 Self-Assessment and included Individuals #25, #60, #115, #119, #181, #195, #200, #235, #265, #278, #555, #568, #624, #626, #695, #736, #780, and #798 **People Interviewed:** 1. Lloyd Robert Buckner, MS, BCBA – Behavior Services director 2. Cynthia Fannin – Director of Education and Training 3. Carol Agu – QMRP Coordinator 4. Billie Dejean, MA, BCBA – Psychologist 5. Approximately 30 direct care staff in the following residences and day treatment areas: Angelina, Guadalupe, Lavaca, Leon, Neches, Pecos, Sabine, San Antonio, San Jacinto, Trinity, and all vocational settings. **Meeting Attended/Observations:** 1. Active Treatment Meeting – 5/15/2012 2. ISP annual planning meeting for Individual #17 – 5/15/2012 3. Behavior Support Committee – 5/16/2012 4. Behavior Service departmental meeting – 5/16/2012 5. Restraint Reduction Committee – 5/16/2012 6. Human Rights Committee meeting – 5/16/2012 7. Observations were conducted in the following residences and day treatment areas: Angelina, Guadalupe, Lavaca, Leon, Neches, Pecos, Sabine, San Antonio, San Jacinto, Trinity, and all vocational settings.
	Facility Self-Assessment: At the time of the site visit, RSSLC reported that one Provision, Provision K2, was in substantial compliance with the SA. The Provision pertained to the qualifications of the Behavior Services director. The Monitoring Team was in agreement with the Facility in regard to the status of compliance with the Settlement Agreement. The Self-Assessment presented by RSSLC was comprised of two parts: A Self-Assessment of the current

	practices at the Facility and Action Plans that outlined steps the Facility planned to enact to address weaknesses in identified in the Self-Assessment. The Monitoring Team found that the information provided in the Self-Assessment component was frank and accurate. Unfortunately, several sections of the Self-Assessment component were not complete as not all elements included in the Settlement Agreement Provision relating to that section were addressed. For example, Provision K4 pertains to the system for collecting and documenting displays of behavior, as well as the process of using data to monitor the efficacy of behavioral interventions. The Self-Assessment, however, addressed only the data collection and data graphing elements. Similarly, Provision K9 pertains to the consent and approval process for PBSPs, as well as the quality of the Positive Behavior Support Plans (PBSPs). The Self-Assessment component did not reflect consideration of the quality and accuracy of the consents and approvals obtained for PBSPs. Without assessment of all aspects of each Provision, it will be difficult for RSSLC to achieve substantial compliance with the Settlement Agreement. The second component of the Self-Assessment involved Action Plans. These plans were steps the Facility developed to achieve substantial compliance with the Settlement Agreement. As in the Self-Assessment component, the material provided in the Action Plan component was typically accurate. In several sections of the Action Plan component, however, the focus was upon revising formats, providing training, and monitoring outcomes. These were all valuable activities. As often noted during the site visit, however, awareness of weaknesses was not sufficient to ensure that weaknesses were corrected. As in a behavior intervention, clear expectations for performance must be established and plans developed for when expectations are not met. Without such expectations and plans, the Facility will likely find it difficult to achieve progress toward substantial compliance with the Settlement Agreement.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 5/14/2012 through 5/18/2012. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that Provision K2 was in substantial compliance with the Settlement Agreement. That Provision pertained to the qualifications of the Behavior Services director. No other Provisions were determined to be in substantial compliance. Despite the lack of substantial compliance for most Provisions, the Facility demonstrated progress during the current site visit. Areas of noted improvement for the Facility included the completion of Psychological Assessment reports for the majority of people living at the Facility. Although intellectual and adaptive behavior testing was very limited, the Facility had completed several more reports. The Facility also demonstrated improvement in several elements of both the Structural and Functional Assessments and the PBSPs. In addition, the Facility reversed a trend noted during the previous site visit and had increased the number of staff with the BCBA credential, as well as the number of staff pursuing the BCBA. Although not sufficient for substantial compliances, these actions reflected considerable improvement. Not all areas, however, had improved. Although several individuals living at RSSLC were involved in counseling services, none of these individuals was provided with the necessary treatment plans. As a result, counseling interventions did not reflect evidence-based practices. There was also little improvement in the

	data collection and graphing process in comparison with the baseline site visit. In many circumstances, it was not possible to readily identify specific trends in behavior and demonstrate that individuals were benefiting from the PBSPs. It was also noted that, although SFAs had improved, there continued to be little integration between behavioral and psychiatric assessments and interventions. It was encouraging to see that the Facility had achieved progress and had plans for further improvement. At the time of the current site visit, however, there was substantial compliance with only one Provision of the Settlement Agreement, and some areas that reflected only minimal change since the start of the Monitoring process. As a result, a considerable amount of work remained before compliance with the Settlement Agreement could be achieved.

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<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 and 15 staff members had enrolled in or completed the training courses. At the same time, 25% of the Behavior Services staff was not participating in any training related to board certification in applied behavior analysis. In October 2010, the number of BCBA credentialed staff had fallen to three. Of the remaining 16 staff eligible for board certification, only nine (56%) were actively pursuing board certification.

At the time of the current site visit, RSSLC employed six psychologists/behaviors analysts with the BCBA credential. This was double the number employed at the time of the previous site visit. Furthermore, all but one of the staff who lacked board certification was actively pursuing the BCBA through training and supervision.

<table>
<tr><td></td><td>5/2010</td><td>5/2011</td><td>5/2012</td></tr>
<tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>16%</td><td>30%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>0%</td><td>56%</td><td>93%</td></tr>
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These figures represented considerable improvement on the part of the Facility. Although sufficient staff had not yet earned board certification to allow for substantial compliance with the Settlement Agreement, the Facility was progressing toward that goal.

The documentation provided by the Facility was not organized to allow for determination of the number of PBSPs completed during the previous six months. The current tracking process for PBSPs revealed 313 PBSPs. Of those PBSPs, only 51 (16%)</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		had been completed by a staff member with board certification. All of these were isolated in specific residences: Pecos, Cottages, and San Jacinto. As a result, it was evident at the least that individuals living in other residences were not provided PBSPs developed by BCBAs. This indicated that the Facility was not in compliance with the requirement that individuals are provided with behavioral interventions developed by demonstrably competent staff.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The Facility continued to employ Mr. Lloyd Robert Buckner, MS., as Behavior Services Director. 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 participates. 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. At that time, no committee members were board certified behavior analysts. During the site visit in October of 2010, there was little evidence to support a substantial improvement in the peer review process at RSSLC. In addition, RSSLC continued to lack the demonstrably competent Behavioral Services staff necessary to accomplish internal peer review. Changes were once again introduced by the Facility immediately prior to both the May 2011 and October 2011 site visits. The recent nature of the changes prevented a review of the outcome produced by the new processes. At the time of the current site visit, notes were reviewed from 23 Behavior Support Committee meetings conducted during the past six months. The notes reflected a process	Noncompliance

#	Provision	Assessment of Status	Compliance
		that addressed many aspects of behavior assessment and intervention, including formatting, the quality and content of graphs, elements of the behavior contingencies and related functions, the rationale for intervention, and data quality. Such a broad approach suggested dedication to improvement. Neither the records nor the observed process, however, provided sufficient documentation to allow for tracking of improvement in individual PBSPs or the overall changes in the PBSPs developed at the Facility. The Facility reported during the site visit that, due to the noted limitations, a new peer review process would be implemented shortly after the current site visit. Due to these upcoming changes, which were to include new rating forms, procedures, and staff training, it was necessary to delay comprehensive review of the peer review process to a later site visit.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	During the baseline visit in April of 2010, it was noted that data collection for PBSPs at RSSLC was inadequate to the task of measuring behavior and determining the need for or benefit from behavioral or psychopharmacological interventions. At that site visit, in 24 out of 24 records reviewed, data collection consisted of narrative documentation of circumstances surrounding the display of an undesired behavior. The status of data collection practices remained essentially unchanged during the October 2010 and May 2011 site visits. At the time of the October 2011 site visit, although some changes had been introduced, several of the preexisting weaknesses continued to be evident. Based upon materials obtained during the current site visit, there were few indications of substantive changes in the data tracking and treatment monitoring process in relation to the 18 individuals included in the sample. Information obtained during staff interviews, as well as in the Facility Self-Assessment, corroborated the continuation of the previously existing issues. Assessment of the overall situation, however, was complicated by the generally poor quality of the materials provided by the Facility. For several individuals, no Psychology Progress Notes were included, or for those individuals where Progress Notes were provided, the most recent notes predated the site visit by several months. As a result, conclusions drawn from all materials must be viewed as preliminary. Some issues appeared to reflect valid concerns about the ability of the Facility to track behavior and monitor the response to treatment. • In all available monthly data graphs, data were collected and presented as the daily mean displays of behavior per month. In several circumstances, this resulted in numbers, such as ".03 displays," that were very difficult to interpret. Reporting daily mean frequency per month 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		measure of behaviors that occur at high frequencies. • In most of the available Psychology Progress Notes there were multiple data graphs. The data graphs did not reflect a clear convention for selecting the targets for inclusion. As a result, graphs typically included targets with different functions or that otherwise did not appear to be related. Data graphs are important to treatment monitoring as they allow for relatively quick visual comparison of trends. When graphs do not include related targets, however, the ability to compare trends and determine progress can be substantially limited. The Facility might review graphs to ensure they are clear and are useful for treatment monitoring. • In addition to the organization of the data graphs, the narrative summary in Psychology Progress Notes typically lacked statements assessing changes in individual behaviors or groups of behaviors that all were related to the same function. Rather, narrative statements in the Psychology Progress Notes, when notes were made available, typically contained generic statements about overall progress. Therefore, conclusions drawn in relation to treatment often were unable to capture whether in fact there had been meaningful changes in specific behaviors. • Based upon information provided in the available Progress Notes, it was not possible to determine if the person compiling the data and performing the review was a BCBA and thereby possessing the expertise to draw conclusions about progress. • In all records reviewed, the relevant PBSPs did include criteria for success. In none of the available records, however, were criteria for failure included. The lack of failure criteria may allow any ineffective program to be perpetuated for weeks or months before the necessary review and revision are completed. • No indications of treatment conditions were included on any reviewed graphs. Without an indication of when a behavior intervention or psychotropic medication was started or changed, it was not possible to determine if that treatment produced a change in the treatment target. An additional and substantial limitation was the absence of reliability measures for treatment data. None of the records included in the sample contained reliability data. The Facility indicated in the Self-Assessment that only isolated reliability measures were conducted and that reliability measurement practices were inadequate at the time of the site review. Due to the problems with the data collection and presentation, it was not possible to draw any conclusions about the ability of the Facility to implement an evidence-based approach to treatment monitoring. The Facility did report that efforts were scheduled to	

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<tr><td></td><td></td><td>be undertaken shortly after the site visit to modify the data collection and presentation procedures. Such improvements were very much in need. Without a more systematic and appropriately organized effort to maintain consistent records, however, any improvements will be difficult to ascertain during future site visits.</td><td></td></tr>
<tr><td>K5</td><td>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.</td><td>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 October 2011 site visit, however, the Facility indicated a person had been hired to fulfill the role of completing intellectual and adaptive testing and write Psychological Assessment reports.

At the time of the current site visit, the Facility reported that the person responsible for intellectual and adaptive testing was no longer employed by the Facility. There was no indication that any intellectual or adaptive assessments had been completed since the previous site visit. There were, however, other indications of progress. Documentation provided by the Facility revealed that 360 individuals (99%) had a Psychological Evaluation report in the record. Of those 360 individuals, 324 (89%) had a Psychological Evaluation report completed within the past year. None of these evaluation reports was shown to include current intellectual or adaptive assessment results, but the provision of Psychological Evaluation reports reflected progress.

<table><tr><td></td><td>5/2010</td><td>5/2011</td><td>5/2012</td></tr><tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>0%</td><td>99%</td></tr><tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>0%</td><td>89%</td></tr><tr><td>The Psychological Assessments contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>0%</td><td>0%</td></tr><tr><td>The Psychological Assessments contained findings of adaptive assessment conducted within one year</td><td>0%</td><td>0%</td><td>0%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

prior to the date of the Psychological Assessment.			

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. During the October 2011 site visit, the Facility presented that efforts were underway to improve SFAs, but that sufficient time had not passed to allow many of those changes to be present in the record. During the current site visit, it was evident in a sample of the 18 most recent SFAs that improvement had taken place.

	5/2010	5/2011	5/2012
Assessment or review of biological, physical, and medical status	0%	0%	50%
Review of personal history	0%	0%	40%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	0%	70%
The process or tool utilizes both direct and indirect measures	0%	0%	78%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	0%	67%
Identification of antecedents relevant to the undesired behavior	0%	0%	67%
Identification of consequences relevant to the undesired behavior	0%	0%	67%
Identification of functions relevant to the	0%	0%	78%

#	Provision	Assessment of Status	Compliance

undesired behavior			
Summary statement identifying the variable or variables maintaining the target behavior	0%	0%	78%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	0%	44%
Identification of preferences and reinforcers	0%	0%	56%

The table above reflects that several areas in the assessment of behavioral functions had substantially improved. In particular, the SFAs were more likely to involve anecdotal and direct observation assessments, identify specific functions relevant to the undesired behavior, and include statements that identified the contingencies that were maintaining those undesired behaviors. No area reflected a lack of improvement, although some areas suggested the need for additional improvement.

Of particular note in the SFAs and other materials reviewed was the inability to compile the many parts of a behavior assessment into a coherent system of assessment. Many of the records suggested that Behavior Service staff accessed and implemented the various tools related to the assessment process. Unfortunately, those staff often demonstrated an inability to recognize the role of each tool or element in the larger, evidence-based process of behavior assessment.

- For Individual #25, baseline measures were identified for several of the individual's target behaviors. The baseline data, however, were from disparate dates. If a multiple baseline design were involved, this would have reflected no substantial problem. As a multiple baseline treatment design was not involved, the use of baseline data from different dates would have made the determination of progress within a single PBSP difficult.
- For Individual #115, some data regarding behavior frequency were collected in 2008 and 2009, while indirect and direct assessments were conducted in 2011.
- For Individual #119, the identified function of the target behavior was escape. The replacement behavior identified in the SFA, however, was to provide social interaction. It was unclear how social interaction would effectively replace a behavior maintained by escape.
- For Individual #555, the findings of anecdotal assessments identified functions different that the final hypothesized function presented in the SFA summary. Although the various assessments included in the functional assessment process may not always agree, when findings are not congruent, there must be effort to explain the differences and justify the final conclusions. The SFA for this individual contained no such effort.

#	Provision	Assessment of Status	Compliance
		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. Interviews with the Behavior Service director and other staff during the site visit, as well as the Facility Self-Assessment, revealed that the Facility was aware of the noted weaknesses in the SFA process. Action plans prepared by the Facility indicated that revisions to the SFA tools and procedures were to be implemented in June 2012. 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 identify the mental illness being experienced by the individual, as well as determine which undesired behaviors are primarily related to mental illness, which arise primarily due to learning and the environment, and which may reflect a combined origin of mental illness and the environment. It is crucial, therefore, that the behavior assessment process be sufficient to identify the interrelationships between the biological conditions, the environmental contingencies, and the behaviors that are displayed. Once identified, it is then possible for the psychologist or behavior analyst and psychiatrist to collaborate upon identifying the appropriate treatment targets, selecting the appropriate psychotropic and behavioral interventions, and developing a strategy for tracking the efficacy of the interventions. Many of the 18 individuals included in the sample of SFAs were diagnosed with a mental illness. It was not possible to identify exactly how many individuals, or the occurrence of specific disorders, as for many individuals the psychiatric diagnosis included in the SFA did not match the diagnosis included in the Psychiatric Evaluation. In addition, many of the records submitted by the Facility were lacking parts or the entirety of some documents. 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). At the time of the current site visit, a substantial drop was noted in the screening for psychopathology, emotional, and behavioral issues. This did not necessarily reflect a drop in the administration of the Reiss Screen. Rather, it could have reflected the failure	

#	Provision	Assessment of Status	Compliance
		to report or otherwise integrate an existing assessment into the SFA. It was noted often in the sample materials that the SFA did not include accurate information regarding psychiatric assessment and diagnosis. For example, the SFA listed Autism as the sole mental illness diagnosis for Individual #25. The Psychiatric Evaluation listed the following diagnoses for the same individual: "Bipolar disorder, PDD NOS, Mood disorder, history of Asperger's PDD, Rett's Disorder, and Impulse Control Disorder NOS." The implications for functional assessment and PBSP planning differ across these diagnoses. For example, there are certain characteristics of autism (such as presence of stereotyped behaviors and interests) that could lead to selecting different specific assessments than would be selected based on a diagnosis of bipolar disorder. Other elements of the SFA reflected slight improvements. Although missing documents could have easily masked additional examples, the available information suggested that elements reflecting successful integration of mental illness and operant behavior involved the isolated occurrences rather than a general improvement. • For Individual #25, a single behavior was described as a behavioral marker for a mental illness. Although this behavior was included in the anecdotal assessment, it was not included in the proposed functional hypotheses or the SFA summary.	

	5/2010	5/2011	5/2012
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	99%	40%
The assessment process included differentiation between learned and biologically based behaviors.	0%	0%	11%
Identification of behavioral indices of psychopathology	0%	0%	11%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	0%	40%

The assessment and treatment of mental illness in people with concomitant intellectual or developmental disabilities requires a carefully coordinated approach. In many cases, limited expressive communication skills or other aspects of the developmental or intellectual disability can mask symptoms of mental illness. In addition, undesired behaviors may reflect the symptoms of mental illness as well as learned responses to environmental stimuli. Finally, knowledge of the characteristics and symptomatology reflected in a specific diagnosis may make the process of identification of function and of potential reinforcers more efficient as it points toward specific directions. It is therefore

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>essential that the psychiatrist and behavior analyst work toward a common goal in a manner that allows their areas of expertise to complement each other.

Based upon available information, despite some noted progress, the Facility was not in substantial compliance with the Settlement Agreement.</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>Based upon the information presented in Provision K5, the functional assessments completed by the psychology staff were considerably improved over previous site visits. Minimal documentation in the record, however, reflected that intellectual, adaptive behavior, or mental illness assessments were current, accurate, or complete.</td><td>Noncompliance</td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.</td><td>At the time of the current site visit, the Facility reported that the person responsible for intellectual and adaptive testing was no longer employed by the Facility. There was no indication that any intellectual or adaptive assessments had been completed since the previous site visit. There were, however, other indications of progress. Documentation provided by the Facility revealed that 360 individuals (99%) had a Psychological Evaluation report in the record. Of those 360 individuals, 324 (89%) had a Psychological Evaluation report completed within the past year. None of these evaluation reports was shown to include current intellectual or adaptive assessment results, but the provision of Psychological Evaluation reports reflected progress.

Similarly, the Facility reported 17 recent admissions. Of the 17 people admitted, each was provided a Psychological Assessment within the specified timeframe. None of those reports, however, included current assessments of intelligence or adaptive behavior.

<table><tr><td></td><td>5/2010</td><td>5/2011</td><td>5/2012</td></tr><tr><td>Individual records demonstrate that these psychological assessments are conducted as often as needed, and at least annually, for each individual.</td><td>0%</td><td>0%</td><td>99%</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>0%</td><td>100%</td></tr></table>
The information obtained reflected progress by the Facility. Due to the lack of necessary testing, the Facility was not in Substantial Compliance with the Settlement Agreement.</td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>By six weeks of the assessment</td><td>At the time of the current site visit, the Facility reported that 16 individuals were</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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.	provided group and/or individual counseling services. For all individuals, however, the counseling services did not involve individual treatment plans and did not adhere to evidence-based practices. 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. Furthermore, counseling was not always considered in situations in which it might be appropriate. For Individual #511, the individual's mother stated that she believed many of the individual's behavioral barriers were as a result of a lack of coping skills related to the death of the individual's father. The IDT did not address the development of coping skills or grief counseling in the ISP.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	During the October 2011 site visit, documentation 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. As a result, Facility documentation did not consistently reflect that the review and consent process offered adequate protections for the individuals living at RSSLC. During the current site visit, material submitted for several of the 18 PBSPs in the review sample included a current consent form. Documentation for other PBSPs in the sample, however, did not include a consent form or were missing portions of the consent form. Furthermore, no Human Rights Committee reviews were included for many of the submitted PBSPs. It was therefore difficult to determine the actual status of the review and approval process. The Self-Assessment provided by the Facility during the current site visit reflected that no system was in place for tracking consents and approvals. Without tracking information from such a system, the ability of the Monitoring Team to assess consents and approvals was limited. Documentation provided by the Facility at the time of the current site visit reflected that every individual referred for a PBSP either had a formal intervention or was undergoing the assessment process for an intervention. Furthermore, a review of 18 of the most recently developed PBSPs revealed substantial improvements in the quality of those intervention plans. PBSP Element | 5/2010 | 5/2011 | 5/2012	Noncompliance

#	Provision	Assessment of Status	Compliance

Rationale for selection of the proposed intervention	0%	6%	60%
History of prior intervention strategies and outcomes	0%	0%	33%
Consideration of medical, psychiatric and healthcare issues	0%	6%	44%
Operational definitions of target behaviors	21%	28%	67%
Operational definitions of replacement behaviors	0%	17%	33%
Description of potential function(s) of behavior	0%	6%	89%
Use of positive reinforcement sufficient for strengthening desired behavior	0%	11%	22%
Strategies addressing setting event and motivating operation issues	8%	11%	67%
Strategies addressing antecedent issues	0%	11%	67%
Strategies that include the teaching of desired replacement behaviors	0%	11%	22%
Strategies to weaken undesired behavior	0%	6%	11%
Description of data collection procedures	0%	6%	0%
Baseline or comparison data	0%	11%	33%
Treatment expectations and timeframes written in objective, observable, and measureable terms	0%	6%	0%
Clear, simple, precise interventions for responding to the behavior when it occurs	0%	100%	11%
Plan, or considerations, to reduce intensity of intervention, if applicable	0%	0%	11%
Signature of individual responsible for developing the PBSP	0%	83%	89%

As with the SFAs, the review of the PBSPs suggested that improvement in the various elements of the PBSP did not reflect a growing sophistication on the part of the Behavior Service staff. This was especially apparent in the following areas.

Effective Use of Reinforcement. When attempting to strengthen pre-existing behaviors, it is important to understand the role of efficiency in the reinforcement process. Undesired behaviors often obtain reinforcement very efficiently, that is quickly, powerfully, and with the least necessary effort. To strengthen an existing behavior to take the place of an undesired behavior requires more than just delivering reinforcement. The reinforcement for the replacement behavior must be more efficient than for the undesired behavior. That is, the reinforcement for the replacement behavior must be more powerful, more quickly delivered, and require less effort than the reinforcement for the undesired

#	Provision	Assessment of Status	Compliance
		behavior. For example, if an individual receives a great deal of attention from several people for simply sitting in a chair and refusing to complete a work task, having one person tell the individual "Good job" for completing the task is not likely to substantially increase cooperation. If reinforcement for the replacement behavior is not more efficient, then the probability of altering the individual's behavior is substantially reduced. In behavior interventions, there must be efforts to make reinforcement for the replacement behavior more efficient than for the undesired behavior. For example, if the goal of an intervention was to teach a person to raise her hand rather than spit to get attention, the intervention would need to include steps to ensure that the person was given attention more quickly and more intensely for raising her hand than for spitting. This might involve having several people immediately offer attention to the individual when she raised her hand, but require 30 seconds of ignoring the individual after spitting. In the majority of PBSPs in the review sample, there was no indication that the intervention included steps for addressing reinforcer efficiency. Therefore, although the interventions may have been logically sound, procedurally they lacked the ability to change behavior. Replacement Behaviors. Several of the PBSPs in the sample included behaviors intended to replace the undesired behaviors. In many instances, it was unclear how these behaviors would effectively replace the undesired behavior, as they did not appear to share the same function as the undesired behavior. For example, the replacement behavior identified for Individual #265 was to make a choice between two objects. The identified function of the undesired behavior was "social" and "automatic". Therefore, although choice-making behavior is a valuable skill, it was unlikely to be used in the place of the undesired behavior regardless of the amount of reinforcement offered. It was also noted that the majority of PBSPs included a communication skill as a replacement for undesired behavior. In many instances, undesired behavior can involve a communicative purpose. That does not mean, however, that improvements in communication skills will always be the best form of replacement behavior. To better support the use of communication as a replacement behavior, it would be beneficial for the SFA and PBSP to more fully integrate the exploration of communication issues into the assessment process. Teaching Procedures. None of the PBSPs reviewed included a rigorous approach to teaching replacement behaviors. In the majority of PBSPs, the teaching strategies were very general. For example, for Individual #195, the teaching strategy included, "Encourage her to communicate when she wants or needs something." Although this practice could occasionally be helpful for a specific situation, it was unlikely to provide sufficient training to produce a long-term change in behavior.	

#	Provision	Assessment of Status	Compliance
		In other PBSPs, the teaching procedures were somewhat more sophisticated and resembled an outline for incidental teaching. Incidental teaching involves structuring and sequencing educational objectives and learning opportunities so that they occur within ongoing, typical activities and take advantage of an individual's interests and motivation. For example, a program to teach a person to communicate the desire to go outside might involve permitting 10 minute times outside and prompting the person to sign "Go" when he or she approached the door. While incidental teaching can effectively enhance skills, it would be difficult to use as a means to teach a replacement for an efficient undesired behavior. The Use of Data. Without data, it is not possible to represent changes in behavior or demonstrate the efficacy of an intervention strategy. The majority of PBSPs in the review sample, however, did not reflect the importance of data or reflect the detailed instruction necessary to ensure valid and reliable data. The majority of PBSPs referenced baseline data. Roughly, only one third of those PBSPs, however, reflected an appropriate understanding of baseline. Several PBSPs used data from more than two or three years prior to the SFA and PBSP as baseline, even though those data were likely recorded under different conditions and possessed only limited utility in assessing current behavior. For data to be relevant as baseline measures, they must be sufficiently recent and from conditions generally similar to those currently experienced by the individual. The majority of PBSPs included very sparse instructions for how to record current displays of target or replacement behaviors. In most cases, the PBSP instructed the person implementing the program to use the standard data form for recording behavior displays. Without instructions that were more precise, there was a greatly increased probability for unreliable and inadequate treatment data. Treatment Expectations. It is crucial to determining treatment efficacy that precise treatment expectations be included in the PBSP. In the majority of PBSPs in the sample, the criteria for successful intervention were included. For example, the PBSP for Individual #555 included as a definition of success that displays of aggression would drop to .05 incidents per day for three consecutive months by 7/1/2012. Such a definition or treatment expectation does not address the criteria for when an intervention is not successful. In many situations, even if a PBSP is effective, there are occasions in which the undesired behavior increases. An intervention must therefore include criteria that differentiate between general fluctuations in behavior and substantial increases that reflect a lack of success. For example, a PBSP might state that a review for lack of efficacy must be initiated if the target behavior increases more than	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>20% in any rolling 14-day period. None of the PBSPs reviewed at RSSLC included such failure criteria.

Despite the improvements in several elements of PBSPs, the specific limitations noted above suggested that PBSPs at RSSLC continued to lack the necessary sophistication and precision.</td><td></td></tr>
<tr><td>K10</td><td>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.</td><td>During all previous site visits to RSSLC, weaknesses in the presentation of treatment data were noted. Although modest efforts at revising data graphs were reported by the Facility in the past, none had proven generally effective.

At the time of the current site visit, no element of the data graphs reflected substantive improvement. Furthermore, some elements reflected a decline in proficiency. It should be noted, however, that documents provided by the Facility for the 18 individuals included in this sample frequently were lacking Psychology Progress Notes. When Progress Notes or other sources of data graphs were provided, the most recent graphs often predated the current site visit by several months. As a result, conclusions drawn from all materials must be viewed as preliminary.

When current data graphs were available, those graphs typically included data points and paths, as well as a clearly marked horizontal axis. None of the available graphs, however, included labels for the vertical axis. Typically, the label for the vertical axis describes the measure used and the behavior, such as the number of successful requests per day. Furthermore, none of the graphs included a mark or indication of changes in treatment or environmental conditions, so it was not clear when treatments or environment conditions changed and how those changes were related to changes in the behaviors graphed.

<table>
<tr><th>Graph Element</th><th>5/2010</th><th>5/2011</th><th>5/2012</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>0%</td><td>10%</td></tr>
<tr><td>Horizontal axis and label</td><td>8%</td><td>83%</td><td>50%</td></tr>
<tr><td>Vertical axis and label</td><td>8%</td><td>83%</td><td>0%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Data points and path</td><td>100%</td><td>78%</td><td>60%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Based upon the available information, the Facility had not made progress toward compliance with the Settlement Agreement in this section.	
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. 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 October 2010 and May 2011 site visits, the Facility reported that no changes had been made concerning 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 to be implemented, there was no indication in October 2011 that changes had been implemented in the staff training process. At the time of the current site visit, the Facility Self-Assessment, as well as comments by Behavior Services staff, reflected that no system was in place to track staff training, data reliability or treatment integrity. Interviews with approximately 30 DCP staff produced numerous comments that PBSPs were easy to understand and were consistently implemented. Observations conducted in several residences and program areas did not reveal any circumstances in which a PBSP was implemented to address an undesired or challenging behavior.	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 six staff members who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 61 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 19 individuals residing at the facility. RSSLC currently employed nine 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 is not demonstrably competent in applied behavior analysis. (K1, K3, K4)

2. The Facility should review the consent and approval practices for behavior interventions and take the steps necessary to ensure that consents and approvals are accurate and adhere to mandatory timeframes, allow for prompt implementation of behavior intervention, and ensure that the information needed for informed consent is provided. (K9)
3. 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)
4. 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)
5. 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)
6. 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)
7. 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)
8. 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. (K1, K12)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. Facility presentation book, May 2012 4. RSSLC Medical Services Policy 100a 1/21/12 5. RSSLC Individuals Immunization Policy, dated 8/2/2010 6. RSSLC DSM and ICD medical and psychiatric diagnosis update policy (no policy number) 12/12/12 7. RSSLC Chronic clinical indicator policy I.31 10/12/11 8. RSSLC Administration, Actions Following Death of Individual Served, A.7, Policy, Revised: 1/5/11 9. RSSLC Clinical Death Review Committee Minutes 10. RSSLC Administrative Death Committee Minutes 11. RSSLC Unusual Incident Investigation-Incident Tracking Numbers: 12-109, 2/10/12; 12-075, 1/2/12; 10-047, 11/13/11; 12-113, 2/19/12; and 012-119, 3/3/12 12. RSSLC Death Review Investigation – Nursing Services for Individuals #385, #150, #233, #134, and #283 13. RSSLC Physicians' Death/Discharge Summaries for Individuals #385, #150, #233, #134, and #283 14. RSSLC Death Review Recommendations and Follow-ups for Individuals #385, #150, #233, #134, and #283 15. Clinical records of Individuals #142, #300, #544, #256, #398, #251, #248, #555, #726, #81, #227, #468, #448, #678, #426, #185, #173, #727, #133, #284, #265, #559, and #379 16. Randomly generated list of 20 male individuals, 50 years old and older, along with copies of their PSA results 17. Randomly generated list of 20 individuals, 50 years and older, along with copies of their most recent colonoscopy 18. Randomly generated list of 20 female individuals over the age of 40 years old, along with copies of their most recent mammogram 19. List of all persons who sustained a fracture during the previous six months 20. X-ray, and consultation reports, along with follow-up integrated progress notes (IPN), and individual service plan (ISP), specific for hip fracture, for Individual #542 21. Current copy of the collaborative practice agreements for the advanced nurse practitioners at the Facility 22. Copy of physicians' and nurse practitioners' continuing medical education (CME) certificates for CME achieved during the past six months 23. List of all support staff assigned to medical services 24. List of all individuals with seizure disorder 25. List of all individuals who were prescribed three or more anticonvulsants 26. Lists of all individuals prescribed Felbamate, phenobarbital, Dilantin, and Primidone 27. List of all individuals who experienced status epilepticus during the previous six months, along with copies of their annual medical summary, neurology consultation reports for past six months, ISP, and medication list

	28. List of all individuals who have an implantable vagal nerve stimulator (VNS) 29. List of all individuals who were diagnosed with pneumonia 30. List, and all related hospital records, progress notes, nurse liaison notes, and IDT reports for individuals who were hospitalized for pneumonia 31. Provider audit scores for round 4, external clinician audits 32. Provider audit scores for round 5, internal and external clinician audits 33. Quality assessment (QA) action plan follow-up for the internal and external audits for round 5 34. Copies of the medical management assessment tools for clinician audits 35. Copy of date base report for diabetes 36. Copy of date base report for osteoporosis 37. Copy of medical follow up database and associate report, policy and QA report 38. At risk policy, local policy I.08, dated 5/11/12 39. Blank copy of the annual medical summary **People Interviewed:** 1. Tran Quan, DO Medical Director 2. Robyn Partridge, BSN, RN, Quality Assurance Nurse **Meeting Attended/Observations:** 1. Observation of individuals #142, #300, #544, #256, 398, #251, #555, and #448 2. Observation of individuals at the living areas Trinity, Leon, and Neches 3. Integrated Clinical Meeting 5/16/12
	Facility Self-Assessment: The Facility provided a well-organized self-assessment that enabled the Monitoring Team to assess all new and updated initiatives. The Facility determined itself to be non-compliant in Provisions L1, L2, and L4, and substantially compliant with Provision L3. The Monitoring Team concurred with the Facility's determination of noncompliance with Provision L1, L2, and L4, but disagrees with its finding of substantial compliance with Provision L3. For Provision L1, the Facility listed seven action steps that it completed, and indicated that it was not in compliance because additional procedures need to be developed to enhance clinical practice. The Monitoring Team concurs with the seven steps taken by the Facility; however, there are many other areas that require improvement, such as appropriately developing comprehensive medical action plans in the annual medical summary, ensuring that all diagnosis are adequately reflected on the active problem list, making sure that all acute medical conditions are followed through to full resolution by the clinician, and ensuring that all chronic conditions are appropriately assessed, and managed. For Provision L2, the Facility reported that it completed its first internal medical audit, and participated in round four and five of the medical external audits, and found itself not to be in compliance because the process is in its early phase, and has yet to demonstrate that the process appropriately evaluates the clinician's medical skill. In addition to the medical audits, the Facility must identify other sources at the Facility that provide insight into the practice performance of its clinicians, such as enhancing the mortality review process.

	The Facility self reported substantial compliance for Provision L3, stating that its newly developed diabetic database and medical follow up database satisfactorily met the requirements for the Provision. Although the Monitoring Team is complimentary, and fully supportive of these initiatives, having only one clinical indicator does not satisfy the requirement for Provision L3. The Facility must have a robust quality assurance process that tracks many core indicators, and must have a comprehensive quality assurance committee that addresses deficiencies, develops corrective action plans, and follows up to ensure that action plans were completed and efficacious. The Facility determined itself to be noncompliant with Provision L4 because it was unable to determine efficacy of its current policies. While it is important, and necessary for the Facility to determine efficacy of its policies, the Facility must remember that it has several policies that have not been fully implemented, such as the policy for the osteoporosis database. The Monitoring Team concurred with the self-assessment of noncompliance.
	Summary of Monitor's Assessment: Medical services continues to make significant improvements, and progress towards compliance. The Facility had developed many progressive initiatives, such as an electronic database to track, and trend core clinical indicators. Physicians had also demonstrated marked improvement with documentation, and follow-up on acute medical conditions. The Facility must continue such efforts, and ensure more assertive assessment of chronic medical conditions. **Provision L1:** It was most obvious that there was overall improvement with provision of medical services at the Facility. Clinicians were more promptly and comprehensively following up on reported acute medical problems, and annual medical assessments were much more comprehensive. Follow-up to diagnostic studies and consultation reports was also an area of marked improvements. The clinical management of acute seizures was noted to be good. Documentation practice was also an area of improvement. Despite its progress, the Monitoring Team agreed with the Facility, and determined noncompliance for Provision L1. Compliance will require continued progress in areas of following up on acute medical problems through full resolution; and more assertive evaluation and management of chronic conditions, especially neuromotor, musculoskeletal, clinical management of syndromal conditions, aspiration, and aspiration pneumonia. Clinicians must better participate in the IDT process, and ensure that the IDT is well aware of all medical issues; that the health risk assessments include all clinical issues that pose, or potentially pose, risk to the individual; that all Facility clinicians work collaboratively, and their assessment be reviewed, and incorporated into the overall assessment by physicians, and nurse practitioners. **Provision L2:** Following its review of Provision L2, the Monitoring Team concurs with the Facility, and determined noncompliance. The Facility must enhance its internal, and external audit process by ensuring that at least some of the clinical records provided for the external auditors are not previously assessed through the internal audit process or prescreened by the Facility; enhance the quality, and quantity, of the core indicators used for the medical management audit; and ensure that the work being assessed through

	the audit process is the work completed by the clinician of record, and not other clinicians. Also, the Mortality review process must be more comprehensive and include a review of all potential causes of death, all system issues, and care provided by all disciplines. **Provision L3:** The Facility had taken a progressive approach to developing a medical quality assurance process at the Facility. The development of core indicator databases for diabetes, and osteoporosis will enable close monitoring of these conditions, and improved outcomes, if fully implemented. The Medical follow-up database is also another progressive approach to ensuring that diagnostic tests and consultations are tracked through completion, and that appropriate action plans are developed. The Monitoring Team was impressed with, and complimentary of, these new processes. Following its review, the Monitoring Team disagrees with with the Facility self-assessment of substantial compliance, and determined noncompliance for Provision L3. Compliance will require full implementation of the current databases; development of additional core indicator databases for common, significant medical conditions that occur in individuals with intellectual disabilities; ensure that there is a meaningful committee to report on QA outcomes; that process improvement recommendations are tracked for completion and efficacy; and incorporate QA outcomes from the external and internal clinician audits into the medical QA process. **Provision L4:** The Monitoring Team compliments the Facility for its continued development of process improvement initiatives, and the necessary policies, and procedures required to implement these new processes. Much improvement has been noted, especially in the area of documenting on the annual medical summary, and the implementation of the chronic care policy. Although much improvement was noted, the Monitoring Team agrees with the Facility and determined that the Facility is noncompliant with Provision L4. Compliance will require full implementation, and adherence to its policies.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a	Provision L1 is a broad topic that requires the Facility to ensure efficacious provision of medical services. To assess medical practice at the Facility, the Monitoring Team reviewed clinical records, requested medical related documents, observed individuals at their living areas and day programs, and discussed medical services with the Facility's medical director. Specific areas addressed by the Monitoring Team included clinical staffing, acute and chronic medical conditions, preventative health, follow-up to hospitalizations, and physician documentation practice <u>Clinical Staffing</u> To assess appropriate clinician staffing at the Facility, the Monitoring Team reviewed the staffing of physicians, and nurse practitioners, continuing medical education (CME) that was completed since the last compliance visit, current CPR certifications for clinicians, copies of nurse practitioners' practice agreements, and clerical support staffing for medical services.	Noncompliance

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	separate monitoring plan.	Clinician Staffing: At the time of this review, the Facility maintained four full time primary care physicians, and two, advanced practice nurse practitioners. CME: All clinicians participated in CME events during the previous six months. All were specific to routine primary care and pharmacological issues. There were no CME events noted specific to issues related to disabilities, such as evaluation and management of neuromotor conditions, spasticity, contractures, chronic constipation, or aspiration pneumonia. Nurse Practitioner Practice Agreement Review: The collaborative practice agreement/practice protocol for nurse practitioners and other advanced practice registered nurse in Texas were reviewed for the two advanced nurse practitioners at the Facility. The agreements were noted to be complete and current. The medical director informed the Monitoring Team that she had registered the nurse practitioners with the Texas Board of Medicine, under her license. Support Staff for Medical Services: The Facility provides one full clerical support, and one full time medical compliance coordinating / system analyst. The medical coordinator is providing valuable service in helping to develop strategies, and follow up to systems issues related to medical services. Summary: The Monitoring Team noted sufficient physician staff, and compliments the Facility on developing the medical compliance coordinator/systems analyst position. The Facility did not provide educational experiences for issues related to developmental disabilities, and should develop a process to help clinicians develop expertise in the area of developmental medicine, such as evaluation, and treatment of chronic constipation, spasticity, contractures, and aspiration pneumonia. <u>Physician Documentation And Assessment Of Acute Medical Issues:</u> While reviewing clinical records, the Monitoring Team noted that clinicians have significantly improved their documentation practice. Of the following clinical records reviewed (Individuals #142, #300, #544, #256, #398, #251, #248, #555, #726, #81, #227, #468, #678, #426, #185, #173, #727, #133, #284 and #448), 20 out of 20 (100%) of acute medical issues occurring during this reporting period noted by the Monitoring Team demonstrated a dictated note in SOAP format, and that an acute clinical issue was promptly and appropriately triaged by the clinician. The Monitoring Team did not identify any examples whe$_{\text{n the}}$ clinician documented follow-up through resolution of an acute clinical issue. Importantly, the documentation process did not dictate the time of the dictation (time stamp), which is an essential component of medical dictation. Of particular concern was the overall lack of a well integrated approach to clinical care at	

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		the Facility. Clinical records, and requested documentation, did not provide evidence that physicians are commenting on or integrating other Facility clinicians' assessments, and serious medical conditions were not routinely and comprehensively integrated through the IDT process. Summary: Clinicians are appropriately following up on reported acute medical conditions, and documenting is SOAP format. Documentation demonstrating clinician follow through resolution of acute medical conditions remains deficient. The dictation services did not provide a time stamp of when the clinicians dictated their notes. The Monitoring Team has significant concern over the continued lack of integration of health care issues into the IDT process. <u>Hospitalizations:</u> As a part of the Monitoring Team's review of pneumonia, the Facility's process for hospitalizations was assessed by reviewing the records of individuals who were hospitalized, secondary to pneumonia, during the reporting period (Individuals #603, #515, #30, and #402). Of the four cases reviewed, three out of four (75%) included a post hospital note by the physician that included a physical examination; four out of four (100%) included a post hospital nursing assessment; three out of four (75%) included a comprehensive IPN, specific to the hospitalization; zero of four (0%) included a hospital admission and discharge summary; and one out of four (25%) included a hospital transfer report completed by the clinician. <u>Preventive Health</u> To assess the Facility's ability to provide preventive health services, the Monitoring Team assessed current immunization practices, and its practices for screening mammography, colonoscopy and prostate specific antigen (PSA). As part of preventive health maintenance specific to individuals with syndromal conditions, the Monitoring Team reviewed the clinical records of five randomly generated individuals who had a diagnosis of Down syndrome. Prostate Cancer Screening by Prostate Specific Antigen: The Facility provided the Monitoring Team with a randomly generated list of men who were 50 years old, and older, along with a copy of their most recent PSA result. Of the 20 examples provided, 20 out of 20 (100%) examples had a current PSA evaluation. The Monitoring Team is aware that new standard of care guidelines for prostate screening have been introduced, that a physician clearly discuss the risk and benefits of obtaining a PSA, prior to obtaining a PSA for prostate cancer screening. The	

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		Monitoring Team did not find evidence of an IDT discussing the risks, and benefits of obtaining screening PSAs. Colon Cancer Screening by Colonoscopy: The Monitoring Team requested a randomly generated list of 20 individuals aged 50, and older, along with copies of their most recent colonoscopy, or documented evidence indicating why a screening colonoscopy was not obtained. Of the 20 examples reviewed 19 of 20 (95%), demonstrated having had a screening colonoscopy, or documentation indicating why the colonoscopy was not provided. Female Breast Cancer Screening by Mammography: The Monitoring Team requested a randomly generated list of 20 female individuals over the age of 40 years old, along with copies of their most recent mammogram, or documented evidence why a screening mammogram was not obtained. Of the 20 examples reviewed 13, of 20 (65%) demonstrated evidence of an annual breast screening mammogram, or appropriate documentation indicating why the mammogram was not completed. Immunizations: The Monitoring Team requested a randomly generated list of 20 individuals, along with copies of their audiology and vision screening reports, and immunization records. Of the examples provided 20 out of 20 (100%) demonstrated evidence of having a current vision screening; 18 out of 20 (90%) demonstrated evidence of having a current hearing screening; 20 out of 20 (100%) demonstrated evidence of annual influenza immunization; 14 out of 20 (70%) demonstrated documentation of having MMR immunization; and six out of 20 (30%) demonstrated having had a Tdap booster. The Facility's current policy on immunization practice, Individuals Immunization Policy, dated 8/2/2010, did not comment on the importance or practice to ensure that individuals are provided a Tdap booster. Because of emergence of pertussis, it is essential that individuals are provided Tdap booster, per Center for Disease Control (CDC) guidelines, unless medically contraindicated. <u>Down Syndrome:</u> To evaluate the Facility's ability to regularly assess common conditions known to occur in individuals who have congenital syndromes, the Monitoring Team reviewed the clinical records of five Individuals (#142, #300, #544, #256, and #448) who were known to have Down syndrome. The clinical records were selected by the Monitoring Team,	

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		from a list of all individuals who have Down syndrome, and reside at the Facility. Of the five cases, four out of five (80%) had an annual TSH, and when necessary, the abnormal TSH values were appropriately addressed by the clinician; one out of five (20%) was assessed for degenerative joint disease of the hips; and zero out of five (0%) were regularly assessed for degenerative spine disease; two out of five (40%),] demonstrated evidence of regular assessment, and when necessary, had appropriate treatment of hematological conditions; two out of five (40%), demonstrated appropriate assessment, and follow-up, for cardiac conditions; and zero out of five (0%) demonstrated a regular assessment for cognitive decline. The Monitoring Team determined that individuals with Down syndrome were not regularly assessed for common, and serious conditions that are known to occur in Down syndrome. Hematological conditions, such as myelodysplastic syndrome, congenital and acquired musculoskeletal issues, and cardiac and thyroid problems are all common and serious issues that occur in individuals with Down syndrome. The following are examples of some of the concerns, related to Down syndrome, noted by the Monitoring Team: Individual #142: The individual was noted to have serious degenerative spine disease and subluxation of the spine, which are serious medical conditions that must be assertively followed up on. The individual was sent to a rheumatologist for evaluation of these conditions, who in turn recommended follow-up with a surgeon, on 2/10/12. As of the date of this review, the Individual had not been scheduled to follow-up with a surgeon. The health risk screening did not address the importance of these orthopedic conditions. The Monitoring Team has concern over the lack of urgency with regard to this serious issue. Individual #300: The Individual was noted to have severe, bilateral degenerative joint disease of the hips, and progressive worsening of spine disease. The clinical record indicated that the Individual was evaluated in the past by an orthopedic surgeon, specific to the hip condition, who recommended conservative treatment, unless the IDT considered bilateral hip replacement. There was no meaningful documentation demonstrating that this issue was addressed by the team, and the Individual was not provided with hip replacement. Importantly, the Individual was not followed by the primary care physician assertively for this issue. In addition, the individual was noted on a x-ray of the spine, dated 10/12/10, as having "progressive worsening" of the cervical spine, and there was no evidence demonstrating appropriate consultation with specialists, or assertive follow-up by the clinician. Both conditions are known to cause significant pain, and although the Individual has	

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		been provided standard dose of Motrin, twice per day, there were no regular measures to assess pain on a daily basis. The Monitoring Team has serious concern over the management of both conditions, and would expect more assertive monitoring by the clinician, periodic diagnostics to assess worsening, and follow-up by specialists. The IDT process, and the ISP did not adequately address these conditions. The health risk screening did not address the importance of these orthopedic conditions. Individual #544: The Individual was noted to have a cardiac condition and anemia that required regular assessment. The individual had an echocardiogram on 1/6/10, which demonstrated borderline mitral valve prolapse, mild mitral and tricuspid valve regurgitation, and inadequate flow Doppler results. The most recent EKG, dated 12/09, indicated "borderline EKG". There was no further follow-up, or assessments completed for these conditions. Also, the annual medical summary, dated 12/12/11, stated that echocardiogram demonstrated normal ventricular function, but did not comment on the valve disease. The individual had a spine x-ray to rule out subluxation on 9/08 that demonstrated mild degenerative joint disease. Both conditions should be regularly assessed, and pain should be regularly assessed. The health risk screening did not address the importance of these orthopedic conditions. A review of current laboratory studies indicated that the Individual had mild macrocytic anemia with normal B12 and folate levels, and no further assessments or comments were noted about this condition. Individuals with Down Syndrome are predisposed to myelodysplastic syndromes, that can manifest this clinical profile. The Monitoring Team would expect that macrocytic anemia be further evaluated in Individuals with Down Syndrome. Individual #256: The Individual was noted to have a diagnosis of degenerative joint disease of the hip, and spine, as well as subluxation of cervical spine. In 2008, an orthopedic surgeon recommended surgery; however, it was reported that the legally authorized representative (LAR) declined a surgical option. There was no further evaluation completed by the Facility since 2008, and there was no regular schedule to assess pain. Importantly, the ISP did not delineate potential risks associated with these conditions. An x-ray of the hips, dated 7/19/10 demonstrated bilateral hip arthritis, and there was no evidence of follow-up consultation with an orthopedic surgeon.	

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		The health risk screening did not address the importance of these orthopedic conditions. An abnormal TSH (thyroid study) was noted on 2/29/12, and was not commented on in the IPN or on the laboratory form. At the time of this review, a follow-up TSH was not noted to be in the clinical record. Individual #448: The Individual was noted to have congenital heart disease and was followed up by a cardiologist on January 23, 2012. The cardiologist recommended that the individual was to have the pacemaker assessed by February, 2012. Because of a hospitalization, the individual did not have the pacemaker assessed in February, and there was no indication that the pacemaker had been assessed at the time of this review, as there were no orders written, reports identified, or IPN written to support that the pacemaker was assessed. After discussion with the medical director, it was learned that the individual did have the pacemaker assessed on 5/10/12. The Monitoring Team is concerned over the lack of clinical documentation, scheduling, and follow-up of diagnostics, and timely filing of medical records. On 2/16/12, the Individual had an x-ray of the spine that demonstrated multilevel degenerative changes and osteophyte formation with disc space narrowing, indicating degenerative spine disease. There was no follow-up documented for this condition, and no indication that pain is being assessed at least daily. Summary: In general, the Facility provided routine vision, and hearing assessments timely; ensured that annual immunizations were completed when appropriate; and ensured that routine cancer screening for colon and prostate cancer was provided as necessary. The Facility did not provide appropriate documentation indicating why mammographies were not provided. The Facility must update its policy and practice with regards to CDC recommendations for Tdap, and also ensure that all individuals are current with MMR immunization, per CDC recommendations. It was most evident that the Facility did not have a systematic approach that ensured individuals with congenital syndromes were appropriately and regularly assessed for routine health care issues. <u>Chronic And Acute Conditions</u> To assess the provision of medical services in the area of acute, and chronic conditions, the Monitoring Team conducted comprehensive reviews of clinical records, and assessed clinical management of seizure disorder, osteoporosis, pneumonia, fractures, and cerebral palsy. To assess the Facility's ability to provide comprehensive routine medical care of chronic conditions, the Monitoring Team randomly selected the clinical records of eight individuals to review (Individuals #398, #251, #555, #726, #81, #227, #248, and #468).	

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		Individual #468: The clinical record was assessed to ensure that the clinical impression and plan were appropriately documented. Review indicated that all components of the assessment were documented appropriately. Follow-up to acute issues was noted, and the integrated progress notes (IPN) were well documented. For example, follow-up to seizures on 3/31/12, and 4/9/12 demonstrated a clear understanding of the clinical issues, and provided a good assessment and plan. Individual #227: The clinical record was assessed to ensure that the individual's history of brain cancer was delineated and assessed in the most recent annual summary. The physician clearly noted the history of brain cancer, and also included the issue within the clinical assessment. Overall, the annual assessment was completed appropriately and provided a clear understanding of the individual's clinical issues. Individual #81: The clinical record was assessed to evaluate the follow-up of a history of breast cancer. The annual medical summary, dated 2/5/12, demonstrated that a physical exam of completed by the physician, noted that recent mammogram was obtained and was normal, and outlined in the plan that the individual had a history of breast cancer and that appropriate assessments would be provided. The clinical follow-up to breast cancer was clinically appropriate. Upon reviewing the record, it was noted that the individual had an elevated prolactin level, and the clinician documented that the elevated level was most probably due to a medication, and no further comment or evaluation was completed. The Monitoring Team concurs that the etiology of the elevated prolactin level was probably medication related; however, further comment on how this condition may be complicating osteoporosis, and that there was a need to monitor the level further, would be expected. The Individual was noted to have anemia. The work-up performed by the clinician was incomplete, as there was no evidence to support that a vitamin B12, peripheral smear, heptoglobin or reticulocyte count, was done. Such tests should be completed as part of a work-up for anemia. Individual #726: The clinical record was assessed to evaluate if the individual's history of skin cancer was closely followed up on. The Individual was noted to have had basal cell carcinoma of his cheek in the remote past. The annual medical assessment did not indicate when the carcinoma was diagnosed, or treated. The documented physical exam did not demonstrate that a complete assessment of the skin was performed by the clinician, as is recommended by the American Cancer Society, and the National Cancer Institute. There were no specific recommendations listed in the plan to ensure that protective measures were taken, such as the use of sunscreen, hat, and long sleeve shirt.	

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		Individual #555: The clinical record was reviewed to assess follow-up for prolonged QT interval, which is a electrical conduction problem of the heart. It was noted that a cardiology consultation was completed on 12/13/11 that recommended a follow-up echo to be completed. As of this review, the echocardiogram had not been ordered. A quarterly drug regimen review (QDRR), dated 2/28/12, indicated a concern regarding the QT interval, and that a baseline EKG should be done, and the clinician agreed that the EKG would be obtained; however, there was no follow-up EKG identified in the clinical record. Individual #248: The clinical record was reviewed to assess follow-up for prolonged QT interval. The annual medical assessment, dated 7/26/11 indicated a diagnosis of bradycardia and prolonged QT interval syndrome; however, there was no clinical follow-up documented in the clinical plan. An EKG result, dated 2/21/12, was signed and in the clinical record, and indicated a critically low heart rate of 39 beats per minute. There was no comment in the IPNs, and no medical orders for follow-up or treatment of this condition were noted. The Monitoring Team notified the medical director of this condition; the clinician was to address the issue. In addition, the individual was noted to have a diagnosis of anemia on the annual medical summary, dated 7/26/11, which indicated "workup in progress". The anemia was determined to be from iron deficiency, and the individual was noted to have blood in the stool, indicated a gastrointestinal bleed. At the time of this review, the condition was not fully evaluated. Individual #398: The Individual was observed by the Monitoring Team at the living area, while being provided physical therapy by physical therapy aides. The Monitoring Team assessed that the Individual was in severe distress during the treatment. The physical therapy aides were following treatment protocol, with the intent to assist the Individual to recover from deconditioning, secondary to a prolonged hospitalization. Following review of the clinical record, it was noted that the Individual was seen in 1996 by an orthopedic specialist, who recommended "regular follow-up" for "vast degenerative arthritis changes" of the spine. There was no regular follow-up noted in the clinical record. An x-ray of the spine, dated 7/14/10 demonstrated severe arthritis of the spine, and also subluxation of the lower spine, and these conditions were not further evaluated. The most recent annual medical summary dated 11/1/11 did not comment on the severe degenerative spine disease, and the health risk screening did not address the importance	

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		of these orthopedic conditions, nor was this condition documented in the ISP. The Monitoring Team is very concerned over the lack of medical follow-up on the degenerative spine disease, and that the condition was not fully evaluated prior to initiating an assertive physical therapy program. Importantly, whenever an Individual demonstrates signs, or symptoms of significant pain or discomfort, the individual and physical therapy to be provided should be reassessed before continuing. Individual #251: The Individual was observed by the Monitoring Team at the day training program, and was noted to have severe lesions of the skin. Review of the clinical record indicated that the Individual was diagnosed with a form of dermatitis. The Individual was last seen by dermatology on 8/8/11, and was to return for follow-up by February, 2012. At the time of this review, the Individual had not followed up with dermatology. The annual medical summary dated 2/22/12, indicated that the individual had "no rashes or urticarial" and no scalp lesions. The lesions noted by the Monitoring Team, and documented by the dermatologist on 8/8/11, were chronic lesions. Because of active oozing, and crusting of the lesions, the Monitoring Team was concerned because the issue was not assessed by nursing or reported to the physician for acute exacerbation. The Monitoring Team was also concerned over the lack of follow-up with dermatology. Summary: Following a comprehensive review of the clinical records, to assess the provision of medical services of individuals #398, #251, #555, #726, #81, #227, #248, #468, it was noted that six out of eight examples demonstrated lack of assertive medical management meeting standard of care practice. The Monitoring Team is concerned with the over lack of follow-up, and assertive management of serious medical conditions by the primary clinician. <u>Fractures</u> The Monitoring Team reviewed all fractures that occurred at the Facility during the past six months, and assessed the clinical evaluation and follow-up by the clinician of all individuals who experienced a long-bone, hip or skull fracture. During the past six months, a total of eight individuals sustained a fracture injury. One individual sustained a trans-cervical fracture of the hip; two individuals sustained a fracture of a finger; one individual sustained a fracture of the toe; two individuals sustained a fracture of the ankle; and two individuals sustained rib fractures. The following is a review of medical care for Individual #542, who sustained the hip fracture: Individual #542 sustained a serious fracture of the hip, and required orthopedic surgery, with artificial hip replacement. Review of all related IPNs, relevant x-rays, hospital	

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		reports, IDT minutes, and hospital liaison documentation, indicated that the primary clinician immediately assessed the individual upon notification of the Individual's injury, and appropriately triaged the Individual to the local emergency room. Appropriate post hospital follow-up consultations and imaging studies were obtained. The Hospital Liaison nurse assessed, and reported on the Individual throughout hospitalization. The Individual was provided with post hospital physical therapy at the Facility. Following the primary clinician's initial assessment, there was no indication that the clinician evaluated or followed up on the individual post operatively upon return to the Facility. There was no documentation by the physician that he/she assessed the individual through resolution of the post surgical healing process. Summary: The Monitoring Team is concerned with the lack of the primary care physician's involvement with post fracture follow-up. <u>Evaluation And Management Of Cerebral Palsy</u> The Monitoring Team recognizes that neuromotor conditions, such as cerebral palsy (CP), and its clinical manifestations, are common and serious conditions, and are known to progress throughout lifetime, result in worsening morbidity, early mortality, and pain. To assess the Facility's ability to evaluate, and manage neuromotor conditions at the Facility, the Monitoring Team reviewed the clinical records of five Individuals, who were randomly chosen from a list of all Individuals known to have CP. The following is an overview of some of the serious issues identified during the review: Individual #212: The Individual was known to have CP, with severe spasticity, and contractures, and a history of spinal fusion with Harrington rod placement, and degenerative hip disease. The annual medical summary, dated 4/16/12, did not demonstrate that a comprehensive evaluation for an individual with CP was completed, and did not indicate that an assertive medical plan had been developed specific for CP, follow-up to Harrington rod placement, and hip disease. There was no specific plan on how to routinely monitor this Individual for pain, which can be a manifestation of her severe neuromotor and musculoskeletal condition. Individual #477: Individual #447 was known to have CP with spasticity, scoliosis, and congenital hip dysplasia, and was prescribed Baclofen. The annual medical summary did not comment on the need to assess for possible pain, did not address the Individual's congenital hip dysplasia, did not evaluate the efficacy of Baclofen, and there were no consultations or imagine studies to support assertive management of these serious conditions. Individual #635: This Individual was known to have CP with spasticity, and was	

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		evaluated by an orthopedic surgeon in 2010, at the request of the Individual's LAR. The orthopedic surgeon recommended follow-up for scoliosis in 2013.The annual medical summary, dated 8/23/11, did not demonstrate an assertive musculoskeletal examination, and the assessment did not list CP and spasticity as an active condition. Although a plan was developed for scoliosis, there was no plan to address spasticity. The ISP, dated 9/19/11 did not list recommendations by physical therapy/occupational therapy (PT/OT) specific for scoliosis or CP. The Individual's LAR requested an x-ray of the spine because of worsening posture. X-rays noted Harrington rods placement, which were not documented on the annual medical summary. X-ray of the spine, dated 4/13/12, indicated that the individual had degenerative changes of the spine, and dysplasia of the left hip; neither of these chronic conditions were delineated in the annual medical summary. There was no mention in the annual medical summary, or ISP, for the need to routinely assess for functional decline and pain. Individual #185: The Individual was known to have CP with spasticity. The physical examination component of the annual medical summary, dated 12/30/11, indicated severe contractures, and spasticity, but did not provide an adequate assessment, such as motor strength and reflexes. The medical assessment did not list severe contractures as an active problem, and there was no comment on the efficacy of Baclofen. Although the medical plan indicated that the Individual received Botox injections by a neurology consultation clinic, this issue was not documented within the body of the annual medical summary. There was no mention in the annual medical summary, or ISP, for the need to routinely assess for functional decline and pain. Individual #765: Individual #765 was diagnosed with CP with spasticity and the annual medical summary, dated 2/8/12 did not reflect an assertive physical exam of the musculoskeletal system, and the neurologic examination did not clearly delineate the extent of motor, sensory function, or range of motion, except by indicating that the individual had extreme contractures of the upper extremity. Importantly, the summary did not demonstrate assessment of Baclofen efficacy. The active problem list did not list severe contractures as an active medical problem. The medical action plan commented that the Individual was provided botulism injections for contractures, and that the injections did not provide benefit. The severe contractures were not further referred, or evaluated by orthopedics, and there was no mention in the annual medical summary, or ISP, for the need to routinely assess for functional decline and pain. Summary: In five of the five examples reviewed, the Monitoring Team noted lack of assertive evaluation and management of CP, and its associated manifestations, including degenerative hip and spine disease, as well as spasticity, and contractures. There was no systematic approach to ensure that pain and functional decline was assessed, long-term.	

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		Management Of Seizure Disorder The Monitoring Team recognizes that seizure disorder is a common medical condition for individuals with intellectual disabilities, and in many cases can be refractory to treatment, and result in early mortality. Since older anticonvulsants are known to contribute to worsening cognitive function, and sedation, there is a trend to reduce anticonvulsant polypharmacy, and decrease the use of older anticonvulsants, when clinically appropriate, and with full agreement by the LAR. The following is a review of the Facility's use of older anticonvulsants, and its use of new technology to treat certain refractory seizure disorder, neurology consultations, and evaluation and management of status epilepticus: Anticonvulsant Use at the Facility: The Facility reports that 137 of the individuals who reside at the Facility have a seizure disorder. Of the 137 individuals with a seizure disorder, 32 (23%) were prescribed anticonvulsant polypharmacy; 34 (25%) were prescribed Dilantin; 20 (15%) were prescribed phenobarbital; three (2%) were prescribed Primidone; and only one (0.7%) was prescribed Felbamate. Impressively, 11 (8%) had an implanted vagal nerve stimulator. Neurology Consultations: From a list of all individuals with a diagnosis of seizure disorder, the first ten cases (Individuals #678, #426, #185, #173, #727, #133, #284, #265, #559, and #379) were chosen by by the Monitoring Team, and their clinical records were reviewed to ensure that regularly scheduled neurology consultations were provided. Of the examples reviewed ten out of ten (100%), demonstrated that a neurologist evaluated the individuals during the previous six-month period. Status Epilepticus: The Facility reported a total of three individuals who experienced a status epilepticus during the previous six months (individuals #685, #99, and #500). The following are observation following review of the clinical records: Individual #99: Individual #99 experienced several episodes of status epilepticus, and was noted to have toxic blood levels of Dilantin. Review of the clinical records indicated that the individual received prompt identification and treatment for status epilepticus, appropriate treatment, and follow-up for Dilantin therapy, and the Individual was seen by a consulting neurologist regularly, and as needed. The Individual was noted to have a toxic Dilantin level that resulted in an emergency room admission, during the current monitoring period. Individual #500: Individual #500 has a vagal nerve stimulator implanted. During the previous six months, the Individual experienced two episodes of status epilepticus.	

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		Review of the clinical records indicated prompt identification and treatment for status epilepticus, and appropriate follow-up by a consulting neurologist. The Individual was noted to have experienced an episode of subtherapeutic Dilantin levels, prior to the status epilepticus. Individual #685: The Individual experienced two episodes of status epilepticus during the previous six months. Review of the clinical record indicated prompt identification, and treatment for status epilepticus, and appropriate follow-up by a consulting neurologist. The Individual was noted to have experienced Dilantin toxicity during the current monitoring period. Summary: The Facility provides robust neurology services by offering regularly scheduled neurology consultations, and it assertively manages reported cases of status epilepticus. Of three cases reviewed for status epilepticus, it was noted that drug levels were either in toxic range or subtherapeutic range. The Monitoring Team strongly recommends more frequent monitoring of drug levels for individuals on polypharmacy, and who have histories of altered drug levels. <u>Pneumonia</u> To assess the Facility's management of pneumonia, the Monitoring Team reviewed the incidence of pneumonia that occurred during the reporting period, the Facility's system approach to pneumonia by reviewing reports, graphs and action plans to reduce pneumonia at the Facility, and their clinical records. Incidence of Pneumonia: The Facility reported a total of 16 cases of pneumonia during the reporting period, with eight out of 16 (50%) of the cases reported to be individuals who are enteral-tube fed, and the remaining eight out of 16 (50%) reported to be orally fed but required to have a special textured diet. Of the five mortality cases reported during the monitoring period, five out of five (100%), were either directly or indirectly caused by pneumonia. Four out of 16 (25%) of the cases of pneumonia resulted in hospitalization, and three out of 16 (19%) of the cases of pneumonia resulted in death, hence, seven out of 16 (44%) of the cases of pneumonia resulted in significant morbidity, or mortality. Review of the Facility's System Approach to Reducing Pneumonia**:** The Facility did not review or report on pneumonia at a system level, and there were no reports, graphs, summaries, or action plans to mitigate cases of pneumonia at the Facility. While making clinical observations for medical services, the Monitoring Team did not see physician or nurse practitioner periodically on the units, day program or dining areas. It would be advantageous for physicians, and nurse to evaluate positioning issue for all Individuals with aspiration risks.	

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		Summary: Pneumonia is a leading cause of mortality for individuals with intellectual, and other disabilities. The Facility experienced a high mortality rate during this monitoring period, and four out of 16 (25%) of the cases of pneumonia resulted in hospitalization, while three out of 16 (19%) of the cases of pneumonia resulted in death; therefore seven out of 16 (44%) of the cases of pneumonia resulted in significant morbidity, or mortality. Sixteen out of 16 (100%) of the cases of pneumonia were associated with either enteral tube-feeding or altered diet texture. The Monitoring Team determined that the Facility did not assertively manage pneumonia at the Facility, and it is essential that the Facility develop a quality assurance process that provides a robust review, and process improvement for pneumonia. It would be advantageous for physicians, and nurse practitioners to routinely observe individuals at their homes and day program, and note potential issues, such as poor positioning, inappropriate provision of medical services, and swallowing issues during meal-time. <u>Osteoporosis</u> The Monitoring Team requested the clinical records of ten, randomly generated individuals from a list of all individuals diagnosed with osteoporosis. Upon review, one of the clinical records indicated that the Individual did not have a diagnosis of osteoporosis, so the sample size was reduced to nine. Review of the clinical records indicated that three out of nine annual medical summaries (33%) clearly delineated the suspected etiology of osteoporosis, and provided a comprehensive plan; six out of nine (67%) indicated that an appropriate bone density assessment was completed within the past three years; one out of nine (10%) had been provided a consultation to address the individual's osteoporosis and treatment measures; seven out of nine (78%) had appropriate documentation about osteoporosis in the OT/PT assessment; eight out of nine (89%) had appropriate documentation and risk assessment in the ISP; five out of nine (56%)were provided pharmacological treatment, or documented the rationale for not prescribing pharmacological intervention for osteoporosis; and zero out of nine (0%) demonstrated that an evaluation for secondary causes of osteoporosis was conducted. Summary: The Monitoring Team noted that the Facility must better address this chronic and serious conditions by ensuring that appropriate assessments, routine follow-up, appropriate risk assessment, overall management, and the IDT understanding of the individual's condition related to osteoporosis are well-addressed. <u>Overview</u> It was most obvious that there was overall improvement with provision of medical services at the Facility. Clinicians were more promptly, and comprehensively following	

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		up on reported acute medical problems, and annual medical assessments were much more comprehensive. Follow-up to diagnostic studies, and consultation reports was also an area of marked improvements. The clinical management of acute seizures was noted to be good. Documentation practice was also an area of improvement. Despite its progress, the Monitoring Team agreed with the Facility, and determined noncompliance for Provision L1. Compliance will require continued progress in areas of following up on acute medical problems through full resolution; more assertive evaluation and management of chronic conditions, especially neuromotor, musculoskeletal, clinical management of syndromal conditions, aspiration, and aspiration pneumonia. Clinicians must better participate in the IDT process, and ensure that the IDT is well aware of all medical issues; that the health risk assessments include all clinical issues that pose, or potentially pose, risk to the individual; that all Facility clinicians work collaboratively, and their assessments be reviewed and incorporated into the overall assessment by physicians, and nurse practitioners.	
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.	Provision L2 assesses the Facility's ability to maintain a review system that enables an assessment of clinicians clinical performance, and enhance overall clinical practice at the Facility. To assess compliance for Provision L2, the Monitoring Team reviewed the Facility's internal and external medical provider quality assurance audits, and mortality review process. Internal And External Medical Provider Quality Assurance Audits The Facility participated in the DADS central office medical provider quality assurance audit process, which utilized a standard assessment tool and involved physicians who were external to the Facility, to assess areas of clinical competencies and other performance measures. During the past six months, the Facility was provided two external medical provider quality assurance audits, which were conducted in December 2011 and March 2012. The audits conducted in March included a new component to the audit process, called medical management assessment, which is utilized to assess clinicians' practice performance. Beginning in March 2012, the Facility also began conducting its own internal medical provider quality assurance audit, which utilized the same evaluation tool, and clinical records that were to be used for the external clinician audits conducted in March 2012. External Audits – Round 4 (December 2012): The audit demonstrated that of the six clinicians assessed, six out of six (100%) audits resulted in scores of 80% or greater in essential and non-essential compliance area. Only one out of six (17%) clinicians achieved 100% in essential areas of compliance. Action plans for deficient performance areas were not provided for review.	Noncompliance

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		Internal Audits – Round 4: The Facility did not conduct an internal audit for round 4, as the process had not been finalized at that time. External Audits – Round 5 (March 2012): The audit demonstrated that out of the five clinicians assessed, two out of five (40%) achieved 80% or greater in areas of medical management; four out of five (80%) achieved 80% or greater in areas of essential compliance; and one out of five (20%) achieved 80% or greater in areas of non-essential compliance. Following its review of scores for round 5, the Facility developed 23 action plans for medical management deficiencies, and 13 out of the 23 (59%) had been completed by the time of the Monitoring Team's review. A total of 110 action plans were developed for essential and non-essential deficiencies; 82 (75%) had been completed by the time of the Monitoring Team's review. Action plans were noted to be consistent with areas of deficiency. Internal Audits – Round 5 (March 2012): The audit demonstrated that out of the five clinicians assessed, five out of five (100%) achieved a score of 80% or greater in areas of essential and non-essential compliance; and five out of five (100%) achieved 100% in the area of medical management. Following its review of scores for round five of the internal medical provider quality assurance audit, the Facility did not develop action plans for its internal audits for medical management because all providers achieved 100%. There were a total of 18 action plans developed for internal audits for essential and non-essential areas. Of the 18 action plans, 12 had been completed (67%) at the time of Monitoring Team's review. The action plans were noted to be consistent with areas of deficiency. Summary: The internal and external medical provider quality assurance audit process enables the Facility to assess clinician's clinical performance, and their adherence to practice standards, and policies related to medical services. The Monitoring Team was unable to perform a comprehensive review of the audit forms for each condition; however, the Monitoring Team recognizes that as part of a quality assurance review process for clinicians, it is essential that outcomes be assessed, and that standard of care practice is adhered to. For example: • When assessing performance activity for the management of diabetes, the physician must assess A1C values for acceptable limits, and ensure that the manifestations of diabetes, such as gastroparesis, peripheral neuropathy, retinopathy, foot ulcers, and renal insufficiency are assessed, and treated as	

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		necessary. In addition, all aspects of diabetic management, including diet, exercise, and psychological issues that may be impacting the illness should be included in the evaluation, when developing a treatment plan. • When assessing competency for the management of osteoporosis, the physician must always search for the etiology of low bone density prior to starting medical treatment, and alternate means of assessing bone density, other then DEXA can be employed in the diagnostic evaluation process; also, non-pharmacological treatment for osteoporosis, and osteopenia should be prescribed by the physician. • Constipation is a serious and potentially fatal condition, and must be assertively managed. Untreated constipation can lead to obstruction and perforation of the intestine, aspiration, renal failure, heart failure and serious behavior issues. The audit should require specific assessment for the physical exam, such as whether the clinician performed an inspection, palpation, rectal exam and auscultation of the abdomen, was toileting schedules, physical activity, assessment of fluid intake and positioning assessed. Importantly, was the individual assessed by the clinician at least quarterly, and more frequently if recurrent episodes of bowel delay was identified, and was the use of specialists incorporated into the care plan, when clinically indicated. Based on review of results for round 4 external and internal audits, there was marked discrepancy among the various raters.. Also of concern is that the same charts provided for the external audits were pre-screened through the internal audit process, shortly prior to being reviewed by the external audit team. Although this may be useful for training of internal auditors, external auditors should review at least some records without prior notice. A significant issue exists with the review process not being specific for the clinician being assessed. For example, the auditors review a clinical record, and assign the total burden on the clinician of record; however, various issues confabulate the assessment because the clinician being assessed may have recently been assigned the individual, and most of the activity in the clinical record was contributed by the previous clinician; also many issues assessed may have been contributed by cross-covering, and on-call physicians. Following review of the new audit forms for specific conditions the Monitoring Team compliments DADS Central Office and the Facility for developing and implementing an enhanced and more robust means of assessing physicians core competencies. The Monitoring Team suggests further review of each of the new assessments, and ensure that outcome data, and standard of care practice expectations are incorporated into the assessment process. Additional core indications should also be developed, to better	

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		ensure that management of common, and serious medical conditions is provided. The Monitoring Team also recommends that charts be assigned randomly from a list of clinical records that were not recently review for internal audits, when conducting external audits. The process should ensure that only the work being completed by the clinician of record, be assessed, and not the work of previous clinicians, or cross-covering, and on-call clinicians. <u>Mortality Review</u> The Monitoring Team conducted a comprehensive review of the Facility mortality review process, and the following is a summary of that review: The Quality Assurance Program staff continued to maintain a tracking system for recommendations resulting from the Clinical and Administrative Death Reviews through to resolution for each death. The reason for the Facility to conduct death reviews was to ensure thorough, systemic, and integrated death reviews are conducted. The Monitoring Team reviewed copies of the Recommendation and Follow-up Tracking Logs for each of the five deaths for the purpose of evaluating the quality of the recommendations and to validate whether or not they were carried-out through to resolution. It was positive to find that the Clinical and Administrative Death Review Process had taken a more systemic and integrated approach in reviewing deaths than had been found in previous reviews. Although the recommendations related primarily to issues involving Nursing Services, some recommendations were also related to Habilitation Services, Respiratory Therapy Services, Medical Services, Residential Services, Medical Records Department, and Hospice Services. It was also positive to find that all recommendations were carried out through to resolution and verified by the Quality Assurance Department. As was recommended at the last review, the Medical and Nursing Departments, as well as the Quality Assurance Department, should develop a list of critical questions to answer in reviewing each decedent's medical record. This could further improve the scope and depth of clinical discussions and recommendations, in addition to providing consistency among the reviewers. According to a recent discussion with the State Office Nursing Coordinator, the State was in the process of revising the Death Review Policy. When the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care. The Facility had not conducted a Mortality/Morbidity Review and Analysis of longitudinal data related to deaths in order to track and trend systemic issues, develop corrective action plans, or the efficacy of the corrective actions.	

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		Following its review, the Monitoring Team noted significant areas of concern, specific to clinical recommendations, and clinical determination of the circumstances related to death. First, and foremost, each of the mortality summaries reviewed lacked a comprehensive assessment of potential contributing causes of death, and the quality of clinical care of those potential contributing etiologies. For example, there were several examples of Individuals expiring secondary to complications of COPD, which were contributed to recurrent aspiration, and aspiration pneumonia; however, there was no discussion about how the Facility could possibly mitigate COPD, or exacerbation of COPD. Second, it was apparent that the mortality reviews focused mostly on nursing outcomes, and not other providers, such as physicians, nurse practitioners, physical and occupational therapist, and direct care personnel. Overview: Following its review of Provision L2, the Monitoring Team concurs with the Facility, and determined noncompliance. The Facility must enhance its internal, and external audit process by ensuring that at least some of the clinical records provided for the external auditors are not previously assessed through the internal audit process, or prescreened by the Facility; enhance the quality, and quantity of the core indicators used for the medical management audit; ensure that only the work being assessed through the audit process, is the work completed by the clinician of record, and not other clinicians. Also, the Mortality review process must be more comprehensive and include a review of all potential causes of death, and all system issues, and care provided by all disciplines.	
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.	Provision L3 requires the Facility to implement a quality assurance (QA) process for medical services. To assess the Facility's effort towards compliance for Provision L3, the Monitoring Team reviewed QA issues noted by the Medical Director, including the Facility's chronic clinical indicator policy, diabetic, and osteoporosis databases, and medical follow-up database. <u>Chronic Clinical Indicator Policy</u> The policy was implemented on 10/12/11, and provides an overview of identifying, developing, and implementing core indicators to be used for quality assurance and clinical improvement efforts. The Monitoring Team noted that the policy provided an exceptional method for the Facility's medical quality assurance process, and was clearly progressive in nature, and if implemented completely, should lead to substantial compliance with provision L3. <u>Diabetes Database</u> This is another example of the Facility's progress approach to enhancing clinical outcomes at the Facility. The database is an excellent tool that if fully implemented, will identify trends for the management of diabetes. The database will also enable clinicians,	Noncompliance

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		and other staff, the ability to assess the clinical outcome of diabetes at the Individuals, and system levels. Osteoporosis Database The osteoporosis database had just been developed and not implemented at the time of the review. The Monitoring Team evaluated the database and noted it to be complete, and that it will ensure that secondary causes of osteoporosis would be assessed. The Monitoring Team is complimentary, and impressed by the development of this process. Medical Follow-Up Database A policy for the medical follow-up database was not developed; however, the process was demonstrated to the Monitoring Team. Although not fully developed or implemented, the Monitoring Team was impressed by the tracking system. If used as indicated for all consultations, and diagnostics, the system will enable real time tracking of consultations and diagnostics, and help mitigate delays, and missed consultations and diagnostics. All diagnostics and consultations must be tracked through completion. Overview The Facility has taken a progressive approach to developing a medical quality assurance process at the Facility. The development of core indicator databases for diabetes, and osteoporosis, will enable close monitoring of these conditions, and improved outcomes, if fully implemented. The Medical follow-up database is also another progressive approach to ensuring that diagnostic tests, and consultations are tracked through completion, and that appropriate action plans are developed. The Monitoring Team is impressed, and complimentary of these new processes. Following its review, the Monitoring Team disagreed with the Facility, and determined noncompliance for Provision L3. Compliance will require full implementation of the current databases; development of additional core indicator databases for common, and significant medical conditions that occur in individuals with intellectual disabilities; ensure that there is a meaningful committee to report on QA outcomes; that process improvement recommendations are tracked for completion, and efficacy; and incorporate QA outcomes from the external and internal clinician audits into the medical QA process.	
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	Provision L4 requires that the Facility maintain appropriate policies and procedures to ensure quality medical services at the Facility. To assess compliance for Provision L4, the Monitoring Team reviewed the Facility self-assessment, and discussed their effort with the Facility's medical director, who reported the following procedural improvements: Medical Services Policy	Noncompliance

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	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's medical services policy, dated 1/21/11, was previously reviewed by the Monitoring Team. The Monitoring Team determined that the Facility did not follow its policy in many areas. For example, the policy required physicians to review all active, and chronic problems quarterly, and document this review on the medical summary form, or narrative note but physicians did not assertively review all active and chronic medical issues quarterly. The policy calls for physicians to assess for pain, and the Monitoring Team noted that individuals with medical conditions known to cause pain, were not routinely and appropriately assessed for pain. Active problem lists were not always updated, or accurate. The policy requires that all individuals receive preventative and chronic care, and the Monitoring Team noted examples where many individuals were not provided appropriate clinical management for their chronic medical conditions, especially in the areas of managing syndromal conditions, aspiration, neuromotor, and musculoskeletal conditions. <u>Chronic Care Indicator Policy</u> The chronic care policy was reviewed, and reported on in Provision L3, of this report. The Monitoring Team recognized the comprehensiveness, and potential benefits, of the policy. <u>At Risk Policy</u> Following review of the at risk policy, the Monitoring Team concurred with its approach; however, it is essential that at risk issues not be limited to those outlined in the policy, and clinicians must recognize that guidelines are only to be used as examples, and that good clinical judgment must be used when identifying risks, and developing risk levels, and action plans for high risk conditions. For example, CP is not a risk category, but CP poses significant risk to the individual. <u>Annual Medical Summary Form</u> The updated annual medical summary form was reviewed, and improvements were noted by including the use of tobacco and substances, and the active problem list and plan on the form. The Monitoring Team observed that physician completion of the form had also improved, and in general, noted it to be more comprehensive, accurate and complete; however, many completed annual medical assessments did not accurately list current diagnosis, and action plans where not efficacious for the clinical conditions. Importantly, the Monitoring Team recommends including a subsection for habits, which would include substance, alcohol, and tobacco use, a section specific for community living option planning. <u>DSM And ICD Medical And Psychiatric Diagnosis Update Policy</u> This policy was developed to ensure that all new diagnoses were updated by the Facility.	

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		Review of the policy indicates a mechanism that if used appropriately, will help ensure that the physician or nurse practitioner updates all diagnoses, as clinically indicated. This process was developed in January 12, 2012, and is fully implemented. The Monitoring Team noted in all clinical records reviewed, that the section for updating medical diagnosis was available for use by the physician and nurse practitioner. <u>Clinical Pathways</u> The Facility had not implemented the DADS clinical pathways. The Monitoring Team did not review the clinical pathways during this review, but did review them during reviews of other Facilities. The Monitoring Team refers readers to the May 2, 2012 compliance report for Rio Grande Supportive Living Center, and the May 8, 2012 draft report for Dental State Supported Living Center for further information regarding its review of clinical pathways. The Facility had begun implementation of a similar approach, a set of clinical guidelines that tied in with a database. At the time of the compliance visit, the Facility had established these for diabetes and osteoporosis. This is a promising approach, especially with the link between the guidelines and the database; the database includes, and can provide reports both for individuals and the Facility about, clinical indicators and other information called for in the guidelines. In addition to the above policies, the Facility developed the following additional policies: The physician order flag policy; the medical department policy on the share drive; and a physician survival guide. The Monitoring Team did not assess these new policies during this review period. <u>Overall Summary</u> Following its review, the Monitoring Team compliments the Facility for its continued development of process improvement initiatives, and the necessary policies, and procedures required to implement these new processes. Much improvement has been noted, especially in the area of documenting on the annual medical summary, and the implementation of the chronic care policy. Although much improvement was noted, the Monitoring Team agrees with the Facility and determined that the Facility is noncompliant with Provision L4. Compliance will require full implementation, and adherence to its policies.	

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

1. Ensure that prostate cancer screening, and PSA evaluations are reviewed annually through the IDT process, and informed consent is obtained prior to obtaining a PSA level (Provision L1)

2. Individuals should be provided Tdap booster, per CDC guidelines, unless medically contraindicated, and ensure that the Facility's policy and practice is updated to reflect current CDC guidelines (Provisions L1, and L2)
3. The Facility must develop, and implement, a process to regularly assess health maintenance issues related to congenital syndromes (Provision L1)
4. Follow-up to resolution of all acute, and post hospital discharges must be well documented by the clinician (Provision L1)
5. Review by root cause analysis, all fractures that occur at the Facility, for possible medical causes (Provisions L1, and L3)
6. Clinicians must better participate in the IDT process and ensure that the IDT is aware of all clinical conditions, concerns, and clinical plans (Provision L1)
7. Clinicians must enhance their ability to follow-up and treat chronic clinical conditions, especially in the areas of neuromotor, musculoskeletal, and aspiration pneumonia (Provision L1)
8. Clinicians should routinely make observational assessments of individuals at their home, and day program, and monitoring for poor positioning, issues related to inappropriate provision of medical services, and challenges associated with swallowing (Provision L1)
9. The Facility should arrange, and provide CME for clinical issues related to developmental disabilities, such as management and treatment of aspiration pneumonia, chronic constipation, neuromotor conditions, spasticity, and contractures, among others (Provisions L1, L2, and L4)
10. It is strongly recommended that more frequent monitoring of drug levels be conducted for individuals on polypharmacy, and who have histories of altered drug levels (Provision L1)
11. The Facility must improve its overall management of osteoporosis by ensuring that appropriate assessments, routine follow-up, appropriate risk assessment, and treatments are provided to individuals with osteoporosis, and the IDT's understanding of the individual's condition related to osteoporosis are well addressed.
12. It is essential that the Facility develop a quality assurance process that provides a robust review, trends analysis, and process improvement to reduce the cases of pneumonia (Provision L1)
13. Clinicians must follow all acute medical issues through full resolution, and document, in the form of a SOAP note such effort (Provision L1)
14. All clinicians' dictations must include a time stamp of whe$_{\text{n the}}$ note was dictated (Provisions L1, L2, and L4)
15. Enhance the medical management audit tools so that they better capture outcome indicators of core conditions, and increase the number of core conditions to better reflect the common and serious medical conditions that occur in individuals with complex disabilities (Provision L2)
16. Ensure that the clinician audits reflect the work of only the clinician being assessed, and not previous, cross covering, and on-call clinicians (Provision L2)
17. At least some of the records reviewed for external clinician audits should not be prescreened through the internal clinician audit (Provision L2)
18. When conducting a mortality review, ensure that a comprehensive review addresses all potential causes and contributing factors leading to the cause of death. (Provision L2)
19. Fully implement the diabetes and osteoporosis databases (Provision L3)
20. Further identify, and develop additional clinical core indicators for medical QA purposes (Provision L3)
21. Ensure that there is a robust committee structure that oversees the medical QA process (Provision L3)
22. Clinicians should ensure completeness of the annual medical summaries by ensuring all active diagnosis are listed on the active problem list, and ensure that a comprehensive, efficacious plan is developed for each diagnosis (Provisions L1, and L4)
23. The Facility must fully implement pending policies, and ensure that its policies are followed (Provision L4)

The following are offered as additional suggestions to the Facility:

1. The annual medical summary form should include a subsection for habits, which would include substance, alcohol, and tobacco use, a section specific for community living option planning (provisions L1, and 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 Section M Self-Assessment, Updated: 5/1/12 2. RSSLC Section M Action Plan, Updated: 4/27/12 3. Presentation Book for Section M 4. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Emergency Response, Policy Number: 044.2, Revised: 9/7/11 5. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: At Risk Individuals, Policy Number: 006.1, Date Approved: 12/29/10, Implementation: 1/1/11 6. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Medication Variances, Policy Number: 053, Effective: 9/23/11 7. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Medication Administration Observation Guidelines, Revised: January 2012 8. Texas Department of Aging and Disability Services, State Supported Living Centers Procedures: Nursing Documentation Guidelines: Date: 3/5/12 9. Texas Department of Aging and Disability Services, State Supported Living Centers: Nursing Services Competency/Skill on-Job Training Assessment Form, Date: 6/16/11 10. Texas Department of Aging and Disability Services, State Supported Living Centers: Nursing Orientation Guidelines for Weekly Goal Sheet, no date 11. RSSLC Providing Health Care Service, Actions During and Following a Medical Emergency, (4444), Revised: 9/7/11 12. RSSLC At Risk Individuals Policy, I.08, Effective: 5/11/12 13. RSSLC Health Care Services, Internal Nursing Monitoring Tools, Revised: 3/1/12 14. RSSLC Nursing Services, Neurological Assessment Protocol, Revised: 2/24/12 15. RSSLC Nursing Services, Gastrostomy Tube Reinsertion, Revised: 3/13/12 16. RSSLC Nursing Services, Physician Quarterly Orders, Revised: 3/19/12 17. RSSLC Health Services, End of Life Care/Hospice Services, Revised: 3/29/12 18. RSSLC Providing Health Care Services, Mediation Variances, 1.34, Effective Date: 2/27/12 19. RSSLC Nursing Services, Medication Variances Guidelines, A-3, Date: 1/24/12 20. RSSLC Nursing Services, Medication Administration Guidelines, A1, Revised: 3/9/12 21. RSSLC Pharmacy Policy and Procedure Manual, Physician Order Review by Pharmacist, 01.05.20.15, Revised: 2/23/12 22. RSSLC Pharmacy Policy and Procedure Manual, Preventing Drug Interactions, 01.05.20.20, Created: 5/1/12 23. RSSLC Medication Administration Observation Form, Revised: 1/18/12 24. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Discharge Summary Form, Revised: 11/7/11 25. RSSLC Health Care Services, Internal Monitoring Tool Instructions for using the Tools 26. RSSLC Nursing POI Committee Meeting Minutes, November 2011 through April 2012 27. RSSLC Wound Care Committee Meeting Minutes, 12/7/11, 4/18/12, 4/25/12, and 5/9/12 28. RSSLC Nurse Managers Meeting Minutes, 11/1/11 through 4/19/12

	29. RSSLC Nursing Administration, Nurse Managers, and Nurse Case Managers Meeting Minutes, November 2011 through April 2012 30. RSSLC Minimum Nursing Staffing Patterns for the last six months 31. RSSLC Nursing Staffing Schedules for Units/Infirmary for April 2012 32. RSSLC Nurse Case Managers' Caseload by Unit/Infirmary, 4/17/12 33. RSSLC Overtime Hours Works by Licensed Vocational Nurses (LVNs), by shift, by month, November 2011 through March 2012 34. RSSLC Regular Compensatory Time Worked by Registered Nurses (RNs), by shift, by month, November 2011 through March 2012 35. RSSLC Schedule of Meetings Requiring Nursing Participation, 5/14/12 through 5/19/12 36. RSSLC Infirmary Admission Log for the last six months 37. RSSLC Emergency Room and Hospitalization Logs for past six months 38. RSSLC Post Hospital/ER/LTAC Nursing Assessment Form, Revised: 1/18/12 39. RSSLC Emergency Drill Instructor Training Curriculum and Competency-based Test on Emergency Response Policy, 044.2 40. RSSLC Competency Training and Development (CTD) Course Due/Delinquent List for Basic Life Support for Healthcare Providers, Printed: 5/11/12 41. RSSLC CTD Course Due/Delinquent List for Cardiopulmonary Resuscitation Basic, Printed: 5/11/12 42. RSSLC Mock Medical Emergency Drill Summaries, January 2012, February 2012, and March 2012 43. RSSLC Quarterly Mock Medical Emergency Drills Report for January 2012, February 2012, and March 2012 44. RSSLC Monthly Mock CPR Drill Reports for the last six months 45. RSSLC Emergency Response Committee Meeting Minutes, 12/9/11, 2/29/12, and 4/5/12 46. RSSLC Emergency Response Committee's Core Membership 47. RSSLC Emergency Response Committee's Mission Statement 48. RSSLC List of AED and Emergency Equipment Locations with Map Marking their Locations. 49. RSSLC Incident Management Meeting Minutes, 2/3/12, 2/10/12, 2/17/12, 2/24/12, 3/16/12,/3/19,/3/19/12, 3/23/12/and 4/6/12 50. RSSLC Individualized Health Care Plan Development Competency-based Curriculum, no date 51. RSSLC Nursing Services, Preceptor Training Program, no date 52. RSSLC Nurse Managers' Review of Monthly Emergency Checklist for last six months 53. RSSLC Staff Responsibilities for Mock Medical Emergency Drills 54. RSSLC Decubitus Reports for 2011 and 2012, year to date 55. RSSLC CTD Course Due/Delinquent List for Infection Control Refresher Training, Printed: 5/10/12 56. RSSLC Infection Control Quarterly and Monthly Meeting Minutes, December 2011 through March 2012 57. Regional Clinical Laboratory, Epidemiology Reports, 11/1/11 through 4/16/12 58. RSSLC Percentage of Individuals with Current Flu Vaccinations 59. RSSLC Percentage of Individuals Current with Tuberculosis Testing 60. RSSLC Percentage of Employees Current with Flu Vaccinations 61. RSSLC Percentage of Employees Current with Tuberculosis Testing 62. RSSLC Percentage of Employees current with Hepatitis B Vaccinations 63. RSSLC Nursing Plan of Improvement (POI) Meeting Minutes, November 2011 through April 2012

	64. RSSLC Community Transition Process from a SSLC 65. RSSLC Pharmacy and Therapeutic Meeting Minutes, 10/26/11 and 1/31/12 66. RSSLC Medication Variance Committee Meeting Minutes, 11/17/11, 12/15/11, 1/26/12, 3/29/12, and 4/9/12 67. RSSLC Monthly Medication Variances Reports for the last six months 68. RSSLC Reviewed Records of Four Currently Hospitalized Individuals: Individuals #386, #146, #278, and #765 69. RSSLC Reviewed Records of Individuals #279 and 259 with Active Decubitus 70. RSSLC Reviewed Records of 12 Recently Completed Acute Care Plans and Associated Integrated Progress Notes for Individuals #798, #420, #8, #530, #612, #276, #678, #386, #275, #663, #112, and #193 71. RSSLC Reviewed Records of 12 Recent Completed Integrated Risk Assessments and Risk Action Plans for Individuals #484, #570, #175, #148, #91, #60, #459, #354, #388, #593, #729, and #300 72. RSSLC Reviewed Record for Individuals #212, #463, #99, #641, #784, #152, #107, #259, #165, and 286 73. RSSLC Nursing Community Discharge Summary and accompanying Health Care Plans were reviewed for three recently discharged Individuals: Individuals #96, 110, and 165 **People Interviewed:** 1. Jane Purcell, Assistant Director of Programs 2. Charlene McCurry, RN, Chief Nurse Executive 3. Constance Bowie, RN, Nurse Operations Officer 4. Genniffer Moore, RN, Program Compliance Nurse 5. Kay Rudasill, RN, Nurse Recruiter/Nurse Educator 6. Emma Purvey, RN, Infirmary/Campus Director 7. Adriano Soria, Jr., RN, Hospital Liaison Nurse 8. Ugo Nweke, RN, Nurse Educator 9. Wycliff Fawibe, RN, Skin Integrity Coordinator 10. Reneda Simmons, RN, Infection Control Nurse 11. Antonio Crescini, RN, Assistant Infection Control Nurse 12. Robyn Partridge, RN, Quality Assurance Nurse 13. Unit Nurse Managers, Nurse Case Managers 14. Gabriel Herrera, Risk Manager **Meeting Attended/Observations:** 1. Meeting with Nursing Administration and Nurse Managers, 5/14/12 and 5/15/12 2. Nursing POI Committee Meeting, 5/14/12 3. QA/QI Council Meeting, 5/15/12 4. Medical Interdisciplinary Meeting, 5/16/12 5. Tour of Units to Review Emergency Medical Equipment with Risk Manager and Nursing Administrative Staff 6. Skin Integrity Meeting, 5/16/12 7. Medication Administration Observations in Nueces and Infirmary and Unit Tour, 5/16/12 8. Medication Variance Committee, 5/17/12

	Facility Self-Assessment: The Facility's Self-Assessment Report included the activities which were engaged in to conduct the self-assessment, data to represent the results, and self-ratings based on the findings. The Facility described the methodology used for rating each Provision. The data used to determine assessment ratings consisted primarily of the scores derived from the percentage of compliance achieved through the results of various monitoring tools, tracking and trending of reports generated through various committees, and training activities. An Action Plan that accompanied the Self-Assessment listed action steps for each Provision to guide the Facility through substantial compliance with each Provision. The action steps primarily related to content from previous reports or specific recommendations made by the Monitoring Team. The actions steps did not reflect a comprehensive strategic action plan to adequately guide the Facility through the process of achieving compliance across all Provisions. The Facility should go beyond the content found in previous reviews and the Monitoring Team's recommendations, and consider forward thinking when developing future action steps directed at achieving compliance with all the requirements set forth in each Provision. Simply relying on previous report findings and the Monitoring Team's previous recommendations will not significantly move the Facility forward in achieving full compliance with each Provision.
	Summary of Monitor's Assessment: Provision M.1: This provision was not found in compliance. Although improvements were found, there remained the need for continued improvement. The Nursing Department continued to maintain a highly motivated and stable Nursing Administrative and Management staff. Since the last review, a nurse was reassigned to serve as an Assistant Infection Control Nurse, and another nurse had been reassigned to serve as Nurse Case Manager Supervisor, effective 6/1/12. All nursing positions were filled. The staffing ratios were reported as consistently being met. However, this required pulling nurses, increased use of overtime, and the use of the Nurse Case Managers to provide staff nursing duties. No agency nurses were used. The Nursing Department reported they had lost 21 nursing positions since the beginning of the Settlement Agreement. The Facility and Nursing Department needs to evaluate the adequacy of nursing staffing to ensure individuals' receive adequate nursing care. The Nursing Plan of Improvement Committee had revised the Nursing Care Monitoring Tool Guidelines to clarify their interpretation between the Nursing Administrative internal audits and Quality Assurance Nurses' external audits. As a result the level of agreement (inter-rater reliability) of the Nursing Care Monitoring data between the two sets of auditors was improving. The items of each monitoring tool were not weighted in value of significance and should be weighted. Corrective Action Plans were being developed, implemented, and tracked by the Quality Assurance nurse. The Facility should begin to develop and implement Corrective Action Plans for the overall percentage of compliance falling below 80%. Local and systemic Corrective Plans of Action should be developed and implemented for monitoring tools falling below 89%.

	There were areas where significant improvement was found with regard to the assessment, management, and documentation of acute changes in status. But there were other areas that needed continued improvement. The Infection Control Program was beginning to show improvement with the two Infection Control Nurses; they need to continue to refine and improve some processes in the areas of tracking, analyzing, and trending infection control data. The Wound Care Nurse continued to provide excellent wound care management in collaboration with other relevant disciplines. As a result there were only two individuals with pressure ulcers, which is commendable considering the medically complex population that resides at the Facility. There is an ongoing need for the Wound Care nurse to work with the Nurse Managers and relevant disciplines to ensure integrated plans of care for wound management are developed, implemented and monitored. The Emergency Response System had continued to make improvements. All of the required emergency equipment had been procured and placed in designated areas located throughout the campus. Signs were posted throughout the campus indicating the location of the emergency equipment. The emergency equipment was checked daily by the nursing staff and monthly by the Risk Manager. All relevant staff had been trained on the Emergency Response Policy. The required Mock Medical Emergency Drills were completed quarterly, or as specified by policy. The drill data were tracked, analyzed, trended and submitted to the Quality Assurance Department. The Emergency Response Committee was comprised of interdisciplinary staff. The Emergency Response Committee needs to ensure Mock Medical Emergency Drills reports are presented at the Incident Management Team meetings. The Mock Medical Emergency Drills should include a variety of scenarios that might require emergency response. The Facility should ensure that all employees are current in Basic CPR and CPR for Health Care Providers. Provision M.2: This provision was not found in compliance. Although improvements were found, there remained the need for continued improvement. The Nursing Department was making steady progress in improving the quality of the Annual and Quarterly Nursing Assessment. The improvements found in the assessments may be attributable to the training the Nurse Case Managers received on the State's required Physical Assessment and Documentation Class. However, the Nurse Case Managers continued to need training to improve summarizing and analyzing raw clinical data into statements that are clear, concise, and meaningful to adequately determine individuals' health status in relation to each of their identified nursing problems/diagnoses. Provision M.3: This provision was not found in compliance. Although improvements were found, there remained the need for continued improvement. The Nursing Department had recently made significant progress on developing health care plans that were individualized sufficient to meet individuals' unique needs. This is probably attributable to the recently developed and implemented excellent competency-based Individualized Nursing Care Plan Development Training received by 100% of the RN staff. Since the staff were recently trained, the Nursing Management and the Nurse Educators need to continue to reinforce training and monitor for compliance in the nursing care plans. The addition of a Nurse Case Manager Supervisor should serve to further provide oversight and direction to the Nurse Case Managers. Provision M.4: This provision was not found in compliance. Although improvements were found, there

	remained the need for continued improvement. The Nursing Department and Nurse Educators continued to implement and train nurses on new policies, procedures, and protocols. The protocols were laminated onto small cards, placed on a ring, and provided to each nurse to carry at all time for easily reference, a opposed to having to look them up in the nursing manual. The Nurse Educator maintained an excellent tracking system for training to ensure that nurses receive all required and other identified training as needed. The Nurse Educators had trained all the incumbent direct care staff on the State's mandated Observing and Reporting Clinical Indicators for Health Status Change of the Individuals Served and were continuing to provide this training at New Employee Orientation. In order for this Provision to meet compliance, not only must the State and Facility Nursing Policies, Procedures, Processes, and Protocols be established, implemented, and the nursing staff trained; they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. As was found throughout the other Provisions, the Nursing Policies, Procedures, Processes, and Protocols have not yet been adequately put into clinical practices sufficient to meet individuals' health status needs. Provision M.5: This provision was not found in compliance. There was no significant improvement found in this Provision. The compliance with this Provision requires the collaboration and integration of all relevant disciplines to accurately identify risk assessments and to develop and implement plans of care sufficient to meet the individuals' needs. It is essential that each discipline responsible for their respective risk rating categories complete comprehensive risk assessments of individuals' overall health status though collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. Establishing a competent and reliable risk rating 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. Provision M.6: This provision was not found in compliance. Although improvements were found, there remained the need for continuing improvement. Since the last review, the Chief Nurse Executive has become the chairperson for the Medication Variance Committee. The Facility had a comprehensive Medication Variance Database for developing reports on medication variances from which a root cause analysis method can be used in analyzing and trending data. The Medication Variance Committee was still evolving and refining the data collected. As data are collected for all types of medication variances and from all relevant disciplines, the Committee should be able to identify deficiencies and take corrective action. The Medication Administration Observation Form had recently been revised to observe for compliance with individuals' PNMPs as related to strategies for safe medication administration. From the Monitoring Teams' medication administration observations it appeared that the nursing staff administering medications could benefit from receiving enhanced dysphagia training to better understand and carryout safe medication administration strategies.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with	Provision M.1: Overall significant improvements were found in all the requirement of this Provision. The Nursing Department maintained a stable administrative staff. Two	Noncompliance

	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.	nurses were reassigned, one as an Assistant Infection Control Nurse, the other to serves as the Nurse Case Manager Supervisor. The Nursing POI Committee had improved the inter rater-reliability level of agreement. The wound Care nurse working collaboratively with other relevant disciplines had significantly reduced the incidents of pressures sores. The Infection Control Program was becoming more organized in addressing all aspects of infection control. The Facility's Emergency Response System had acquired all of the required emergency equipment and placed the in designated areas throughout the campus. All Mock Medical Drills were conducted according to schedule, tracked, analyzed, and trended, and reported to the Quality Assurance Department. <u>Activities engaged in to conduct the self-assessment</u>: • Reviewed and analyzed vacancy and turn-over reports to determine fill rates of nursing positions. • Staffing reports were reviewed to determine if staffing was falling below identified standard numbers to ensure adequate staffing. • Reviewed Quality Assurance/Quality Improvement data for the 12 Nursing Care Monitoring Tools; and analyzed for progress and compliance. An average of 48 monitoring tools had been completed every month since August 2011. Prior to that, an average of 96 monitoring tools were audited per month. The number of tools audited was reduced to focus on closing the gap of disparity of agreement between Nursing's internal and Quality Assurance Nurses' external audits. • Nursing Plan of Improvement (POI) Committee met and reviewed all 12 Nursing Care Monitoring Tools against the Nursing Care Monitoring Tool Guidelines to determine whether clarification was needed. • Infection Control Reports and 12 Nursing Care Monitoring Tools were reviewed for appropriate interventions, treatments, and corrective actions for the quarter of November 2011 to January 2012. • Emergency Response Committee meeting minutes were reviewed for compliance with the Emergency Response Policy, 044.2, revised: 9/7/11. <u>The results of the self-assessment</u>: • As of 12/1/11, there were five vacant nursing positions. Through hiring and recruiting efforts two positions were filled as of 1/1/12, two positions were transferred as of 2/1/12, and one nursing position was vacant as of 4/1/12. • Staffing levels consistently remains at 100% because shortages were covered by pulling nurses from homes with overages, as needed. • Twenty-five out of the 36 (69%) monitoring tool audits were completed and reviewed during the quarter of 11/1/11 to 1/1/12, which fell below the 80% level of agreement between external and internal audits. Corrective Action Plans (CAPs) were initiated for those that fell below 80% compliance. • The use of the Modified Nursing Care Monitoring Tool Guidelines began on 1/1/12.	

		A review of results of the audited Nursing Care Monitoring Tools, February 2012, showed an overall improvement in level of agreement between the external and internal audits. • Infection Control Committee Meeting minutes and the Infection Control Nursing Monitoring Tool were reviewed for the quarter starting November 2011 through January 2012. The analysis of data showed the need for two CAPs: • Disposal of biohazard from suction tooth brushing and the removal of deodorizer/air freshener were replaced with an environmental allergy-free product. • The quarterly compliance average for the Infection Control monitoring tool fell below 80% compliance in the months of November 2011 and December 2011. Compliance was 100% for January 2012, 95% for February 2012, and 85% for March 2012. • AED posters were placed around campus to indicate location of AEDs. Emergency equipment was ordered to stock emergency bags for each unit as indicated by the Emergency Response Policy, 044.2, revised: 9/7/11. <u>Self-rating</u>: Based on the findings from their self-assessment, this Provision was not in substantial compliance, because the level of agreement between internal and external reviews on the Nursing Care Monitoring Tools needs improvement on plan of corrections and data analyses. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Though review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, there was evidence that the Nursing Department had continued to provide additional training and monitoring toward achieving compliance in this Provision. Significant improvement was found from previous reviews. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. 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 Provisions 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.	

		Staffing At the time of the compliance review there were 364 individuals residing at the Facility. This represented a reduction of 12 individuals since the last compliance review when the Facility census was reported as 376. At the time of the review the Facility reported a total of 164 nursing positions, of which 100 were Registered Nurses (RNs) and 61 Were Licensed Vocational Nurses (LVNs) dedicated to the Nursing Department. Three of the RN positions were dedicated to other departments, two to the Quality Assurance Department, and one to the Habilitation Department. Although the census had decreased since the onset of the Settlement Agreement when the Nursing Department had approximately 182 nursing positions there had been 21 nursing position lost, which represent a significant reduction in the total number of nurses. According to the CNE and review of staffing patterns, the Facility had met the required nursing staffing 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. As was found at the last review, maintaining coverage also resulted in significant number of overtime hours worked on all shifts. 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. The Nursing Department continued to not to use agency nurses to supplement staffing. Since the last review, a nurse had been reassigned to serve as the Infection Control Nurse Assistant, and another nurse was reassigned to become the Nurse Case Manager Supervisor, effective 6/1/12. Although the Facility census had been reduced, the individuals residing on the medically fragile units were becoming more complex with higher risk ratings, thus requiring much more intense nursing care, particularly in the Trinity Unit. Of the five deaths that occurred since the last review, two individuals resided on Trinity A and three resided on Trinity B. In a meeting with the Nurse Case Managers, they expressed concern regarding the nursing shortage which often required them to perform staff nursing duties. In doing so, although necessary to care for individuals, it impeded their ability to adequately and timely fulfill their Nurse Case Manager duties and responsibilities. A review of the Nurse Case Managers' caseload indicated the caseload for Trinity A nurses was 19, for Trinity B nurses was 16, for Trinity C nurses was 20, and for Trinity D nurses was 19. While the Monitoring Team was on site, Nursing Administration stated they had found an unrealized RN position that could be assigned to serve as an additional Nurse Case Manager on Trinity Unit. The Nursing Department should collaborate with the Facility administration to review the acuity of individuals and to evaluate the adequacy of nursing staffing to ensure that individuals' health care needs are sufficiently met. The Nursing Department's Administrative and Management Nursing staff had remained stable. They 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 Nurses. 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. <u>Quality Assurance Efforts</u> Since the last compliance review the Nursing Department continued to make significant improvements with regard to quality assurance efforts. The Nursing POI Committee continued to meet weekly to review completed Nursing Care Monitoring Tools. The Committee was comprised of Nursing Administration, Nurse Managers, and Quality Assurance Nurses. The Committee was conducted by the Program Compliance Nurse, who also had the responsibility for ensuring the monthly assigned Nursing Care Monitoring Tools were completed. The Committee reviewed the monitoring tools to ensure they were completed according to schedule and/or when technical problems were found on the monitoring tools. Nursing Administration took corrective action on problems identified on the monitoring tools. The Committee primarily focused on reconciling the disparity found on the level of agreement on monitoring tools between those completed by internal Nursing Department's audits and those completed by the external Quality Assurance Nurses' audits in an effort to improve inter-rater reliability. The Nursing Care Monitoring Tool Guidelines were reviewed along with the completed monitoring tools. It was discovered that there was a lack of clarity in interpreting the guidelines between the internal nursing auditor and the external Quality assurance nurse auditors. Consequently, the committee began revising the Monitoring Tool Guidelines in November 2011 as they completed the assigned monthly Monitoring Tools. By April 2012, the committee had modified the Monitoring Guidelines for all 12 Nursing Care Monitoring Tools. In February and March 2012, it was reported that 91% of the relevant nursing staff had been trained on the modified Nursing Care Monitoring Tool Guidelines, with a projected date to complete the remaining 9% of the nurses by 5/31/12. A review of the completed Nursing Care Monitoring Tools showed the level of agreement between the two set of audits appears closer together in agreement. The Committee reported from November 2011 through April 2012 that 100% of the Nursing Care Monitoring Tools were completed and entered into the database by the assigned date. This showed improvement from the last review when all of the monitoring data was not entered timely and some monitoring tools audits were not completed, thus the data was skewed rendering the data unreliable. The Quality Assurance Efforts described above were positive steps forward in improving the quality and reliability of the Nursing Care Monitoring Tools.	

		The Quality Assurance Department had continued to refine and improve their 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 form for ease in interpreting data results. This provided definitive data for areas on the Nursing Care Monitoring Tools 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 continue to reduce the degree of disparity. As the system continues to decrease the disparity between the internal and external monitoring data and inter-rater agreement consistently reaches at least 80%, or greater, agreement, the Facility and the Monitoring Team will have greater confidence in the reliability of the monitoring data and the status of compliance with the monitoring tools. Each month 48 randomly selected records were audited for a total of 144 records per quarter, of which four records were selected for each of the 12 Nursing Care Monitoring Tools per month, resulting in 144 records per quarter being audited for Nursing Care Monitoring Tools by the Nursing Administrative staff and Nurse Managers. One record per month or three per quarter were audited for each of the 12 Nursing Monitoring Tools by the Quality Assurance Nurses. The three records audited by the Quality Assurance Nurses for inter rater-reliability checks included one per month or four per quarter of the same records audited by the Nursing Administration. The overall quarterly sample size of 144 records represented approximately 40% of the current 364 census. However, the sample size for each of the 12 Nursing Monitoring Tools represented approximately 3% of the total records. Therefore, the adequacy of the sample size for each Nursing Care Monitoring Tool was questionable as to how accurately they could determine the percentage of compliance. The Nursing Department in collaboration with the Quality Assurance Department should evaluate the adequacy of the sample size for each Nursing Care Monitoring Tool to ensure an adequate number of records are audited to determine compliance. A select number of analyzed and trended Nursing Care Monitoring Tools were presented monthly at the QI/QA Council meeting for review, discussion and disposition. The Monitoring Team attended the QI/QA Council meeting on 5/15/12. The quarterly Trend Analysis Report for 2/1/12 through 4/30/12 on the selected Nursing Care Monitoring Tools was presented at the meeting. The results of the trend analysis reflected the following findings: The CAPs review associated with the trend analysis found that the focus of the CAPs was to correct the disparity between the internal and external auditors on specific items on the Nursing Care Monitoring Tools, which seemed to relate primarily to interpretation on	

		the Nursing Care Monitoring Tool Guidelines. It was positive that the guidelines were revised and clarified, in order to bring about closer agreement betwee$_{n \text{ the}}$ two sets of auditor. • Acute Illness and Injury: Following discussion between the internal and external auditors and reconciliation of findings, the compliance scores on this monitoring tool for this quarter showed overall level at 89.47% compliance. Internal audits originally found 90.59% compliance, and external audits originally found 81.82% compliance. The differences in compliance findings were due to the following areas that showed frequent disagreements: Follow-up evaluations, and creating and implementing nursing care plans needed to address changes in individuals' condition. In comparing data on inter-rater agreement to the last quarter, ranging from 11/1/11 through 1/31/12, the overall level of agreement showed an increase from 78.95% to 89.47% this quarter. Corrective action was not recommended for this quarter because both compliance and the level of agreement were above 80%. • Annual Nursing Assessment: Following discussion between the internal and external auditors and reconciliation of findings, the compliance scores on this monitoring tool for this quarter showed overall level at 89.43% compliance. Internal audits originally found 98.86% and external audits originally found 94.87% compliance. The differences in compliance findings were due to the following areas that showed frequent disagreements: Summarizing the use of behavioral chemical restraints, including dates, identifying each nursing diagnosis, reason for diagnosis, and demographic information recorded on the assessments. In comparing trend data to the last quarter, ranging from 11/1/11 through 1/31/12, the overall level of agreement showed an increase from 76.83% to 89.43% this quarter. Corrective action was not recommended for this quarter because both compliance and the level of agreement were above 80% compliance. • Annual Nursing Care Plans: Following discussion between the internal and external auditors and reconciliation of findings, the compliance scores on this monitoring tool for this quarter showed overall level at 69.09% compliance. . Internal audits originally found 93.54% and external audits originally found 72.81% compliance. Several questions on the monitoring tool caused disparity in agreement in the following areas: Documentation of health care needs of the individual, including needs associated with the high risk or at risk conditions, revisions of plans based on clinical needs of individuals, and healthy diet that included proper weight and healthy lifestyle. Other areas included monitoring older individuals for drug levels and dosage reduction due to changes associated with aging. The Nursing POI Committee was in the process of developing a universal care plan for Aging. The Nurse Case Managers continued to be re-trained on these specific areas of the health care plans updating existing care plans. A Nurse Case Manager Supervisor will start in June 2012; this additional supervision of the Nurse Case Managers should help to resolve problem areas identified on health care plans. In comparing trend data to the last quarter, ranging from 11/1/11 through 1/31/12, the overall level of	

		agreement showed an increase from 65.45% to 69.09% this this quarter. A Corrective action plan (CAP) was initiated to reduce the degree of disparity between the internal and external monitoring data to reach compliance in level of agreement. Each step in the first CAP initiated on 2/14/12 was completed; however, scoring for the quarter resulted in 69.09% of agreement. Thus, a second CAP was initiated on 4/26/12 to address the disparity in scoring this tool. In addition, a CAP will be initiated on 6/1/12 to develop a universal care plan for Aging. • Documentation: Following discussion between the internal and external auditors and reconciliation of findings, the compliance scores on this monitoring tool for this quarter showed overall level at 62.96% compliance. Internal audits originally found 93.94% and external audits originally found 62.07% compliance. Review of data on internal audits and external audits identified the following problem areas: There was discrepancy found with external audit questions for M-D9a through M-D9c, which was scored as "No". However, the nurse failed to perform an evaluation on the individual's response to treatment and any problems resulting from the treatment. It was also noted that internal and external audits were reflecting two different episodes of documentation. These areas reflected the reason for the treatment, expected outcomes, and instructions to the staff. It was agreed that the first SOAP entry of each month audited would be used for the documentation audit by both the internal and external auditors. In comparing trend data to the last quarter, ranging from 11/1/11 through 1/31/12, the overall level of agreement showed a decrease from 91.67% to 62.96% this quarter. A CAP was initiated for this quarter due to the overall agreement level falling below 80% compliance. 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%. It was the responsibility of the Quality Assurance Nurses to track a CAP through to resolution. However, as was found in previous reviews, 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 counted the same as the least significant. The Nursing Department should collaborate with the Quality Assurance Department to evaluate weighting items on the Nursing Care Monitoring Tools by value of significance. Now that the Nursing Care Monitoring Tool Guidelines are revised, the next step the Nursing Department and Quality Assurance Nurses should focus on is evaluating longitudinal data derived from the Nursing Care Monitoring Tools to develop local and systemic CAPs relating to overall percentage compliance for each monitoring tool falling below 80% compliance. In addition, the weight/value of significance for each item on the respective monitoring tools should be considered when developing CAPs. In addition to completing the Nursing Monitoring Tools, the Nursing Department	

		continued to conduct a variety of other monthly internal monitoring activities. Those included Quality Peer Review for: • Acute Care Plans • Health Management Plans • Annual/Quarterly Nursing Assessments These data were summarized, analyzed, and trended. A review of monthly summarized data for these months found that corrective actions for deficiencies identified were the responsibility of each Nurse Manager to carry out. However, the deficiencies were not identified as to whether they were local or systemic. Neither was there documentation validating that the corrective actions were carried out or the effectiveness of the corrective action in correcting the deficiencies and minimizing future errors. However, completing the monthly Quality Peer Reviews for these items has the potential to further strengthen efforts toward compliance. The Nursing Department should ensure that Quality Peer Review deficiencies are identified as to whether they local or systemic, track the corrective action through to resolution, and assess the effectiveness of the corrective action evaluated. The monitoring process, development of outcome data, and CAPs for Provision M.1 continued to make progress since the last compliance review. However, the process was still maturing and should soon provide comprehensive measurement of outcomes toward compliance with all Section M provisions. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, there had been significant improvements in the assessment and documentation of individuals with acute changes in status. One of the most significant improvements was a consistent format used for documenting acute changes in status. The documentation format included: • Use of the SOAPE methods for charting. The "E" was used to document follow-up information related to the acute changes in status. • The entries of the notes included documenting. o The reason for the note, i.e. follow-up on the Acute Care Plan related to specific nursing problem. o The receipt of a report from the previous shift nurse when notes were initiated at the beginning of a new shift. o The use of the SOAPE methods for charting. The "E" was used to document follow-up information related to the acute changes in status. o Focused assessment of the affected bodily system for identified nursing problem, findings, and nursing interventions performed. o Reports from the direct care professionals. o Instructions to direct care professionals, including a statement of their verbal understanding of the instructions.	

		o The status of the problem, i.e. whether or not the problem was resolved. <u>Other areas that demonstrated improvement included:</u> • Improve legibility of the nurses' handwriting, with the exception of the nurses' signatures and initials. There are still a few nurses need to continue improving their handwriting. • Method temperatures were taken was consistently documented with rare exceptions. • Oxygen saturations were consistently documented as to whether they were assessed on room air or oxygen. • Approved abbreviations were consistently used with rare exception. • Acute Care Plans were consistently followed through to resolution without gaps in documentation, with rare exception. • Primary care providers were consistently notified promptly of acute change in individuals' health status. • Assessment of pain and/or discomfort was more consistently assessed. However, a variety of methods were used to describe the pain and/or discomfort, i.e. verbal description FLACC, and more recently the Wong Baker pain Scale. However, the rating score for FLACC and Wong Baker were not consistently documented. • Compliance with the requirements of Hospitalization, Emergency Room, and Transfer Policy showed improvement. • The nursing protocols were beginning to be used to guide the management of care and documentation. <u>Areas that did not demonstrate significant improvement included:</u> • Some Integrated Progress Notes had blank spaces without lines marked through. • Documentation errors were not consistently corrected with a straight line drawn through the error with the dates and initials of nursing staff making the errors. • More than one nursing problem was documented into one SOAPE note making it difficult to identify the status of each problem. • Military time was not consistently used. • Individuals' activity tolerance in relation to their acute change in status was rarely assessed and documented. • Individuals' mental status in relation to maladaptive behaviors were rarely described. • Individuals' prescribed topical antibiotics rarely were assessed for adverse drug reactions. It is essential that topical antibiotics are assessed for adverse drug reactions. • Individuals' prescribed all types of antibiotic rarely were assessed for their therapeutic effectiveness until they were complete, if at all. It is essential that the nurses assess the effectiveness of the therapeutic response to ongoing antibiotics as	

		well as other medication, and contact the primary care provider when the medications are not achieving the desired therapeutic response. • Individuals prescribed per necessary (PRN) pain medication were rarely assessed for the effectiveness of pain relief. • Individuals' scratches, abrasions, bruises, and wounds were not consistently described by appearance, size, and stage of healing. • There was continued need for nurses to improve the focused assessments of bodily systems affected by acute changes in status. Examples of concerns identified regarding the assessment, management and documentation are listed below: • Individual #612 was diagnosed and treated with Bactroban ointment, applied three times a day to the chin. An Acute Care Plan was initiated for Skin Infection and was being followed according to the antibiotic protocol. Although the Integrated Progress Notes indicated the bruise and abrasion was assessed according to protocol, only one note adequately described the size of the abrasions. The stage of the bruise healing was not documented, neither was the stage of the abrasion's healing described except to say it was improving. • Individual #386: In this example the LVN did not complete a focused assessment through auscultation of the lungs and abdomen in relation to the presenting symptoms, or notify a RN to complete the focused assessments. . On 5/3/12 at 1158 the nurse notified the primary care provider that he was coughing, gagging, hand mouthing, and drooling. Vital signs were documented as temperature 96.4 axillary, pulse rate 104, respirations 20, blood pressure 133/98, and oxygen saturation was 98% on room air. A focus assessment was not performed on the lungs or abdomen. The primary care provider immediately saw Individual #386. The nurse documented that the primary care provider did not see any need for further intervention as it was probably related to his behavior or gas. At 2:20 p.m., he was still having frothy drooling and yellowish drainage was observed around the G-tube stoma. Vital signs were documented temperature 95.4 axillary, pulse rate 98, respirations 21, blood pressure 133/98, oxygen saturation was 91% on room air. Again, there was no focused assessment of the lungs or abdomen. The primary care physician immediately saw Individual #386 again and he was sent to the emergency room by ambulance. Consequently, he was admitted to the hospital with diagnoses of high grade small bowel obstruction and left lower lobe pneumonia. It was of concern that the nurse did not complete focus assessments of the lungs and abdomen as required. Of further concern was that the primary care provider assumed the presenting symptoms were related to behavior or gas, discounting the change in baseline vital signs. Unfortunately, these presenting findings did not initially alert the staff of a significant change in status and a decision made to immediately send Individual #386 to the emergency room for evaluation. The nurse	

		involved needs re-training on completing focus assessments. • Individual #193: In this example the injury Individual #193 sustained to her hand on 5/12/12, resulting in a fracture of the fifth metacarpal, did not receive adequate evaluation and treatment by the physician until 5/14/12, which was two days later on a Monday. The fracture must have been painful. The nursing staff and or physician on call should have attended to the injury on 5/12/12. It was documented in the baseline data on 5/12/12 (Saturday) that Individual #193 became aggressive to the environment, knocked a shelf off the wall in the hallway and hit the hand sanitizer with her left hand. She was in sick call on 5/14/12 (Monday) and sent to the emergency room for an x-ray and computed tomography (CT) scan and found to have a fracture of the left fifth metacarpal (little finger). A cast was applied to the left forearm and hand with the fourth and fifth wrapped in the cast. An Acute Care Plan for Fracture to the Left Hand was initiated on 5/14/12. An Acute Care Plan was initiated on 5/14/12, which was individualized sufficiently to meet Individual #193's needs from the nursing standpoint, the direct care professionals were trained on the plan, and the plan was being followed. However, there was no documentation in the Integrated Progress Notes that the nurses collaborated with the habilitation therapist regarding the fracture and casting. Any plan of the Habilitation therapist should have been integrated into the Acute Care Plan due to the mobility issues related to the use and proper healing of the fracture. • • On 5/14/12 Individual #193 was administered Motrin 400 mg for pain and on 5/15/12 Tylenol 650 mg was administered for pain. The effectiveness of the pain medications were not documented in the Integrated Progress Notes. There was no documentation in the Integrated Progress Notes that the IDT was notified of the Acute Care Plan for Fracture of Left Hand. • Individual #420: In this example Individual #420 was diagnosed with a thumb boil (abscess) and was treated with a tropical antibiotic on 5/3/12. The thumb boil became more painful and swollen over time and did not appear to be responding to the topical antibiotic. The nursing staff did not initiate an Acute Care Plan for Infection until 5/8/12, although individual #420 was prescribed topical antibiotic ointment to the thumb on 5/3/12. According to the Acute Care Plan the nurses were assessing the thumb on every shift, but the nurses failed to consistently and adequately describe the appearance and size of the swelling of the thumb or the therapeutic response to the topical antibiotic. There was no documentation regarding sending Individual #420 back to sick call until 5/6/12. However, it was not until 5/8/12 that he was seen again by the nurse practitioner who documented that the thumb boil had improved and to continue the treatment of Bactroban. His pain and discomfort continued throughout the day. On 5/8/12 at 1910 the physician was notified and prescribed Augmentin 500 mg three times a day for 10 days and Tylenol 650 mg per necessary (PRN) for pain for five days. An Acute Care Plan was	

		initiated for Left Thumb Abscess on 5/812. Throughout the time he was treated with the topical antibiotic ointment it was apparent from reading the Integrated Progress Notes that the infected thumb was not responding to the topical antibiotic ointment. However, there was no nursing documentation regarding the effectiveness of the topical antibiotics. It is essential that the nursing staff assess the effectiveness of topical antibiotics as they do oral antibiotics; and when the desired therapeutic response is not attained, the physician is notified. There was no documentation that the Infection Control Nurse was notified of the infection. On 5/11/12, the direct care professional reported Individual #420's eyes were red. The nurse assessed his eyes and he was sent to sick call. He was diagnosed and treated with Tobmycin two drops for seven days for conjunctivitis. Although the nurses continued to assess and treat his eyes, and provided instruction to the direct care staff, there was no documentation in the Integrated Progress Notes indicating that the Infection Control nurse was notified or that an Acute Care Plan for conjunctivitis was initiated. The nursing assessment and treatment for both the infected thumb and conjunctivitis were entered into one note, which made it difficult to discern Individual #420's progress for either infection. According to the Nursing Department's instruction, each nursing problem/diagnosis is to be documented in a separate note. There was no documentation in the Integrated Progress Notes that the IDT was notified of either infection until 5/14/12. • Individual #112: In this example Individual #112 had acquired scratches and abrasion on his right foot from his shoes on 5/16/12 and that nursing staff had conducted assessment; however, the assessment did not lead to notice of appropriate other clinicians to ensure comprehensive assessment was completed. The nurse assessed the foot and found abrasions on the right ankle, fifth toe and bottom of the foot. The physician said to keep the foot dry and he was referred to sick call in the morning for impaired skin integrity. The Wound Care Nurse was also notified of the abrasions. An Acute Care Plan was initiated for Impaired Skin Integrity Related to Abrasions on Right Foot as related to nursing care. There was no documentation that the habilitation therapists were contacted. They are the discipline best qualified to evaluate the shoe for proper fit. The Acute Care Plan should have been developed in collaboration with the Habilitation therapist. The Nursing Department and Nurse Educator need to continue to reinforce training and monitoring nursing staff on Assessment and Documentation of Acute Change in Status Policy and Procedures. <u>Hospital Nurse Liaison Nurse Activities</u> The Hospital Liaison Nurses continued to follow-up on individuals who were hospitalized in local/area hospitals and Long Term Acute Care (LTAC) facilities through daily (except for weekend) 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 nursing and medical meetings and reported on hospitalized individuals. He maintained communication with the Nurse Case managers, Unit Directors, Qualified Developmental Disabilities Professionals (QDDPs), Wound Care Nurse, Occupational and/or Physical Therapist, and other IDT members as necessary. The IDT members were notified as soon as pending discharges were known in order to discuss any necessary training or equipment needed on discharge. Since the last review, it was positive to find that the Hospital Liaison Nurse had begun attending Integrated Support Plan (ISP) and ISP Addendum meetings for individuals who were hospitalized or in LTAC facilities. The Hospital Liaison Nurse's attendance at the post discharge meeting provided the IDT with valuable firsthand knowledge of the individual's health status at the time of discharge in order to be able to identify when there were significant changes in status that would require revising their risk assessment ratings. This information was validated through an interview with the Hospital Liaison and a joint record reviews for individuals who were hospitalized at the time of the Monitoring Team's visit. Records reviewed included Individuals #386, #146, #278, and #278. The details of the acute change in status of these individuals leading up to hospitalization and compliance with Hospital/ER/ LTAC Transfer Policy are reported above. <u>Wound Care Nurse Activities</u> The Wound Care Nurse reported that 17 Skin Integrity Committee Meetings were held between November 2011 and April 2012. A total of 27 individuals with skin integrity issues were reviewed and discussed, and recommendations were made for integrated management of two new pressure ulcers and 38 non-pressure ulcers. The Monitoring Team attended the Skin Integrity Meeting on 5/16/12, which demonstrated that the meeting was integrated with relevant disciplines. The Skin Integrity membership included: Medical Director, Physicians, Dietitian, Habilitation therapist, Clinical Pharmacist, Chief Nurse Executive, Nurse Educator, Quality Assurance Nurse, Nurse Managers, Infection Control Nurse, and Nurse Managers. The individuals with skin integrity issues and pressure sores were reviewed and discussed, and recommendations for care were made at the meetings. It was impressive to find since the last review that the Wound Care Nurse was photographing individuals' wounds	

		weekly to show their various stages of healing over time. The individuals' photographs were shown and discussed during the Skin Integrity meeting. Since the last review, the Wound Care Nurse began presenting findings to the IDT when major skin integrity issues were identified on individuals who were hospitalized or discharged and/or who developed significant skin integrity issues. The Wound Care Nurse reported he had attended four IDT meetings, three meetings focused on an individual who developed a wound to the right ante cubital fossa and required hospitalization. The incidents of decubitus reported September 2010 through August 2011, showed 12 individuals developed pressure ulcers, of which three were hospital acquired and nine were Facility acquired. The incidents of decubitus reported September 2011 through May 2012 showed two pressure ulcers, of which one was hospital acquired and one was Facility acquired. If these decreases in the incidents of pressure sores continue for the remainder of 2012, it will demonstrate the effectiveness of the integrated efforts put forth by the Wound Care Nurse in collaboration with other relevant disciplines. It was commendable that there were presently no more than two individuals with pressure sores considering the Facility's large population of which many individuals were determined to be medically complex and fragile with high risk ratings for skin integrity issues. At the time of the review there was one pressure ulcer and six non-pressure wounds. Records were reviewed with the Wound Care Nurse on Individuals #276 and #259 who had active pressure ulcers. After reviewing their records, the Monitoring Team found that the Individuals' Acute Care Plans (ACPs) for Skin Integrity did not consistently integrate all of the treatments and interventions that were being carried out by the Wound Care Nurse and other disciplines. However, the ACPs for Skin Integrity were adequately individualized for the actions/interventions the nursing staff were carrying out. Although the Wound Care Nurse had been conducting weekly reviews of new Acute Care Plans and Health Management Plans, he had not considered the inclusion of all pertinent care interventions related to other relevant disciplines' into the plans developed by the Nurse Case Managers. The Wound Care Nurse should review all newly developed Skin Integrity Acute Care Plans and Health Management Plans to ensure they include integrated actions/interventions of all relevant disciplines. The Wound Care Nurse continued to teach the competency-based Wound Assessment and Documentation Course. Fifteen new nurses were trained on the course between November 2011 and April 2012. The Wound Care Nurse completed Nursing Care Monitoring Tools for Skin Integrity. He developed and implemented Corrective Plans of Action for overall compliance scores	

		falling below 100%. <u>Infection Control Nurses Activities</u> It was positive to find since the last review, that a Nurse Case Manager had been reassigned to serve as an Assistant Infection Control Nurse. Since the last review the Infection Control Nurses had focused their efforts on updating the Infection Control Program's Policies, Procedures, and practices. Some of the activities performed by the Infection Control Nurses included: • The revision and updating of all Infection Control Policies and Procedures. The Infirmary and Units were each provided an Infection Control Manual and a copy was placed on the shared drive. • The improvement in the management and storage of dirty laundry. Residential staff were trained on correct handling of dirty laundry. Plans were to provide this training as part of the Infection Control New Employee Orientation Training. • The improvement in the management and disposal of biohazard medical waste and suction toothbrush canisters. The Infection Control Nurses were working with the Housekeeping and Maintenance Departments to resolve the storage problem of the biohazard waste. Storage areas for the biohazard waste were being located outside the living units. • Provided in-service training on identified Infection Control Issues: o Infection Control Training to all New Employees o Handwashing and Use of Glove Training to Residential Coordinators and Unit Nurse Managers, 2/27/12. o Clostridium Difficile (C-Diff) for Infirmary nursing staff, 2/27/12 o New Infection Control Reporting Form, all nursing staff, January and February 2012 o Care of Individuals with Scabies At Trinity-D, for Qualified Developmental Disability Professional (QDDP), Residential Coordinator, Residential Supervisor, and Direct Support Professionals on 4/16/12 and 4/17/12 o Pneumonia Tracking Sheet and Infection Control Forms to Infirmary nursing staff on 4/26/12. o Spread of Conjunctivitis on Trinity, for Residential Supervisor, and Direct Support Professionals on 5/7/12. • Conducted monthly handwashing and environmental surveillance observations. • Environmental work was completed by the Facility to improve the air quality included: o Ultraviolet "c" band lighting was retrofitted into the medically fragile units to treat air quality at the air conditioning coil which was at the point all returning air passed through. o An Aerocide indoor air scrubber was placed in the Infirmary as a pilot program to reduce infections through removing contaminates in air that	

		could be harmful to individuals who reside in rooms for isolation. The air is treated and scrubbed with the aerocide unit before it returns for recycling through the return air process. o As a precaution, Maintenance had three additional types of portable air scrubbers to be placed on units when fumes, dust particles or any other potential hazardous substance may be present from cleaning, construction, or other substances that might cause air quality impairment. o Simix floor sealer that has hydrogen peroxide properties within the formula when used with lighting assists in killing infections. It was a hypo-allergenic compound that housekeeping uses to seal the floors and was a "green" product. o Betazyme compound products were used for mattress cleaning and furniture to eliminate and kill toxins from bodily fluids such as urine and saliva as well as eliminating orders. This is also a "green" product. o The use of Febreze air freshener was discontinued because it was found to be an irritant to individuals and employees, causing allergic and respiratory reactions. It was replaced by Odoban deodorizer pump spray. This product had no volatile organic compounds, contained no allergens, and was a mild disinfectant. It can be used instead of dangerous aerosols like Febreze or Lysol type products. • Reviewed monthly Epidemiology Reports and provided the information to the medical staff and to the Pharmacy and Therapeutics Committee. • Completed Nursing Care Monitoring Tools for Infection Control. Developed and implemented Corrective Plans of Action for overall compliance scores falling below 100%. • 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. • Produced Infection by Type Reports. It was only within in the past month, with the addition of the Assistant Infection Control Nurse, that it was possible for the Facility to enter all of the backlogged infection control data. The Infection Control Database reported data by month, individual, unit, type of infection, organism, date of onset, date resolved, precautions taken, date, type, and result of diagnostic testing, and comments. The data was further represented in tabular and graphic form using bar graphs and pie charts to identify the percentage of occurrence by type and unit on the pie charts. The Infections by Type Report for the period of 11/1/11 through 5/15/12 were reviewed. The results of the report are listed below from highest to lowest incidents of Infection by Type : o Urinary Tract Infections (UTIs): ▪ UTIs Straight Catheters = 1	

		▪ UTIs No Catheters = 29 ▪ UTIs = 15 Total = 45 Percentage of UTIs Combined by Unit: ▪ Infirmary = 2% ▪ Neches = 2% ▪ San Antonio = 11% ▪ Three Rivers = 11% ▪ Four Rivers = 15% ▪ Trinity = 28% ▪ Leon = 31% o Soft Tissue Infections: ▪ Soft Tissue = 19 ▪ Cellulitis = 15 Total = 34 Percentage of Soft Tissue Infections Combined by Unit: ▪ Three Rivers = 6% ▪ Neches = 9% ▪ Four Rivers = 12% ▪ San Antonio = 15% ▪ Trinity = 18% ▪ Leon = 40% o Ophthalmic and Otic Infections: ▪ Bacterial Conjunctivitis = 4 ▪ Viral Conjunctivitis = 4 ▪ Conjunctivitis = 15 ▪ Otitis Media = 6 ▪ Otitis Externa = 4 Total Infections = 33 Percentage of Ophthalmic and Otic Infections Combined by Unit: ▪ Slice = 3% ▪ Four Rivers = 12% ▪ San Antonio = 15% ▪ Three Rivers = 15% ▪ Leon = 21% ▪ Trinity = 34% o Lower Respiratory Infections were broken down by type of infection: ▪ Bacterial = 11 cases ▪ Aspiration Pneumonia = 5 ▪ Bacterial Pneumonia = 1 ▪ Pneumonia = 4 Total Infections = 21	

		Percentage of Lower Respiratory Infections Combined by Unit: ▪ Infirmary = 0% ▪ Neches = 5% ▪ Three Rivers = 5% ▪ San Antonia = 14% ▪ Leon = 19% ▪ Trinity = 57% o Upper Respiratory Infections by Unit: ▪ Upper Respiratory Infection = 5 Total Infections = 5 Percentage of Upper Respiratory Infections Combined by Unit: ▪ Neches = 20% ▪ Three Rivers = 20% ▪ Trinity = 20% ▪ Leon = 40% o Organisms Identified: ▪ Methicillin-resistant Staphylococcus aureus (MRSA) = 1 Total Infection = 1 Percentage of Organisms by Combined by Unit: ▪ Four Rivers = 100% A review of the Infection Control Committee meeting minutes did not include a summarized trend analysis or rate of the Infections by Type. The minutes simply stated there were no infectious trends. Considering the Infection by Type data that identified the number of infections and percentage of the location where they occurred, it was concerning that the minutes reported there were no infection trends. Perhaps, at the time of the Infection Control Committee meetings all of the Infection by Type data had not been entered. In order to accurately analyze infection data for trends/rates, a standardized formula for calculating rates/trends, i.e. the number of infections, by type, divided by census times the number of days times 1000 (for 1000 patient bed days.). The availability of Infection by Type data from the comprehensive Infection Control Database provided the Facility with information from which to analyze, trend, and rate infections. Neither was analysis and trend data included in the minutes for handwashing and environmental surveillance observations data. It is essential that the Infection Control Nurses track and analyze pertinent infection control data to identify local and systemic trends for internal management purposes; and present their findings to the integrated Infection Control Committee for review, discussion, and disposition. The Infection Control Program did not have an Immunization tracking system in place. They were awaiting an Immunization Database to track immunizations. Individuals' and employees' tuberculosis skin testing and influenza vaccination status:	

		• Individuals' were reported to be 100% current with tuberculosis skin testing. There were 26 individuals with converted tuberculosis skin tests, all of which were current with their follow-up screening. Individuals' who received influenza vaccinations were reported as 100% complete. • Employees' tuberculosis skin testing and chest x-ray/screenings were reported at 42% complete. Employees' who received influenza vaccinations were reported at 35% complete. Employees' who received hepatitis B vaccines completed were reported at 59%. The CTD Course Delinquency List reported eight employees were delinquent in Infection Control refresher training. According to Provision M.1 Action Steps, the following activities were in process with completion dates projected for 4/30/12, and for which there was no documented evidence of the status of the activities: • Analyze data quarterly from data reports to identify local and systemic trends. • Participate in the review of Health Management Plans which include prescribed antibiotics. • Analyze data quarterly from data reports to identify local and systemic trends. • Participate in the review of Acute Care Plans which include prescribed antibiotics. • Enter immunizations including seasonal flu vaccine data into AVATAR when finalized by the State Office. The Monitoring Team will review the status of completion of these Action Steps at the next review. Although improvements were found, now that the Infection Control Program is staffed with two Infection Control Nurses, as they refine the Infection Control Program and mature in their roles and responsibilities; the Nursing Department should ensure that the Infection Control Nurses address the following: • Track, analyze, trend, and summarize pertinent infection control data, including, but not limited to, Infections by Type, handwashing observations, and environmental surveillance monitoring data to identify local and systemic trends that require corrective action. • Develop and implement 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. • Review the all new Acute Care Plans and Health Management Plans for infections with the Nurse Case Manager to ensure that plans are integrated with other relevant disciplines and contain all pertinent infection control measures in the plan sufficient to meet individuals' needs. • 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. • CTD to ensure that all relevant employees are current in Infection Control refresher training. <u>Availability of Pertinent Medical Records</u> Records were made available onsite without difficulty or delay. However, it was discovered when looking for individuals' active Acute Care Plans, that they were kept in the Care Plan Books on the Units/Homes for ready access. When active problems were resolved the Acute Care Plans were filed in the unified record. The Care Plan Books were not part of the unified records. If the nursing staff had not assisted with securing the Acute Care Plans from the Care Plan Books, it would have been assumed there were no Acute Care Plans for the individuals that the Monitoring Team was attempting to review. The original Health Management Plans were maintained in individuals' unified records with working copies placed in the Care Plan Books on the Units/Homes for ready access. By keeping the Health Management Plans in two different locations, there is the potential that individuals' original Health Management Plans may not be updated if the working copies in the Care Plan Books were updated. <u>Mock Medical Emergency Drills and Emergency Response Activities</u> Since the last compliance review, the Facility continued to maintain the positive practices identified. The Facility continued to make steady progress toward issues identified that needed further improvement. Improvements were verified through review of documents, interviews and observations which included the following: • The Facility had fully implemented the State's Emergency Response Policy, 044.2 and RSSLC Actions During and Following a Medical emergency (4444). There was documentation that all nursing and other relevant staff were trained on the policies. • The Facility had obtained all of the required emergency equipment, including the AEDs as required by revised Emergency Response Policy, with the exception of eight backboards and eight small portable oxygen tanks that were on order. In addition to purchasing the emergency equipment, large red canvas bags with wheels were purchased to store and make equipment readily accessible to staff during an emergency event. A spare emergency bag and other emergency equipment were kept in the security van. Three additional emergency bags were available but were not stocked, awaiting arrival of additional emergency equipment. The emergency equipment bags were secured with numbered breakaway locks. • The Facility identified the designated AED and emergency equipment locations throughout the campus and supplied a map of the campus marking their locations. • The emergency equipment bags, suction machines, oxygen tanks, automated external defibrillators (AEDs), and other required emergency equipment were located together in the designated areas. The nursing staff checked all emergency equipment daily; and the Risk Manager checked all emergency equipment monthly	

		during routine walkthroughs. The emergency bags were not opened at each check unless the numbered breakaway away locks were broken. When a lock was broken it was replaced with another numbered breakaway lock. The locks were replaced by the Risk Manager and the new numbers were entered on the emergency equipment checklists. The required emergency equipment checklists were maintained in red notebooks for each set of emergency equipment. • In April 2012, the Risk Manager was assigned the responsibility for overseeing the Facility's Emergency Response System and to serve as the chairperson for the Emergency Medical Response Committee. It was positive to find the Facility had assigned a specific staff to oversee the Emergency response system, which should further improve the compliance with the Emergency Response Policy. The core membership included the Risk Manager, Medical Director, Chief Nurse Executive, Nurse Educator, CTD Director, and Security Director. The Quality Assurance Nurses were added to the core membership in April 2012 in order to directly report issues that may need Quality Assurance attention. The committee's mission statement that was in process at the last review had been completed. • A review of the quarterly Mock Medical Emergency Drill Report, indicated data were analyzed and trended. It was reported that 99% of the scheduled drills were completed in January 2012, February 2012, and March 2012. Data were represented in tabular and graphic form with narrative explanations of any identified deficiencies. There was documentation that Monthly Mock Medical Emergency Drill Reports were consistently sent to the Quality Assurance Department for the last six months, as required by policy. No CAPs were required because the monthly drills were completed correctly by 97% to 100%. On 5/16/12, the Monitoring Team, accompanied by the Risk Manager, Nursing Operation and respective Unit Nurse Managers conducted a walkthrough inspection of emergency equipment in Trinity, Leon, Nueces, and Neches (dining room). All emergency equipment was present, in good working order. A review of the May 2012 Emergency Checklists , found the equipment was checked daily by the nursing staff. In addition, these Units had laminated AED signs posted with arrows on both sides of the main hall ways pointing to the location of the AEDS. The Risk Managers stated all designated areas with AEDs had laminated AED signs posted to identify their locations. According to the 12/9/11 Emergency Medical Response Committee meeting minutes, the committee was to meet monthly, unless events prevented the meeting, and then the committee would meet by the next business day. A review of the Emergency Medical Response meeting minutes only found minutes for 12/9/11, 2/29/12, and 4/5/12. Therefore, as was found at the last review, it could not be determined if the committee met monthly or if the minutes for October 2011, November 2011, and March 2012 were not made available for review as requested. The minutes reviewed were more substantive than was found in the past. It was positive to find that issues identified as	

		needing follow-up at the next meeting were addressed in following meetings. In the 4/5/12 minutes the Risk Manager shared his concerns identified in reviewing the past three months drills with the lack of CTD Emergency Response Drill Instructors' documentation and reporting corrections, coaching, and re-drilling staff that had performance issues. He also discussed his concerns identified during his walk through to inspect the emergency equipment in designated areas. The suction machine carts were old and non-conducive to the activities and actions to be carried out and may cause injury to staff responding to an emergency. He also discussed concerns regarding the accountability, protections and location of the emergency bags throughout the Facility. The Medical Director shared a draft policy regarding the role of physicians' involvement in the Emergency Response Policies and procedures. The draft was not available for the Monitoring Team to Review. The Monitoring Team will follow-up on this draft policy at the next review. It was positive to find that the concerns identified in the 4/5/12 minutes had been addressed by the time of the Monitoring Team's review. There was documentation that the nine Emergency Drill Instructors were retrained on the competency-based Emergency Drill Instructors Training Curriculum and the Emergency Response Policy In March 2012. At the time of the Monitoring Team's walkthrough to check the emergency equipment, the Risk Manager stated he had corrected the problem identified with unsecured emergency equipment in the designated area, by placing cages around the equipment to avoid harm and had corrected the problems with the old suction machine carts by ordering new carts. Areas that did not show significant improvement included: • A review of the Incident Management meeting minutes, February 2012 through April 2012, did not include reports on Mock Medical Emergency Drills/Emergency Response. Only the 4/13/12 contained such a report. The Facility should ensure that relevant Emergency Response information is reported at the Incident Management Meetings. • The CTD Due/Delinquency Training Lists identified one employee delinquent in BLS for Health Care Providers. The CTD Course Delinquency Lists identified four employees who were delinquent in CPR Basic. This represented a significant decrease in the number of delinquent employees in BLS for Health Care Providers and Basic CPR Training, which showed an improvement since the last compliance review. The Facility should ensure that all required employees are current with Basic Life Support and/or Basic CPR training. • There was no documentation in the information reviewed indicating that the Mock Medical Emergency Drills included scenarios to address any illness or injury that might require emergency response, as listed in Emergency Response Policy, 044. The Facility's Mock Medical Emergency Drills should include a variety of scenarios	

		that might require emergency response, as described in the Emergency Response Policy, 044. Although there had been continued improvements made; the Facility should maintain the positive practices identified in the report and make improvements on the following practices: The Facility should ensure that: • Relevant Emergency Response information is reported at the Incident Management Meetings. • All required employees are current with Basic Life Support and/or Basic CPR training. • The Facility's Mock Medical Emergency Drills should include a variety of scenarios that might require emergency response, as described in the Emergency Response Policy, 044.	
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.	Provision M.2: <u>Activities engaged in to conduct the self-assessment</u>: • Monthly Quality Peer Reviews were conducted on 20 Annual and Quarterly Nursing Assessments to verify the use of a standardized format and completion of overall nursing summaries for November 2011 and December 2011. • Monthly monitoring of 20 Health Management Plans (HMPs) was completed to verify documentation and the effectiveness of the plans in relation to individuals' health status, from November 2011 through March 2012. <u>The results of the self-assessment</u>: • Audits of the Nursing Care Annual and Quarterly Nursing Assessments Monitoring Tools showed an overall compliance of 96.6%. • Audits of the Nursing Care Annual and Quarterly Nursing Assessments Monitoring Tools, reviewed from December 2011 to January 2012, revealed the standard format was used and the nursing summaries were completed. • Of the HMPs reviewed, 65% revealed no documentation as to their effectiveness. CAPs included retraining on documenting the effectiveness of the HMPs. <u>Self-rating</u>: Based on the findings from their self-assessment, this Provision was not in substantial compliance. Nurses need to make significant improvement in the documentation of the effectiveness of the HMPs. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, there was evidence that the Nursing Department had continued to provide additional	Noncompliance

		training and monitoring toward achieving compliance in this Provision. Significant improvement was found from previous reviews. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. The Monitoring Team selected a sample of records to review from each unit for the two most recent Annual and/or Quarterly Comprehensive Nursing Assessments on Individuals: #463, #99, #641, #784, #152, #107, #259, #165, and #286. • Eighteen of the 18 (100%) Annual and/or Quarterly Comprehensive Nursing Assessments were completed according to the ISP schedule. • Eighteen of the 18 (100%) Annual and/or Quarterly Comprehensive Nursing Assessments contained BRADEN skin assessments. • Eighteen of the 18 (100%) Annual and/or Quarterly Comprehensive Nursing Assessments contained the signature and date of the RN Case Manager completing the assessments. • Fifteen of the 18 (83%) Annual and/or Quarterly Comprehensive Nursing Assessments contained documentation that the Qualified Developmental Disability Professionals were notified of the completed assessments. • Fourteen of 18 (78%) Annual and/or Quarterly Comprehensive Nursing Assessments, Section I through IX contained completed assessment data and adequate summaries for each section assessed. • Seven of 18 (39%) Annual and/or Quarterly Comprehensive Nursing Assessments, Section I through IX contained completed assessment data and adequate summaries for each section assessed. Sections I through IX of the assessments found the following trends: o The assessments in these sections showed some steady improvement in completing these section assessments with more substantive information in the summaries relative to the system assessed. The quality of the assessments and summaries varied from Unit to Unit and from RN Case Manager to RN Case Manager. The most notable improvements may be attributable to the RN Case Managers who received the State Physical Assessment and Documentation training. o The Immunizations status was not consistently completed for all required immunizations. The template left off a block to document polio; consequently individuals' polio status was not addressed. In addition to omission of polio immunization documentation, measles, mumps, and rubella (MMR), varicella, and hepatitis immunization documentation was frequently omitted. The State and Facility should add polio vaccination information to the Comprehensive Nursing Assessment template and ensure all other required immunization documentation is complete. • The quarterly Comprehensive Nursing Assessments were not updated when there	

		was a significant change in health status. • Section X, Nursing Problems, often failed to include a nursing problem/diagnosis for one or more high and/or medium risk ratings and an accompanying Health Management Plan (HMP) for the identified high and medium risk ratings that required nursing interventions. Not all identified nursing problems/diagnoses had an accompanying HMP. Conversely, not all HMPs had accompanying nursing problems/diagnoses. The Nursing Department should ensure that nursing problems/diagnoses and accompanying HMPs are developed and implemented for all of individuals' high and medium risk ratings that require nursing interventions. • Despite training and monitoring the Nursing Department had put forth in order to improve the quality of the Section XI Nursing Summaries, since the last review, marginal improvement was noted in the analyses and summaries of clinical data. The quality of the nursing summaries varied from Unit to Unit and Nurse Case Manager to Nurse Case Manager. A review of the Section XI Nursing Summaries found the following trends: o Four of 18 (22%) Section XI Nursing Summaries adequately summarized each identified nursing problem and stated the individuals' health status progress and the effectiveness of the Health Management Plans (HMPs). o The summaries continued to contain raw clinical data, as described in previous reviews. The summaries did not adequately describe individuals' health status progress, or lack of progress, or the effectiveness of the HMP. o The summaries often stated in relation to the nursing problem that the "plan was progressing" rather than stating how the individual's health status was progressing. Also stated was, "the individuals' goals were progressing, maintaining or regressing" rather than stating that individuals' health status was progressing, maintaining, or regressing in relation to the established goal. o The revised format for documenting the overall nursing summaries found that the segregation of the clinical data did not improve the quality of the summaries. The items contained in the summaries continued to contain raw clinical data without analyses to identify individuals' health status in relation to their problems. With the additional categories in the format, the clinical data were more fragmented, making it even more difficult to discern the individuals' health status in relation to each of their problems. o As was found at the last review, there was no consistent format used in writing the nursing summaries; although a standardized format, as described above, was supposed to be used. The format varied from Nurse Case Manager to Nurse Case Manager. Nursing Community Discharge Summary and accompanying Health Care Plans were reviewed for recently discharged Individuals #96, #110, and #165. It was positive to find since the last review, that the Nurse Case Managers had been trained on and were	

		using the new Nursing Community Discharge Summary form. A review of the content found the summaries were essentially the same as was found in the nursing assessments described above, with the exception of nursing summaries for special instructions. Although the special instructions contained pertinent information, they were written in long fragmented sentences that were difficult to read and understand. In order for the community providers to read and understand, each special instruction should be written in clear, concise, and easy to read sentences without unnecessary medical jargon. The same is true for the health care plans. Based on the findings of this review, in comparison to 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 Nurse Case Managers understand how to analyze, summarize, and document clinical health data that will result in adequately and accurately demonstrating 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 Nurse Case Mangers in appropriately planning and evaluating individuals' care but it is also important for the IDT to incorporate into individuals' ISPs. Although improvements were found, 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: • Continue to provide the Nurse Case Managers with training on Section XI nursing summaries to ensure that nursing problems/diagnoses are analyzed and summarized concisely to adequately and accurately represent individuals' health status; and to measure the effectiveness of their respective HMPs. • Ensure that the Nurse Case Manager review/revise Comprehensive Nursing Assessments when there was a significant change in health status. • Ensure that nursing problems/diagnoses and accompanying HMPs are developed and implemented for all of individuals' high and medium risk ratings that requires nursing interventions. • Ensure a standardized format is used by the Nurse Case Managers for completing the overall nursing summaries on the Comprehensive Nursing Assessment template. • Ensure community discharge special instructions are written in clear, concise, and easy to read sentences without unnecessary medical jargon. The same is true for the health care plans. The State and Facility should: • Add polio vaccination information to the Comprehensive Nursing Assessment template.	

		• Consider providing the Nursing Department with technical assistance from an expert to provide competency-based training to assist the relevant nursing staff with critically analyzing clinical data into clear and concise summaries reflective of individuals' health status.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Provision M.3: <u>Activities engaged in to conduct the self-assessment</u>: • Twenty HMPs were reviewed monthly to verify that the required HMP components were included for the months of November 2011 to March 2012. • A minimum of 40 Acute Care Plans (ACPs) were reviewed monthly to verify that the required ACP components were included for the months of November 2011 to March 2012. <u>The results of the self-assessment</u>: • The results were 65% of the HMPs reviewed did not have documentation as to the effectiveness of the HMP. CAPs included retraining on evaluation and documentation of effectiveness of the HMPs. • The results were 83.7% (11/01/11 to 1/31/12) of the ACPs reviewed verified that required ACP components were included. The trend reflected progress as the month of February monitoring reflected 90.7%. The areas that fell below 80% in November through January were: Individualization, measurable goals, and documenting changes in healthcare status. <u>Self-rating</u>: Based on findings from this self-assessment, the provision was not in substantial compliance. Nurses need to make significant improvement in their documentation of the effectiveness of the HMP. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, there was evidence that the Nursing Department had continued to provide additional training and monitoring toward achieving compliance in this Provision. Significant improvement was found from previous reviews. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. It was impressive to find the investment of effort the Nursing Department had put forth since the last review to improve the quality of health care plans. The Nurse Educator had developed and implemented an excellent comprehensive competency-based training program on Development of Individualized Health Care Plans Curriculum, of which there were 95 (100%) of the RN staff trained. The Nurse Managers reviewed each new Acute	Noncompliance

		Care Plan and Health Management Plan for compliance. The Nursing Department had also enhanced monitoring efforts for the health care plans. In front of each health care plan was a reminder sheet with the required health care components for the health care plans and the required corresponding documentation in the Integrated Progress Notes. These efforts for improvement were reported completed as of 4/1/12. The Monitoring Team reviewed a sample of 12 of the most recently completed (since 5/1/12) Acute Care Plans. The sampled Acute Care Plans were selected from all Units in to determine the progress made toward improvement throughout the campus. The Acute Care Plans were for Individuals: #798, #420, #8, #530, #612, #276, #678, #386, #275, #663, #112, and #193. The results of the findings included the following: Acute Care Plans • Twelve of 12 (100%) Acute Care Plans contained adequate baseline data sufficient to identify the reason for the care plan. • Eleven of 12 (92%) Acute Care Plans contained goals that were observable, measureable, and realistic. • Six of 12 (50%) Acute Care Plans were individualized sufficient to meet individuals need with respect to nursing intervention. Two Acute Care Plans should have been integrated with Habilitation therapy, e.g. Individuals: #193 and #112. Two Acute Care Plans for Urinary Tract Infections did not include nursing intervention or instruction to the direct care professionals to encourage adequate fluid intake, e.g. #275 and #530. Two Acute Care Plans for eye infections did not include nursing intervention or instruction to the direct care professionals on management of contaminated linens and disposal of contaminated waste to prevent cross contamination. • Zero of 12 (0%) Acute Care Plans contained information that was irrelevant or not applicable to individuals' care. • Twelve of 12 (100%) Acute Care Plans' instructions for the direct care professionals were written in terms they could easily understand. • Twelve of 12 (100%) Acute Care Plans contained documentation verifying that the direct care professionals had been trained on the plans. • Twelve of 12 (100%) Acute Care Plans and associated documentation indicated that the Antibiotic Therapy Protocols were consistently followed. • Nine of 12 (75%) Acute Care Plans contained documentation in the associated Integrated Progress Notes that the Infection Control Nurse was notified of the infections. • Eight of 12 (67%) Acute Care Plans contained preventative measure. • Four of 12 (33%) Acute Care Plans contained documentation in the associated Integrated Progress Notes that the IDTs were notified of the infection. Forty-four current Health Management Plans were reviewed on Individuals: #463, #99,	

		#641, #784, #152, #107, #259, #165, and #286. The findings are listed below: • Forty-two of 44 (95%) Health Management Plans contained adequate baseline data sufficient to identify the reason for the care plan. • Thirty-eight of 44 (86%) Health Management Plans contained goals that were observable, measureable, and realistic. • Thirty-eight of 44 (86%) Health Management Plans were individualized sufficient to meet individuals' needs with respect to nursing interventions. • Thirty-three of 44 (75%) Health Management Plans contained no information that was irrelevant or not applicable to individuals' care. • Forty-four of 44 (100%) Health Management Plans' instructions for the direct care professionals were written in terms they could easily understand. • Forty-four of 44 (100%) Health Management Plans contained documentation verifying that the direct care professionals had been trained on the plans. • Twenty-seven of 44 (61%) Health Management Plans were reviewed and/or revised annually and/or quarterly. • Eight of 44 (18%) Health Management Plans contained preventative measures. • Five of 25 (20%) Health Management Plans that needed integration/collaboration with other disciplines plans included evidence of such integration/collaboration in the plans. • The Health Management Plans did not consistently specify the frequency nursing interventions were to be carried out or where to document. However, frequently found on the plans was the requirement for the Nurse Case Managers to document on the plan quarterly. The Health Management Plans reviewed were initiated from August 2011 forward to date. As was found with the 10 most recently initiated Acute Care Plans, there was progressive improvement found in the Health Management Plans. The most notable improvements were found in the plans initiated after February 2012. These improvements are most likely attributable to the re-training the Nurse Case Managers received on the Development of Individualized Health Care Plans, beginning in January 2012. Although improvements were found, 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: • Health Management Plan nursing interventions should include instructions for the frequency they are to be performed and where to document the actions taken. • Acute and Care Plans should include preventative measures. • Acute Care Plans and Health Management Plans should ensure that plans are developed in collaboration with other relevant clinical disciplines when appropriate.	

		• Health Management Plans should be reviewed/revised on a quarterly basis and when there is a change in individuals' status.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Provision M.4: <u>Activities engaged in to conduct the self-assessment</u>: • Conducted daily documentation review of SOAP charting post training from December 2011 to February 2012. A minimum of four records were reviewed daily. • Random audits were conducted on the units to verify that updated State Policy and Procedure revisions were added to the Nursing Policy and Procedure Manuals. • Random audits were conducted to ensure that both sets of State-Office-issued Protocol Cards were readily available to the nurses. <u>The results of the self-assessment</u>: • The data on appropriate SOAP charting showed monthly compliance as: o December 2011 83.9% o January 2012 90.7% o February 2012 87.6%. • One hundred percent of the Nursing Policy and Procedure Manuals on campus were updated with new policies/procedures/revisions. • Audits conducted on the availability of protocol cards showed 100% were available to nurses on all units. <u>Self-rating</u>: Based on findings from their self-assessment, this Provision remained in compliance due to continuing implementation and improvement in nursing assessments and reporting protocols sufficient to address the health status of the individuals served. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were in substantial compliance with this Provision and the Monitoring Team did not concur. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, there was evidence that the Nursing Department had made significant progress toward achieving compliance with this Provision by maintaining a well-organized and comprehensive Nursing Education Program, which included updated and revised State and Facility Policies, Procedures, Processes, and Protocols. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, with exception of finding substantial compliance with this Provision. Since the last review, the second set of nine Protocol Cards had been developed and implemented. The protocol cards were for nine additional protocols had been developed for: Enteral Feeding: Tolerance/Complications, Hypothermia, Minimum Documentation, When to Contact the PCP, Seizure Activity, Status Epilepticus, PICA, and Abdominal	Noncompliance

		Distention/Pain. The nursing protocol cards appeared to be clinically appropriate and in accordance with nursing standards of practice and consistent with the State's Nursing Policies, Procedures and Processes to ensure consistency. Only the key components were placed on the protocol cards. The nursing protocol cards continued to be printed pocket size, laminated, and put onto a ring to carry. The Nursing protocols were to be carried by all nursing staff while on duty to provide a quick reference and to ensure adherence to the protocols. At the time of the review 100% of the nursing staff had been trained on the protocol cards and they had been distributed across campus. All protocols should be demonstrated through actual nursing practices. Additional nursing protocols need to be established and implemented in order to sufficiently address all aspects of individuals' health status needs. It was impressive to find that the Nurse Educators had the recently developed and implemented a competency-based Individualized Health Care Plan Development Power Point Presentation in-service training for all RNs. The Monitoring Team found the training content comprehensive and appropriate for writing heath care plans sufficient to meet individuals' unique health care needs. The Nursing Department had implemented a Preceptor Program. The Preceptor Program was designed to provide supervised clinical experience for the nursing orientee. Thirteen existing nurses were recruited and trained to perform as preceptor. The objectives were to: • Provide the new nurses with a support mechanism during the early and crucial period of employment. • Create an individualized orientation program for each nurse based on his or her clinical expertise, experience, and work situation. • Provide assistance to the Nurse Educators in providing continuity during the orientation period. • Provide preceptors and new nurses with an opportunity for professional growth and increased job satisfaction, which should foster retention of employment. Since the last visit, some nursing policies and procedures had been revised. These included both Facility and State policies and procedures, and some State forms as listed below: Revised Policies: • State Policies: o Medication Administration Observation Guidelines o Nursing documentation Guidelines • RSSLC Policies: o Medication Administration Guidelines o Neurological Assessment Protocol o Gastrostomy Tube Reinsertion	

		o End of Life Hospice o Quarterly Physician Orders • RSSLC Revised Forms: o Post Hospitalization/ER/LTAC Nursing Assessment o Medication Administration Guidelines • RSSLC New Form: o Nursing Discharge Summary • RSSLC New Guidelines: o Medication Variance Guidelines • State/RSSLC Second Set of Nursing Protocols: The State Office conducted the Annual Nursing Competency Testing in February 2012. It was impressive to find since the last review, that the Facility had provided the Nursing Department with a large training room to use as a lab with training equipment to use for competency skill check-offs; as well as a large classroom with student desks for didactic training, and a large meeting room with a large table adequate to conduct nursing meetings. It was essential for the Nursing Department to have adequate space to conduct training and meetings because an adequate and comfortable physical environment is conducive to participants' ability to learn. As was found in past reviews, the Nurse Educators continued to maintain a comprehensive and updated Nurse Training Database to track all training provided to the nursing staff through to completion. The Nurse Educators continued to use the Nurse Education Handbook for New Nurse Orientation and Annual refresher training. They continued to train the nursing staff on any new and/or revised policies, procedures process, and/or protocols. A review of the database and accompanying training data validated that all of the nurses' required training had been completed by at least 95% to 100% of the nurses. Listed below are the in-service trainings provided to the new nursing staff: • Since the last compliance review, the Nursing Department had four New Nurse Orientation trainings. The dates were as follows: 10/28/11, 11/28/11, 1/23/12, and 1/23/12. Five new nurses were recently hired and will begin employment in June 2012. The New Nursing Orientation trainings were competency-based using formalized curriculums/lesson plans. One hundred percent of the new nurses were trained on the following policies, procedures, processes, and protocols: o Self-Administration of Medications o Weight Management Procedure o Neurological Assessment Protocol o Care Plan Development o Management of Acute Illness and Injury o Nursing Documentation Guidelines	

		o Nursing Standardized Abbreviations o 24-Hour Clock o Pre-Treatment and Post Sedation Monitoring Nursing Protocol o Medication Administration Guidelines o Seizure Management Nursing Protocol o Vagal Nerve Stimulator Nursing Protocol o Nursing Competency-based Training Curriculum o Post Anesthesia Care Nursing Protocol o Nursing Peer Review Policy o Nursing Services Policy o Hospitalization, Transfers, and Discharge Protocol o Emergency Response Policy o Skin Management and Wound Prevention Protocol o Medication Administration Observation Guidelines o PICA Protocol o Medication Variance Policy Listed below are the in-service trainings provided to the general nursing staff since the last review: • 11/21/11, Trained all nursing staff on: o Post Hospitalization/ER/LTAC Nursing Assessment o Aspiration Trigger Data Sheet o Wong Baker Pain Assessment Scale ▪ Number of nurses trained = 155 ▪ Percent trained = 100% • 12/8/11, Nurse Case Managers were trained on: o Nursing Discharge Summary o Aspiration Trigger Data Sheet (retrained) ▪ Number of Nurse Case Managers trained = 21 ▪ Percent trained = 100% • 12/29/11, Protocol Cards, First Set implemented: o Number of nurses trained = 155 o Percent trained = 100% • Starting on 1/12/12, the Nurse Educators retrained all RNs on Development of Individualized Health Care Plans: o Number of RNs = 95 o Percent trained = 100% • 2/2/12, in-service trainings conducted for all nursing staff on the revised: o Medication Administration Observation Guidelines/Forms o Neurological Assessment Procedure ▪ Number of Nurses trained = 155 ▪ Percent trained = 100%	

		• 2/7/12 Preceptor Development Workshop:
		  o Number of nurses selected as preceptors = 13
		  o Number of nurses trained = 13
		  o Percent trained = 100%
		• 3/20/12 Medication Administration Guidelines:
		  o Number of Nurses trained = 147
		  o Percent trained = 97%
		  o Three percent of the nurses were on Family Medical Leave Assistance (FMLA)
		• Campus-wide training was conducted for all nursing staff starting on 4/4/12, for the Nursing Plan of Improvement Recommendations, Emergency Response/Posters, Medication Variance Guidelines, FLACC Pain Scale, revised areas of: Documentation Guidelines, End of Life Hospice Policy, and Gastrostomy Re-insertions:
		  o Number of nurses trained = 147
		  o Percent trained = 97%
		  o Three percent of the nurses were on Family Medical Leave Assistance (FMLA)
		For the 3% of the nurses on FMLA, the expected completion date for the missed training will be completed upon return to duty. Therefore, the projected completion date will be in two weeks following return to duty.
		• In addition, to the trainings listed above, the Nurse Educators trained nine (100%) of the Competency Training and Development Emergency Drill Instructors on the RSSLC Emergency Drills and Emergency Response Policy. The Nurse Educators trained and retrained 746 incumbent and new support staff on the State's mandated Observing and Reporting Clinical Indicators for Health Status Change of the Individuals Served. The Nurse Educators continued to teach is class in New Employee Orientation.
		
		Although compliance was found in the last review, the Monitoring Team has determined the need to focus on implementation rather than just development and training—that is, to ensure implementation of protocols is sufficient to meet the needs of individuals as the provision requires. In order for this Provision to meet compliance, not only must the State and Facility Nursing Policies, Procedures, Processes, and Protocols be established, implemented, and the nursing staff trained; they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. As was found throughout the other Provisions, the Nursing Policies, Procedures, Processes, and Protocols have not yet been adequately put into clinical practices sufficient to meet individuals' health status needs. Therefore, this Provision was not found in compliance.
		
		The Nursing Department and the Nurse Educators should act to reinforce training and monitor the nursing practices contained in Nursing Policies, Procedures, Processes and Protocols, to ensure they are demonstrated through actual clinical practices sufficient to	

		address the health status of individuals served.	
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.	Provision M.5: <u>Activities engaged in to conduct the self-assessment</u>: • Reviewed official list of individuals with confirmed diagnosis of pneumonia. • Reviewed communications between Medical Director and Infection Control Officer relating to individuals with confirmed diagnosis of pneumonia. • Reviewed the proposed revisions to At Risk Individuals, I.08, Policy. • Reviewed Risk Action Plans in At Risk Individuals Committee Meetings; activities initiated as result of discussion, however; none were assigned to Nursing. <u>The results of the self-assessment</u>: • The Infection Control Officer maintained the Facility's list of individuals who were diagnosed with pneumonia. • The Medical Director notified the Infection Control Officer when an individual had been diagnosed with pneumonia. • The final draft for At Risk Individuals, I.08, Policy was still pending approval. • The At Risk Individuals Committee continued to meet monthly to report progress and discuss further initiatives. <u>Self-rating</u>: Based on findings from their self-assessment, this Provision was not in substantial compliance. The final draft of At Risk Individuals, I.08 Policy needs to be approved by the Facility. When this is done, the At Risk Individuals Committee will need to implement the system for assessing and documenting clinical indicators of risk for each individual. <u>Monitoring Team's Findings</u> The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Although through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, there was evidence that the Nursing Department had continued to receive additional training toward achieving compliance in this Provision, no significant improvement was found from previous reviews. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. According to the At Risk Individuals, Policy Number: 006.1, "A regular risk assessment and management system will be used to identify persons at risk for illness and injury. The Personal Support Team (PST) will work collaboratively to assess, and develop plans to address individual risk factors so the effect of those risks may be reduced in severity and the quality of the individuals' life improved. All plans to address identified risk will	Noncompliance

		be incorporated into the Personal Support Plans (PSP) with proactive and preventative supports as well as supports to mitigate the risk…" The Nurse Case Managers, in conjunction with the physicians, were responsible for aggregating, reviewing risk factors, and drafting Integrated Risk Assessments to present to the IDT at the ISP meetings for 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. The At Risk Individuals Policy and instructions required the relevant disciplines to complete their risk assessments 10 days prior to the ISP date and make them available to the Nurse Case Managers to review in collaboration with the responsible physicians. Then, the Nurse Case Managers aggregates the assessment data onto the final drafts of the Integrated Risk Assessments to be used at the ISP meetings for the IDT to review, discuss, and determine risk ratings. A review of 12 recently completed Integrated Risk Ratings for Individuals #484, #570, #175, #148, #91, #60, #459, #354, #388, #593, #729, and #300 revealed the following trends: • Zero of 12 (0%) individuals' Integrated Risk Rating Forms, where clinical data were documented in the Rationale Columns, consistently contained adequate clinical data for all risk categories to support the risk rating categories. However, three of 12 (25%) contained somewhat adequate clinical data in the Rationale Columns for a few of the Risk Rating Categories, while the Rationale Columns were left blanks for other Risk Rating Categories. The clinical data documented in the Rationale Columns primarily consisted of medical diagnoses, history of medical problems, medications/treatments prescribed, and/or a statement of "no problem" related to specific risk rating categories when the risk was rated low. • Zero of 12 (0%) individuals' Integrated Risk Rating Forms demonstrated risk ratings based risk ratings on the interrelationship with other related risk rating categories. The IDT appeared to consistently rely on the Risk Guidelines to determine risk ratings for the various categories and failed to exercise critical thinking in correlating the interrelationship of the risk categories. • Three of 12 (25%) included BRADEN scores for the skin integrity risk rating categories. • Zero of 12 (0%) Integrated Risk Assessment Attendance Sheets were included with the document request. From a review of the 12 Integrated Risk Assessments, it did not appear that all relevant clinical disciplines contributed substantive clinical data for their respective areas of expertise. In general the individuals' Integrated Risk Ratings varied in the quality of substantive clinical data to support the various risk rating categories with the different IDTs.	

		Examples of findings Included: • Individual #354's Integrated Risk Assessment Rating, 3/21/12, included the following documentation for risk rating rationales: High risk rating for Seizures rationale stated, "VNS used". The IDT should have included the number of seizures for the past year and or last six months and/or within the last quarter, as well as including the seizure medications, if any were prescribed. High risk rating for Osteoporosis rationale stated, "Diagnosed with Osteoporosis". Medium risk rating for Constipation rationale stated, "Medications". Medium risk rating for Gastrointestinal Problems rationale stated, "GERD". Medium risk rating for fractures did not include rationale documentation. All of the remaining risks rating category rationales were equally as inadequate as those described above. • Individual #484's Integrated Risk Assessment Rating, 2/29/12, included the following documentation for risk rating rationales: High risk rating for Respiratory Compromise rationale stated, "Allergic to many things. Will continue to take Neb treatments". Individual #484 had a history of severe reactive airway disease with numerous hospitalizations. The rationale should have contained substantive clinical data related to her severe reactive airway disease to support the high-risk rating. The only risk rating categories assessed were for Respiratory Compromise, Osteoporosis, and Polypharmacy. The remaining risk rating categories were not assessed. • Individual #148's Integrated Risk Assessment Rating, 3/21/12, included the following documentation for risk rating rationales: High risk rating rationale for Aspiration stated, "GERD". High risk rating rationale for Cardiac Disease stated, Bradycardia – ICU". High risk rating rationale for Osteoporosis stated, "Osteogenosis, imperfect, Recasts." High risk rating rationale for fractures stated, "Osteogenic". High risk rating rationale for dental stated, "TIVA." Medium risk rating for Choking, Respiratory Compromise, Weight, Gastrointestinal Problem, Infections, Polypharmacy, did not include rationales to support the these risk ratings. • Individual #91's Integrated Risk Assessment Rating. 3/6/12, included the following documentation for risk ratings rationales: High risk rating for Circulatory rationale stated, "Uses DVT". This was a misstatement because DVT stands for Deep Vein Thrombosis and it is a diagnosis, not a treatment to be used. Eight of the 12 (67%) individuals had accompanying Risk Action Plans: Individuals #354, #60, #484, #570, #175, #148, #91, and #459. It could not be determined whether Individuals #300, #729, #593, and #388 simply did not have Risk Actions Plans or if they were not included in the document request. A review of the Risk Action Plans revealed the following trends: • Zero of eight (0%) Risk Action Plans were adequate to sufficiently meet individuals' needs related to individuals' high and medium risk ratings. The Risk Action Plans did not consistently include plans for all identified high and medium risk ratings. For the plans that did address some of the high and medium risk ratings, they contained	

		some basic action steps, but failed to include all relevant action steps to adequately address the risk ratings, nor were all relevant disciplines included in the action steps. For high and medium risk ratings, Risk Action Plans should have had nursing Health Management Plans (HMPs), but they were rarely, if ever, referred to in the plans, nor were other relevant disciplines specific plans referred to. Therefore, the Risk Action Plans were not adequately integrated. • Zero of eight (0%) Risk Action Plans adequately reflected the identified risk factors. • Zero of eight (0%) Risk action Plans included preventative interventions sufficient to minimize the condition of risk. • Zero of eight Risk Action Plans contained appropriate functional and measurable objectives incorporated into the ISP/ISPA to measure the efficacy of the plans. • Zero of eight (0%) Risk Action Plans adequately identified appropriate clinical indicators to be monitored and frequency of monitoring. The Monitoring Team met with the CNE, NOO, Specialty Nurses, Unit Nurse Managers, Unit Nurse Case Managers, and the Assistant Director of Programs to review and discuss the 12 Integrated Risk Assessments and the eight Risk Action Plans against the At Risk Individuals Policy and Risk Guidelines. Each participant was given a set of the documents to review. After the participants reviewed the documents, each participant was asked to provide their findings regarding the Integrated Risk Assessments and Risk Action Plans as related to compliance with the At Risk Individuals Policy. Then the Monitoring Team shared findings. The participants agreed their findings were similar to the Monitoring Team's findings and that none of the Integrated Risk Assessments and Risk Actions Plans met compliance with the intent of the At Risk Individual Policy. When the Monitoring Team asked the participants why they thought there was lack of compliance with the policy, the Assistant Director of Programs stated she thought it was due to inadequate training. She explained that an audio-video teleconference had been set up with the State to train the relevant staff but the video portion did not work; they were only able to hear the audio portion. She stated there had been one other brief training secession provided. She further stated the Facility was revising the At Risk Individuals Policy, and later stated the State was also in the process of revising the policy. After further discussion it was discovered that the Qualified Developmental Disability Professionals (QDDPs) were completing the draft Integrated Risk Assessments to bring to the IDT meetings. Therefore, other disciplines responsible for developing draft risk assessments to provide to the Nurse Case Managers to aggregate and develop the final draft Integrated Risk Assessments to take to the ISP meetings did not comply with the policy. Throughout the discussion there seemed to be some thought by the participants that since the Risk Guidelines were developed and issued by the State they had to be strictly adhered to. These are only guidelines and as such should not prohibit the IDT from using	

		critical thinking when determining risk ratings or prevent them from considering the interrelationship of relevant risk rating categories. According to the Facility's Action Plans for Provision M.5, the Action Step F. stated, "The Nurse Educator would provide competency-based training to the Nurse Case Managers to: i) Corroborate risk assessment findings with individuals' primary care provider prior to the IDT meetings to ensure that all medical/health related risk factors are identified and that the risk levels are accurately scored. ii) Ensure accurate documentation in the Aspiration Pneumonia/Enteral Nutrition Evaluations and Aspiration Trigger Sheets". The Facility's Action Steps stated the training would start on 5/1/12, the projected completion date was 5/30/12, and the completion date indicated the training had not started. It is essential that each discipline responsible for their respective risk rating categories complete comprehensive risk assessments of individuals' overall health status though collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. The assessment should be completed at least 10 days prior to the ISP meeting dates and submitted to the respective RN Care Managers. The Nurse Case Managers should corroborate their risk assessment findings with respective physicians prior to the ISP meetings to ensure that all medical, mental and behavioral health related risk factors are identified; and the risk ratings are comprehensive, integrated, and accurate. Establishing a competent and reliable risk rating 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. Refer to Sections M.2 and M.3 for additional information related to nursing assessments of risks and health care plans. The Facility should ensure that: • All relevant members of the IDT receive competency-based training on the At Risk Individuals Policy (or the revised At Risk Individuals Policy), and provide monitoring to ensure adherence to the policy. • All members of the IDT exercise critical thinking when assessing levels of risks and consider the interrelationship of relevant risk rating categories. • Each discipline responsible for their respective risk rating categories complete comprehensive risk assessments of individuals' overall health status through collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. The assessments should be completed at least 10 days prior to the ISP meeting date and submitted to the respective Nurse Case Managers. • The Nurse Case Managers should corroborate their risk assessment findings with respective physicians prior to the ISP meetings to ensure that all medical, health, mental health, and behavioral health related risk factors are identified; and the risk	

		ratings are comprehensive, integrated, and accurate.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Provision M.6: <u>Activities engaged in to conduct the self-assessment</u>: Monthly Medication Variance Committee Reports and Nursing Care Medication Administration and Documentation Monitoring Tools were reviewed from 12/1/11 through 2/29/12, for appropriate reporting and completion on Medication Variance Reports, Medication Administration Observations, and Medication Room Surveys on a monthly basis. <u>The results of the self-assessment</u>: • For the month of December 2011, 100% of the Medication Variance Reports were not completed appropriately because some of the categories were not addressed on report forms. CAPs were developed and implemented with 100% of the nurses retrained on appropriate completion of Medication Variance Reports. • In January 2012, DADS Regulatory Surveyors found that oral and topical medications were not separated appropriately. CAPs were developed and implemented with 100% of the nurses retrained on appropriate storage and separation of oral and topical medications. Multiple storage bins were ordered to separate storage of oral and topical medications. • Weekly Medication Room Survey audits were conducted for the months of January 2012 and February 2012, with 100% compliance attained each month. Medication Administration Observations were found in 100% compliance for that two months period. However, during DADS Regulatory survey in January 2012, an LVN was observed to have pre-set and crushed medications for one individual prior to the medication pass. Also, while conducting the Medication Room Surveys in March 2012, another nurse on a different unit was observed to have pre-set and crushed medications. Both nurses were counseled and retrained, and additional Medication Administration Observations were completed on the nurses by their supervisors prior to allowing them to pass medications independently again. • The level of agreement on the Nursing Care Medication Administration and Documentation Monitoring Tools between Nursing's internal and the Quality Assurance Nurses' external review of monitoring tools for Medication Administration and Documentation showed: December, 2011 at 62.96%; January, 2012 at 96%; February at 100%; and March at 98.15%. <u>Self-rating</u>: Based on findings from their self-assessment, this Provision was not in substantial compliance. The nurses continued to leave some sections blank on the Medication Variance Report forms. There continued to be an issue of under reporting of ADRs and near miss medication variances.	Noncompliance

		Monitoring Team's Findings The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, there was evidence that the Nursing Department had continued to provide additional training and monitoring toward achieving compliance in this Provision, significant improvement was found from previous reviews. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance. Since the last review, the Facility had operationalized and implemented the Providing Health Care Services, Medication Variances Policy, 1.34, Effective Date: 2/27/12 and Nursing Services Medication Variances Guidelines, A-3, Date: 1/24/12. There was documented evidence that 97% of the nursing staff had received competency-based training on the policy and guidelines, as well as primary care providers and pharmacy staff. The training placed special emphasis on: Correctly rating the medication errors/variances category; discovery, reporting, and timely notification of the primary care providers of medication error/variance; timely implementation of corrective action; documenting corrective action taken; and reporting each medication error/variance separately, as opposed to combining multiple errors/variances onto one Medication Variance Report; and documentation of the location where the medication errors/variances occurred. The chairperson for the Medication Variance Committee had been changed from the Chief Pharmacist to the Chief Nurse Executive. In addition, the Chief Nurse Executive had consulted with another Supported Living Center regarding their Medication Variance process. The Chief Nurse Executive, Nursing Operations Officer, Pharmacy Director, Program Compliance Nurse, and Quality Assurance Nurse attended the other State Supportive Living Center's Medication Variance Committee meeting on 12/28/11. Consequently, some modifications were made to RSSLC's Medication Variance processes, forms, and trend analysis process by utilizing the Quality Assurance Nurses to perform the final review of medication variances and to enter the data into the Medication Variance Database. A review of the Medication Variance Database, developed in relation to the Medication Variance Policy, used a root cause analysis model, which included tracking, analyzing, and trending medication variances by: Node/Types of Variance: Prescribing Administering, Documenting, Dispensing, and Transcribing, as well as by Severity Index: Categories A through I. In addition, the database included: Count of Medication Variances by Month, Types of Medication Variances by Month, Responsible Departments, Medication Variances by Location, Medication Variances by Shift, by Summarized Medication Variance by Individual affected (date discovered, date of error, home, shift,	

		node of error, type of error, severity index, and department involved), and Medication Variances for past rolling 12 months, including individual specific and Facility aggregate with the total number of medication variances year to date. The data was represented in tabular, as well as graphic forms using bar graphs and pie charts. Medication Variance Reports were generated from the database monthly for the Medication Variance Committee, quarterly Pharmacy and Therapeutics Committee, and QA/QI Council. The functionality of the Medication Variance Database was demonstrated through review of the database reports for date range 10/1/11 through 3/31/12 and 4/1/12 through 4/30/12. The availability medication variance data using the root cause analysis model provide the Facility with information from which to further investigate medication variances, as required per policy, to ask such questions as: What happened? Why did it happen? What caused it? How can we correct it? Have we corrected it? A review of the monthly Medication Variance Committee meeting minutes November 2011 through April 2012, along with the Monitoring Team's attendance at the 5/17/12 committee meeting, found progressive improvement in the review, discussion, and disposition of medication variances and other medication administration practices. Still, as the examples reported in Provision N8 demonstrate, further improvement was needed. It was positive to find that the Infirmary Director and Unit Nurse Managers monthly provided the committee with detailed medication variance reports describing the number, description, and corrective action taken, as well as detailed reports on the number of Adverse Drug Reactions Reports, Medication Administration Observations, Medication Room Surveys, a Medication Administration Record Audits, and individuals' refusal of medication. The committee decided they would not track medication refusal but that instances of medication refusals would be reported to their primary care providers and/or behavior analyst for follow-up. It is essential to report individuals' persistent refusal of medications to the primary care providers and behavior analyst to ensure appropriate follow-up is taken. The committee expressed the concern that medication variances may be underreported. The Nurse Managers were instructed on improvements they need to make with their nursing staffs. The focus on corrective actions for medication variances was primarily directed toward nursing. There were no specific medication variance reports from the Pharmacist, Medical Director, or Dentist contained in the Medication Variance Committee minutes, with the exception of the reports from the Medication Variance Database. It is essential that the other clinical disciplines responsible for medication administration practices, also report their medications variances to the committee monthly for review, discussion, and disposition. The Medication Variance Committee minutes, 4/19/12, included a discussion with the Habilitation Director who reported that the therapists were noticing some nurses were not using the required adaptive equipment during medication administration as stated	

		on individuals' PNMP. The therapists were to provide one-on-one training when they observed this happening. It is essential that the nursing staff administering medications are adequately trained on each individual's PNMP for all instructions relating to the safe administration of oral and enteral medications. Although, the Nurse Managers reported corrective actions taken with the individual nurses who committed medication variances, there was no indication that Medication Variances Committee tracked, analyzed, and trended medication variances data for systemic issues related to all clinical disciplines responsible for committing medication variances. The Facility should ensure that the Medication Variance Committee puts in place a tracking system to identify, analyze, and trend systemic medication variances; and develop and implement systemic CAPs which are followed through to resolution and their efficacy evaluated. The Pharmacy and Therapeutics Committee also reviewed Medication Variance data on a regular basis. A review of the Pharmacy and Therapeutics Committee minutes found the Medication Variance data for the fourth quarter of 2011 was not presented due to the absence of the Medication Variance Committee chairperson. The minutes indicated the fourth quarter of 2011 and the first quarter of 2012 would be reviewed at the next Pharmacy and Therapeutics meeting in May 2012. According to a review of the Pharmacy and Therapeutics Committee meeting, 5/16/12, agenda, Medication Variance Database Reports for the fourth quarter of 2011 and first quarter of 2012 were discussed at the meeting. The Monitoring Team was unable to attend the meeting; therefore the review, discussion, and disposition of the Medication Variance data were not determined. Refer to Provision N.8 for information regarding the Pharmacy and Therapeutics Committee meetings. As was reported in past reviews, a review of the 17 most recently completed Medication Variance Reports found that 11of 17 (65%) reports were not completed according to the instructions contained in the Medication Variance Report Policy. It is essential for the safety and welfare of the individuals for whom the medication variances were committed as well as for accuracy in reporting medication variances into the Medication Variance Database, that all Medication Variance Reports are completed according to the Medication Variance Report Policy. The Facility should ensure that all clinical disciplines responsible for medication administration practices should be re-trained on the Medication Variance Report Policy and a monitoring system put in place to ensure that Medication Variance Reports are completed timely, correctly, and effective corrective action taken. A review of the monthly Medication Variances reported, 10/1/11 through 4/30/12 found that medication variances were reported across all relevant disciplines responsible for medication administration practices. The review found the following	

		number of medication variances reported by discipline: October: • Manufacture – 1 • Medical – 6 • Nursing – 6 • Pharmacy – 13 Total - 26 November: • Nursing - 21 • Pharmacy – 19 • Medical – 2 Total - 42 December: • Nursing – 13 • Medical - 2 • Pharmacy – 9 Total – 24 January: • Nursing – 8 • Pharmacy – 11 Total – 19 February: • Nursing – 8 • Medical – 11 Total – 19 March: • Nursing – 14 • Medical – 1 • Pharmacy – 10 Total – 25 April: • Nursing – 2 • Pharmacy – 6 • Other – 1 Total – 9 (Total number of medication variances may contain incomplete data.) Medication Administration and Documentation Monitoring: It was positive to find, as mentioned above in Provision M.1, that the Nursing Administration, Nurse Managers, and Quality Assurance Nurses had worked collaboratively through the Nursing Plan of Improvement Committee to bring about inter-rater reliability agreement between the internal and external percentages on the	

		Nursing Care Medication Administration and Documentation Monitoring Tools. In addition to the audits conducted by the Nursing Department and Quality Assurance Nurses on the Nursing Care Monitoring Tools, they conduct monthly internal Medication Rooms Survey Analyses and Medication Administration Records (MARs) Audits. The result for April 2012 showed: • The Medication Room Survey Audits met an overall compliance of 98.57%. • The Medication Administration Record Audit data was skewed because the computer program's formula calculated the non-applicable responses on the audit tool as no. This error was not identified until data was printed just prior to the Medication Variance Committee meeting. The CNE will interface with the data analyst to correct the program. It was positive to find since the last review, the Medication Administration Observation Form had been revised on 1/18/12, to include items to observe when administering medications related to individuals' Physical and Nutrition Management Plans. The Nursing Department reported a total of 288 Medication Administration Observations were conducted during the months November 2011 through April 2012. The Nursing Department maintained a monthly schedule indicating the number of observations that were completed each month to ensure that all nurses administering medication were observed at least once per quarter. Nurses responsible for Medication Administration Observations included the Nurse Managers, Infirmary Director, Infirmary Nurses, Nurse Case Managers, and Campus Nurses. The results of the Medications Observation indicated there were no problems observed. It was positive to find that the internal and external inter-rater reliability for Medication Administration Observations were 100% in agreement between the Nursing Department and the Quality Assurance Nurses. On 5/16/12, the Monitoring Team conducted a tour of the medication rooms in the Infirmary, Nueces, and Lavaca. The medication rooms were clean, the medication refrigerators were clean, no personal food items were found in the refrigerators, temperature sheets were completed daily for 5/1/12 through 5/16/12 and the temperatures were found within appropriate temperature ranges. Oral and topical medications were separated. In Nueces and Lavaca medications carts were not used. Oral medications were stored in cassettes. Small bins had been procured recently and each individual's topical medications were stored separately in the bins. All open bottles of medications were dated. No expired medications were found. The Controlled Drug Logs for May 2012 were signed shift to shift by two nurses. It was positive to find that the Infirmary's antiquated medication cart, found at the last review had been replaced with new state of the art medication cart. The Universal Signatures for nurses contained in the Medication Administration Record Notebooks were signed and up to date for the Infirmary and all Units. The Glucometer Records were checked in Lavaca for two	

		individuals who receive insulin. The glucometers were found to be checked daily using the two-step method. On 5/16/12, the Monitoring Team for Nursing and PNM conducted medication administration observations in Nueces. The Nursing Operations Officer and the Unit Nurse Manager accompanied the Monitoring Team. Although the nurse administering medication did not commit medication variances during the med pass, she failed to consistently follow standard medication administration practices. The nurse did not refer to individuals' PNMP for safe medication administration when she started to administer medications. She did not seem aware of the PNMP or the purpose of the PNMP until prompted by the Monitoring Team. Unfortunately, there were several sheets of paper between the individuals' PNMPs and their Medication Administration Records. This prevented the PNMPs from being placed directly in front of the MARs, and could cause them to be overlooked. She failed to complete the three basic checks with the MAR, i.e. check each the medication against the MAR when removing it from the medication cassette, check each medication against the MAR upon opening and placing the medications in the cup, and check each medication against the MAR before administration. After administering an individual's medication she started to give the next individual's medication but was prompted by the Monitoring Team to chart the medications she had just given before giving the next individual's medications. One individual hyperextended their neck when drinking from a cup and the nurse did not seem to realize this had the potential to cause aspiration. The Monitoring Team explained the risk for aspiration when individuals drink with their neck hyperextended. She failed to tell individuals what medications they were receiving and the purpose of the medications. She tentatively attempted to provide Self-Administration of Medication to individuals' who had programs. It was apparent the nurse was anxious, although the Monitoring Team made every effort to lessen any anxiety she might be experiencing. This was a relatively new nurse who had been hired less than six months. The need to provide this nurse with some additional coaching/mentors was discussed with Nursing Operation Officer and Unit Managers, who agreed to do so. White picnic style spoons continued to be used for medication administration. This was also discussed with the Nursing Operation Officer and the Unit Nurse Manager. They explained they had supplied the nurses with the maroon spoons but they were being thrown away and there was a problem with getting them washed. The Nursing Operation Officer assured the Monitoring Team that additional maroon spoons had been ordered and that arrangements were being made with the kitchen supervisor to have them washed. The Nursing Department needs to ensure that maroon spoons are used when administering medications mixed with food. It was apparent from a review of the PNMPs contained in the Medication Administration Record Notebook that they did not include all of the strategies to ensure safe oral intake	

		or other special strategies related to enteral administration. It is important for this information to be included in the medication administration instructions in order to make it readily accessible to the nurses during heavy medication passes when time is limited and they do not have time to review the entire PNMP to identify all strategies to administer medication safely. It was also apparent that the nursing staff could profit from enhanced dysphagia training, such as the Dysphagia Training that the PNM nurses receive, to help them better understand the rationale for the strategies contained in the PNMPs for safely administering medications orally and enterally. Refer to Provision O.3 for additional information. It was positive to learn from the Unit Nurse Manager for Leon that they collaborated with Habilitation therapy and had initiated a pilot project, 5/1/12, for the use of adaptive equipment and positioning for medication administration. The guideline for the pilot project appears promising. The Monitoring Team will follow-up on the outcome of the pilot project at the next review. Although progress was found toward compliance with the Medication Variance Policy, it was apparent the processes were still evolving, and 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 make the following improvements: • Maroon spoons are used when administering medications mixed with food. • The Nursing Department should ensure nursing staff receive enhanced dysphagia training, such as the Dysphagia Training that the PNM nurses receive. • The Medication Variance Committee should put in place a tracking system to identify, analyze, and trend systemic medication variances; and develop and implement systemic CAPs which are followed through to resolution and their efficacy evaluated. • All clinical disciplines responsible for medication administration practices should be re-trained on the Medication Variance Report Policy and a monitoring system put in place to ensure that Medication Variance Reports are completed timely, correctly, and effective corrective action taken.	

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

1. The Nursing Department should collaborate with the Facility to review the acuity of individuals and to evaluate the adequacy of nursing staffing to ensure that individuals' health care needs are sufficiently met. (Provision M.1)
2. The Nursing Department in collaboration with the Quality Assurance Department should evaluate the adequacy of the sample size for each Nursing Care Monitoring Tool to ensure an adequate number of records are audited to determine compliance. (Provision M.1)

3. The Nursing Department should collaborate with the Quality Assurance Department to evaluate weighting items on the Nursing Care Monitoring Tools by value of significance. (Provision M.1)
4. The Nursing Department should collaborate with the Quality Assurance Department Nursing Care Monitoring Tools to develop local and systemic CAPs relating to overall percentage of compliance for each monitoring tool falling below 80% compliance. (Provision M.1)
5. The Nursing Department should ensure that Quality Peer Review deficiencies are identified as to whether they are local or systemic, track the corrective action through to resolution, and evaluate the effectiveness of the corrective action. (Provision M.1)
6. The Nursing Department and Nurse Educator need to continue to re-train and monitor nursing staff on Assessment and Documentation of Acute Changes in Status Policy and Procedures. (Provision M.1)
7. The Wound Care Nurse should review all newly developed Skin Integrity Acute Care Plans and Health Management Plans to ensure they include integrated actions/interventions of all relevant disciplines. (Provision M.1)
8. The Nursing Department should ensure that the Infection Control Nurses address the following: (Provision M.1)
    - Track, analyze, trend, and summarize pertinent infection control data, including, but not limited to, Infections by Type, handwashing observations, and environmental surveillance monitoring data to identify local and systemic trends that require corrective action.
    - Develop and implement 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.
    - Review the new Acute Care Plans and Health Management Plans for infections with the Nurse Case Managers to ensure that plans are integrated with other relevant disciplines and contain all pertinent infection control measures in the plan sufficient to meet individuals' needs.
    - 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.
    - CTD to ensure that all relevant employees are current in Infection Control refresher training.
9. The Nursing Department should continue to make the following improvements: (M.2)
    - Continue to provide the Nurse Case Managers with training on Section XI nursing summaries to ensure that nursing problems/diagnoses are analyzed and summarized concisely to adequately and accurately represent individuals' health status; and to measure the effectiveness of their respective Health Management Plans.
    - Ensure that the Nurse Case Managers review/revise Comprehensive Nursing Assessments when there is a significant change in health status.
    - Ensure that nursing problems/diagnoses and accompanying HMPs are developed and implemented for all of individuals' high and medium risk ratings that require nursing interventions.
    - Ensure a standardized format is used by the Nurse Case Managers for completing the overall nursing summaries on the Comprehensive Nursing Assessment template.
    - Ensure community discharge special instructions are written in clear, concise, and easy to read sentences without unnecessary medical jargon. The same is true for the health care plans.
10. The Nursing Department should continue to make the following improvements: (Provision M.3)
    - Health Management Plan nursing interventions should include instructions for the frequency they are to be performed and where to document the actions taken.
    - Acute and Care Plans should include preventative measures.
    - Acute Care Plans and Health Management Plans should ensure that plans are developed in collaboration with other relevant clinical disciplines when appropriate.
    - Health Management Plans should be reviewed/revised on a quarterly basis and when there is a change in individuals' status.
11. The Nursing Department and the Nurse Educators should reinforce training and monitor the nursing practices contained in Nursing Policies,

Procedures, Processes and Protocols, to ensure they are demonstrated through actual clinical practices sufficient to address the health status of individuals served. (Provision M.4)

12. The Nurse Case Managers should corroborate their risk assessment findings with respective physicians prior to the ISP meetings to ensure that all medical, health, mental health, and behavioral health related risk factors are identified; and the risk ratings are comprehensive, integrated, and accurate. (Provision M.5)
13. The Nursing Department should ensure: (Provision M.6)
    - Maroon spoons are used when administering medications mixed with food.
    - Nursing staff receive enhanced dysphagia training, such as the Dysphagia Training that the PNM nurses receive.
14. The Facility should ensure that the Medication Variance Committee puts in place a tracking system to identify, analyze, and trend systemic medication variances; and develop and implement systemic CAPs which are followed through to resolution and their efficacy evaluated. (Provisions M.6 and N8)

The following are offered as additional suggestions to the Facility:

1. The State and Facility should: (Provision M.2)
    - Add polio vaccination information to the Comprehensive Nursing Assessment template.
    - Provide the Nursing Department with technical assistance from an expert to provide competency-based training to assist the relevant nursing staff with critically analyzing clinical data into clear and concise summaries reflective of individuals' health status.
2. The Facility should ensure that: (Provision M.5)
    - All relevant members of the IDT receive competency-based training on the At Risk Individuals Policy (or the revised At Risk Individuals Policy), and provide monitoring to ensure adherence to the policy.
    - Each discipline responsible for their respective risk rating categories complete comprehensive risk assessments of individuals' overall health status through collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thorough review of clinical records. The assessments should be completed at least 10 days prior to the ISP meeting date and submitted to the respective Nurse Case Managers.
3. The Facility should ensure that: (Provision M.1)
    - Relevant Emergency Response information is reported at the Incident Management Meetings.
    - All required employees are current with Basic Life Support and/or Basic CPR training.
    - The Mock Medical Emergency Drills should include a variety of scenarios that might require emergency response, as described in the Emergency Response Policy, 044.
4. The Facility should ensure that all clinical disciplines responsible for medication administration practices should be re-trained on the Medication Variance Report Policy and a monitoring system put in place to ensure that Medication Variance Reports are completed timely, correctly, and that effective corrective action taken. (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 Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. RSSLC Presentation Book for Section N 4. RSSLC Policy I.34 Medication Variances 2/27/12 5. RSSLC drug uses evaluation (DUE) and DUE process policy and procedure, dated 5/12/11, no policy number provided 6. RSSLC patient polypharmacy review policy, which was undated and without number 7. RSSLC pharmacy policy and procedure manual, Adverse Drug Reactions Policy, 01.05.25 8. Twenty new medication orders, as of 4/14/12, and prior, along with copy of documentation to support that the pharmacist evaluated the medication order for drug-drug interactions, allergies, appropriate indication, and dose, and when clinically indicated, evidence to support that the pharmacists reviewed drug levels, and other diagnostics, as well as an associated single patient drug interventions (SPDI) reports, and evidence that the pharmacist followed up on the physicians action plan to the SPDI report 9. The last ten QDRRs completed on 4/14/12, and prior, and for each QDRR, copies of last six months laboratory data, annual medical summary, most recent ISP, and physician ISP documenting review of the QDRR 10. QDRRs for all STAT medication use during the past six months 11. Graphs, and summaries for the use of STAT medications, anticholinergics, benzodiazepines, and polypharmacy 12. Ten QDRRS completed within the past six months that were selected by the Facility, of Individuals prescribed benzodiazepines 13. Copy of the polypharmacy database and reports for polypharmacy use during the past 12 months. 14. Pharmacy and Therapeutics Committee (P&TC) minutes, dated 10/26/11 15. Medication variance committee minutes for January 2012 through April 2012 16. Medication variance database report for past six months 17. Copy of last ten medication variance report forms **People Interviewed:** 1. Anto Parambil, Pharmacy Director 2. Dr. Michael Shatz, Pharm.D., Clinical Pharmacist **Meeting Attended/Observations:** None
	Facility Self-Assessment: Provision N1: The Facility reported substantial compliance for Provision N1 because upon its review of medication interventions, there were no pending interventions, and because an audit of processed orders showed 100% of the orders had attached lab reports to prove the monitoring of lab values was completed, if indicated. Upon discussion with the pharmacy director, the Facility did not have a formal process that

	the pharmacist was to follow, with regards to evaluating necessary diagnostics; however, they were in the process of formalizing the process at the time of the compliance visit. The Monitoring Team concurs with continued compliance, and will evaluate their enhanced process for evaluating diagnostic data, when processing medication orders. Provision N2: The Facility reported substantial compliance for Provision N2 because following a review of 10% of QDRRs, they noted that the primary care provider addressed the pharmacists' recommendations. The Monitoring Team disagrees with the self-assessments because psychiatrists did not review or address recommendations specific to psychotropic medications. Importantly, the QDRRs did not address all relevant medications prescribed to the individual. Provision N3: The Facility reported substantial compliance with Provision N3 because the pharmacists conduct a review of all STAT drug orders and presents data to the P&TC, and because they ensure that metabolic syndrome is appropriately assessed through the QDRR process. The Monitoring Team disagrees with the self assessment, and determined that the Facility was no longer in compliance because the STAT medication graphs did not delineate between psychotropic, and non-psychotropic indications, and because QDRRs did not adequately address STAT medications, anticholinergic medications, benzodiazepines, and polypharmacy. The Facility will need to update its Action Plan to address these issues. Provision N4: The Facility reported that after assessing 5% of the QDRRs, the sample verified that clinical pharmacists have reviewed 100% of the PCP comments on each QDRR, and reported compliance because the PCP considered the pharmacists' recommendations in 95% of the time, and that documentation was made for the recommendations that were not followed. The Monitoring Team noted that psychiatrists did not address QDRRs for psychiatric medication issues and recommends they do so, but determined the provision was in substantial compliance. Provision N5: Provision N5 is assessed as a component of Provision J12. The Facility identified several actions done to assess compliance and determined it was in Substantial Compliance. However, as noted in Provision J12, there were inaccuracies in tracking of people with screen scores indicating possible tardive dyskinesia and some errors in scoring. The assessment for this provision should be coordinated with the assessment for Provision J12. Provision N6: The Facility reported that they have a proven system in place for reporting ADRs in a timely manner to identify, report, and follow-up on significant and adverse drug reactions. The Monitoring Team concurred with their self assessment, and will continue substantial compliance; however, as discussed with the pharmacy director, the Facility will need to be sure to provide evidence that all staff, including physicians, who are regularly in direct contact with individuals, are appropriately trained on identifying and reporting of ADRs. Provision N7: The Facility reported that it provided two DUEs during this reporting period, and that it does provide DUEs as needed, such as in the case of FDA advisories. The Monitoring Team noted the high quality of DUEs, and their process, and will continue with substantial compliance. The Monitoring Team

	noted that the Facility to did not provide DUE for all relevant FDA advisories issued during the past six month period. For example, an important labeling change was initiated for statin medications, by the FDA on 2/28/12, and a DUE was not developed or implemented. The pharmacy director informed the Monitoring Team that it was in the process of enhancing their current process to better track and address FDA and manufacturers advisories. Provision N8: The Facility reports noncompliance with Provision N8 because of underreporting of medication variances. The Monitoring Team concurs with the Facility's self assessment; however, in addition to it underreporting of medication variances, the Monitoring Team also noted that it must develop and implement a system to track and report on medication variance trends, longitudinally, and ensure that all medication variance data elements are represented graphically; ensure that medication variance report forms are appropriately completed; and ensure that recommendations for medication variances are more robust, and that recommendations are assessed for efficacy, and are followed through until complete.
	Summary of Monitor's Assessment: Overall, the pharmacy department continues to work towards substantial compliance, and is proactive in addressing areas of noted deficiencies. It maintains a process to address adverse drug reactions, and provides meaningful drug utilization reviews. The Facility continues to improve on developing a more comprehensive approach to quarterly drug regimen reviews, and is working with other departments to ensure that medication variances are carefully reviewed. **Provision N1:** The Monitoring Team noted the Facility's efficacious mechanism to ensure that the dispensing pharmacist evaluates all new orders for allergies, indication, dosing, drug interaction, and follow-up of physician action plans related to pharmacy recommendations per SPDIs. The Pharmacy also maintained a process whereby the pharmacy checked all necessary diagnostics, when clinically indicated by printing off a copy of the diagnostic report form the laboratory database, or requesting a copy of the diagnostic test result; however, the pharmacist did not sign or initial the copy of the diagnostic, indicating that it had been reviewed. The Monitoring Team was satisfied with the Facility's process in the past, and because the Facility was able to demonstrate that they maintained a copy of the diagnostic, the Monitoring Team determined that the Facility remains in substantial compliance for Provision N1. The Facility indicated that it will enhance its current process, and develop a mechanism whereby the pharmacy will document review of diagnostic reports, such as laboratory results. **Provision N2:** The Monitoring Team compliments the clinical pharmacists for attending psychiatric, and neurology consultations, and to the physicians for their comprehensive, and well documented review of QDRRs, and associated recommendations. Provision N2 requires that the Facility maintain a QDRR process that includes a review of drug monitoring labs. The Monitoring Team expects a robust QDRR process, that fully evaluates medications as they relate to the Individual, and follow a standard of care approach, such as that outlined in the 2006, Centers for Medicare & Medicaid Services, Medication Regimen Review guideline. The Monitoring Team noted significant deficiencies in eight out of the ten QDRRs reviewed. For this reason, the Monitoring Team determined that the Facility is not in compliance with Provision N2. Compliance will require a comprehensive review of all medication prescribed, and relevant clinical data,

	and ensure that physician action plans are followed through to completion. **Provision N3:** The Monitoring Team determined that the Facility is noncompliant with Provision N3, because it did not provide meaningful assessments of the use of STAT medications, anticholinergices, and polypharmacy. Compliance will require the Facility to enhance its processes in these essential areas, by ensuring that psychiatrists review all QDRRs associated with psychotropic use; QDRRs must assertively address the use of polypharmacy, STAT medications use, benzodiazepines, and anticholinergics; improve on graphing of STAT medications, and polypharmacy use, so that psychotropic, and non-psychotropic indications are well delineates; and develop a committee structure that reviews, assesses and reports on chemical restraint use; in its review of STAT medications, the pharmacists must clearly report on the type of STAT psychotropic used, dose, delivery method, indication, review of noted side effects, potential drug-drug interactions, and comment on the appropriateness of use, and determination if the Individual's regularly scheduled psychotropic medication requires adjustment. **Provision N4:** Because physicians were informed, and concurred with pharmacists' recommendations for all SPDI reports that were reviewed by the Monitoring Team, and because of the well-documented review of QDRRs by the primary care physicians that indicated their understanding and acceptance of the pharmacists' recommendations, the Monitoring Team determined that the Facility remains in substantial compliance with Provision N4. The Monitoring Team does expect that upon subsequent reviews the psychiatrist will follow-up on all QDRRs that involves the review of psychotropic medications. **Provision N5:** Please refer to Provision J12 for findings. **Provision N6:** The Monitoring Team noted that the Facility had a comprehensive mechanism to review, analyze, and report on ADRs, and determines that the Facility remains in substantial compliance with Provision N6. Importantly, given the large population, and number of medications prescribed, the Monitoring Team has concern over the low incidence of ADRs identified at the Facility, and urges the Facility to assess compliance issues in reporting ADRs and completing the ADR report form. The Facility reported that direct support staff and nurses had been trained on ADRs and that refresher training is planned. During the next compliance visit, the Monitoring Team will more comprehensively assess documentation to ensure that all staff, who are in regular contact with Individuals, are trained on the ADR reporting process. **Provision N7:** The Facility had a process in place for the provision of DUEs, and provided two scheduled DUEs during the past six months. During the past six months, there were no unscheduled DUEs provided for FDA advisories. The Facility did not maintain a calendar specific for pending, and completed DUEs, and did not have a mechanism to document that all recommendations issued for DUEs were followed up to resolution. The Monitoring Team will continue substantial compliance for N7; however, continued compliance will require the Facility to update its policy on DUEs to include a process for providing DUEs for manufacturer, and FDA drug advisories, develop a calendar for pending, and completed DUEs, and develop a process to document that recommendations issued for DUEs were followed to resolution and were effective.

	Provision N8: The Facility has yet to fully develop, and implement its medication variance process, and the Monitoring Team determined that the Facility remains not in compliance with Provision N8. Compliance will require that a better system to track, and report on medication variance trends, longitudinally, and ensure that medication variance data elements are represented graphically; ensure that medication variance report forms are appropriately completed; and ensure that recommendations for medication variances are more robust, and that recommendations are assessed for efficacy, and are followed through until complete.

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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.	To assess compliance for Provision N1, the Monitoring Team requested copies of 20 new medication orders, as of 4/14/12, and prior, along with documentation to support that the pharmacist evaluated the medication order for drug-drug interactions, allergies, appropriate indication, and dose, and when clinically indicated, evidence to support that the pharmacists reviewed drug levels, and other diagnostics. Also requested, were associated single patient drug interventions (SPDI) reports, and evidence that the pharmacist followed up on the physicians action plan to the SPDI report. Of the 20 examples provided, 20 (100%) demonstrated documentation that the pharmacists reviewed the medication order for known allergies, drug-drug interventions, appropriate indication, and dose. The pharmacists indicated completion of these efforts by checking off a checklist that was signed and dated by the pharmacist. Of the 20 examples of new medication orders, 14 (70%) required a SPDI, and of the 14 SPDIs completed by the pharmacists, 13 (93%) demonstrated evidence that the pharmacists followed up on the physician action plan through resolution of the issue. In such cases, the pharmacist's documented the physician's action on the SPDI report form. The pharmacy maintained a process where by all medications that required diagnostic monitoring, such as a drug level, are reviewed by the pharmacists, but as with previous reviews, they did not sign or initial this process. In the future, the pharmacy will enhance documentation of their diagnostic study review for new medication orders. <u>Overview</u> The Monitoring Team noted the Facility's efficacious mechanism to ensure that the dispensing pharmacist evaluates all new orders for allergies, indication, dosing, drug interaction, and follow-up of physician action plans related to pharmacy recommendations per SPDIs. The Pharmacy also maintained a process whereby the pharmacy checked all necessary diagnostics, when clinically indicated, by printing off a copy of the diagnostic report form the laboratory database, or requesting a copy of the	Substantial Compliance

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		diagnostic test result; however, the pharmacist did not sign or initial the copy of the diagnostic, indicating that it had been reviewed. The Monitoring Team was satisfied with the Facility's process in the past, and because the Facility was able to demonstrate that they maintained a copy of the diagnostic, the Monitoring Team determined that the Facility remains in substantial compliance for Provision N1. The Facility did indicate that it will enhance its current process, and develop a mechanism whereby the pharmacy will document review of diagnostic reports, such as laboratory results.	
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.	Provision N2 requires that the Facility maintain a quarterly drug regimen review (QDRR) process to evaluate pharmacology practice at the Facility. The QDRR process requires a comprehensive clinical review of medications, that includes the review of laboratory monitoring of medications prescribed, and must follow a standard of care approach, such as that outlined in the 2006, Centers for Medicare & Medicaid Services, Medication Regimen Review guideline. The Facility had two full time clinical pharmacists that were active in the review of all individuals on a quarterly basis. The pharmacists performed a comprehensive review of clinical records, and discussed clinical issues with the prescribing physician, when necessary. Importantly, the attending physician, or nurse practitioner was noted to dictate an integrated progress note (IPN), indicating their review of the QDRR, and recommendations. <u>QDRR Schedule</u> The Monitoring Team reviewed the QDRR schedule for Trinity and Leon residential homes, noting that all QDRRs were completed within expected time frames. The Monitoring Team observed that all 74 QDRRs for Trinity were reported completed on the same day, 4/6/12, and that all 71 QDRRs for Leon, were reported completed on the same day, 3/30/12. The Monitoring Team finds it unusual that all QDRRs could actually be completed on the same day, as this would not provide adequate time for review. The Facility should ensure that the dates reported for completion of QDRRs are the actual dates for each QDRR. <u>Monitoring Team Review Of QDRRs</u> Following review of the last ten QDRRs completed on 4/14/12, and prior, the Monitoring Team noted that clinician's review of QDRRs, and follow-up to recommendations was evident in ten out of the ten (100%) QDRRs reviewed. When clinically indicated, the clinical pharmacist documented a complete assessment for metabolic screening, on the QDRR. Of the ten QDRRs reviewed, the Monitoring Team noted significant deficiencies with	Noncompliance

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		eight (80%) of the QDRRs completed by the pharmacist. The following is a summary of some of the more concerning issues noted by the Monitoring Team: Individual #685: The QDRR was completed on 3/31/12. There were significant changes made with the Individual's anticonvulsant medications in March 2012, and Dilantin was discontinued. The Individual was noted to have had increased seizure activity during March, and the pharmacist did not comment on the rationale for discontinuing Dilantin, or comment on abnormal Dilantin levels, which were noted during the QDRR period. The Individual was noted to have mild anemia, which was not commented on, and anemia can be a side effect of the medication the individual was on. The pharmacist should have included a review for anemia, and commented on abnormal Dilantin levels. Individual #152: A QDRR was completed on 3/31/12. The pharmacist documented review of MOSES, DISCUS, and metabolic syndrome. The Individual was prescribed vitamin B12, and the pharmacists did not comment on its efficacy, need to assess B12, and to search for the etiology of the anemia, despite the Individual having a persistent mild anemia. Individual #561: The QDRR was completed on 3/31/12. The Individual was on risperidone, and the pharmacist appropriately assessed MOSES, DISCUS, and metabolic syndrome. An EKG was present, and without prolonged QTc. However, the pharmacist did not question the off-labeled use of risperidone for "personality change", and rationale for using risperidone in an individual who was diagnosed with dementia. Risperidone carries a black box warning by the FDA warning for use of risperidone individuals with dementia. Also, there was an abnormal prolactin level on 2/6/12, which may be drug related, and was not commented on by the pharmacists. Individual #632: A QDRR was completed on 4/27/12. The Individual was prescribed albuterol, which can cause tachycardia. An EKG that was completed on 2/18/12 demonstrated moderate tachycardia, of 125 beats per minute. The pharmacists did not document review of side effects for albuterol, or comment on the Individual's heart rate. Close monitoring of the medication is essential, as the Individual had a history of heart failure, and enlarged heart. Prolonged tachycardia can cause an enlarged heart, and heart failure. Individual #185**:** The Individual was prescribed iron therapy, and had anemia; however, the therapeutic use of iron, and its efficacy, was not commented on. Chronic iron therapy must be well justified. In this case, the anemia was associated with an eosinophilia, and must be more	

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		assertively assessed. Importantly, the Individual was noted to have had an elevated hepatic alkaline phosphatase, which could be medication induced, and was not commented on by the pharmacist. The Monitoring Team was also concerned of the Individual being prescribed baclofen for spasticity, as the pharmacist did not indicate its efficacy or justification for continued use. Individual #227: The QDRR was completed on 4/6/12, and a subtherapeutic Dilantin level was not commented on in the QDRR. Individual #500: The Individual was prescribed Baclofen for spasticity, and the pharmacist did not comment on its efficacy, or review potential side effects. Baclofen is a medication that can cause cognitive side effects. Individual #593: The Individual was prescribed Baclofen for spasticity, and the pharmacist did not comment on its efficacy, or potential side effect. Baclofen is a medication that can cause cognitive side effects, and spasticity is a very important medical condition that requires efficacious treatment. Baclofen should be discontinued if not proven to be efficacious, and increased if clinically indicated. Alternative delivery systems, such as a Baclofen pump should be considered in some cases, especially when there is demonstrated benefit, but side effects prevent pushing the dose higher. <u>Overview</u> The Monitoring Team compliments the clinical pharmacists for attending psychiatric, and neurology consultations, and the physicians for their comprehensive, and well documented review of QDRRs, and associated recommendations. Provision N2 requires that the Facility maintain a QDRR process that includes a review of drug monitoring labs. The Monitoring Team expects a robust QDRR process, that fully evaluates medications as they relate to the Individual, and follows a standard of care approach. The Monitoring Team noted significant deficiencies in eight out of the ten QDRRs reviewed. For this reason, the Monitoring Team determined that the Facility is not in compliance with Provision N2. Compliance will require a comprehensive review of all medication prescribed, and relevant clinical data, and ensure that physician action plans are followed through to completion.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical	Provision N3 is a comprehensive provision that requires the Facility to ensure appropriate use of STAT medications, benzodiazepines, anticholinergics, and polypharmacy. The Monitoring Team's review of these issues is as follows:	Noncompliance

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	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.	<u>Stat Medication Use</u> During this reporting period, the pharmacy reported a total of three STAT administrations of psychotropic medics for psychiatric emergencies (Individuals #199, #165, and #235). However, upon further review of the emergency medication monitoring database report, the Monitoring Team noted an additional three Individuals who were administered STAT psychotropic medications for behavioral issues (Individuals #447, #600, and #672). Six out of the six (100%) of the cases identified as having a STAT psychotropic medication administration during this reporting period were reviewed by the pharmacist, and appropriateness, medication type and dose, and indication were documented on the Facility's emergency medication monitoring database. The pharmacists did not document on the face-to-face assessment, debriefing, and reviews for crisis intervention restraint form, as their process only required pharmacists to report on the emergency medication monitoring database. The clinical pharmacist informed the Monitoring Team that immediately after the administration of a STAT medication, the clinical pharmacist would meet with the psychologist and psychiatrist to discuss chemical restraints; however, as part of the document request, the pharmacy department did not provide evidence to support that any recommendations were provided, and followed up on, or documentation to support that the pharmacist met with the psychologist and psychiatrist. The Monitoring Team requested a copy of all committee meeting minutes, documenting the discussion of the Facility's use of STAT medications. At the time of the October 2011 Monitoring Team compliance review, the pharmacy reported that all STAT medications were reported by the restraint reduction committee, and provided the Monitoring Team committee meeting minutes, which reflected a review of STAT medication use; however, for this compliance review, the pharmacy indicated that there was no formal sub-committee that reviews STAT medication use, but a report was made to the pharmacy and therapeutic committee (P&TC), and that STAT medication use was discussed during psychiatric clinics. The Monitoring Team noted that STAT medication, and chemical restraints were reported at the 10/26/11 P&TC meeting, which were the only P&TC minutes reviewed by the Monitoring Team. Printouts of graphs for the use of STAT medications were provided as part of the document request. As with previous reviews by the Monitoring Team, the graphs did not differentiate the type of indication. The Monitoring Team noted that the uses of STAT medications were reviewed in several venues, including direct discussion among psychologists, psychiatrist and clinical pharmacists, and by report to the P&TC committee. To be most useful, graphical representation for the use of STAT medications must be differentiated into indications for psychiatric, and non-psychiatric issues. The pharmacists must clearly report on the type of STAT psychotropic used, dose, delivery method, indication, review of noted side effects, potential drug-drug interactions, and	

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		comment on the appropriateness of use, and determination if the Individual's regularly scheduled psychotropic medication requires adjustment. Summary: The Monitoring Team noted that the use of STAT chemical restraints were reviewed in several venues, including direct discussion among psychologists, psychiatrist and clinical pharmacists, and by report to the P&TC committee. Graphical representation for the use of STAT medications must be differentiated into indications for psychiatric, and non-psychiatric issues. The pharmacists must clearly report on the type of STAT psychotropic used, dose, delivery method, indication, review of noted side effects, potential drug-drug interactions, and comment on the appropriateness of use, and determination if the Individual's regularly scheduled psychotropic medication requires adjustment. <u>Benzodiazepine Use</u> The pharmacy department presented a benzodiazepine usage audit report, which was dated 5/17/12. The report indicated that the Facility had a total of 43 active orders for benzodiazepines with 24 (56%) prescribed for psychiatric indications; 4 (1%) for sleep aid; and 14 (33%) used for neurological purposes, such as seizure control or spasticity. The Monitoring Team noted, as a positive finding, a reduction from a total of 56 individuals prescribed scheduled benzodiazepines in 2010, to a total of 43 individuals prescribed scheduled benzodiazepines in 2012. Ten QDRRs of individuals who were prescribed a scheduled dose of a benzodiazepine were selected by the Facility. Of the ten cases reviewed, six out of 10 (60%) were for a psychiatric indication, and four out of ten (40%) were for a neurological indication. Nine out of the ten QDRRs reviewed (90%) demonstrated robust documentation about the use of benzodiazepines. Of the six QDRRs reviewed with psychiatric indications, zero out of six (0%) indicated that the psychiatrist reviewed the QDRR by signing and dating the QDRR form. Summary: The Facility ensures that benzodiazepines are assessed within the context of the QDRR reviews; in addition, the Facility was able to well demonstrate systems review of benzodiazepine utilization at the Facility, and continued to strive to decrease its use for psychiatric indications. The Monitoring Team strongly recommends continuation with the process, and to present benzodiazepine utilization to the medical staff, periodically. <u>Anticholinergic Use</u> The pharmacy reported that it discussed the use of anticholinergic medications at the time of the psychiatric clinics. The pharmacy reported that they will begin documenting	

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		on anticholinergic use on future QDRRs. Summary: The Monitoring Team concurred with the pharmacy's plan to ensure that anticholinergics are comprehensively addressed on the QDRRs, and that data, and data analysis, on anticholinergic use should be presented to the P&TC in the future. <u>Polypharmacy Use</u> The pharmacy maintained a database to track polypharmacy use at the Facility, and tracked polypharmacy for both psychiatric medications and non-psychiatric medications. Graphs presented to the Monitoring Team for review did not differentiate polypharmacy based on indication; hence, the Monitoring Team could not determine various types of polypharmacy. The Pharmacy completed a comprehensive report on the Facility's use of polypharmacy, and presented data and analysis to the P&TC for review. The Facility's patient polypharmacy review policy indicated that the initial review of polypharmacy occurred at the time of the QDRR process. The pharmacist was to provide a comprehensive review of polypharmacy, and document relevant recommendations on the QDRR form for the physician to address. In the event that a polypharmacy issue was unresolved, the pharmacist was to forward the issue to the pharmacy director and medical director. Significant polypharmacy issues were to be referred to the polypharmacy review panel, for further evaluation. The Monitoring Team assessed ten QDRRs per document request, and of the ten QDRRs, ten out of ten were prescribed polypharmacy, and the clinical pharmacist indicated that polypharmacy was prescribed in ten out of ten (100%) of the examples; however, the Monitoring Team did not see meaningful documentation specific to indication, appropriateness of use, potential adverse reaction, and formal recommendations for polypharmacy use. Importantly, the psychiatrist did not sign, date or develop an action plan for any QDRR; only the primary care provider addressed QDRRs. Summary: The Monitoring Team noted the comprehensive reviews of polypharmacy, as documented on the polypharmacy/medication review panel meeting minutes of 1/30/12, and 3/3/15/12, that was presented to the P&TC meeting. The Monitoring Team was unable to interpret polypharmacy graphs because polypharmacy was not report by indications. Upon review of QDRRs, the Monitoring Team believes that polypharmacy should be better delineated, and indication, appropriateness, potential adverse interactions, and other recommendations should be well documented. Also, the psychiatrist must sign, data, and indicate agreement or disagreement with the pharmacist's recommendations on the QDRR.	

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		Metabolic Syndrome The Facility maintained a good process to screen for metabolic syndrome at the time of the QDRR, and included review of triglycerides, waist circumference, blood pressure and fasting blood sugar. At the time of the review, no Individuals at the Facility were diagnosed with metabolic syndrome. The Facility provided 15 samples of QDRRs, from Individuals who were prescribed atypical antipsychotics. Of the 15 QDRRs reviewed, all 15 (100%) included a comprehensive assessment for metabolic syndrome. Although the primary care physician signed, and indicated acceptance of, the QDRR recommendation in 15 out of 15 (100%) of the samples, the psychiatrist signed the QDDRRs in zero out of 15 samples (0%). Summary: The Facility maintained a robust process to assess metabolic risks during the QDRR process. The psychiatrist must review, sign, and indicate agreement or disagreement with QDRRs associated with psychotropic medication use. Overview The Monitoring Team determined that the Facility is noncompliant with Provision N3, because it did not provide meaningful assessments of the use of STAT medications, anticholinergics, and polypharmacy. Compliance will require the Facility to enhance its processes in these essential areas, by ensuring that psychiatrists review all QDRRs associated with psychotropic use; QDRRs must assertively address the use of polypharmacy, STAT medications use, benzodiazepines, and anticholinergics; improve on graphing of STAT medications, and polypharmacy use, so that psychotropic, and non-psychotropic indications are well delineated; and develop a committee structure that reviews, assesses and reports on chemical restraint use. In review of STAT medications, the pharmacists must clearly report on the type of STAT psychotropic used, dose, delivery method, indication, review of noted side effects, potential drug-drug interactions, and comment on the appropriateness of use, and determination if the Individual's regularly scheduled psychotropic medication requires adjustment.	
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	Provision N4 required that the Facility develop a process for the pharmacy to ensure that the medical practitioners consider the pharmacist's recommendations, and for recommendations not followed, document in the Individual's clinical record justification why the recommendation was not followed. To ascertain compliance for Provision N4, the Monitoring Team utilized the SPDI reports generated for Provision N1 of this report, and copies of the QDRRs, and associated physician IPNs documenting review of the QDRR, reviewed for Provision N2 of this report.	Substantial Compliance

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	justification why the recommendation is not followed.	The Monitoring Team noted that 13 out of 14 (93%) of the SPDIs reviewed indicated that the physician was informed of the SPDI, and accepted the recommendation. Of the QDRRs reviewed, ten out of ten (100%) indicated that the primary care physician reviewed, and accepted, the pharmacist's recommendations. The physician also documented review of the QDRR, and clinical plan for pharmacy recommendations in the IPNs. In all cases whereby a psychotropic medication was reviewed, the psychiatrist did not sign, or indicate acceptance of the pharmacist's recommendation. <u>Overview</u> Because physicians were informed, and concurred with pharmacist's recommendations for all SPDI reports that were reviewed by the Monitoring Team, and because of the well documented review of QDRRs by the primary care physicians, that indicated their understanding, and acceptance of the pharmacists recommendations, the Monitoring Team determined that the Facility remains in substantial compliance with Provision N4. The Monitoring Team does expect that upon subsequent reviews the psychiatrist will follow-up on all QDRRs that involve the review of psychotropic medications.	
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.	Provision N5 is assessed as a component of Provision J12. The Monitoring Team determined non-compliance for Provision J12, and refers the reader to section J12, of this report.	Noncompliance
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.	Provision N6 required that the Facility maintain a process to address adverse drug reactions (ADR). The Monitoring Team requested copies of the ten most recent completed ADR reports, copy of all graphs, data base reports, and summaries of all ADRs used for the ADR process. The Monitoring Team determined that the Facility maintained a comprehensive database of all ADRs. During the past six months, there were a total of 14 ADRs, none of which resulted in a hospitalization or need to report to the FDA. Nine, of the 14 (64%) required discontinuation of the medication. Of the ten ADR reports reviewed, all included essential information about the ADR, including type of reaction, medication name, and immediate action taken in ten, out of 10 (100%) cases. The physician commented on five out of ten (50%) of the ADR report forms. The adverse drug reactions policy, dated 5/15/11 delineated the process for reporting,	Substantial Compliance

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		reviewing, and documenting ADRs. The policy also described how ADRs were to be presented to the P&TC, for review. During past Monitoring Team reviews, the Monitoring Team reviewed P&TC minutes, and noted comprehensive review of ADRs; however, the Monitoring Team was only provided with P&TC minutes for October 26, 2011, so was unable to assess the comprehensiveness of the ADR reviews by the P&TC. The Pharmacy Director informed the Monitoring Team that training on completing ADRs was provided to direct care and nursing staff, and understands that the Facility is developing a process to ensure that all staff who are regularly in direct contact with individuals, including physicians, are appropriately trained on ADR reporting and plans to initiate annual refresher training. <u>Overview</u> The Monitoring Team noted that the Facility had a comprehensive mechanism to review, analyze, and report on ADRs, and determines that the Facility remains in substantial compliance with Provision N6. The Facility reported that direct support staff and nurses had been trained on ADRs and that refresher training is planned. During the next compliance visit, the Monitoring Team will more comprehensively assess documentation to ensure that all staff, who are in regular contact with Individuals, are trained on the ADR reporting process. Also, the Monitoring Team will assertively review P&TC minutes to ensure regular reporting of ADRs, and recommendations made for ADRs. Importantly, given the large population, and number of medications prescribed, the Monitoring Team has concern over the low incidence of ADRs at the Facility, and urges the Facility to assess compliance issues in reporting ADRs and completing the ADR report form.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Provision N7 calls for the Facility to develop and implement a drug utilization evaluation (DUE) process that enables regular review of pharmacological intervention. The Monitoring Team reviewed the Facility's policy for its drug utilization program, which is referred to as the drug uses evaluation, and DUE policy, and procedure, dated 5/12/11. The Policy indicated that a DUE would be conducted at least quarterly, and more often as necessary. Members of the P&TC selected 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 Monitoring Team reviewed the P&TC minutes, dated 10/26/11, and noted that the	Substantial Compliance

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		committee had selected four topics for the following year's DUEs: 1. Lacosamide for quarter one 2. Phenobarbital for quarter two 3. Lithium for quarter three 4. Clozapine for quarter four At the time of this review, two DUEs were provided, including a DUE for valproic acid and one for Lacosamide. The pharmacy director informed the Monitoring Team that no additional DUEs were provided or required for the past six months, such as DUEs that would be required secondary to a manufacturer or FDA warning, or because of adverse outcomes at the Facility. Importantly, the FDA had issued several advisories during the past six months, including an advisory for rosiglitazone, and risk of cardiac events, on 11/4/11; Pradaxa, and the risk of serious bleeding, issued on 12/7/11; and simvastatin, having new restrictions, issued on 12/15/11. The Monitoring Team did discuss the importance of providing DUEs for manufacturer and FDA advisories with the director of pharmacy during previous Monitoring Team reviews, and the pharmacy did provide such DUEs, as noted during the last Monitoring Team Review. The pharmacy reported that it follows up on DUE recommendations by monitoring physician orders to ensure that necessary changes were made; however, there was no process that documents follow-up on all recommendations made for DUEs. <u>Overview</u> The Facility had a process in place for the provision of DUEs, and provided two scheduled DUEs during the past six months. During the past six months, there were no unscheduled DUEs provided for FDA advisories. The Facility did not maintain a calendar specific for pending, and completed DUEs, and did not have a mechanism to document that all recommendations issued for DUEs were followed up to resolution. The Monitoring Team will continue substantial compliance for N7; however, continued compliance will require the Facility to update its policy on DUEs to include a process for providing DUEs for manufacturer, and FDA drug advisories, and develop a process to document that recommendations issued for DUEs were followed to resolution and were effective. It is recommended that the Facility develop a calendar for pending and completed DUEs.	
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	Provision N8 calls for the Facility to maintain a process that provides review of all medication variances. To assess compliance, the Monitoring Team reviewed associated policies and committee meeting minutes, assessed its database for medication variance monitoring, and assessed completeness of medication variance report forms. <u>Review Of Medication Variance Policies</u> The Monitoring Team request that all policies, and procedures on medication variances	Noncompliance

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	potential medication variances.	be provided for review. The only policy provided for review was the RSSLC medication variances policy, I.34, updated on 2/27/12. There was no local policy, or procedure to delineated the Facility's local processes hence, the Monitoring Team was unable to determine how the medication variance process functions at the local level, especially in the area of who reports medication variances, and how they are reported, and how the medication variance committee follows up on recommendations. Summary: The Facility did not have a local procedure for the medication variance process. A local procedure should be developed to better delineate the Facility's process for addressing medication variances, and include a statement detailing who reports medication variances, and how they are to be reported, as well as how recommendations made by the committee are followed up on. <u>Review Of Database Reports And Graphs Of Medication Variances</u> The Monitoring Team requested copies of all graphs used to review medication variances. The Monitoring Team was only provided a database table, that outlined demographic information, locations, time, and type of variance, as well as category, and title of staff members involved. There was no graphic representation of data elements derived from the medication variance process, and consequently, it was very difficult to track trends longitudinally. Summary: The Facility maintained a database for medication variances, but did not produce graphic representation of medication variance data elements; therefore, it was challenging to track and trend variances longitudinally. The Facility should enhance its tracking and analyzing of medication variances by implementing graphic representation of medication variance data elements. <u>Review Of Medication Variance Committee Meeting Minutes</u> The Monitoring Team was provided medication variance committee minutes for January 2012, through April 2012. The Monitoring Team reviewed the March and April committee meeting minutes, and noted that the minutes reflected an overview of all reported variances for the previous one-month period. Recommendations made for each variance were not comprehensive. For example, in the 3/29/12 committee minutes, recommendations made for a drug refusal issue was "he prefers to have one particular nurse do this for him, so was referred to behavior analyst and MD". It was unclear as to what the committee expected the MD and analyst to do; Another examples states that "There were incidents of the Individual refusing his meds	

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		on six different days during the month of February, and exhibiting aggressive behaviors. Referred to MD and behavior analyst". There were no details as to what the MD and behavior analyst were to do. In a third example, the recommendation indicated that a nurse thought that because medications were in the medication drawer, consent had been obtained, so all nurses were retrained on that unit. In this case, if the committee had concern over all nurses on the unit, then they should have considered the issue to be a Facility wide issue. Most important, there was no tracking of recommendations to determine if they were implemented and if they were effective. Summary: The medication variance committee did not provide specific and comprehensive recommendations, and did not follow-up on recommendations for completion, and efficacy. <u>Review Of Completed Medication Variance Forms</u> The Monitoring Team requested copies of the last ten completed medication variance report forms, and was provided 17 for review. Of the 17 report forms reviewed ten out of 17 (59%) were completed appropriately, 11 out of 17 (65%) indicated that a supervisor reviewed the form, and seven out of 17 (41%) were signed by the person completing the form. Summary: The Monitoring Team determined that the Facility did not appropriately complete its medication variance report forms. <u>Overview</u> The Facility has yet to fully develop and implement its medication variance process, and the Monitoring Team determined that the Facility remains not in compliance with Provision N8. Compliance will require a better system to track and report on medication variance trends longitudinally, including graphic representation that medication variance data elements to assist in decision-making; ensuring that medication variance report forms are appropriately completed; and ensuring that recommendations for medication variances are more robust, are assessed for efficacy, and are followed through until complete.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. Improve the comprehensiveness of QDRRs, to review of all medications, and related clinical data (Provision N2)

2. Document the actual date when a QDRR was actually completed on the QDRR scheduled, and QDRR form (Provision N2)
3. Graphs used to monitor STAT medications must differentiate the type of STAT medication, and psychotropic or non-psychotropic indication (Provision N3)
4. Ensure that there is documentation of the pharmacists meeting with the clinical psychologist when discussing STAT psychotropic medication administrations, and that all recommendations are follow-up through resolution (Provision N3)
5. Periodically present benzodiazepine utilization to the medical staff, and continue previous efforts to decrease benzodiazepine use for psychiatric indications, when clinically appropriate (Provision N3)
6. Ensure that the psychiatrist completes a review of all QDRRs associated with psychotropic review (Provisions N2, N3, and N4)
7. QDRRS must include a comprehensive assessment of the use of benzodiazepines, anticholinergics, STAT medication use, and polypharmacy, and provide meaningful recommendations to mitigate the such use, when clinically appropriate (Provision N3)
8. Ensure that all staff that are regularly in direct contact with Individuals, including nurse, direct care staff, PT-OT, and physicians, are well trained on the ADR process (Provision N6)
9. Assess compliance issues, and the reporting process for ADRs.
10. The pharmacists must clearly report on the type of STAT psychotropic used, dose, delivery method, indication, review of noted side effects, potential drug-drug interactions, and comment on the appropriateness of use, and determination if the Individual's regularly scheduled psychotropic medication requires adjustment (Provision N3)
11. Update the policy on DUEs to include a process for providing DUEs for manufacturer, and FDA drug advisories, and ensure that DUEs are provided for all relevant manufacturer, and FFDA drug advisories (Provision N7)
12. Develop a calendar for pending and completed DUE (Provision N7)
13. Develop a process to document that recommendations issued for DUEs, were followed to resolution (Provision N7)
14. Track and report on medication variance trends longitudinally, and ensure that medication variance data elements are represented graphically (Provision N8)
15. Ensure medication variance report forms are appropriately completed. (Provision N8)
16. Ensure that recommendations for medication variances are more robust, and that recommendations are assessed for efficacy, and are followed through until complete (Provision N8)
17. The Facility should ensure that the Medication Variance Committee puts in place a tracking system to identify, analyze, and trend systemic medication variances; and develop and implement systemic CAPs which are followed through to resolution and their efficacy evaluated. (Provisions M.6 and N8)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self Assessment (5/1/12) and Action Plan (4/27/12) 2. Record reviews: • Sample #1: Individuals #16, #30, #31, #251, #402 and #661 • Sample #2: Individuals #109, #192, #248, #275, #284, #324, #330, #377, #477, #535, #542, #603, #701 and #718 • Sample #3: Individuals #40, #84, #99, #169, #219, #330, #388, #585, #632, #724, and #765 • Sample #4: Individuals #2, #7, #29, #30, #73, #95, #106, #159, #174, #184, #193, #207, #219, #227, #259, #265, #296, #308, #426, #471, #484, #518, #525, #535, #553, #569, #585, #618, #641, #649, #675, #676, #711, #725, and #765 • Sample #5: Individuals #41, #296, #412 #649, #712, and #726 3. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 4. RSSLC PNMT Policy K.01 Physical Nutritional Management (1/31/11) 5. RSSLC PNMT Process (rev 4/19/12) 6. RSSLC Habilitation therapies Policy K.04 (Developing PNMPs) (2/23/12) 7. RSSLC Habilitation therapies Policy K.07 (Universal Monitoring) (3/1/12) 8. RSSLC Habilitation therapies Policy K.05.1 (Staffing Effectiveness-Occupational Therapy / Physical Therapy) (4.1.12) 9. RSSLC Habilitation therapies Policy K.05.2 (Occupational Therapy / Physical Therapy Services) (4/1/12) 10. RSSLC Habilitation therapies Policy K.06.1 (Staffing Effectiveness-Speech Therapy) (2/1/12) 11. RSSLC Habilitation therapies Policy K.06.2 (Speech-Language Pathology Services) (4/1/12) 12. RSSLC At Risk Individuals policy I.08 13. A list of continuing education sessions or activities participated in by PNMT members since last review (10/2011) 14. Minutes, including documentation of attendance, for the PNMT meetings for the past 6 months 15. Individual PNMT reports as available for individuals reviewed above 16. Tools used to screen and identify individuals' PNM health risk level 17. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 18. A list of PNM assessments and updates completed in the last two (2) quarters 19. ISPs for the sample individuals 20. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 21. Tools used to monitor implementation of PNM procedures and plans 22. A list of individuals for whom PNM monitoring tools were completed in the last quarter 23. Tools utilized for validation of PNM monitoring

	24. 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 25. PNMP template and any instructions for use of template 26. Dining Plan template 27. PNM spreadsheets generated by the Facility 28. 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 29. List of individuals who have received a videofluoroscopy, modified barium swallow study (MBSS), or other diagnostic swallowing evaluation since the last review 30. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 31. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans 32. Since the last review, a list of competency-based training sessions addressing foundational skills in PNM **People Interviewed:** 1. Ping Law OTR Habilitation therapies Director 2. David Taylor OTR PNM Lead 3. Sally Martinez PNMT RN 4. Brandie Rabe PNMT SLP 5. Jean Cuevo PNMT PT 6. Ten DCPs (San Antonio, Trinity, Leon, Lavaca, Sabine, Infirmary and San Jacinto) **Meeting Attended/Observations:** 1. PNMT 5/15/12 and 5/17/12 2. Observations (San Antonio, Trinity, Leon, Lavaca, Sabine, Infirmary and San Jacinto)
	Facility Self-Assessment: RSSLC's Self-Assessment, updated 5/01/2012 and Action Plan dated 4/27/2012, provided

	comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions O.1 through O.8. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. For the self-assessment, the Facility described, for each provision item, the activities the Facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the Facility self-assessment process. Overall, the Self Assessment and Action Plans included relevant steps that would assist in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report. . Examples of this occurring included: • The Facility's Self-Assessment did not define how the samples were selected. • Not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., Provision O.1 did not include information regarding review by the IDT and Provision O.2 which did not include information regarding assessment by the Physical and Nutritional Management Team). If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. • Criteria for success with an action step were not clearly defined. For example, action plan for O.4 identifies what training needs to occur but did not provide information regarding what criteria must be achieved for RSSLC to achieve compliance with PNMP implementation and how this will be validated. • Clear outcomes were not included as part of the Action Plan process. Overall, the Facility had demonstrated some good use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed.
	Summary of Monitor's Assessment: Overall, improvement has been noted, especially as it related to the PNMT and the PNMT evaluations. The PNMT had improved its core membership with the addition of the Registered Dietitian (RD) and planned addition of a QDDP. The PNMT evaluations also showed great improvement as the evaluations began reflecting actual assessment rather than a summary of previous assessments. Another area of improvement were the PNMPs which were more comprehensive than in previous visits; however, the PNMPs still lacked consistency in this regard. Concerns included lack of a timely response to issues associated with PNM. Individuals who were not admitted to the hospital were not consistently reviewed by the IDT or PNMT and individuals who were not identified as "high risk" were not consistently monitored.

	Per observation, nurses at the homes were not very knowledgeable of the PNMPs and how they impacted the act of medication administration as well as other nursing duties. PNMT was working with nurses on Leon to improve understanding, but this was only a pilot and had not spread to other areas of campus. That being said, this was a positive improvement. **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 IDT. 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 this 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 risk process was in place but continued to not consistently identify those individuals who were at an increased 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 lacking in detail in assessments 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 detail regarding head of bed evaluation 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. That being said, the PNMPs, overall, showed a significant improvement since the previous visit. **Provision O.4:** This provision was determined to be not in compliance. Staff was observed not consistently implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were not provided with safe dining or positioning 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 and that all staff were provided with comprehensive competency based training. **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 comprehensive 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 ISP, 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. Individuals were not provided with assessments that identified the medical necessity of the tube and pathways to oral intake.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, 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	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 IDT but lacked evidence of systemic review and/or analysis of recommendations to determine if there a resulting positive impact. Additionally, the PNMT referral process was fragmented as referral to the PNMT only occurred if an individual was admitted to the hospital. Due to this practice, individuals who were diagnosed with pneumonia but were not admitted did not receive assessment by the PNM nurse or referral to the PNMT. The Physical and Nutritional Management Team (PNMT) consisted of: • David Taylor OTR, PNM Lead • Jean Cuevo PT • Sally Martinez RN • Brandie Rabe SLP • Eric Linton RD (as of 1/26/12) The PNM Team met 25 times since the previous compliance visit. PNM team minutes from 1/3/12 to 4/28/12 documented inconsistent attendance by the five PNM Team standing members. The PNMT lead (OT) attended all meetings as did the PNMT PT. The RD also attended all meetings once joining the team. The RN attended 24/25 meetings (96%) and the SLP attended 16/25 (64%) of the meetings. Attendance by the SLP has not achieved a satisfactory level of participation in the meetings for the second visit in a row. Due to the nature of what is discussed, it is essential that the SLP participate with increased frequency. If the SLP is not able to attend, a backup should be identified. Missing from the PNMT was evidence of medical collaboration with a physician or behavioral support by psychology when many individuals discussed had complex medical and/or behavioral issues. A PNMT QDDP position was opened by RSSLC. The role of the QDDP will be to serve as a liaison between the other QDDPs and assist in bridging the gap between the PNMT and the IDT. As of this review, the position had not yet been filled. PNMT minutes were revised 4/5/12 in a manner that provided clearer evidence of	Noncompliance

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	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.	discussion. Minutes reflected an overall impression of the meeting and provided clear actions plans needed to ensure all responsibilities and discussions are documented. This revision was much improved over the previous format. 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 attended by some members of PNMT focused on: • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities • Postural and Back Education-Mechanical and Functional Approach • Habilitation therapies Conference • Demystifying and Interpreting Lab Data • Changing Behavior-Changing Waistlines Frequency of the PNMT meetings was not clearly stated in the PNM policy but upon review of PNMT minutes and signature sheets, meetings were held a minimum of 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 Interdisciplinary Team (IDT). 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. 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. PNMPs were much improved but remained 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 IDT or reviewed consistently by the IDT. For examples, please refer to Provision O.3. Zero of three individuals (0% of Sample #5) who had a modified barium swallow study MBSS that recommended an upgrade or downgrade in diet texture had the findings of the study reviewed and discussed by the team. While there was evidence of acceptance of the recommendation by the PCP, there was no review by the IDT to identify the extent of monitoring that may be needed to ensure tolerance outside of the fluoroscopy suite.	

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		Examples included: • Individual #726 was upgraded from a ground texture to a regular texture. • Individual #412 was upgraded from honey liquids to nectar liquids. There especially was a need for review since the individual had a previous history of aspirating on nectar liquids. A positive practice that continued to be noted was participation by PNMT in the medical morning meetings as well as grand rounds thus allowing for the increased sharing of issues between multiple committees but this still did not reflect active collaboration between the physicians and the PNMT regarding their caseload.	
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.	Sample #1 was chosen from the list of individuals who were diagnosed with an aspiration event since the previous compliance review. The sample consisted of six individuals who accounted for 50% of the individuals who experienced an aspiration event. Sample #2 consisted of 13 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 consisted of approximately 50% of those who were at a high risk of aspiration and 100% of those who were at a high risk of choking. Sample #3 consisted of 11 individuals or 25% of the individuals at RSSLC who received enteral nutrition. Sample #4 was gathered through observation and report from the Monitoring Team. These individuals were identified through observations on various homes Sample #5 consisted of six individuals at RSSLC who had a Modified Barium Swallow Study (MBSS) since the previous review. Based on a review of 19 individuals' (Samples #1 and #2) most recent OT/PT assessments, three of 19 Individuals (15%) 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. The swallowing components of the OT/PT assessment remained vague and did not provide consistent information regarding the impact on functioning. For example: • Individual #718's OT/PT assessment stated the individual had some rotary chewing but did not state the functional relevance.	Noncompliance

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		The Oral Care and Medication Administration sections of the OT/PT assessment at times were missing or contained a general statement of positioning but did not contain any information indicating assessment of the areas. For example: • Individual #542's oral care section stated the positioning but did not provide any information regarding the acquisition of skills regarding this activity. Oral Motor assessments conducted by the SLP were much improved and provided much more detail regarding swallow status and impact on functioning. The issue was that the SLP did not consistently conduct oral motor evaluations outside of referrals to more acute issues. 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 • Thresholds to reassessment • Pathway to oral intake These components if comprehensively completed would represent a comprehensive PNM assessment. Per report from the Habilitation therapy (HT) director, seven evaluations had been completed since the previous compliance visit. In addition to the seven assessments, 18 head of bed (HOB) assessments had been completed. Per review, the PNMT evaluations were much improved and addressed the issue in a more comprehensive manner when provided. An issue that remained with the PNMT evaluation as well as the OT/PT assessments was lack of comparative analysis. This type of analysis will assist in identifying changes in status from year to year or assessment to assessment. Another concern noted was the reactive approach to conducting assessments. An example of this was individual #689 who has skin breakdown, poor posture, and has a history of recurrent pneumonias and emesis. This would be an ideal person for the PNMT to provide a comprehensive assessment but the PNMT was not planning to initiate	

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		a referral. Based on a review of six (Sample #1) records of Individuals who experienced an aspiration event, two of six (33%) 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 #31, #661 and #402 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. Other examples include Individuals #426 and #634 who had severe pica behavior which included ingestion of batteries and chains but were identified as only being at a moderate risk of choking. The IDT had the ability to lower the risk; however, there was no evidence as to why the guidelines were not followed by the team. Lack of critical clinical thinking and discussion was noted when the IDTs 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. Failure to properly identify individuals at increased risk results in an increased likelihood that care will be 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. Secondly, many programs were based upon level of risk; therefore it is essential that people be accurately identified and assigned an appropriate 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. This was an issue noted in the previous compliance visit. Two of six (33%) individuals who were diagnosed and/or hospitalized with a PNM issue (Sample #1) were appropriately assessed and followed by the PNMT or IDT in a timely manner. For example: • Individual #30 was diagnosed with pneumonia and has a significant history of aspiration pneumonia but did not receive PNMT or IDT review/assessment	

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		upon identification of diagnosis. • Individual #16 was diagnosed with aspiration pneumonia on 12/7/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the IDT 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. • Individual #661 was diagnosed with aspiration pneumonia on 1/20/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was eventually made on 1/30/12 but the PNMT did not complete the assessment until 4/5/12 resulting in an unnecessary delay of getting the needed services to mitigate risk. • Individual #251 was diagnosed with aspiration pneumonia on 2/15/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was made on 2/21/12 but the PNMT did not complete the assessment until 5/1/12 resulting in an unnecessary delay of getting the needed services to mitigate risk. Lack of critical thinking as mentioned above in identifying risk as well as lack of discussion surrounding aspiration events remained a pervasive issue. Additionally, when the PNMT did meet and evaluate the individual there was not evidence of follow through regarding recommendations. For example: • Individual #31's PNMT evaluation contained recommendations for diet texture change, and modification of medication administration but there was no evidence of assessment. Dental Services in coordination with the PNMT and IDT continued to implement suction tooth brushing for individuals who were at an increased risk of aspiration, had a history of pneumonia, or who received enteral nutrition. As of this review, the use of suction toothbrushing continued to be expanded.	
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.	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 19 individual PNMPs (Sample #1 and #2), individuals were not provided with a comprehensive PNMP. • Twelve of 19 PNMPs (68%) contained consistent or detailed information regarding head of bed elevation/positioning • Thirteen of 19 PNMPs (71%) contained consistent information regarding	Noncompliance

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	These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	medication administration. Examples included: • Individual #192's PNMP contains inconsistent information regarding HOB elevation. One section states HOB is elevated to 25 degrees while another stated 20 degrees. • Individual #251's PNMP simply stated HOB elevated and did not provide degree of elevation. • Individual #248's PNMP did not contain needed adaptive equipment under the medication administration section. • Individual #535 had one picture representing two positions (left and right sidelying). 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 as well as to increase consistency of implementation in their home at RSSLC. Although issues remained with the PNMPs, there was a significant improvement since the previous visit as evidenced below: Several positive practices that the Facility should ensure continue: • In 19 of 19 PNMPs (100%) reviewed, positioning instructions for wheelchair and alternate positions instructions were included as applicable. • In 19 of 19 PNMPs (100%) reviewed, transfer instructions were included as applicable. • In 19 of 19 PNMPs (100%) reviewed, the mealtime/dining plan included intake information for mealtime and snacks • In 19 of 19 PNMPs (100%) reviewed, the mealtime/dining plan included food/fluid textures as applicable. • In 19 of 19 PNMPs (100%) reviewed, the mealtime/dining plan included behavioral concerns related to intake. • In 19 of 19 PNMPs (100%) reviewed, individual adaptive equipment was included. • In 19 of 19 PNMPs (100%) reviewed bathing/showering positioning and instructions were included. • In 18 of 19 PNMPs reviewed (94%), comprehensive strategies for oral hygiene were included as part of the Oral Hygiene Plan and/or PNMP. • In 18 of 19 PNMPs reviewed (94%), PNM triggers to be observed and reported were listed as part of the plan.	

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		RSSLC continued to provide HOB assessments but these were not consistently provided as indicated by a need of the individual or a change in status. Since the last review, review, 18 HOB assessments had been completed. Per report, the HOB assessments were being completed if the individual had been hospitalized and referred to the PNMT or was identified as a high risk. This represented a reactive approach to the assessment issue. Additionally, the risk identification process as mentioned in Provision O.2 was not sufficient in identifying those who were "high risk" and therefore many individuals would not be provided with the needed assessment. Based on a review of an identified sample of 19 individual records (Samples #1 and#2) PNMPs were not formally developed with input from the IDT. In zero of 19 records reviewed (0%), PNMPs were clearly developed with input from the IDT with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the ISPs that the PNMPs were included, but there was no evidence of discussion or input from other team members or integration.	
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 IDT members as described above. Generally, the PNMP was located in the PNMP notebook that followed the individuals 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. Observations (Sample #4) 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 six of 22 (27%) observations, staff were following mealtime strategies and positioning listed in plans. This percentage represented a decrease since the previous compliance visit. • In one of 13 (7%) observations staff were following positioning instructions. This percentage represented a decrease since the previous compliance visit. For more examples of the positioning issues, please refer to Provision P.2.	Noncompliance

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		Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: • Individual #618 was not provided with prompts to decrease the rate of intake, therefore placing him at an increased risk of choking, and was observed hyper-extending his neck when consuming liquids, therefore increasing his risk of aspiration. • Individual #29 was not provided with liquids during the meal. • Individual #207 was observed taking large bites with no intervention from staff. • Individual #259 HOB elevation was beyond the 35 degrees recommended. • Individuals #525 and #585 did not have pads on their bed rails as stated on the PNMP. • Individual #569 was on an all ground diet but was observed being served whole hamburger buns. The Monitoring Team observed the individuals eating the bottom half of the bun in one bite and the top half in two bites resulting in an increased risk of choking. • Individual #73 was observed with no sheet or pillow on the wedge supporting her knees resulting in increased heal pressure and contraction of her legs. • Individual #535 was observed with a glove ¾ in his mouth resulting in an increased risk of choking and/or hypoxia. The Monitoring Team had to prompt staff that this was an unsafe practice and to remove the glove. Upon removing glove, Individual was coughing. • Individual #30 was observed coughing with struggle with no evidence of staff intervention. 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. Based on interviews with ten DCPs, percentage of correct responses regarding PNMPs were: • Where is the PNMP/Dining Plan located? (80%) • What kind of transfer do they require? (100%) • What do you look for to ensure the individual is in the correct position? (10%) • Why does the individual need thickened liquids? (40%) • Why does individual eat modified texture foods? (50%) • Why does the individual require a specific utensil? (40%) • Why does the individual require a specific assistance technique? (10%) • What are the individual's risk indicators? What do you look for before, during and after the meal? (40%) • Does the individual have an Aspiration Trigger Data Sheet, where is it kept and when do you document? (60%)	

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		• Have you been trained to implement this plan? (60%) • Who do you contact if you have difficulty with the plan or the equipment? (90%) 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 observation, nurses at the homes were not very knowledgeable of the PNMPs and how they impacted the act of medication administration as well as other nursing duties. The PNMT was working with nurses on Leon to improve understanding but this was only a pilot and had not spread to other areas of campus. That being said, this was a positive improvement. In conversation with Karen Hardwick OTR of DADS State Office, the nurse educators will be attending a training session at Corpus Christi that will focus on the medication administration component of the PNMP. Per interview with nursing staff in the Infirmary, elevating the HOB per the PNMP was accomplished by using the inclinometer provided by HT. Although, this was an improvement over "eyeballing" which was previously used, consistency remained a concern. Another concern was that the PNMPs located at the Infirmary were unable to clearly view the positioning photos due to the poor quality.	
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 • Physical and Nutritional Management • Safe presentation techniques for food and fluid • PNMPs • Aspiration Prevention Per interview with the Habilitation Services director, there was no formal 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. Per Habitation Director, the home manager and Physical and Nutritional Management Plan Coordinator (PNMPC) were responsible for reviewing the books with pull staff but this review did not consist of any type of formal competency task based training, and it was unclear as to the frequency or consistency in which this was occurring. 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. Per report from the PNMT lead, OT/PT were developing person-specific training sheets that will include task oriented competency based training. As of this review, approximately three had been completed and RSSLC was still in the process of piloting the process. 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. Again, the home manager and PNMPC were responsible for reviewing the books with pull staff but this review did not consist of any type of formal competency based training and it was unclear as to the frequency or consistency in which this was occurring. 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. Per the HT director, RSSLC was working towards a system in which the Home Manager would have access to all the person specific training, therefore simplifying the process in which pull staff would be trained and/or identified if they had received training in the past. Per Habitation Director, the PNMPC trained the Infirmary staff usually the day after the individual was admitted. This was a concern as staff should be trained on the individuals prior to working with them; therefore, training should occur prior to admission to infirmary and discharge from the hospital.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three	A policy/protocol that addressed the monitoring process and provided clear direction regarding its implementation and action steps to take should issues be noted did not exist at RSSLC.	Noncompliance

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	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.	Two of six (33%) individuals who were diagnosed and/or hospitalized with a PNM issue (Sample #1) were appropriately assessed and followed by the PNMT or IDT in a timely manner. For example: • Individual #30 was diagnosed with pneumonia and has a significant history of aspiration pneumonia but did not receive PNMT or IDT review/assessment upon identification of diagnosis. • Individual #16 was diagnosed with aspiration pneumonia on 12/7/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the IDT 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. • Individual #661 was diagnosed with aspiration pneumonia on 1/20/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was eventually made on 1/30/12 but the PNMT did not complete the assessment until 4/5/12 resulting in an unnecessary delay of getting the needed services to mitigate risk. • Individual #251 was diagnosed with aspiration pneumonia on 2/15/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was made on 2/21/12 but the PNMT did not complete the assessment until 5/1/12 resulting in an unnecessary delay of getting the needed services to mitigate risk. 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. A concern was that the monitoring forms contained a section labeled compliance and noncompliance. Compliance was achieved with a score of 80% or higher. The problem was that each question was weighted equally resulting in staff being allowed to not implement the PNMP and still have a score high enough to be rated as in compliance. Per review of the monitoring list since March 20, 2012 when the new database was developed allowing RSSLC to identify where monitoring was occurring and during what activity, only 31 (35%) of the 87 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 also lack of data acquisition and analysis regarding the completion of the	

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		monitoring forms. As of this review, the PNMT was unable to pull information regarding inter-rater reliability, percentage of activities monitored, and percentage of knowledge of and implementation of PNMPs. Per report of the HT director, high risk individuals were monitored three times per week (twice by the PNMPC and once by the residential coordinator) in a variety of activities, but upon review of documentation, the majority 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 19 individual records (Samples #1 and #2), the PNM Team or IDT did not document progress of individual strategies 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 minimally at the ISP annual planning meeting, 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). Measurable outcomes were beginning to be included as part of the PNMT evaluation but there was no evidence of integration of these outcomes into the nursing care plans to allow for monitoring whether these issue occurred. 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. The clinicians or IDT did not conduct routine, proactive review of the plans with frequency based on health risk level. All members of the PNM team did conduct monitoring but per the Habilitation Director, the monitoring focused primarily on effectiveness of plan and this was only required to be done once monthly and again focused only on individuals who were high risk. Another concern was that the compliance forms were utilized but it was unclear as to how this information displayed effectiveness when the questions focused more on compliance. 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.	Noncompliance

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		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: • Inconsistency of individualized triggers • 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"	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to retur$_{n\ the}$ individual to oral feeding.	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 47 individuals listed as receiving enteral nutrition. All individuals who received non-oral intake (NPO) in the selected sample had been provided a PNMP that included the same elements described above. The At Risk Individuals policy I.08 included 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 IDT. As of this review, this assessment was not consistently completed at RSSLC and did not contain evidence of interdisciplinary discussion. Based on the sample of 17 individuals (Samples #1 and #3), three of 17 (17%) individuals had received the aspiration pneumonia/enteral nutrition (APEN) assessment provided by the State. The APENS that were completed were vague and did not address the provision or reflect an interdisciplinary approach. 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	Noncompliance

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		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 ISP. Based on a review of eleven individuals' ISPs, zero of 11 (0 %) (Sample #3) individual's ISP clearly documented the rationale for the continued need for enteral nutrition. Eleven of 11 individuals (100%) who received enteral nutrition were provided with a PNMP; however, many of these contained the same issues 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 PNMT nurse assessment should identify not only the need for PNMT referral but provide direction regarding potential areas for the IDT to investigate (i.e., OT, PT, SLP) should the need for a PNMT referral is not warranted, (Provision O.1)
3. Ensure the PNMT reviews all individuals with potential PNM issues regardless of whether they were admitted to the hospital or just the infirmary (Provision O.1)
4. Develop a method for ensuring physician participation in the PNMT meetings. (Provision O.1)
5. The IDT 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)
6. 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)
7. 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)
8. PNMPs at the Infirmary should be of high enough photo quality to ensure staff can clearly implement positioning strategies. (Provision O.5)
9. All strategies and equipment identified in the PNMP must be implemented in all settings. This includes the Infirmary. (Provision O.5)
10. Measurable outcomes identified through PNMT assessment or OT/PT assessment should be integrated as part of the nursing care plan to allow for additional tracking regarding the effectiveness of the recommended strategies. (Provision O.6)
11. A formal process should be developed that ensures individuals are monitored throughout all activities in which risk may be increased.. (Provision O.7)
12. 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)
13. Aspiration Trigger Data Sheet should be modified to include triggers specific to the individual (Provision O.7).
14. 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. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
c. Formal schedule for monitoring to occur;
d. Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors;

15. Develop an auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues (Provision P.4 and O.7)
16. 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)

Aspiration Pneumonia/Enteral Nutrition Evaluation should be completed per state guidelines or replaced by a method that will ensure individuals are provided with clear pathways to oral intake. (Provision O.8).

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 Self Assessment (5/1/12) and Action Plan (4/27/12) 2. Record reviews: • Sample #1: Individuals #16, #30, #31, #251, #402 and #661 • Sample #2: Individuals #109, #192, #248, #275, #284, #324, #330, #377, #477, #542, #603, #701 and #718 • Sample #3: Individuals #165, #314, #600, and #689 • Sample #4: Individuals #358, #399, #523, #686 • Sample #5: Individuals #2, #7, #29, #73, #95, #106, #159, #174, #184, #193, #207, #219, #227, #259, #265, #296, #308, #426, #471, #484, #518, #525, #535, #553, #569, #585, #618, #641, #649, #675, #676, #711, #725, and #765 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 three (6) months, including name of individual, date, location, whether there was injury, and, if so, type of injury 4. RSSLC Habilitation therapies Policy K.04 (Developing PNMPs) (2/23/12) 5. RSSLC Habilitation therapies Policy K.07 (Universal Monitoring) (3/1/12) 6. RSSLC Habilitation therapies Policy K.05.1 (Staffing Effectiveness-Occupational Therapy / Physical Therapy) (4/1/12) 7. RSSLC Habilitation therapies Policy K.05.2 (Occupational Therapy / Physical Therapy Services) (4/1/12) 8. OT/PT assessments template 9. For the past 6 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. 10. List of individuals receiving direct OT and/or PT services and focus of intervention 11. Last five assessments completed by OT/PT **People Interviewed:** 1. Ping Law OTR Habilitation therapies Director 2. David Taylor OTR PNM Lead 3. Jean Cuevo PNMT PT 4. Ten DCPs (San Antonio, Trinity, Leon, Lavaca, Sabine, Infirmary and San Jacinto) **Meeting Attended/Observations:** 1. PNMT meetings 5/15/12 and 5/17/12

	2. Observations (San Antonio, Trinity, Leon, Lavaca, Sabine, Infirmary and San Jacinto)
	Facility Self-Assessment: RSSLC's Self-Assessment, updated 5/01/2012 and Action Plan updated 4/27/2012, provided comments/status for Provisions P.1 through P.4 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions P.1 through P.4. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. For the self-assessment, the Facility described, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the Self Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses, as indicated in this report and the Facility's Self-Assessment did not define how the samples were selected. Overall, the Facility had demonstrated some good use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed. The summary of the Self-rating was especially helpful in gaining better insight as to why the facility feels they were in compliance or not in compliance.
	Summary of Monitor's Assessment: Overall, as with PNM concerns, there was a lack of problem solving and identification of issues that contributed to decline in mobility, and/or positioning. 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. There were many positives that should be noted as well. These included timely completions of assessments and screenings for new admits and all individuals having 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. The concern as previously noted was the comprehensiveness of the 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 ISP.

	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 Universal Monitoring Policy K.07, the policy identified frequency of monitors for high-risk individuals but did not include frequency of monitors for individuals who were not at a high risk. Additionally, the policy did not provide clear direction when deficits were noted in staff implementation of the PNMP. Another concern was the lack of clarity regarding how RSSLC will ensure monitoring reaches all areas in which risk is increased (oral care, bathing, positioning, medication administration, lifting/transfers and meals) This was true of both compliance and effectiveness monitoring. Also missing from the policy was: • Method of assessing inter-rater reliability • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	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 5.5 Occupational Therapists (OT), three Certified Occupational Therapy Assistants (COTA), five Physical Therapists (PT) and two Physical Therapy Assistants (PTA). There was an opening for a PT. With the current staffing, ratios for Occupational Therapy were 1:80 and PTs 1:73. This ratio does not meet the 1:60 ratio identified by RSSLC as appropriate. With the assistance of the PTAs and COTAs, the PTs and OTs should be able to address many of the needs of the individuals but due to the need for extensive assessments, the current ratio remains insufficient. COTAs and PTAs should not be included in these ratios because they cannot fully carry an independent caseload. Per the state practice act, therapy assistants were not licensed to conduct assessments or develop intervention plans; they required supervision by the OT and PT respectively. They were, however, able to gather specific data for assessments, provide interventions, conduct staff training, conduct monitoring, and engage in other responsibilities. Their roles were adjunctive to service delivery by the PTs and OTRs and, as such, should not be fully counted when calculating staffing ratios. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		supports available from the therapy assistants. OT and PT completed annual assessments/updates 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. Individuals for Sample #1 were chosen from the list of individuals who were diagnosed with an aspiration event since the previous compliance review. The sample consisted of six individuals who accounted for 50% of the individuals who experienced an aspiration event. Sample #2 consisted of 13 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 consisted of approximately 50% of those who were at a high risk of aspiration and 100% of those who were at a high risk of choking. Sample #3 consisted of four individuals who accounted for 25% of new admissions since the previous compliance review. Sample #4 consisted of 4 individuals who experienced the highest number of falls since the previous compliance visit. Sample #5 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. 100% of individuals (sample #3) (new admissions) had received an OT/PT assessment. Assessments indicated whether or not the individual required OT/PT supports and services for 27of 27 (100%) (Samples #1, #2 #3, and #4) 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 enhance and the method for obtaining this enhancement or progress • Measurable data as well as explanation of how these deficits are functionally affecting the individual.	

#	Provision	Assessment of Status	Compliance
		• 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. Per report, the OT/PT assessment had been revised to be more comprehensive but upon review of the last five assessments completed by OT/PT, the Monitoring Team did not see a clear improvement regarding the issues noted above Ten of the 27 (37%) assessments (Samples #1, #2, #3, and #4) 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 ##16 and #251's OT/PT assessment contained a diagnosis list but did not provide information or links to how these diagnoses impacted the level of care. The inclusion of how diagnoses impacted function was noted to improve on this visit and will be reviewed again at the next compliance visit. Evidence of communication and or collaboration was present in the OT/PT assessments. Based on review of 27 OT/PT assessments (Samples #1, #2, #3, and #4), 100% included signatures and date of both OT and PT. Based on review of individuals with changes in status (Samples #1 and #4), there was not a consistent assessment or comprehensive review for 4 of 8 individuals (50%) as indicated by a change in the individual's status or as dictated by monitoring results. • Individual #16 was diagnosed with aspiration pneumonia on 12/7/11 but there was no evidence of comprehensive reassessment upon return from the hospital. There was evidence of the IDT 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	

#	Provision	Assessment of Status	Compliance
		need for assessment. • Individual #661 was diagnosed with aspiration pneumonia on 1/20/12 but there was no IDT meeting to discuss the event. A referral to the PNMT was eventually made on 1/30/12 but the PNMT did not complete the assessment until 4/5/12 resulting in an unnecessary delay of getting the needed services to mitigate risk. • Individual #686 experienced an increase in falls over the past three months but there was no evidence of formal reassessment of gait and/or IDT discussion of environmental factors that may contribute to or decrease the risk of future falls. • Individuals #525 and #585 did not have pads on their bed rails as stated on the PNMP resulting in an increased risk of injury Routine audits of the assessments were conducted and a number of these were submitted in the Presentation Book for Provision P. The audit tool was not submitted, but the level of compliance submitted was 100%. This audit appeared to reflect a review for format only rather than a qualitative review of content as well.	
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 Samples #1 and #2 were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. For example: • Individual #251's 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. • Individual #31's plan states to have meds crushed but does not provide evidence of assessment. Additionally, the assessment contains strategies for feeding but did not provide information regarding what deficit the strategy was intended to address. Per report from the HT director, 18 head of bed (HOB) assessments had been completed. 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 27 individuals (Sample #1, #2, #3, and #4) equipment	Noncompliance

#	Provision	Assessment of Status	Compliance
		was specified for 26 of 26 (100%) plans reviewed. Within 30 days of the annual ISP, or sooner as required for health or safety, a plan was developed as part of the ISP but was not consistently reviewed by the IDT. Plans were generally limited to the PNMP that was reviewed at the time of the annual ISP 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 IDT related to program changes or changes in status. Please refer to Provision O.3 for more information. The primary support provided 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. Assessments and plans focused only on the PNMPs and did not include identification and implementation of methods to improve functioning or the acquisition of skills. 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. 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 consistent implementation. Please refer to Provision O.3 for additional information. The OT/PT plans did not consistently include measurable outcomes that would assist in the team in determining if interventions were effective in addressing the identified concerns. Observations demonstrated that staff failed to implement interventions and recommendations outlined in the PNMP which were most likely to prevent aspiration, reflux, skin breakdown and contractures. In 6 of 21 (28%) observations, staff were following mealtime strategies listed in plans. This percentage represented a decrease since the previous compliance visit. See Provision O.4 for examples	

#	Provision	Assessment of Status	Compliance
		In one of 13 (7%) observations staff were following positioning instructions. This percentage represented a decrease since the previous compliance visit. • Individuals #184, 227, 675, and 553 were all in bed when their plans called for them to be in their wheelchairs. • Individuals #484, 675, #184, #726 were all poorly positioned in bed with missing pillows, bolsters, and wedges resulting in an increased risk of contractures, aspiration and reflux.	
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 • Physical and Nutritional Management • Safe presentation techniques for food and fluid • PNMPs • Aspiration Prevention 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 two of five (40%) 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 San Antonio was not able to describe why individual would benefit from a transfer vest vs. a gait belt.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• DCP on Trinity was not able to state why alternate positioning was appropriate and needed. • DCP on the Infirmary was unable to express why the foot of the bed needed to be elevated.	
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 existed that was designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. RSSLC had an adaptive dining equipment list, wheelchair maintenance list/schedule, list of individuals who utilize mechanical lifts, and list of individuals who wear protective helmets. 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). 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. Again, the home manager and PNMPC were responsible for reviewing the books with pull staff but this review did not consist of any type of formal competency based training and it was unclear as to the frequency or consistency in which this was occurring. 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. Per the HT director, RSSLC was working towards a system in which the Home Manager would have access to all the person-specific training, therefore simplifying the process in which pull staff would be trained and/or identified if they had received training in the past. Universal Monitoring Policy K.07 existed that identified frequency of monitors for high-risk individuals but did not include frequency of monitors for individuals who were not at a high risk. Additionally, the policy did not provide clear direction when deficits were noted in staff implementation of the PNMP. Another concern was the lack of clarity regarding how RSSLC will ensure monitoring reaches all areas in which risk is	Noncompliance

#	Provision	Assessment of Status	Compliance
		increased (oral care, bathing, positioning, medication administration, lifting/transfers and meals). This was true of both compliance and effectiveness monitoring. Also missing from the policy was: • Method of assessing inter-rater reliability • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician 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. A concern was that the monitoring forms contained a section labeled compliance and noncompliance. Compliance was achieved with a score of 80% or higher. The problem was that each question was weighted equally resulting in staff being allowed to not implement the PNMP and still have a score high enough to be rated as in compliance. Per review of the monitoring list since March 20, 2012 when the new database was developed allowing RSSLC to identify where monitoring was occurring and during what activity, only 31 (35%) of the 87 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 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, percentage of activities monitored, and percentage of knowledge of and implementation of PNMPs (note that the only monitoring done was for PNMPs). That being said, a data system did exist to collect data from the compliance monitors but as stated, there was no way to utilize the data for analysis and review.	

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 and 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. Shift focus of assessment audits to content and quality. This may be incorporated as a peer review function. (Provision P1)

3. There was a continued need for improved staff attention to the details of proper positioning and alignment in wheelchairs and dining chairs and compliance with the PNMPs. (Provision P.2)
4. There was a continued need to develop programs to address increasing or expanding functional skills. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (Provision P2).
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. There should be established thresholds for staff re-training; identification, training, and validation process for monitors to achieve accurate scoring; and inter-rater reliability (Provision P.3 and P.4).
7. 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
    e. 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.);
    f. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    g. Formal schedule for monitoring to occur;
    h. Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors;
8. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues (Provision P.4 and O.7)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. RSSLC Section Q Presentation Book 4. DADS Policy 004 Individual Support Plan Process 7/30/10 5. List of Individuals, per document request, who are candidates for suction toothbrushing 6. Integrated progress notes (IPN), and Dental Progress Records for document request per document request 7. Randomized list of 20 Individuals seen by the dental office , and for each, copy of last two annual dental assessments, copy of associated IPN for dental issues, most recent ISP, and copy of dental x-rays 8. Integrated progress notes (IPN), and dental treatment records of Individuals who experienced dental emergencies 9. Randomly generated list, by the Facility, of ten Individuals seen by the dental office for routine dental care, and dental assessments, as part of document request 10. On-site clinical records for Individuals #213, #400, #751, #210, 442, #499, and #364 11. Oral health care plans, provided in document request 12. Dental assessments, IPNs, consent forms, anesthesia and post-anesthesia monitoring forms, as part of document request 13. Most recent ISPs for Individuals #499, #321, #30, #159, #364, #265, #540, #103, #290, and #415 **People Interviewed:** 1. Carol Heath, DDS, Dental Director **Meeting Attended/Observations:** None
	Facility Self-Assessment: **Provision Q1.** Based on its self-assessment of having achieved areas of improvement in oral hygiene and reported 100% compliance in preventive dental care, completion of annual dental examinations, and timely provision of dental care, the Facility reported that is was in substantial compliance with Provision Q1. The Monitoring Team disagrees with the Facility's self-assessment and strongly recommends that the Facility assess the quality of services provided for oral health care at the Facility (noting that the self assessment reported that 53% of individuals sampled had fair oral hygiene, and 26% had poor oral hygiene, a finding that should indicate noncompliance). In addition, many of the programs assessed, through the self-assessment process had not been fully implemented, such as the oral health care plan, and suction toothbrushing initiatives. The self-assessment reported that three individuals out of 15 sampled used suction toothbrushing; given that the Facility should have a list of all individuals receiving suction toothbrushing, it is unclear why that information isn't used, rather than a sample; then, a sample of individuals could be checked to determine whether the suction toothbrushing was used appropriately and effectively. **Provision Q2**. The Facility reported noncompliance with Provision Q2, and the Monitoring Team concurs

	that the Facility is not in compliance with the Provision. The self-assessment for Provision Q2 indicated that that it is assessing the ISP and Oral Hygiene care plan processes. The Monitoring Team recommends that ISP be assessed for comprehensiveness, and ensure that it provides meaningful insight into the Individuals oral health care issues, and necessary supports and services needed by the Individual. Compliance will require full implementation of programs that are determined to be essential for providing the necessary supports and services necessary to achieve quality outcomes.
	Summary of Monitor's Assessment: The Monitoring Team noted that the Facility had developed, and is in the process of implementing an oral hygiene program that will incorporate each Individual's oral hygiene needs into a dedicated services plan through a multidisciplinary approach. Importantly, the Monitoring Team noted that the oral hygiene of many of the individuals who reside at the Facility has significantly improved. The Facility maintains an effective emergency dental services process that helps to ensure that individuals who require emergency dental procedures are triaged appropriately. The Facility is in the process of implementing a dental database, which should enable better tracking of dental services. The Monitoring Team noted that dental services was not well represented within the context of the interdisciplinary team process, and it is essential that the ISP clearly delineates all oral hygiene, and oral health care needs. **Provision Q1:** The Monitoring Team observed that treatment plans were not comprehensive, and did not demonstrate integration of dental assessments, services needs, and supports into the interdisciplinary team process. Each Individual must have a comprehensive assessment that delineates all of the Individual's oral health care needs, required treatments, alternative treatments, risks and benefits of treatments, necessary supports to achieve dental care, and time frames. No such examples were identified by the Monitoring Team. The Monitoring Team is also concerned with the lack of documentation by the dentist in the IPN, in language that non-dental staff personnel can understand. Although the Facility has several very useful programs in development, such as the suction toothbrushing program and oral hygiene care plan initiative, the Facility must fully implement these, and assess them for efficacy. For these reasons, the Monitoring Team determined that the Facility remains noncompliant with Provision Q1. Compliance will require the Facility to enhance dental treatment assessments and plans; ensure assertive integration of dental services into the IDT process; ensure that complete IPNs are developed for all dental treatments; ensure that Individuals are followed by the dental office to full resolution of a dental emergency or other dental issue; and fully implement, and ensure efficacy of, the suction toothbrush, and oral hygiene care plan initiatives. One area of improvement was oral hygiene; the oral hygiene of many of the individuals who reside at the Facility has significantly improved. **Provision Q2:** The Monitoring Team found a lack of integration of dental services into the ISP. The Monitoring Team noted many examples when dental services were not discussed at all by the IDT, nor reflected in the ISP. Oral health care is a critical component of health care services that must be adequately provided to Individuals with developmental disabilities. The Monitoring Team noted that the Facility lacked an efficient means to address data elements related to dental issues, because it lacked an effective process to manage such elements. The dental department did not effectively collaborate with psychology

	services to develop and implement necessary approaches to assist in mitigating the need for sedation. For these reasons, the Monitoring Team determined that the Facility remains not in compliance with Provision Q2. Compliance will require the development of a process to better manage database elements related to dental issues, such as the scheduling of appointments, being able to efficiently review dental treatments, and pending services. The dental office must also assertively collaborate with psychology services to develop processes that help mitigate the need for pre-treatment sedation. Most important, dental services must develop comprehensive assessments, and treatment plans that are well integrated into the ISP.

#	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.	Provision Q1 requires that the Facility maintain a process to ensure that routine and emergency dentistry is adequately provided to Individuals served by the Facility. To assess compliance, the Monitoring Team reviewed the provision of general dentistry, use of anesthesia and oral hygiene practices, ability to provide effective emergency dental care. The following are the results of the Monitoring Teams findings in these areas. <u>Provision Of General Dentistry</u> The Monitoring Team requested a list of 10 Individuals, along with copies of their last two annual dental assessments, past six months IPNs, that were specific for dental issues, the Individuals' most recent ISP, and copy of dental x-ray report. In response, the Facility provided documents that did not include the recent ISP. Upon reviewing the IPNs it was observed that the dentist did not document the oral health care needs of the individual in the IPN record. Also, the Facility did not maintain specific dental x-ray reports, but integrated the x-ray findings into the dental record. Review of the dental records proved to be challenging for the Monitoring Team, as they did not clearly delineate a comprehensive clinical review, in context with a clear plan for the Individual's oral health care needs. The dentist did not document on the dental visit in the IPN, but referred staff to review the dental records. During discussion with the dental director, the Monitoring Team was informed that the dental office was unable to efficiently review the dental scheduling system, and that it would not enable the generation of database elements that could be used to determine frequency of dental visits, or the reason for dental visits. The dental office did not maintain a schedule of which Individuals required and received dental x-rays. The dental record form did not have a specific area to assess gross description of the oral cavity, or to indicate such issues like oral cancer, pre-cancer, and other lesions. Many areas for assessments, such as for periodontal disease, dental caries, and dentures did	Noncompliance

		not have a checkbox for normal exam, and there was no specific area that indicated when routine x-rays were required. Most important, the area for treatment plan was not comprehensive. **S**ummary: The Monitoring Team was concerned over the provision of routine dental care at the Facility, as the Facility did not well document a comprehensive assessment, and treatment plans for routine and restorative dental care, in the dental record; and for not providing documentation of a dental summary in the IPNs, in language that non-dental office staff could interpret. The dental office was unable to demonstrate a mechanism that could efficiently demonstrate when dental services were provided, and for what reason. The dental record form, for initial and follow-up dental care, was not comprehensive, and needed to be enhanced. For these reasons, the Monitoring Team determined that routine dental services were not adequately provided at the Facility. <u>Oral Hygiene</u> To assess the provision of oral hygiene efforts at the living area, the Monitoring Team assessed suction toothbrushing, made oral hygiene observations at the living area, and discussed oral hygiene efforts with the dental director. Suction Toothbrushing: To assess the Facility's suction toothbrushing process, the Monitoring Team requested a list of all Individuals who were prescribed a suction toothbrush, and a list of all Individuals who were assessed, and were pending suction toothbrushing. The document request, The Dental Director stated that the Facility did not have a list of Individuals who had been assessed, and were pending suction toothbrushing, and the only list provided for review was a list of Individuals who were candidates for suction toothbrushing. During discussion with the dental director, the Monitoring Team learned that Individuals who resided at Trinity, and tube fed, were receiving suction toothbrushing, and that others at the Facility remain to be assessed, and assigned suction toothbrushing. Oral Hygiene Observations: While observing Individuals at their homes, and day programs, the Monitoring Team observed Individuals #666, #388, #632, #324, #462, and #207 for glistening plaque, gross debris, and edematous, bleeding gums. Of the six individual observed, six (100%) demonstrated good oral hygiene. The observation was not a clinical assessment, and was performed in the context of greeting the Individual. Oral Hygiene Service Plans: Discussion with the dentist indicated that the Facility was developing a comprehensive oral hygiene plans that will include a specific service plan, to address the unique needs of each Individuals. There was no formalized policy or procedure developed for the process, as the process was in a pilot project stage. The Monitoring Team compliments the Facility for its attempt to improve oral health care at the living area.	

		Summary: The Monitoring Team observed good oral hygiene of Individuals at the Trinity living area, and compliments the direct care staff and dental hygienist for their efforts in improving oral hygiene at this home. The Facility's initiative for developing oral hygiene care plans is a positive step. The Monitoring Team was unable to determine the number of Individuals who received suction toothbrushing, or who had already been assessed, and pending suction toothbrushing, because there was no database tracking these issues. The Facility must complete its full assessment of all Individuals at the facility, develop suction toothbrushing treatment plans, and ensure that all Individuals who require suction toothbrushing are provided such service. The Facility should develop a robust quality assurance program to ensure that suction toothbrushing is being provided efficaciously. Importantly, the Facility must have a process to refer Individuals for suction toothbrushing, on an as needed basis. The Monitoring Team is most Interested in seeing full implementation of its efforts to improve oral health care at the living area. <u>Dental Emergencies</u> The Facility had a functional process to address dental emergencies. In the event of a dental emergency, the nurse would assess the individual, and notify the on-call dentist. The on-call dentist would 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. The Monitoring Team requested a list of all Individuals who required dental emergencies during the past six months, along with copies of their dental assessment for the dental emergency. The dental office database was unable to efficiently provide such a list, and a list was not provided, as requested. The Facility provided copies of integrated progress notes (IPN) and dental treatment records of Individuals who experienced dental emergencies. The progress notes and treatment records were not collated together, so it was challenging for the Monitoring Team to associate IPNs with specific dental progress/treatment records. In addition, many non-essential progress notes were included with the documents provided. Review of the documents indicated that the dental progress record did not clearly delineate the dental emergency, but reported mostly on the dental assessment, and provided treatment . The IPN did not routinely include a dental report that could be interpreted by non-dental office staff. Summary: It was clear to the Monitoring Team that the Facility had a process to triage dental emergencies; however, the Facility did not provide a list of dental emergencies, and the dentist did not document a comprehensive note in the IPN. The Facility must better track dental emergencies, and ensure appropriate documentation within the IPN,	

		so that non-dental office staff can interpret the assessment, treatment, and plan for the dental emergency. <u>General Anesthesia</u> The Monitoring Team asked the dental director if it was possible to generate a list of a Individuals who required, and who were provided general anesthesia, and was informed that the Facility did not have a mechanism to efficiently provide such a list, but that six individuals require general anesthesia for dental treatment. The Monitoring Team submitted a written request for a list of all individuals who required general anesthesia for their dental treatments; however, the requested documents for these cases were not provided; instead, the document request included nine cases of Individuals who had dental treatment under intravenous sedation. The Monitoring Team was unable to assess the Facility's process for individuals who required general anesthesia. <u>Intravenous Anesthesia (Tiva)</u> The Facility provided the Monitoring Team with nine examples of Individuals who were provided TIVA at the Facility. The Monitoring Team requested the consent forms, anesthesia record, post anesthesia monitoring, IPNs, and dental records. Anesthesia records were present, and complete in nine out of nine (100%) of the cases; nurse progress notes for post anesthesia follow-up were noted to be comprehensive for nine out of nine (100%) of the cases; Post anesthesia vital flow sheet was provided for seven out of nine (77%) of the cases; a dental assessment report was completed in nine out of nine (100%) of the cases. However, the Monitoring Team determined that the dental record demonstrated comprehensive treatment plan in zero out of nine (0%) cases reviewed. In none of the cases reviewed did documentation clearly delineate the oral health care needs of the individual, nor provide a meaningful timeframe of when all necessary treatments would be provided. The Monitoring Team was unable to assess if the Facility provided adequate TIVA services to support the needs of all Individuals at the Facility, as there was no comprehensive dental plan identified to address the Individuals' on-going oral health care needs. For example when reviewing the dental record associated with a TIVA procedure, the dentist would indicate what treatment was provided under TIVA, and would then provide a comment stating "anticipate future tooth loss", and there was no additional plan, or recommendations for follow-up treatment. While on-site, upon reviewing the annual ISPs for Individuals #213, #400, #751, #210, 442, #499, and #364, the Monitoring Team did not identify a well defined review of dental services, that included a comprehensive dental treatment plan. Summary: The Monitoring noted that when TIVA services were provided, there was comprehensive monitoring throughout the process, and good nursing follow-up.	

		Documentation of dental services lacked a comprehensive dental treatment plan, and the Individual Support Plan (ISP) did not outline a comprehensive needs assessment for oral health care, nor a meaningful oral health care treatment plan. The Monitoring Team was concerned with statements in the dental record stating; "anticipate future tooth loss", without further explanation in the record and review by the IDT. <u>Pre-Treatment Oral Sedation</u> Please refer to Provision J4 for review of pre-treatment oral sedation. <u>Overview</u> The Monitoring Team noted a significant lack of integrating dental assessments, services needs, and supports into the interdisciplinary team process. Each Individual must have a comprehensive assessment that delineates all of the Individuals' oral health care needs, required treatments, alternative treatments, risks and benefits of treatments, necessary supports to achieve dental care, and time frames. No such examples were identified by the Monitoring Team. The Monitoring Team is also concerned with the lack of documentation by the dentist in the IPN, in language that non-dental staff personnel can understand. Although the Facility has several very useful programs in development, such as the suction toothbrushing program, and oral hygiene care plan initiative, the Facility must fully implement and assess these programs for efficacy. For these reasons, the Monitoring Team determined that the Facility remains noncompliant with Provision Q1. Compliance will require the Facility to enhance dental treatment assessments and plans; ensure assertive integration of dental services into the IDT process; ensure that complete IPNs are developed for all dental treatments; ensure that Individuals are followed by the dental office to full resolution of a dental emergency or other dental issue; and fully implement, and ensure efficacy of the suction toothbrush, and oral hygiene care plan initiatives.	
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	Provision Q2 requires the Facility to ensure that there are meaningful processes in place to help minimize the need for sedation, ensure integration of dental services in the integrated team process, and ensure a robust scheduling system that efficaciously tracks all dental services. The following is the Monitoring Teams assessment of each of these areas. <u>Integration Of Dental Services In the Isp</u> The Monitoring Team requested documentation for 20 randomly selected Individuals, along with the last two annual dental assessments, copy of the most recent ISP, and dental x-ray report, and was provided records that only included a copy of the ISP. Review of most recent ISPs for Individuals #499, #321, #30, #159, #364, #265, #540, #103, #290, and #415, indicated that none of the cases reviewed demonstrated any meaningful integration of dental services. Both Settlement Agreement Provision F2 and DADS Policy 004 Individual Support Plan Process require integration of services,	Noncompliance

	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.	supports, and treatments. Summary: Services and supports to meet dental health care needs were not meaningfully integrated into the team process, and there was a lack of the development of a comprehensive dental treatment plan, based on the Individuals' needs and abilities. The Facility must immediately develop a plan to review the oral health needs of Individuals in an integrated way, and reflect the oral health care condition and services needs of the individual, in the ISP. <u>Programs To Minimize Sedation</u> As reported in Provision J4, the dental clinic provided data that showed that between October 2011 and March 2012, the number of sedations varied between a low of 26 (March 2012) and a high of 55 procedures (Jan 2012). The monthly average number of procedures was 44. General anesthesia was used on average for 3% of procedures, and oral pretreatment sedation was used for about 7.7% of procedures. These figures were similar to what was reported for the prior six months. The dental department had been working on a process to improve the delivery of oral hygiene at the living area. The process included an integrated approach in developing oral hygiene plans and facilitating enhanced oral hygiene at the living area, and included behavioral techniques and specific recommendations on ways to support the Individual for oral hygiene. This process had recently been developed, and was being piloted at the time of this review. Although this is of value in itself, the Facility will need to review whether this process also affects the need for pre-treatment sedation. The dental director reported that the only other process to reduce the need for sedation was that once per week, Individuals were brought to the dental office for opportunities to visit the dental office, with gradual exposure to the dental experience. According to the dental director, the dental office did not collect specific data or develop trends analysis of outcomes for this process. The Facility provided no evidence that there was a routine mechanism for collaboration between psychology and dental services to develop plans for programs to minimize need for pre-treatment sedation. Summary: The Monitoring Team recommends that dental services and psychology services collaborate, and collaboratively develop systems to assist in mitigating the need for sedation when being provided dental treatment by the dentist and hygienist. <u>Scheduling And Missed Dental Appointments</u> During discussion with the dental director, the Monitoring Team was informed that the Facility will be implementing the DADS dental database system, which will enable	

		efficient scheduling and tracking of all dental services; however, at the time of this compliance review, it was reported by the dental director that the Facility could not efficiently track appointments, and dental services. For example, a reliable list could not be generated at that time, to delineate the reason why a dental appointment was missed. Summary: The Monitoring Team looks forward to the Facility's implementation of the DADS dental database. The Facility must ensure that a scheduling system is implemented that will enable a comprehensive review of all dental appointments, the reason for the appointment, pending and completed appointments, what services were provided, and services that require follow up appointments; for example, it should be able to generate a list of Individuals who have had dental x-rays and who require dental x-rays. It is essential that when comprehensive treatment plans are developed for dental services, that follow-up appointments are readily entered into the scheduling database, and tracked for timely completion of all necessary services. <u>Quality Assurance (QA) For Dental Services</u> During discussion with the dental director, the Monitoring Team was informed that the only QA process being addressed was that the dental office was in the process of developing a suction toothbrushing QA review. Through document request, the Monitoring Team was provided QA reports with a date range of 11/2/11 – 1/31/12, which assessed the Facility's compliance with the settlement agreement, but there was no evidence to suggest that there was a QA process to assess clinical efficacy and adverse outcomes following dental procedures. Summary: The Monitoring Team will further review the QA process for dental services at subsequent reviews. It is important that, in addition to assessing system issues, such as scheduling, and completion of documents, a dental QA process include clinical outcomes, such as how effective was treatment, and assessing adverse outcomes following treatments. The Facility must have a process to will track adverse outcomes, such as pneumonia, injuries and behavior exacerbations following dental treatments. <u>Overview</u> The Monitoring Team observed a lack of integration of dental services into the ISP. During its' review, the Monitoring Team noted many examples when dental services were not discussed at all by the IDT, nor reflected in the ISP. Oral health care is a critical component of health care services that must be adequately provided to Individuals with developmental disabilities. The Monitoring Team noted that the Facility lacked an effective process to manage data elements for dental services, such as having an effective process to efficiently identify individuals who received, and require general anesthesia for dental procedures, and a meaningful scheduling system. The dental department did not effectively collaborate with psychology services to develop and implement necessary	

		approaches to assist in mitigating the need for sedation. For these reasons, the Monitoring Team determined that the Facility remains not in compliance with Provision Q2. Compliance will require the development of a process to better manage database elements related to dental issues, such as the scheduling of appointments, being able to efficiently review dental treatments, and pending services. The dental office must also assertively collaborate with psychology services to develop processes that help mitigate the need for sedation. Most important, dental services must develop comprehensive assessments, and treatment plans, that are well integrated into the ISP.	

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

1. Ensure that all Individuals are promptly assessed for suction toothbrushing, and, when indicated, develop and implement a treatment plan (Provision Q1)
2. Maintain a list of all Individuals who receive suction toothbrushing, and who actually require toothbrushing but are pending a suction toothbrush program (Provision Q1)
3. Each Individual must have a comprehensive dental assessment that clearly outlines all of the Individual's oral health care issues, and delineates a comprehensive treatment plan, that includes risk and benefits of treatments and alternative treatment options, as well as indicates the necessary supports and services necessary to achieve good oral health (Provision Q1)
4. Individuals must be scheduled for all necessary dental procedures that are outlined in a comprehensive treatment plan (Provision Q1)
5. Ensure that there is a process that can readily determine when dental x-rays have been obtained, and when they are required (Provision Q1)
6. The Dentist must include an IPN for routine and emergency dental issues, that can be interpreted by non-dental office staff, and that clearly defines the dental emergency, assessment, and follow-up plan to full resolution of the dental issue (Provision Q1)
7. The Facility must develop an efficient and efficacious method to track Individuals who received, and who are pending all dental services, including if the service or requires the use of TIVA, general anesthesia, or pre-treatment sedation (Provisions Q1 and Q2)
8. The IDT must review all dental emergencies and adverse outcomes (Provisions Q1 and Q2)
9. Ensure a robust dental quality assurance process for all relevant dental outcomes, including treatment efficacy, and adverse reactions following dental procedures (Provisions Q1 and Q2)
10. The Monitoring Team recommends that dental services, and psychology services collaborate, and collaboratively develop systems to assist in mitigating the need for sedation (Provision Q2)
11. The dentist must follow-up on all dental emergencies, and other dental issues, through full resolution, and document their effort in the IPNs (Provision Q2)

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 Self Assessment (5/1/12) and Action Plan (4/27/12) 2. Record reviews: • Sample #1: Individuals #16, #30, #31, #251, #402 and #661 • Sample #2: Individuals #109, #192, #248, #275, #284, #324, #330, #377, #477, #542, #603, #701 and #718 • Sample #3: Individuals #165, #314, #600, and #689 • Sample #4: Individuals #39, #99, #100, #184, #321, #399, and #751 • Sample #5: Individuals #248, #447, and #555 3. A list of people with Alternative and Augmentative Communication (AAC) devices 4. AAC evaluation and Speech Language assessment template 5. Monitoring tools template for ACC and SLP programs 6. List of individuals receiving direct speech services, and focus of intervention 7. PBSPs for sample individuals 8. Communication assessments for sample individuals 9. Communication programs for sample individuals 10. Habilitation therapies Policy K.06.1 (Staffing Effectiveness-Speech Therapy) 11. Habilitation therapies Policy K.06.2 (Speech-Language Pathology Services) 12. Last five assessments completed by each Speech Language Pathologist (SLP) **People Interviewed:** 1. Ping Law OTR Habilitation therapies (HT) Director 2. David Taylor OTR PNM Lead 3. Brandie Rabe MS-CCC-SLP 4. Ten DCPs (San Antonio, Trinity, Leon, Lavaca, Sabine, Infirmary and San Jacinto) **Meeting Attended/Observations:** 1. PNMT 5/15/12 and 5/17/12 2. Observations (San Antonio, Trinity, Leon, Lavaca, Sabine, Infirmary and San Jacinto)
	Facility Self-Assessment: RSSLC's Self-Assessment, updated 5/01/2012 and Action Plan dated 4/27/2012, provided comments/status for Sections R.1 through R.4 of the Settlement Agreement. The Facility indicated it was in compliance with Provision R.1 and not in compliance with Provisions R.2 through R.4. This was inconsistent with the Monitoring Team's findings as all provisions were found to be noncompliant. Provision R.1 was found to be noncompliant due to lack of staffing to allow for SLPs to participate in all facets of care. For the self-assessment, the Facility described, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent

	improvement in the facility self-assessment process. Overall, the Self Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the monitoring team assesses as indicated in this report. Examples of this occurring included: • Not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., Provision R.1 focused only on the hiring of staff and did not reflect the expected outcomes that would be seen by having adequate staffing.). If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. • Sample size and how samples were chosen were not provided. Additionally, time frames for data acquired were not provided. • The self assessment focused on the presence of many aspects (i.e., # of assessments or monitors completed) but did not discuss the quality of such documents. Overall, the Facility had demonstrated some good use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed.
	Summary of Monitor's Assessment: There continued to be little progress as it related to meeting the communication needs of the individuals living at RSSLC. Communication assessments continued to be vague and not provide the in-depth investigation regarding how to increase an individual's communicative functioning. 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. Much work had been done on polices surrounding Communication supports. This included policies K.O6.1 and K.06.2. Another positive practice identified was that the majority of assessments identified whether the individual required direct or indirect therapy. **Provision R.1:** This provision was determined to be not in compliance. RSSLC increased their number of SLPs to four on campus but 1.5 were dedicated to dysphagia and the ratio still exceeded the ratio identified by the Facility as being needed to address all issues. . As stated, the priority for 1.5 of the SLPs was to focus on dysphagia; therefore, the communication caseload for the entire campus belonged to 2.5 therapists. The ratio of therapist to client was 1:90, which was too large a caseload for the therapists to actively participate in all facets of care. There remained two open SLP positions.

	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 were not developed and many of the ones in place were not being consistently implemented. **Provision R.3:** This provision was determined to be not in compliance. Communication strategies and programs were not consistently integrated into the ISP, and DCPs interviewed were not knowledgeable of the communication programs. Additionally, AAC devices (individualized as well as common area) were not functional or consistently utilized. **Provision R.4:** This provision was determined to be not in compliance. RSSLC had a list of shared devices but did not have clear monitoring process that tracked the presence, working condition, and effectiveness of the AAC equipment. Additionally, there was little evidence of SLP involvement in the review of the effectiveness of the devices or programs as well as the review of progress.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Individuals for Sample #1 were chosen from the list of individuals who were diagnosed with an aspiration event since the previous compliance review. The sample consisted of six individuals who accounted for 50% of the individuals who experienced an aspiration event. Sample #2 consisted of 13 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 consisted of approximately 50% of those who were at a high risk of aspiration and 100% of those who were at a high risk of choking. Sample #3 consisted of four individuals which accounted for 25% of new admissions since the previous compliance review. Sample #4 consisted of individuals receiving direct speech services which accounted for 50% of the caseload. Sample #5 consisted of three individuals who accounted for 100% of the individuals identified by RSSLC as having Behavior and Communication difficulties. The Facility did not provide an adequate number of speech language pathologists or other professionals The Facility increased the number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. At the time of the onsite monitoring review, SLP staffing consisted of four SLPs. This	Noncompliance

#	Provision	Assessment of Status	Compliance

		represented an increase of two SLPs since the previous compliance visit.
		
		General tasks in which Speech Pathology is responsible:
		• Attend:
		  • Pre-admission meetings
		  • 30 day planning conferences for all new admissions
		  • 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 1:96. This ratio did not allow for the appropriate follow up or involvement of the SLP in all facets of the individuals care. This was evident by lack of SLP presence and involvement at many of the ISP meetings in which the individual discussed had severe communication impairments. Per policy K.06.1, the recommended staffing ratio was 1:60.
		
		As stated above, the SLPS did not actively participate in all facets of care (samples #1, #2, and #4):
		• Three of 26 records reviewed (11%) indicated the SLP consistently participated as a member of the IDT.
		• Five of 26 records (19%) reviewed indicated an SLP assists in the development of goals and objectives related to communication.
		• Zero of 26 records reviewed (0%) indicated an SLP reviews/ monitors the implementation and effectiveness of goals at a minimum monthly if direct and quarterly if indirect.
		• Seven of 23 Behavior Support Committee (BSC) minutes (30%) reviewed indicated SLP membership and participation in the Positive Behavior Support Committee.
		• Two of two Speech Related Training programs reviewed (100%) indicated a SLP participated in the Training of Staff (NEO, Annual, Ongoing).	

#	Provision	Assessment of Status	Compliance
		Individuals did not consistently receive communication assessments and programs to address communication and communicative needs (samples #1, #2, #3, and #4). • 11 of 30 individuals (36%) reviewed received communication assessments. • Eight of 30 individuals (26%) were provided with communication programs.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	Speech Policy did not exist that provided clear operationalized guidelines regarding: • Staff responsibilities • Frequency of assessments/updates, such as whether: o All people have received a communication screening or assessment within 30 days of admission, readmission or change in status o All people identified with therapy needs through a screening, received a comprehensive communication assessment within 30 days of identification if one has not already been provided upon admission o If receiving services, direct or indirect, the individual is provided a comprehensive Speech-language assessment at a frequency that ensures relevance and appropriateness of goals (monthly- direct, quarterly -indirect) • Criteria for providing update vs. full assessment • Outlines assessment schedule • Methods of tracking progress and documentation standards • Monitoring of the: o Presence and working condition of adaptive equipment o Effectiveness of adaptive equipment--goal review and monitoring of implementation • Participation as a clinical instructor for communication-related facility trainings The Facility did not have a method to track individuals and their designated level of communicative functioning. Per interview with the Habilitation Director, gathering this information would require each therapist to review his or her caseload and write down the level of severity once the assessment was reviewed. Having a comprehensive list allows for better review of systems to ensure those who are in the most need receive the services they need, which in this case, is communication. All people have received a communication assessment within 30 days of admission, readmission or change in status. (Sample #3) • Four of four records reviewed (100%) revealed individuals received assessments and reassessments as indicated (within 30 days) upon admission, readmission, or change in status.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individuals did not receive a Comprehensive Communication Assessment: (Samples #1, #2, #3 and #4): • Five of 30 records reviewed (17%) revealed individuals' assessments included verbal and nonverbal skills • Two of 30 records reviewed (7%) revealed individuals' assessments included expansion of current abilities • Zero of 30 records reviewed (0%) revealed individuals' assessments included development of new skills • Zero of 30 records reviewed (0%) revealed individuals' assessments included comparative analysis of function with previous assessments. • 11 of 30 records reviewed (37%) revealed individuals' assessments included whether the individual requires direct or indirect Speech Language services • Eight of 30 records reviewed (27%) revealed individuals' assessments included the need for further assessment in Augmentative Communication • Zero of 30 records reviewed (0%) revealed individuals' assessments included specifics regarding the appropriateness and functionality of the goal • Four of 30 records reviewed (13%) revealed goals/objectives that were in line with identified skills sets of the individual. • Zero of 30 records reviewed (0%) revealed individuals' assessments specified the developmental progression of the objectives • Zero of 30 records reviewed (0%) revealed individuals' assessments included how the determined goal was meaningful to the individual. • Zero of 26 records reviewed (0%) revealed individuals' assessments included how strategies/interventions/programs could be utilized throughout the day. • Zero of 30 records reviewed (0%) revealed investigation into cognitive disorders Examples of Individuals not receiving a comprehensive assessment included: • Individual #542's assessment only provided a general statement regarding status and did not include information or strategies in which communication may be expanded. Per interview with the HT director, the revised speech assessments were provided to those who were new admits and who had a change in status first, but he anticipated that all assessments would be completed in one year. Per review of the most recent completed assessments (five for each therapist), it did not appear that the level of comprehensiveness had improved, which was a cause for concern that RSSLC was still not meeting the required standards for comprehensiveness.	

#	Provision	Assessment of Status	Compliance
		Another concern noted by the Monitoring Team was the increased use of parallel talk as a recommendation. Parallel talk is a valuable tool that may potentially assist the individual in comprehending their surrounding environment or increasing participation but does not provide a clear direction or process regarding how to improve one's speech/communication capabilities. Parallel talk is a strategy and does not replace the need for a functional communication goal. This was noted on the majority of evaluations that were provided to those individuals who have severe speech/communication disorders. For these individuals, it is important for the team to identify how the individuals express themselves and work around those strengths to build a communication system. There was no consistent evidence of active collaboration between the SLP and Psychology (Sample #5) as evidenced by: • Zero of three records reviewed (0%) revealed problem behaviors were integrated into assessment. • Zero of three records reviewed (0%) revealed integration of Communication programs into the PBSP. • Zero of three (0%) identified potential connections between behaviors and difficulties with communication and, • Seven of 23 Behavior Support Committee (BSC) minutes (30%) reviewed indicated SLP membership and participation in the Positive Behavior Support Committee. A concern noted by the Monitoring Team was the lack of identification of those individuals who experienced both a behavior and communication deficit. The list provided by RSSLC listing three individuals as needing behavioral and communication supports were inaccurate as the Monitoring Team found many more individuals who were identified as having both behavior and communication difficulties.	
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	Rationales and descriptions of interventions regarding use and benefit from AAC, EC, and/or other communication programs were not clearly integrated into the ISP (Samples #1, #2 and #4) • Zero of 26 ISPs reviewed (0%) included the type of equipment/supports utilized. • Zero of 26 ISPs reviewed (0%) included how equipment/goal is useful and meaningful. • Zero of 26 ISPs reviewed (0%) included information regarding progress of goals/objectives/programs. • Zero of 26 ISPs reviewed (0%) included how communication interventions will be integrated into the daily schedule and skill acquisition programs.	Noncompliance

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	and adaptable to a variety of settings.	• Zero of 26 ISPs reviewed (0%) included information regarding how the person communicates and strategies staff may utilize to enhance communication. Examples of Individuals' communication skills and interventions not being integrated into the ISP included: • Individual #251's ISP simply stated that the individual had a severe language disorder • Individual #30's ISP only stated that the individual was nonverbal General common area AAC devices were available but were not utilized and were not functional for the individuals living at RSSLC: • All homes had AAC devices present in the Common areas and/or dining rooms. • Five of the 10 observed common area AAC devices (50%) contained clear directives on how staff should utilize said devices. • Zero of ten observations (0%) demonstrated that individuals utilized common area AAC devices. The Monitoring Team questioned the functionality of the common area devices due to: • The majority of individuals at many of the homes (e.g., San Antonio) did not have the cognitive skills needed to comprehend and use the communication boards. • Wall mounted electronic devices in the dining rooms stated "help me." It was unclear as to what purpose this device would serve for the individuals living at the home. Per discussion with staff, they were unclear as to when they would utilize the device. Another concern with the common area boards was that they were small and would not be functional for individuals with any loss of vision. Communication staff, through their participation as IDT members, should not only identify appropriate use and format of common AAC devices, but also should also recommend devices designed to meet the current skills and needs of individuals. There is a great need to look beyond the specific indicators listed in the audit tools and look at the big picture and the intent that lies behind the overt indicators. RSSLC must give greater thought into the purpose of general area devices. This thought process must go beyond just putting up devices. They must serve a functional purpose and have a plan behind them that will lead to their utilization and most importantly the expansion of communication. Staff were not knowledgeable regarding communication and the use of AAC/EC devices. • In one of five interviews (20%), direct support professionals could explain the	

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		importance of AAC/EC and how the assigned programs lend themselves to the development of language. • In one of five interviews (20%), direct support professionals were able to locate adaptive equipment. • In one of five interviews (20%), direct support professionals could describe individual-specific communication strategies. • In zero of five interviews (0%), direct support professionals could describe the schedule for implementation of communication strategies. • In zero of five interviews (0%), direct support professionals stated they had received individual-specific training for communication strategies. Based on review of training curriculum, direct support staff and therapy aides **were** provided with formal communication training. These trainings contained: • Methods to enhance communication • Implementation of programs • Benefits and use of AAC • Identification of non-verbal means of communication. • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. The concern was that although training was provided, there was no evidence that the training had any impact on the improvement of services.	
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	Speech Policy did not exist that provided clear operationalized guidelines regarding monitoring of the: • Presence and working condition of adaptive equipment. • Effectiveness of adaptive equipment--goal review and monitoring of implementation • Use of the AAC during all aspects of the person's daily life in and out of the home. • Frequency of monitoring SLPs did not consistently participate in the monitoring of programs to ensure they remain effective and relevant to the individual: • One of seven individuals (14%) receiving direct therapy (Sample #4) was provided with a minimum of a monthly progress notes by the SLP(s). • Zero of five individuals (0%) receiving indirect therapy (any type of communication/AAC/EC supports) (Samples #1 and #2) were provided with a minimum of a quarterly progress notes by the SLP(s).	Noncompliance

#	Provision	Assessment of Status	Compliance
	communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Progress Notes (Sample #4) were not comprehensive as evidenced by: • One of seven progress notes (14%) contained information regarding whether the individuals showed progress with stated goal. • Zero of seven progress notes (0%) documented benefit of device and/or goal. • Zero of seven progress notes (0%) documented consistency of implementation. • Zero of seven progress notes (0%) identified future plan of treatment. Evidence of discussion of goal and why it remains appropriate was not identified in the ISP. This is in addition to the description of communication status (ISPs). • Zero of 26 ISPs reviewed (0%) included how equipment/goal is useful and meaningful. AAC/EC devices were not monitored to ensure they remain readily available to those who need them. • Presence of device • Working condition of device An informal monitoring system was noted that focused on the presence and working condition of general area devices, but it was not formalized nor was it clear as to the frequency in which the monitoring occurred. Per review of monitoring forms completed over the past month, devices were monitored, but there was no method to track and trend acquired data thus resulting in having to review each monitoring form to gain knowledge of device status.	

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

1. Many recommendations appeared to be left to the IDT 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. The SLPs should increase their participation in the Behavior Support Committee and do a better job of identifying those individuals in which both behavioral and communication support is needed. (Provision R.2)
3. 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)
4. 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)
5. Provide increased guidance for therapists completing the speech assessments, thus facilitating improved consistency and comprehensiveness of

assessments. The new revised assessments reviewed did not consistently present as more comprehensive than the previous compliance visit. (Provision R.2)

6. Assessments must be comprehensive and include not only speech and communication status but also investigate the cognitive status of the individual and how assistive technology, memory aids, and AAC can benefit the individual in obtaining increased independence. (Provision R.2)
7. Current communication abilities, staff strategies, objectives to expand existing skills and a discussion of the effectiveness of communication supports should be addressed consistently in the individual ISPs (Provision R3).
8. RSSLC must give greater thought into the purpose of general area devices. This thought process must go beyond just putting up devices. They must serve a functional purpose and have a plan behind them that will lead to their utilization and most importantly the expansion of communication. (Provision R.3)
9. Individual communication programs should be integrated into ISPs through skill acquisition programs, as well as PBSPs (when appropriate), to ensure the AAC device and/or communication strategy is meaningful to the individual and the individual can communicate and be an active participant in multiple environments (Provision R.3).
10. 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 Self-Assessment 05/01/2012 2. RSSLC Action Plan 4/27/12 3. RSSLC Presentation Book for Section S 4. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Programs (SAPs), 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 Self-assessment and included Individuals #8, #19, #23, #86, #91, #144, #223, #349, #400, #497, #503, #513, #526, #550, #598, #615, #619, #666, #673, #701, #729, #744, #758, #773, #783, and #799. **People Interviewed:** 1. Cynthia Fannin – Director of Education and Training 2. Carol Agu – QMRP Coordinator 3. Michael Phelps – Vocational Services Director **4.** Approximately 30 direct care staff in the following residences and day treatment areas: Angelina, Guadalupe, Lavaca, Leon, Neches, Pecos, Sabine, San Antonio, San Jacinto, Trinity, and all vocational settings **Meeting Attended/Observations:** 1. Active Treatment Meeting – 5/15/2012 2. ISP annual planning meeting for Individual #17 – 5/15/2012 3. The following residences and day treatment areas: Angelina, Guadalupe, Lavaca, Leon, Neches, Pecos, Sabine, San Antonio, San Jacinto, Trinity, and all vocational settings
	Facility Self-Assessment: At the time of the site visit, RSSLC reported that no Provision was in substantial compliance with the SA. The Monitoring Team was in agreement with the Facility. The Self-Assessment presented by RSSLC was comprised of two parts: A Self-Assessment of the current practices at the Facility and Action Plans that outlined steps the Facility planned to enact to address weaknesses in identified in the Self-Assessment. The procedures and tools used in the Self-Assessment component appeared to correctly capture information relevant to assessing compliance with the Settlement Agreement. For example, the Self-Assessment identified that problems existed in utilizing findings of assessments in the development of skill acquisition programs. At the same time, however, it was not evident that the assessment processes were conducted with sufficient frequency and across sufficient areas to accurately depict the conditions at the Facility. In addition, although the Self-Assessment did

	identify limitations to be addressed, the Self-Assessment report did not describe those issues in sufficient detail to ensure that adequate tracking and correction could be implemented. In regard to the Action Plan component, the Facility presented several steps that would be undertaken for each Provision of Section S of the Settlement Agreement. These steps, however, consisted entirely of actions to be taken by the Facility to provide monitoring and training. The Facility has conducted extensive training and monitoring throughout the Settlement Agreement monitoring process. At the time of the current site visit, the issues identified at the Facility often did not involve failure to train or monitor. Instead, the issues involved the failure by the Facility to enforce policies and ensure the skills that were the subject of training were implemented consistently, whether that involved use of assessments to identify goals, development and implementation of training plans, or maintaining activities that provide opportunities for engagement and learning. If RSSLC expects to achieve compliance with the Settlement Agreement, it will be necessary to act decisively to ensure that staff performs as expected. Without such action, it cannot be anticipated that the Facility will achieve progress toward the stated objectives.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 5/14/2012 through 5/18/2012. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that no Provisions of Section S were in substantial compliance with the Settlement Agreement. The site visit revealed instances in which staff demonstrated initiative and utilized solid skills in addressing the needs of individuals living at the Facility. For example, a staff member was observed using outstanding prompting and fading in assisting an individual to use dining utensils independently. In another situation, a staff member was observed to effectively maintain activities for several individuals. Such circumstances were isolated, however, and generally involved staff who were acting independently. In the majority of circumstances, staff was ill-prepared to meet the training needs of the individuals. In many circumstances, individuals living at the Facility were observed to be without adequate engagement and without adequate educational materials. Weaknesses were not limited to issues of engagement and resources. In the majority of records reviewed, there was no indication that skill acquisition programs were built upon a foundation of assessment and individualization. In numerous examples, it was not possible to show that training objectives were based upon formal or informal assessment. Skill acquisition programs also did not reflect adequate knowledge of each individual's preferences and did not include the use of reinforcers shown to be effective with each individual. Rather, skill acquisition programs were highly similar across individuals and at times reflected the use of templates in which only the name of the individual was changed. Although staff verbally reported familiarity with skill acquisition plans, observed performance and reviewed documentation reflected that skill acquisition plans were often not implemented as intended.

	Data collection forms often included fewer teaching trials and sessions than were required in the program instructions. These data sheets frequently did not include documentation of why there was a deviation from the required training trials. Observations of homes and training areas did not reflect staff actively implementing skill acquisition programs or using informal procedures to strength individual behavior. Information obtained during the site review did not reflect that the Facility had achieved substantial progress in comparison with the baseline site visit. Previous site visits had revealed numerous trainings opportunities for staff, as well as the development of several monitoring procedures. The current site visit indicated, however, that no systematic process was in place at the Facility to ensure that staff implemented procedures on which they had been trained or followed Facility procedures and requirements. Staff reported to the Monitor that corrective action was seldom taken when staff did not meet Facility expectations. Without systematic and comprehensive efforts by the Facility to ensure that all staff perform as expected, it is unlikely that substantial improvements will be achieved at RSSLC.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>S1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td><u>Use of Assessment Information in Planning Skill Acquisition</u>
Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training.

During the May 2010 site visit, RSSLC had just implemented a series of efforts to improve the quality of skill acquisition programs. In October 2010, a limited sample 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 revealed some improvement in terms of task analysis, use of discriminative stimuli, opportunity for skills to be displayed, and instructions for documentation. These improvements were very inconsistent and, in many cases, problems first identified during the baseline site visit remained unaddressed. During the October 2011 site visit, skill assessment and skill acquisition programs continued to reflect only very modest improvement in limited areas.

At the time of the current site visit, a sample of 26 ISPs and corresponding SAPs was selected. This sample included the most recent ISP completed for each residence area. If an ISP had not been completed in a residence area since the previous site visit, no ISP was selected from that area. For each ISP included in the sample, at least two SAPs were reviewed in depth.

<table>
<tr><td></td><td>5/2010</td><td>5/2012</td></tr>
<tr><td>Skill acquisition plans are implemented to address</td><td>0%</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

needs identified in:			
	ISP	0%	0%
	Adaptive skill or habilitative assessment	0%	0%
	Psychological assessment	0%	0%
Skill acquisition plans are chosen in an individualized manner.		0%	0%
Skill acquisition plans are related to the individual's preferences.		0%	0%

Based upon the sampled ISPs and related SAPs, there was no indication that assessment information was used in the development of skill acquisition programs. None of the ISPs in the sample included information specific to the SAPs, such as assessment findings or documentation that IDT discussions had encompassed skills targeted by the SAPs. In fact, it was noted that ISPs included very little formal assessment information, instead including anecdotal information about potential preferences and events from the previous year.

Neither the reviewed ISPs nor the corresponding Psychological Assessments included specific information regarding adaptive skills. Although anecdotal information was presented in the ISP, the lack of formal adaptive behavior assessments for any of the individuals included in the sample substantially curtailed the ability of psychology staff or other IDT members from presenting substantive information regarding adaptive abilities. Most of the individuals in the sample (24 of 26 individuals, 92%) had a completed Functional Skills Assessment (FSA) included in the permanent record. Although the FSA is not a standardized instrument and cannot provide specific measures of skills, it was possible that the FSA could provide some insight into each individual's abilities. For none of the ISPs or SAPs reviewed, however, were there FSA findings discussed in the ISP that corresponded with the specific skills targeted by the SAPS.

It was also noted that none of the ISPs included in the sample involved formal assessment of preferences or reinforcers. Anecdotal information about preferences was presented in most ISPs. This information was obtained through the Personal Focus Assessment (PFA), however, rather than a widely recognized procedure or tool for identifying preferences. Anecdotal information from even more widely recognized structured interview tools is not the most accurate way to identify reinforcers or contribute to the teaching process but may be used as an initial step in a functional assessment. As the PFA lacked an evidence base and standardized administration, the weaknesses associated with anecdotal assessment were likely to be more pronounced with the PFA. As a result, there was only limited information to suggest that SAPs were based upon the preferences of the individuals or used reinforcers selected through structured assessment.

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		Due to the lack of formal assessments and the failure of the IDT to integrate the assessment process into the development of SAPs, it was evident that skill acquisition goals were not selected in an individualized manner. In addition, in the review of the ISPs and SAPs, it was noted that numerous SAPs targeting money management, self-administration of medication, leisure skills and personal hygiene were virtually identical across the sampled individuals. In several instances, due the differences in fonts and character spacing, it was obvious that a boilerplate was used in the creation of SAPs that required only that an individual's name be entered into the appropriate blank spaces. Based upon information obtained in the review process, it was clear that the Facility had failed to integrate the use of assessments into the planning process for skill acquisition programs. It was possible, although not documented, that learning had taken place due to SAPs and other informal teaching. The Facility, however, had not demonstrated that the necessary assessments had been utilized to appropriately identify skills to be increased. Neither was there evidence to indicate that teaching strategies and SAP components were based upon formal assessments. As a result, the skill acquisition programs in place at RSSLC were unlikely to achieve the stated training objectives. <u>Teaching New Skills</u> Teaching new skills requires the use of the same learning principles involved in changing undesired behavior. Therefore, effective 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. At the time of the current site visit, a sample of 26 ISPs and corresponding SAPs was selected. This sample included the most recent ISP completed for each residence area. If an ISP had not been completed in a residence area since the previous site visit, no ISP was selected from that area. For each ISP included in the sample, at least two SAPs were reviewed in depth. The documents provided by RSSLC in regard to this sample were not organized to reflect a coherent system of implementing and monitoring the skill acquisition training process. This could in part have reflected poor organization in the preparation of the material provided to the Monitoring Team. For many individuals included in the sample, however, the lack of organization was noted to be inherent to the original documents rather than an artifact of the document preparation process. For example, the following circumstances were noted in the document sample.	

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- Several SAPs for single individuals included the name for a different individual in the document.
- Data sheets often lacked association with a specific SAP.
- Several task analyses were missing one or more pages.
- For several SAPs, data sheets were missing for one or more months.
- At least five SAPs included elements from more than one SAP in a single document or page.

Due to the poor organization and lack of completion in the documents provided by the Facility, it was not possible to fully assess the sampled skill acquisition programs. Therefore, the information presented below should not be considered a comprehensive review.

Area	5/2010	10/2011	5/2012
Plan reflects development based upon a task analysis	0%	77%	0%
Behavioral objective(s)	0%	37%	0%
Operational definitions of target behavior	0%	3%	0%
Description of teaching conditions	0%	20%	0%
Schedule of implementation comprised of sufficient trials for learning to occur.	0%	50%	0%
Relevant discriminative stimuli	0%	77%	100%
Specific instructions	0%	60%	0%
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%	0%

*However, as noted below, the consequences were general, were not individualized, and were not based on assessment that would establish a likelihood of being effective.

Based upon information obtained during the site visit, only two elements relating to SAPs were consistently satisfactory. The first of these involved the presentation of discriminative stimuli, such as a prompt, to initiate the training process. Every SAP reviewed included discriminative stimuli. The second element of the SAPS that was consistently satisfactory was the opportunity for the targeted skill or behavior to be displayed by the individual. In every instance, the SAPs provided such an opportunity.

For the remainder of the SAP elements, limitations were observed in all available SAPs.

#	Provision	Assessment of Status	Compliance
		Task Analyses. Documentation provided by the Facility included at least a partial task analysis for each individual in the sample, suggesting that it was routine practice to complete a task analysis. Due to missing sections, it was not always possible to compare task analyses with SAPs. In those cases where comparison was possible, it was not evident that the training steps in the SAPs were individualized or that the task analyses were formulated to reflect individual differences. A task analysis is not a document or tool that exists apart from the person whose skills are assessed. Rather, a task analysis should reflect an attempt to break down a complex task into discrete steps that reflect the unique learning needs of the individual. Although some individuals may share certain characteristics and therefore may have similar task analyses, it is not common that multiple individuals should have virtually identical task analyses. When the majority of task analyses, and corresponding training steps, are essentially identical across multiple individuals, it is suggested that individualized task analyses are not being performed. The task analyses at RSSLC suggested that there was no individualized assessment. Therefore, it could not be said that SAPs were based upon actual, individualized task analyses. During previous site visits, SAPs reflected the content of the associated task analysis on a more frequent and consistent basis. In addition, there was variation across SAPs for the similar skills and objectives. A number of possibilities existed that could explain the substantial change in task analysis and SAP practices, including changes in QDDPs, ISP procedures, or training. Regardless of the reason, the use of task analyses had substantially changed at RSSLC since the previous site visit. Behavioral Objectives. As encountered with the task analyses, the majority of SAPs did include an Objective statement that reflected behavioral language. A valid Objective statement must be based upon thorough assessment of the individual and a precise understanding of the individual's abilities and limitations: the use of behavioral language alone is not sufficient. As noted above, SAPs reviewed during the current site visit lacked the individualized task analyses and other assessments noted during previous site visits. Without these assessments,, the Objective statements did not reflect goals based upon individual needs or reasonable expectations of performance. Therefore, although there was a semblance of behavioral objectives, actual behavioral objectives were not provided. • A task analysis was completed for Individual #497 on 12/21/2011. This task analysis indicated that the individual would wipe his mouth during meals with three verbal prompts and after meals with two verbal prompts. The Training Objective approved on 1/3/2012 stated that, "By 4/14/2012, when the instructor provides three verbal prompts, [the individual] will get the napkin and wipe his mouth after eating for three out of four trials for three reporting periods". This	

#	Provision	Assessment of Status	Compliance
		statement used the appropriate terminology to describe a Behavioral Objective. As the statement addressed developing skills that the individual already possessed according to the task analysis, despite the use of the correct terminology, the statement did not comprise a valid Behavioral Objective. Operational Definitions. The formulation of operational definitions requires a formal, individualized, and precise assessment process. As no such assessment was provided in relation to SAPs at RSSLC, none of the definitions included in the SAPs reflected operational definitions. Furthermore, the definitions included in SAPs were imprecise and often highly similar across different individuals and SAPs. It was therefore apparent that actual operational definitions or even basic individualized definitions were not included in the SAPs at RSSLC. Description of teaching conditions. None of the materials provided by the Facility in relation to SAPs included descriptions of teaching conditions sufficient to inform those implementing the SAPs on how to setup the teaching sessions. In order for teaching programs to be implemented as intended, the staff implementing those programs must be given explicit instructions including what materials to use, how those materials are to be presented, where training should be conducted and how the environment should be controlled. Without such instructions, training procedures often drift or change across staff and location. As a result, training may be ineffective and can strengthen the wrong behavior. None of the SAPs included in the review contained such descriptions. Schedule of Implementation. It has been repeatedly demonstrated in research regarding learning that 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. The rate of reinforcement may later be reduced as the individual develops mastery. If the rate for reinforcement opportunities falls too low or too quickly, however, that specific reinforcement may not successfully compete with other reinforcement in the environment. Under such circumstances, learning could be inhibited or skills lost. In all skill acquisition programs reviewed included in the sample, there was no indication that sufficient trials were provided or that the individual's progress or lack thereof in relation to the SAP was considered in relation to the number of trials offered. Specific Instructions. Staff responsible for the implementation of skill acquisition programs must be provided with specific, precise, and comprehensive instructions for implementing the SAP. In all of the SAPs provided at RSSLC, instructions included either general statements of what the individual being taught was expected to do or generic instructions to follow the prompting hierarchy in relation to the step of the training program. There was no indication of specific, individualized instructions for any SAP.	

#	Provision	Assessment of Status	Compliance
		Consequences for correct and incorrect responses. The SAPs included in the sample contained the provision for a specific response to follow a successful display of the target behavior. The majority of SAPs relied upon verbal praise as reinforcement although no formal reinforcer assessment supporting verbal reinforcement had been completed. Generally, the instructions were to say "Good job" after every success. With the lack of structured preference or reinforcer assessment, there was no evidence this generic statement will be reinforcing. For training to be effective there must also be a consequence for an incorrect response. It is accepted practice to either prevent an incorrect response or to follow an incorrect response with an attempt to correct the response. The SAPs at RSSLC did not include such instructions. In most SAPs, the consequence for an incorrect response was described in general terms, such as to provide assistance. Generalization and Maintenance. None of the SAPs provided by the Facility included provisions for generalizing acquired skills to new settings or for maintaining acquired skills once formal training was completed. Based upon the materials provided by the Facility at the time of the current site visit, it was unlikely that any skill acquisition plans were of sufficient quality to make the acquisition or strengthening of skills likely. In addition, due to the stated issues with the content and organization of the presented materials, it was also unlikely that the Facility possessed the ability to accurately assess the quality of the overall skill acquisition process. | | 5/2010 | 10/2011 | 5/2012 | | Overall, the set of skill acquisition programs promote growth, development, and independence | 0% | 0% | 0% | Implementation of formal and informal skill acquisition training 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 Functionally Engaged | Percent Functionally Engaged |	

#	Provision	Assessment of Status					Compliance
		Trinity C Bedroom 1	0	4	0	0%	
		Trinity C Bedroom 2	0	1	0	0%	
		Trinity C Living Room	1	6	0	0%	
		Trinity Day Treatment	1	3	2	67%	
		Trinity A Living Room	2	5	2	40%	
		Trinity B Bedroom 2	0	2	0	0%	
		Trinity B Bedroom 3	0	3	0	0%	
		Trinity B Living Room	2	4	0	0%	
		Trinity D Bedroom 2	0	2	0	0%	
		Trinity D Bedroom 3	0	3	0	0%	
		Trinity D Bedroom 4	2	3	1	33%	
		Neches D Group 1	2	6	2	33%	
		Neches D Group 2	2	5	0	0%	
		Neches A San Antonio Classroom	1	4	0	0%	
		Neches A Guadalupe Classroom	1	3	1	33%	
		San Antonio Dining Room	7	7	2	29%	
		Leon Dining Room	4	6	1	17%	
		Sabine Living Room	3	6	1	17%	
		San Jacinto Living Room	3	6	5	83%	
		Lavaca Living Room	3	6	1	17%	
		Guadalupe Living Room	3	6	2	33%	
		Pecos Living Room	6	6	2	33%	
			43	97	22		
		Total percentage of individuals functionally engaged				23%	
		Percentage of locations with greater than 50% functional engagement				9%	

During the current site visit, observations reflected that only 9% of locations involved functional engagement by more than 50% of the individuals present in that location. Furthermore, only approximately 23% of the individuals observed were engaged in some type of formal or informal functional activity. This was less than half of the functional engagement level of 50% noted during the previous site visit.

Of particular concern was the lack of any engagement when individuals were in their bedrooms. For most observations, individuals were encountered in training areas, living rooms, workshops, and other areas away from their bedrooms. When individuals were encountered in their bedrooms, however, there consistently was a very low level of functional engagement. Bedrooms are not typically associated with functional engagement. In several circumstances at RSSLC, however, individuals were in their bedrooms during times scheduled for program implementation and other activities. In was therefore expected that these individuals should have been either engaged in activities in their

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		bedrooms or located in environments such as living rooms or classrooms more typically associated with learning. • In the first bedroom from the door on Trinity C, four individuals were observed seated in wheelchairs for several minutes without any materials or opportunity for engagement. Two of the four individuals were engaged in rocking and other stereotypic behaviors. • On Trinity B, in the second bedroom from the door, two individuals remained seated alone in wheelchairs for several minutes. One individual was asleep. The second individual, Individual #30, was coughing loudly. Additional sounds produced by this individual suggested bruxism. One staff member walked past the bedroom door, and paused for a moment when the individual who was awake coughed. The staff member offered no inquiry about the individual, did not enter the room, and quickly moved on. Although not as consistently poor as bedrooms in terms of functional engagement, many other areas of the Facility did not provide adequate functional engagement. Furthermore, in many of these areas, there was limited observational evidence that suggested ongoing skill acquisition training. • In the Neches D1 classroom, a staff member was observed reading aloud to four individuals. Two of these individual were engaged in stereotypic behavior and were not attending to the reading. A third individual was asleep and the fourth was looking about the room. Although the staff offered occasional verbal prompts to attend to the reading, none of the individuals became more focused on the activity. When an individual was noted to coincidentally look toward the reader or provide an opportunity for engagement, the staff member did not attempt to engage the individual or reinforce the interaction. • In the San Antonio dining room, numerous nutritional and habilitation services staff were present in the room, most frequently coaching other staff on dining skills and swallowing issues. It was noteworthy that the Facility was making the effort to support staff. In most cases, although the information presented during coaching was very basic, staff did not demonstrate familiarity with the skills being coached, and frequently stopped using the new skills when the coaching was terminated. • In the Leon dining room, staff demonstrated only minimal prompting. One individual was attempting to ingest overly large spoonfuls of food. Staff blocked the individual's attempts to place the large portions in his mouth, but did not act to encourage or teach selecting more appropriate volumes of food. In several instances, staff displayed very little familiarity with schedules or procedures for teaching activities. In addition, staff was also noted to lack basic skills in prompting and motivation.	

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		• In the Leon dining room, Individual #296 refused to eat. Staff reported this was a frequent occurrence. Despite the refusal to eat, the individual readily drank liquids that were made available. The willingness of the individual to accept and ingest liquids provided the opportunity for staff to use a teaching procedure such as a behavior momentum procedure. This procedure would have involved offering the individual a series of drinks to build up momentum for cooperation, immediately followed by a prompt to eat a bite of food. Such procedures are commonly used to address resistance and poor cooperation. When asked, staff did not indicate familiarity with behavior momentum. • In the Trinity B living room, four individuals were seated around a table. Materials were placed before them, but no prompting or encouragement was offered. For several minutes the four individuals were provided no interaction or engagement. At the same time, staff was observed briskly walking up and down the hall, asking about the location of specific individuals and what was on each individual's schedule. On three occasions, an additional individual was introduced into the room only to be promptly removed again. On at least one occasion, the lack of preparedness and engagement by staff placed an individual in considerable risk. In the San Jacinto dining room, Individual #569 was observed leaning down against the plate and scooping food directly into her mouth. Staff shouted at her to slow down from across the room, but did not approach the individual. Immediately following the staff shout, the individual scooped most of a hamburger bun into her mouth and swallowed it. The individual was documented as being at risk of choking and was not to receive hamburger buns. When the ingestion was pointed out to staff, the staff argued that she had not had a hamburger bun but had been given grits. In addition to not being accurate, the statement by staff was concerning as the individual was not supposed to receive grits according to her dining card. Furthermore, the situation likely strengthened the behavior of eating food that was unsafe. It would have been more appropriate had staff acted to interrupt the behavior and used the situation as an opportunity for teaching more appropriate dining behavior. Not all observations reflected poor engagement or use of training skills. In some cases staff was observed using sophisticated teaching strategies. • In the Trinity C living room, a single staff member was noted to have set up specific activity stations around the room. She arranged for an individual at each workstation and then floated from station to station, prompting individuals to engage in the training activities. At regular intervals, individuals were rotated to the next activity station. During each rotation, the staff member discussed preferences with the individuals and demonstrated considerable familiarity with each person.	

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		• In the Leon dining room, one staff member was observed prompting an individual to independently use a spoon. The prompting process began with full physical guidance that was faded to a verbal prompt within five trials. At each step, the staff paired verbal cues with the physical prompts, which provided guidance for the individual and prepared him for independent use of the skill. In the circumstances where sophisticated teaching strategies were used, it was evident that the staff responsible was independent and highly motivated. Comments by staff and supervisors indicated that no system existed to encourage or support sophisticated teaching. In particular, it was reported that in most cases successful training programs were the result of independent people or groups rather than organized efforts. Based upon data collected from observations and record reviews during the current site visit, it was apparent that the Facility did not have the ability to monitor functional engagement or ensure that individuals were provided with active treatment. Furthermore, evidence regarding the quality of skill acquisition programs clearly reflected an inability to provide formal training and supports. Without the means to ensure either formal or informal services, conditions extant at the Facility during the current site visit reflected no overall progress in comparison with baseline conditions.	
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. • The reviewed ISPs did not include specific information regarding adaptive skills. • None of the ISPs in the sample included information specific to the SAPs, such as assessment findings or documentation that IDT discussions had encompassed skills targeted by the SAPs. • Most of the individuals in the sample (24 of 26 individuals, 92%) had a completed Functional Skills Assessment (FSA) included in the permanent record. For none of the ISPs or SAPs reviewed, however, were there FSA findings discussed in the ISP that corresponded with the specific skills targeted by the SAPs. • None of the SAPs included in the sample presented formal or informal assessment of preferences or reinforcers. • It was not evident that the training steps in the SAPs were individualized or that the task analyses were formulated to reflect individual differences.	Noncompliance

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		As a result of the broad weaknesses in assessment practices at RSSLC, it was not evident that the assessments provided adequate measurement of individual abilities or were likely to facilitate the skill acquisition process. Based upon this information, it was not possible to identify any areas of substantial progress in skill or preference assessment at RSSLC.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	Due to the limitations noted in Provisions S1 and S2, it was frequently not possible to determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that RSSLC did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor, or revise training programs with accuracy. In addition, due to the numerous limitations in the skill acquisition programs, it was not possible to determine that SAPs were practical or functional. Observations reflected, and SAP data sheets supported, that formal programs were not frequently implemented. In many instances, staff failed to demonstrate the basic skills necessary to implement SAPs and support skill development. Based upon information obtained from observations, interviews and record reviews, there was little evidence to suggest that the Facility had progressed beyond conditions noted during the baseline site visit.	Noncompliance
	(b) Include to the degree practicable training opportunities in community settings.	Prior to the October 2011 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 October 2011 site visit, employment had dropped to 59 individuals employed on campus and 112 in workshops. At the same time, however, three individuals	Noncompliance

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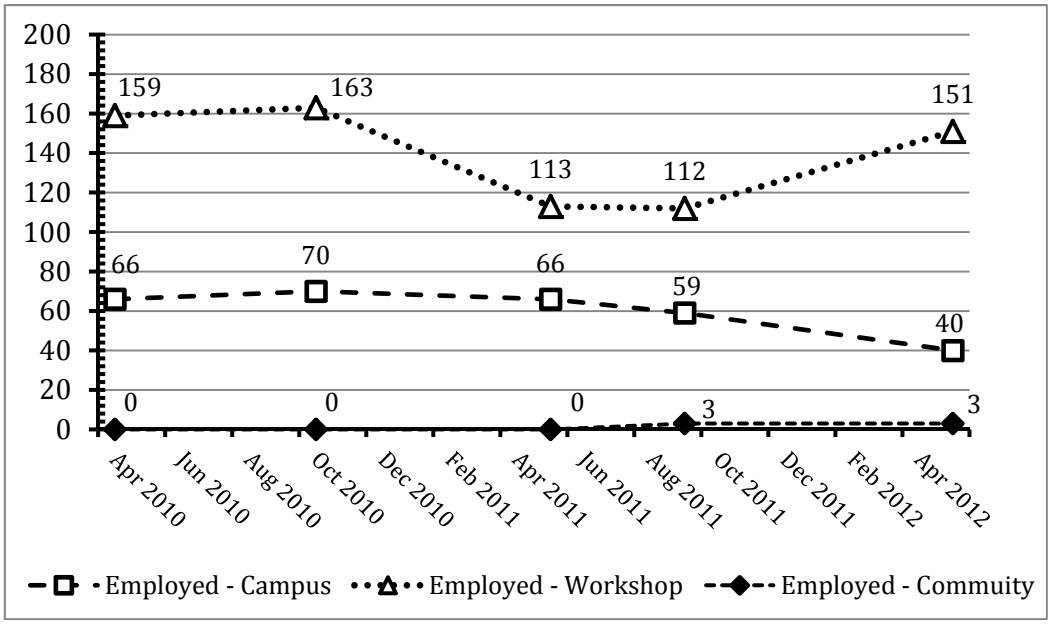
		had been provided employment in the community. During the current site visit, campus employment had dropped further to 40 individuals, while workshop employment had increased substantially to 151 individuals. No further community employment opportunities had been created beyond the three individuals documented during the previous site visit.  During the current site visit, the Facility reported for the first time summarized information concerning community outings. Although substantial variation was noted in individuals participating in community outing over the six month interval, the trend for the entire interval revealed a slight increase, from 270 to 278 per month. Documentation provided by the Facility indicated that skill acquisition programming was provided for each individual that participated in community outings. SAPs used for community-based training were the same programs developed for on-campus training. As presented earlier in Provision S1 of this report, the SAPs developed at RSSLC reflected considerable weaknesses. It was therefore suggested that community skill acquisition training provided limited likelihood of developing skills needed for community living or to meet individual preferences to the individuals being served by the Facility.	

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		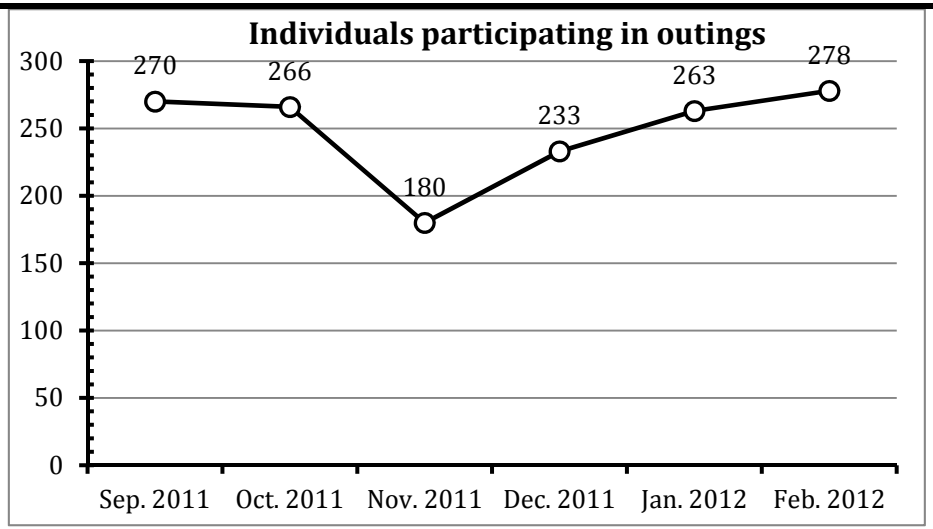	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Ensure that skill acquisition programs reflect the findings of comprehensive assessments utilizing adequate assessment instruments and procedures. (S1, S2, S3)
2. Ensure that skill acquisition programs are individualized, and reflect the needs and preferences of the individuals for whom they are intended. (S1, S3)
3. Staff tasked with implementing skill acquisitions programs must possess the necessary teaching skills and make use of those skills when implementing programs. The Facility must develop a process to ensure that staff performs to these expectations. (S1)
4. Skill acquisition programs must include the specific information that informs staff about how to implement the teaching procedures. The Facility should develop the means to ensure that all necessary components of the skill acquisition programs are included in the document, are clearly organized, and are comprehensible to the staff implementing the programs. (S1, S3)
5. The Facility must ensure that ample opportunities for community employment are made available to the individuals living at the Facility. It is important, therefore, that the Facility diligently pursues more community employment opportunities and adequately prepares individuals to succeed in community jobs. (S3)

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 18. Richmond State Supported Living Center (RSSLC) Self-Assessment, updated 05/01/2012 19. RSSLC Status Update May 2012 Visit 20. Richmond State Supported Living Center Action Plans, updated 04/27/2012 21. Section T Presentation Book materials 22. Draft DADS Policy 018: Most Integrated Setting Practices, undated 23. DADS Policy 004: Personal Focus Assessment, dated 09/01/11 24. RSSLC Policy G.6 Admitting/Moving Individuals: Community Movement, Revised 08/11/11 25. RSSLC Policy G.5 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement, Revised 08/11/11 26. RSSLC Policy G.05.1 Admitting/Moving Individuals: Community Exposure, Revised 09/11/11 27. RSSLC Policy G.6.1 Admitting/Moving Individuals: Post Move Monitoring, Revised 08/11/11 28. RSSLC Policy G.12 Admitting/Moving Individuals: Alternate Discharge, Revised 10/24/11 29. RSSLC Policy G.8 Withdrawal of Referral for Community Movement 8/11/11 30. Community Integrated Discussion Record, revised 03-2010 31. Since last on-site review, a list of all individuals who have been referred for community placement between 11/1/2011-4/13/2012 32. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 33. 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" 34. Since July 2009, a list of all individuals who have died after moving to community living 35. Since July 2009, a list of individuals who have moved to the community from RSSLC 36. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 37. For the last twelve months, a list of individuals who were reported to have been assessed for placement 38. Community Placement Report, dated 11/1/2011-4/30/2012 39. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 40. Annual Report: Obstacles to Community Transition, Richmond State Supported Living Center, Fiscal Year 2011 41. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 42. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for individuals who had ISPs during April 2012 43. Sample QDDP Summary for the CLDP

	44. Individual Support Plans/Personal Support Plans (ISPs/PSPs) and Personal Focus Assessment (PFA) for Individuals #29, #165, #268, #388, #641, #775, and #776 45. Completed CLDPs for Individuals #96. #98. #353, #643, and #665 46. Pre Move Site Reviews for Individuals #96. #98. #353, #643, and #665 47. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #96, #98. #353, #643, and #665 48. Completed Post Move Monitoring (PMM) checklists for Individuals #96, #98. #353, #643, and #665 49. Alternative Discharge packets for Individuals #52, #683, and #740 50. Section T Monitoring Tool **People Interviewed:** 7. Cynthia Newton, Transition Coordinator 8. Carol Agu, QDDP Consultant 9. Cynthia Fannin, Director of Education and Training 10. Terri Carter, Post Move Monitor 11. Joan Poenitzsch, Director of Quality Assurance 12. David Savage, QA Auditor 13. QDDP for Individual #51 **Meeting Attended/Observations:** 5. ISP annual planning meetings for Individuals #17, #387, #462, and #508 6. PFA for Individual #429 7. Post-Move Monitoring Visit for Individual #353 8. Human Rights Committee
	Facility Self-Assessment: The Monitoring Team reviewed the RSSLC Self-Assessment. The current Self-Assessment reported on the activities the Facility engaged in to conduct the self-assessment, provided its assessment of the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Facility had not yet begun to couple the self-assessment with its internal quality assurance processes to assess ongoing progress toward completion and the actual outcomes. Development of this process and identification of specific measures still need to occur. The Monitoring Team urges the Facility to continue to refine and develop its own critical outcome indicators based on its own strengths, needs and experiences, and implement monitoring processes that address these. **For Provision T1**, the Facility indicated it was not in full compliance with this provision, but it did report it had achieved some level of compliance in the issuance of a Community Placement Report under Provision T1h. The Monitoring Team did not concur with this latter assessment of compliance due to concerns about data accuracy. It did find there was substantial compliance in Provisions T1c2 and T1c3, but did not find substantial compliance with the remaining provisions. **For Provision T2**, the Facility self-rated substantial compliance in T2a due to timely completion of all PMM visits and reports, which is not a sufficient measure of compliance. As noted above, the Facility should refine and develop its own critical outcome indicators based on its own strengths, needs and experiences

	and as new issues emerge. The Facility did not complete a self-rating in T2b, as it addresses the Monitoring Team's on-site verification of the Facility's PMM processes. Noncompliance was also found for this provision. **For Provision T3**, no rating is required. **For Provision T4**, the Facility indicated it was not in compliance, based on a 100% review of the three alternate discharge packets. The Monitoring Team concurred.
	Summary of Monitor's Assessment: This Section was not yet in compliance. A summary of noted progress included a renewed emphasis on transitions to community living. There had been 17 such transitions between November 1, 2011 and April 30, 2012, according to the Community Placement Reports and three more had occurred since that report was issued. This was a substantial increase over the seven transitions accomplished in the previous six month period. Over the past six months, RSSLC had devoted additional resources to training on topics related to ISP and CLDP development, including several initiatives by the Transition Coordinator toward improving CLDP assessment quality and ensuring that responsible RSSLC staff were identified for all supports. The Monitoring Team also commended the efforts of the Transition Coordinator toward developing creative approaches for promoting education and awareness. Other specific findings are detailed below. **For Provision T1,** the Monitoring Team found substantial compliance in two CLDP requirements: T1c2, specifying the Facility staff responsible for CLDP actions, and the timeframes in which such actions are to be completed; and, T1c3, review 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. Overall, however, additional training continued to be needed on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. As a result of these deficits, the process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement. Despite some progress noted above, there remained 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 IDTs to adequately identify the appropriate essential and nonessential supports for each individual. The processes the Facility implemented to ensure supports were in place and being adequately implemented were still insufficient. The Facility's implementation of the Pre-Move Site Review was not adequately documented and improvements were recommended by the Monitoring Team. The Facility should examine its provider inservice training processes to ensure they result in the requisite staff competency, as there was evidence during this site visit of lack of provider staff knowledge of important support needs of individuals.

	For Provision T2, the Monitoring Team found noncompliance. PMM Checklists were being completed in a timely manner, and the PMM visits were documented using the prescribed standardized tool, but overall there was insufficient attention to detail exhibited in the PMM process. The Post-Move Monitor self-reported that she was not having any difficulty completing monitoring duties, even given the pace of transitions over the past six months. With current referrals standing at 24, however, and the findings made during this monitoring visit, the Facility should monitor the workload for negative impact it may have on quality and thoroughness. The Facility reported it was planning to obtain additional training for the Post-Move Monitor, which is to be commended. The Monitoring Team also recommends that quality assurance procedures be put into place that include an on-site validity check component on some regular basis. **For Provision T3**, no rating is required. **For Provision T4**, the Facility was not in compliance. The Facility reported three Alternate Discharges during the past six months. Two of these were for individuals who moved to other SSLCs within the state, and one was a transition from an acute care hospital to hospice. Two of the three (66%) discharges did not fully comply with DADS/RSSLC policies on alternate discharges. While there were certain extenuating circumstances, it remained incumbent upon RSSLC to make every effort to ensure ample and current assessment information and recommendations were made available at the point of discharge.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the	Policies and Procedures related to Movement to the Most Integrated Appropriate Setting: RSSLC did not report any changes to or new policies in this area since the previous compliance visit. The Transition Coordinator reported that a revision of DADS Policy 018 was expected in the near future. This was confirmed during the Admissions and Placement Coordinators (APC) conference call held during the site visit Transition Outcomes During Last Six Months: • Community Transitions: There were 17 transitions to community living between November 1, 2011 and April 30, 2012, according to the Community Placement Reports, and three more had occurred since that report was issued. This was a substantial increase over the seven transitions accomplished in the previous six month period. As was the case during the last site visit, funding continued to be reported as an obstacle to transition for two individuals related to their lack of citizenship. Otherwise, there were no confirmed instances of a placement being delayed or prevented due to lack of funding, • Referrals for Community Transitions: The Facility reported that IDTs had made a total of 15 referrals for community placement between November 1, 2011 and	Noncompliance

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	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.	April 30, 2012. RSSLC had 24 active referrals in process, according to the Community Placemen Report. This number was approximately seven percent (7%) of the Facility's current population of 364. • Pace of Transition: The Facility was not yet meeting the 180 day target for transition to occur. Eight of the 24 (33%) current referrals had been referred for more than 180 days. Almost half of the 17 community placements exceeded 180 days. This is further discussed in Provision T1c. • Adverse Outcomes Related to Transitions: There had been no significant adverse outcomes for individuals who had moved to the community in the past year. o Returns from Community Placement: There were no returns from a community placement during this six month period or the previous period. o Deaths Following Community Placement: There were no deaths of any individuals following a community placement that occurred during this six month period. o Psychiatric hospitalizations: There was one psychiatric hospitalization reported for an individual following a community placement during this six month period. o Unauthorized Departure/Police Contact/Transferred to a Different Setting: One individual was reported to have had an unauthorized departure for which the police were called, but no arrest was made. The individual moved to a new residence operated by the same provider immediately after the incident, and moved to a third home in the provider's network approximately three months later. The information provided indicated no additional moves had occurred since September 2011. o Emergency or unexpected medical hospitalizations: There were emergency medical hospitalizations for two individuals following a community placement that occurred during the past year. One individual was hospitalized twice for fluid in the lungs and for weakness due to low sodium and potassium levels, while the other had a respiratory illness. No adverse outcomes were reported to have resulted. The Monitoring Team also reviewed a list of all deaths of individuals who have moved to the community from RSSLC since July 2009. Since 7/01/09, 112 individuals had transitioned to community living, and six (5%) had subsequently died. The causes of death varied, but some appeared to have been preventable, including a drowning and a choking incident. The Monitoring Team recommends DADS and the Facility undertake a process to evaluate the mortality data post-transition across the past three years to gain an understanding of any trends and lessons that may be learned to minimize deaths	

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		from preventable causes. This will also inform the development of the CLDP. Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting: RSSLC continued to engage in many activities during the past six months to encourage and assist individuals to move to the most integrated setting. These activities were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the statutory authority of the state, and the needs of others with developmental disabilities. Examples included: • DADS State Office provided training to 120 staff on identification of essential and non-essential supports and obstacles to referral and transition. • The Transition Coordinator provided training on the transition process to 34 staff. • A PSP/ISP Committee continued to meet to develop strategies to improve assessment quality and ISP outcomes. • A new staff member, the Admissions and Placement Case Manager had been added to the Transition Coordinator's office to assist with transition activities. There was no evidence provided that these activities were yet being methodically evaluated for their efficacy. The Facility should consider developing specific outcome measures related to each of the activities it undertakes for the purpose of encouraging individuals to move to the most integrated setting appropriate to their needs. Conclusion: This provision as found to be not in compliance.	
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:	Policies and Procedures related to transition and discharge processes: The Facility reported that it had made no changes to transition and discharge policies. The Monitoring Team found many instances in which the requirements of the statewide 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	Status of Process and Training on ISP Development: Over the past six months, RSSLC had provided some additional training on topics related to ISP development, including, for example: • DADS State Office provided training on identification of essential and non-essential supports and obstacles to referral and transition. • The Transition Coordinator provided training on the transition process.	Noncompliance

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	adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	Additional training continued to be needed on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. <u>Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting:</u> The Monitoring Team found the IDT still failed to identify in each individual's ISP 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, particularly since the teams often failed to appropriately identify the most integrated setting, as further described in Provisions F1e and T1b3. The Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2 below, a small proportion of individuals living at RSSLC had opportunities to tour community living options and the annual CLOIP process was not meaningful for most. The PFAs reviewed during this compliance visit provided little in the way of a visioning of an individual's ideal living arrangement. See Provisions F1b and F1c for further discussion regarding the Facility's processes for identifying and supporting individuals' preferences. These processes continued to need considerable enhancement. Preferences of LARs and families for living arrangement were more often understood and documented. The Facility was providing some opportunities for families and LARs to learn more about community options, but these were limited, as described in Provision T1b2 below, and many families were not interested in participating in them. The annual ISP process typically did not lend itself to a comfortable discussion of community living opportunities, as described in Provision F1e. There continued to be evidence, as further documented in the Facility's *Annual Report: Obstacles to Transition Richmond State Supported Living Center, Fiscal Year* 2011, that IDT members were not as familiar with community living options as they needed to be to appropriately assist in planning for the protections, services and supports in the most integrated setting. In most instances, the ISP simply identified the supports and services to be provided at the Facility and indicated the same array would be required if community living were to be considered. The lack of a well-defined vision for an individual's life typically resulted in a failure of the teams to fully imagine what the	

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		possibilities could be. Another significant deficit in the planning process was a lack of knowledge of services that could be made available, which sometimes resulted in inappropriate identification of obstacles. <u>Identification of and Plans to Overcome Obstacles to Transition:</u> RSSLC reported it gathers obstacle information through the ISP process, and then categorizes these using a list of DADS-approved obstacles. These included: • Individual's reluctance for alternate placement • LAR's reluctance for alternate placement • Lack of supports for people with significant challenging behaviors • Lack of availability of specialized therapy supports • Lack of availability of specialized medical supports • Lack of funding due to an individual's legal and citizenship status • Lack of specialized mental health supports • Need for environmental modifications to support the individual • Need for services and supports for persons with forensic needs/backgrounds • Lack of specialized educational supports • Need for transportation modifications to support the individual Facility staff had received training from DADS State Office in the identification of obstacles to referral and obstacles to transition, using the categories described immediately above. This included discussion points as to the reasons such obstacle might exist as well as how such apparent obstacles might be successfully addressed. This type of practical training is to be commended. Overall, the Monitoring Team found that obstacles to transition were not yet consistently appropriately identified or addressed by the IDTs. In a review of seven recent ISPs, zero of seven (0%) recent ISPs reviewed evidenced proficiency in this regard. Examples of issues related to identification and addressing of barriers included: • For Individual #511, the individual's mother stated that she believed many of the individual's behavioral barriers were as a result of a lack of coping skills related to the death of the individual's father. The IDT did not identify this in the obstacles and did not address the development of coping skills in the ISP. • For Individual #775, individual and LAR reluctance was identified as obstacles to referral. There was no exploration as to the basis for the reluctance of the LAR, nor was there discussion of the individual's specific awareness needs. In the Living Options discussion, the IDT agreed the individual could be successful if appropriate supports were in place, but did not specifically identify what those would be, nor how the reasons for the LAR reluctance could be used to fashion appropriate supports that would resolve those concerns.	

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		• For Individual #165, a relatively new admission, the IDT stated in one section that, per the guardian, recent history at another Facility would indicate that community living options should be considered later, after six months. There was no discussion as to the criteria that the LAR would want to see in order to be able to support community living. In a later section, the IDT stated there were no obstacles to community living, but that options would be reviewed in six months. Again, no measurable outcomes were identified to be worked on during that time frame that would address specific concerns of the LAR. Conclusion: This provision was found to be not in compliance. Substantial continued training is needed by the IDTs.	
	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.	Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices: In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria. An individualized plan for each individual (e.g., in the annual ISP): The Facility did not yet succeed in developing individualized plans for community education and awareness. There was some progress observed in the sample of recent ISPs reviewed. For Individual #462, the IDT worked with a reluctant LAR to assist the LAR to define the reasons for the reluctance, identifying a specific type of residence that might be acceptable and then developing a plan for accompanying the LAR on a tour of this specific location. This type of plan was the exception rather than the rule, however. More common was an example, for Individual #387, in which the IDT found the individual needed more opportunities for community exploration. The Action Plan developed was simply that the individual would participate in a community tour "when one becomes available." Annual provider fair: The Facility held its most recent annual provider fair on October 25, 2011, as reported during the previous monitoring site visit. That event was 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. The Facility did measure attendance, also as previously reported in the last monitoring period. The Facility had also collected survey information from provider attendees, but had not yet taken any action or developed any plans in response to these data. The Facility was planning another provider fair for May 20. 2012, to be held in conjunction with a meeting of the Parent Association on Saturday. The Monitoring Team commends the Facility and Transition Coordinator for continuing to develop creative strategies for these events to enhance participation and attendance.	Noncompliance

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		Annual Local Authorities (LA) Inservice: On 1/13/12, the Continuity of Care Coordinators from the 3 LAs (formerly known as MRAs) assigned to RSSLC provided education to IDT members and any interested family members on specifics of what the community offers, how community services are funded and the various systems in place to assure successful community transitions. The Transition Coordinator reported she planned to discuss with the LAs whether the content of the inservice needed to be updated. Regular SSLC meeting with LAs: The Transition Coordinator stated her department and the Admissions and Discharge staff at Brenham State Supported Living Center continued to meet jointly with the LAs in the Facilities' catchment area on a quarterly basis, although there was no set or formal agenda. Topics of discussion were reported to be status of admissions and discharges, forthcoming referrals, and any other activities related to transitions. Education about community options is evaluated for improvement: RSSLC did not have any consistent or formalized plan for collecting data on specific outcomes or measures related to education about community living, nor for using such information to evaluate opportunities to improve outcomes. Examples included: • IDT Action Plans: The Facility reported it was not collecting data regarding the implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. It should develop a process to do so. Although IDTs are required to document progress and activity in the ISP monthly and quarterly reviews, the reality is that much of the documentation is limited to statements such as "service provided/not provided," to the extent that it is not useful in developing future community awareness strategies. • CLOIP: As indicated in previous reports, the annual LA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals. The Monitoring Team reviewed a sample of 32 CLOIP Worksheets for ISPs held in April 2012. For 15 of the 32 (47%), the LAR did not allow the LA Service Coordinator to provide the individual with information about living options. For only one of the 17 (5%), in which the LA did engage the individual in the CLOIP, was the LA Service Coordinator able to document the individual had any interest in or meaningful response to the materials or information being offered. This would indicate DADS needs to assess how the process, materials and/or information might be modified to more effectively meet the needs of the individuals. • Community Tours: As described further below, the Facility did not have a consistent or formal process for documenting and/or evaluating the community	

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		tour process. Tours of community providers: In the past six months, there were nine community tours reported. There did not yet appear to be a consistent, formalized process in place at the Facility to fashion these tour as a part of an individualized community living awareness and education plan. The Transition Coordinator confirmed this to be the case and indicated the Facility still needed to work to make the tour experiences into a meaningful learning event. Specific findings regarding community tours included: • Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours): There did not yet appear to be a consistent, formalized process in place at the Facility for ensuring opportunities for community tours were available to all. In the past six months, a total count of 57 individuals participated in nine CLOIP community tours, a number which is slightly more than 15 percent (15%) of the population of the Facility. It is noted this is not an unduplicated count, so the percentage may actually be lower. • Places chosen to visit are based on individual's specific preferences, needs, etc: An individualized education and awareness plan should define the types of settings to which an individual may need exposure to facilitate his or her understanding of community living options. There was no consistent or formalized process described for choosing tour sites based on individual preferences and needs. • Size of tours: The number of individuals attending a single tour may have a significant impact on the learning experience for the participants, as well as the ability of staff to gauge individuals' reactions and respond appropriately to facilitate learning. During the past six months, tour sizes at RSSLC ranged from one individual up to 26. At least three of the nine tours were nine people or more. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the most integrated setting. There was no consistent or formal process described for making an assessment of an individual's response to the tour experience unless the individual had been referred for transition planning. Opportunities are provided to visit friends who live in the community: There was anecdotal evidence provided that individuals living at the Facility had been provided with some opportunities to visit friends who lived in the community. For example, staff	

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		reported that individuals from RSSLC had attended holiday events sponsored by a community provider in the winter of 2011. In addition, it was reported by staff during the ISP for Individual #462 that the individual had attended birthday parties at the homes of former RSSLC residents who had moved to the community. The Monitoring Team encourages the Facility to expand upon these opportunities and to routinely evaluate these experiences and their learning potential for the individuals involved. Education provided in various venues: In addition to the Provider Fair and the Annual MRA Inservice described above, the Facility had begun to issue a monthly newsletter that described community awareness opportunities that would be taking place. Letters and brochures were also sent to LARs and families to inform them of the availability of CLOIP tours on a quarterly basis. One of the most innovative and helpful strategies developed by the Transition Coordinator was the maintenance of a resource library on the shared drive that included informational brochures and other materials about community providers and other community resources. This made information widely and readily available to staff throughout the Facility. The Transition Coordinator indicated she was going to see if she could also make this available to individuals in the computer center to which they have access. A plan for staff to learn more about community options: The Transition Coordinator reported there was no formal coordinated plan at this time to educate staff about community options, nor had the Facility developed or provided any written materials for staff to inform them about community living options. Some educational opportunities had been provided through staff participation in community tours and community exploration activities for individuals. During the six months since the last monitoring site visit, the Facility documented 55 staff participating in ten community awareness activities, including tours, accompanying individuals on pre-placement exploration visits and, on one occasion, attending a holiday party at a provider location. Staff also had the opportunity to attend the annual LA inservice and the semi-annual Provider Fair. Individuals and families who are reluctant have opportunities to learn about success stories: The Transition Coordinator had met with the Facility's social workers and asked that they take pictures of individuals during pre-placement visits or on the day of their move, and provided a camera for their use. The intent was to use these, with appropriate consents, in the newsletter and other venues to highlight positive transition outcomes. There had been little progress toward this goal as of yet. It was also noted during discussion with the Post-Move Monitor that she observes many obvious positive changes in individuals over the course of the 90 days in which she provides monitoring. If she were to obtain pictures or otherwise document these outcomes, these could also be used for the purposes of education and awareness.	

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		Conclusion: This provision was found to be not in compliance. The Monitoring Team commends the efforts of the Facility toward 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. IDTs continued to need 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.	Assessment Practices Related to Transition and Discharge: The Facility reported it used the Community Living Options Discussion Record (CLODR) as the process for assessing individuals for community placement. The Community Living Options discussion was not yet implemented in such a manner that it could be considered an effective assessment for placement. 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 IDTs 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. DADS and the Facility had undertaken some efforts to improve these processes. The new ISP format, which was in the early stages of implementation, placed additional emphasis on the living options discussion and specifically required the IDT to assess individual and LAR preferences as well as IDT recommendations in distinct sections, followed by a section entitled Living Option Determination at the conclusion of the plan. This appeared to have some promise in terms of identification of the most integrated setting appropriate to the individual's needs, a team decision that frequently was different from the actual team decision to make a referral for community living, but IDT members were not yet implementing this in an adequate manner. This is discussed in more detail in Provision F1e above. In addition, as noted in Provision F1e, IDT members were to provide a recommendation regarding the most integrated setting in their individual assessments, and this was not yet consistently occurring. Professionals did not yet consistently provide their determination regarding the appropriateness of referral for community placement in their annual assessments. As reported in Provision F1e the Monitoring Team found only five of 47 (11%) discipline specific assessments of assessments provided for seven recent ISPs included such a determination. The only discipline that consistently provided	Noncompliance

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		this determination was nursing, and even in those assessments, the determination included no individualized rationale or recommendations. IDTs typically did not engage in an integrated discussion of how these individual opinions could be synthesized into a team decision, as described in Provision T1b1. Overall, living options for individuals were not thoroughly discussed during the annual ISP meeting Percentage of Individuals Assessed as Required: The process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement; therefore, the Monitoring Team found that no individuals (0%) had been adequately assessed for placement. Conclusion: This provision was found to be not in compliance.	
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, 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:	CLDP Policy and process: There were no changes reported to policies related to the CLDP. The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. The Transition Coordinator was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. Facility staff had received additional training on the identification of essential and non-essential supports for the CLDP. Timeliness of Development and Implementation of CLDP: Documentation indicated CLDPs were initiated upon referral. The Monitoring Team also reviewed the Community Placement Report, dated 11/1/2011-4/30/2012. Eight of the 24 (33%) current referrals had exceeded the 180 days, and almost half of the 17 community placements that occurred exceeded 180 days from the time of referral. 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. The Facility should ensure that timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Provision T1f. It should be noted as a disclaimer that the evaluations above of these timeframes were based on the meeting dates that were listed in the Community Placement Report, which may not always accurately reflect the original referral date. The statewide database resets the meeting date to the most current ISP date when each new annual ISP data is entered, such that the report would never show a referral lasting longer than 365 days. Development of CLDP in coordination with the LA: A review of five completed CLDPs indicated that 100% evidenced that the plan was	Noncompliance

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		developed in coordination with the responsible LA. In addition to the required participation in the referral meeting, the LA attended the CLDP meetings and completed the Continuity of Care-Move Site Review Instruments for the Community Living Discharge Plan as further described in T1e below. Conclusion: Overall, Provision T1c was found to be not in compliance. Coordination with the LA in the development of the CLDP did not appear to be of significant concern at this time, but there remained 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 IDTs to adequately identify the appropriate essential and non essential supports for each individual. These deficiencies are described in more detail in Provisions T1c1, T1c2, and T1c3 below.	
	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.	Identification of Essential and Non-Essential Supports: The Monitoring Team reviewed documentation for five completed CLDPs. No CLDP meetings were held during this compliance visit. There was considerable progress noted in the process to ensure the CLDP captured the information that was contained in these assessments and in the IDT discussions held during the CLDP process. The CLDPs reviewed had a much more extensive list of essential and non-essential supports. It was clear the Transition Coordinator was attempting to ensure the identification of CLDP supports was comprehensive. This process continued to be hampered by assessments and pursuant recommendations did not yet provide an adequate basis for the development of a comprehensive CLDP. 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 ISP. The IDT did appear to rely heavily on the ISP and the assessments associated with it to guide the identification of the essential and non-essential supports. The potential problem with this was that the IDTs 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 ISP planning meeting of the supports and services needed and desired in a community setting, as described in Provision T1b, Provision F1c, and Provision F2a. For example, the Monitoring Team found in a review of seven recent ISPs that none (0%) included any specific recommendations as to opportunities for new skill development that would be presented in a community living option. Examination of this element of the Settlement Agreement will therefore be contingent to some degree on a positive evaluation of these items at some point in the future.	Noncompliance

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		The CLDP still did not consistently provide sufficient direction as to how it expected the Post-Move Monitor to adequately verify the presence or absence of supports. For example, for Individual #353, one non-essential support was for new staff to be trained on diet, diet texture, feeding techniques, adaptive equipment, medical needs, medications, safety and supervision needs, assistance needed with self-care, preferences and hw to address behavior. The CLDP indicated this would be evidenced through written inservice signature sheets and daily progress notes and by PMM observation and interview. It was not clear what specific information the Post-Move Monitor should be expected to glean from an interview or observations, or what key outcome indicators she should be focusing on. This was a common finding throughout the CLDPs reviewed. The Post-Move Monitor, while a QDDP and a skilled generalist in the field, cannot be expected to have discipline-specific knowledge in every case. The CLDP should, when appropriate, provide the Post-Move Monitor with the specific criteria the IDT expects as verification. This need not be an extensive narrative, but should include the essential points. If the IDT determines that discipline-specific expertise is required to adequately monitor the provision of the support, it should specify this in the CLDP. For example, if an individual has significant behavioral needs, the IDT might prescribe that the RSSLC behavior analyst participate as part of the PMM visit in order to assess staff knowledge and expertise. <u>Coordination of CLDP with provider staff:</u> A review of five completed CLDPs indicated provider staff were very involved throughout the CLDP process. Provider staff attended each CLDP meeting. There was documentation of training of provider staff and the visits by the individual to the provider sites and the individual's responses. The Monitoring Team notes, however, that the presence of this documentation did not necessarily reflect that provider staff were adequately prepared to meet the complex needs of some individuals. As described in T2b below, during a 7-Day PMM visit held during this site visit, provider staff were found to have significant gaps in their knowledge of an individual's health care needs. It was also noted, as described in T2a below, that in one instance the Facility relied on inservice training that was provided during a trial visit that occurred several months before the individual actually moved, which would provide no assurance of current staff competence. The Facility should examine its provider inservice training processes to ensure they result in the requisite staff competency. <u>Conclusion:</u> This provision was found to be not in compliance. There was progress noted in the CLDP processes in terms of documenting individual's needs for supports and services, but this was not yet consistent. The Monitoring Team also found the assessments and pursuant recommendations did not yet provide an adequate basis for the development of a comprehensive CLDP.	

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	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Responsible staff identified for needed actions: For five of five (100%) of CLDPs the Facility consistently identified Facility staff responsible for each of the essential and non-essential supports by name. It was clearly stated that Facility staff had responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness for each and every support. Completion timeframes for needed actions identified: For five of five (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. Conclusion: This provision was found to be in substantial compliance.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Review of CLDP with Individual and, as appropriate, the LAR: The Facility was to be commended for the progress it had made in ensuring the CLDP was reviewed with the individual and LAR as appropriate on an ongoing basis, and that this review was thoroughly documented. The Monitoring Team reviewed the documentation for five completed CLDPs, to assess compliance with this provision. For five of five (100%), there was ample documentation of the level of involvement by the individual and/or the LAR in the decision-making process. Conclusion: This provision was found to be in substantial compliance.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	Timeliness of Assessments: The Transition Coordinator had a process in place to review assessments and make assignments for any updates or revisions that needed to be made to an individual's current assessments. This was a positive practice that should be continued. The final assessments were then reviewed as a part of the CLDP meeting. These processes in themselves appeared to be adequate for purposes of ensuring that assessments were available and current within 45 days prior to the individual leaving the Facility. RSSLC needed to focus its attention on whether these assessments were adequately prepared, as described in Provision T1c1 and below. Adequacy and Comprehensiveness of Assessments: 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 IDT and the community provider would need to develop an appropriate transition plan. As described in Provision T1c1 above, in a review of five completed CLDPs, the Monitoring Team found that the assessments did not consistently address the services and supports	Noncompliance

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		needed for each individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. In addition, none of the assessments reviewed placed any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. The Facility was taking some action to improve the quality of ISP assessments, including a specific focus on the CLDP assessment process. The Transition Coordinator had developed a format for a QDDP Summary for the CLDP that was intended to assist the IDT in identification of individualized essential and non-essential supports. She had also provided training to several discipline specific groups on the assessment process for CLDP. At the request of the Transition Coordinator, the Monitoring Team also met with key discipline/department heads during the site visit to discuss the assessment process for the CLDP. Attendees included the Director of the Forever Young program, the Director of Residential Services, he Director of Education and Training, the Director of Habilitation therapies, the Director of Vocational Services, the Director of Day Programming, the Transition Coordinator and the Admissions and Placement Case Manager. <u>Conclusion:</u> This provision was found to be not in compliance. Facility action must further address the adequacy of assessment practices overall before compliance can be achieved under this provision.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's	<u>LA Continuity of Care Process:</u> The Monitoring Team reviewed the LA Continuity of Care Pre.-Move Site Review Instruments completed for five individuals who had transitioned in the past six months. For Individual #353, the packet provided did not include the Continuity of Care Pre.-Move Site Review for the Monitoring Team to review. It was not clear if this was simply an oversight. For the remaining four, three appeared to have been completed in a timely manner. For Individual #665, the Continuity of Care Pre.-Move Site Review was completed at the same time the move occurred. This may have been impacted by the circumstances, in that the individual's sister had decided to become a foster care provider in her home, but this was not a last minute decision and should have provided for sufficient time for a pre-move visit to occur before the move actually took place. Each of the four was completed within the required timeframe and included the required DADS QRS report as an attachment. None of the instruments indicated any issues that required follow-up. <u>Pre-Move Site Visit Completed by Facility:</u> The Post-Move Monitor was designated as the responsible Facility staff for completion of the Pre-Move Site Visit. No such visits were conducted during the monitoring visit, so the	Noncompliance

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	departure from the Facility.	Monitoring Team was not able to observe the process but rather relied upon documentation to assess compliance. The Monitoring Team reviewed the Pre-Move Site Review documentation completed for five individuals who had transitioned in the past six months. As with the Continuity of Care Pre.-Move Site Review, the packet provided for Individual #353 did not include the Pre-Move Site Review for the Monitoring Team to review. It was again not clear if this was simply an oversight. For the remaining four, three appeared to have been completed in a timely manner and included a visit to each service provision site. For Individual #665, the Pre.-Move Site Review was completed at the same time the move occurred, but there should have been sufficient time for a pre-move visit to occur before the move actually took place. The Pre-Move Site Reviews were conducted by the RSSLC Post-Move Monitor. They did not consistently provide adequate detail as to the presence of essential and non-essential supports. For example: • For Individual #665, the Pre-Move Site Review provided no documentation in several key areas covering the individual's support needs, but simply listed a due date. • For Individual #98, the Pre-Move Site Review occurred on 3/29/12. In several key areas addressing support needs such as adaptive equipment, health care and communication, the only comment by the reviewer was that provider staff had been inserviced on 11/15/11. This length of time between inservice and transition called at least for a careful review of staff knowledge, if not an updated inservice. There was no documentation staff were questioned as to their knowledge. • For Individual #96, for some environmental supports, such as a home alarm system and an outside patio, the comment was "staff inserviced by RSSLC on…" (blank). The Pre-Move Site Review further indicated that observations and staff interviews were required as evidence that certain supports, such as knowledgeable staff regarding the individual's diagnoses, weight, and administration of Hepatitis B medications, were in place. There was no documentation of any inquiry as to staff knowledge. <u>Conclusion:</u> This provision was found to be not in compliance. The Pre-Move Site Visit completed by the Facility was intended to provide an important vehicle for assuring that supports were in place, or that adequate plans had been made for those non-essential supports, in a much more detailed way than the LA Continuity of Care process. The Pre-Move Site Visits reviewed did not appear to be carefully completed. The Monitoring Team would recommend the Facility maintain a comprehensive evidence documentation file in the same manner as the PMM file. This provision also relies on supports having been adequately identified in the CLDP comprehensive assessments and the Monitoring	

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		team did not find this to be the case, as described under Provisions T1c1 and T1d, further resulting in a finding of noncompliance.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	Quality Assurance Processes to Ensure Development of CLDPs: RSSLC had implemented some quality assurance processes in this area. The Transition Coordinator had a tracking mechanism for the 45 day assessments and a process for review prior to the CLDP meeting. Quality Assurance Processes to Ensure Implementation of CLDPs: The Pre-Move Site Review provided an additional layer of scrutiny to ensure that essential supports were in place prior to an individual leaving the Facility. The Monitoring Team commended this initiative, as the existing LA pre-move site visit did not focus heavily on ensuring specific supports were in place. As described under Provision T1e above, however, the Facility's implementation of the Pre-Move Site Review was not adequately documented and improvements were recommended by the Monitoring Team. Trends and Improvement Actions: The Facility's QA Department reported it had not yet begun completing Section T Monitoring Tools. The QA Auditor had held some informal meetings with the Transition Coordinator to discuss a process for monitoring CLDP assessments. QA staff stated that DADS State Office was not going to continue to provide external monitoring of CLDPs; however, during a conference call held during the monitoring visit, State Office staff indicated they would resume this review process in the near future. Conclusion: This provision was found to be not in compliance. The Facility had initiated some actions toward developing quality assurance processes. This was a positive step. It is recommended that clear performance goals and outcome measures be defined, along with appropriate methodology for obtaining the data. RSSLC should also ensure these are coordinated with quality assurance measures that address the overall quality of assessments at the Facility.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of	Obstacle Information Gathered: RSSLC reported it began data collection on obstacle information on April 18, 2011 through the ISP process, using a list of DADS-approved obstacles, as described in Provision T1b1. The IDTs/QDDPs had received training in the identification of obstacles during the ISP. Annual Obstacle Analysis by Facility: The Facility had produced an assessment report regarding these obstacles, with data through August 31, 2011, entitled *Annual Report: Obstacles to Transition Richmond State*	Noncompliance

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	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.	*Supported Living Center, Fiscal Year 2011*. The report focused on obstacles to referrals for transition to community living and developed some action plans to address these. • The highest percentage category of obstacle (33%) was individual reluctance for community placement and most of this was attributed to a lack of understanding of community options. The Annual Report indicated the QDDP Coordinator and QDDP Educator would work jointly with IDTs to develop individual action plans for obstacles related to lack of understanding and would contact the QDDP for each of the individuals to arrange meetings to ensure effective actions were in place. There was no evidence provided that this had been accomplished as of yet, nor did the review of recent ISPs indicate significant progress in this area, as further described in Provisions T1b1 and F2a2. • The report noted that RSSLC serves a significant number of individuals who have LARs and that most of these are resistant to transition. The report further indicated this accounted for approximately 21% of obstacles the Facility had documented, the second highest category. Action Plans to address this obstacle included: o The PST will develop individual specific action plans addressing educational needs at the PSP. o The Transition Coordinator and QDDP Coordinator will work with the local community center regarding improving the quality of the CLOIP with LARs. o The Transition Coordinator will provide educational materials through quarterly mail outs to LARs and involved family members and friends providing additional information. . The Monitoring Team found minimal evidence that these Action Plans had been implemented to any significant degree. RSSLC should ensure it implements each of these as planned. <u>Appropriate Steps Taken by DADS to Overcome or Reduce Identified Obstacles:</u> DADS took steps to overcome or reduce the identified obstacles, including the following: • DADS created a report summarizing obstacles across the state and included the Facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. • The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the facilities collect) data regarding obstacles. • DADS indicated actions that it would take to overcome or reduce these obstacles o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with	

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		local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). <u>Conclusion:</u> This provision was found to be not in compliance, although activities at the facility and state levels demonstrated progress towards substantial compliance with this provision item. Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
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	<u>Issuance of Report:</u> The Facility issued a Community Placement Report, covering the period of 11/1/2011-4/30/2012. The report was issued in a timely manner. <u>Required Reporting Categories:</u> The report was in the standardized format as prescribed by DADS State Office. During December 2010, the Monitoring Teams requested some information regarding transition be added to the reports in order to capture categories of individuals who had either requested community transition, or whose teams had determined they could be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template each of the Facilities uses, including Individual Prefers Community, Not Referred – LAR Choice; Individual Prefers Community, Not Referred – Other Reasons; and LAR Prefers Community, Not Referred, and these are included in this report: • Seventeen community placements • Twenty-four current referrals • One rescinded referral • Zero individuals who preferred community, not referred-LAR choice • Zero individuals who preferred community, not referred-other reason • One individual for whom the LAR prefers community, not referred. <u>Reporting on Individuals not referred due to LAR choice:</u> It was not clear that the data provided in the category of individuals who preferred community, not referred-LAR choice was accurate, as it did not appear to fairly represent the scope of LAR choice in a team decision not to make a referral. While the Community Placement Report listed no individuals who preferred community but were not referred due to LAR choice, RSSLC's	Noncompliance

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	services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	annual obstacles report lists 99 such individuals in *Table 4: Individuals not recommended for movement that prefer to reside in the community from the Richmond State Supported Living Center, 2011.* The Monitoring Team also observed during this site review that IDTs continued to find no barriers to community living, yet decided RSSLC was the most integrated setting based on the LARs' preferences. The Monitoring Teams have also asked that a final category be added that includes a list of names of individuals who would be referred by the IDT except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. The Monitoring Team looks forward to reviewing data that provides an accurate picture in this area in the future. Conclusion: This provision was found to be not in compliance. The report was made in a timely fashion but the Monitoring Team notes its concern related to the accuracy of some of the data and encourages DADS and the Facility to examine these issues.	
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	Policies and Procedures related to Post-Move Monitoring: The Facility reported there had been no changes or additions to policies related to Post-Move Monitoring. Staffing: The Post-Move Monitor reported that she was not having any difficulty completing monitoring duties, even given the pace of transitions over the past six months. With current referrals standing at 24, the Facility should monitor the workload for any negative impact it may have on quality and thoroughness. Review of PMM Checklists The Monitoring Team reviewed PMM Checklists for five individuals who had moved to the community. The Monitoring Team assessed both timeliness of the PMM visits and the use of the standardized tool for completing the assessment for the presence of CLDP-prescribed supports. Findings included: Timeliness of Post-Move Monitoring Visits: The Monitoring Team found that the PMM Checklists were being completed in a timely manner. Each of the 7, 45 and 90-day PMM visits (100%) were made within the required timeframes. Use of Standard Assessment Tool: In each case, the PMM visits were documented using the prescribed standardized tool, the Post-Move Monitoring Checklist as revised in May 2011.	Noncompliance

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	indicated, notifying the appropriate MRA or regulatory agency.	<u>Assessment of Presence of Supports Called for in CLDP:</u> In many cases, the PMM Checklists reviewed during this compliance visit appeared to include a verification that each support was in place and being implemented. If there were supports that were not in place as required, the Post-Move Monitor had often taken actions and maintained a record of emails and phone logs that documented follow-up and loop closure. There continued to be some significant deficiencies noted, however. Examples included: • DADS and RSSLC policies clearly state that the PMM process should identify the plan to achieve non-essential supports. In many instances, for non-essential supports that were not "due" at the 7-day visit, the RSSLC Post-Move Monitor did not document the plan to ensure the supports were provided as prescribed in the CLDP. Many of these supports were to be provided within the first 30 days, but the Post-Move Monitor indicated only that she would follow-up at the 45-day visit, even though this would be past the due date. • In several instances, the Post-Move Monitor failed to provide any evidence of any discussion with day habilitation staff as to their knowledge of the individual's essential and non essential supports. The documentation of interaction with staff was limited entirely to home staff. The documentation indicated the individuals were attending the day program, but no information was provided that would indicate the Post-Move Monitor had first-hand knowledge of the supports being provided in that environment. • In addition, the Monitoring Team observed the PMM process to lack an adequate level of attention to detail during the on-site PMM visit described in Provision T2b below. <u>Facility's Efforts to Ensure Supports are Implemented:</u> The Facility kept documentation of efforts to ensure supports were implemented. The Post Move Monitor maintained a file with materials to verify the implementation of supports as well as to document follow-up. The Monitoring Team commends the work of the Post Move Monitor for this process of maintaining supporting documentation. There were a few instances in which the Facility did not document adequate follow-up action to ensure supports were implemented. <u>Conclusion:</u> This provision was found to be not in compliance. The PMM process was not always implemented in a thorough manner, and some gaps and deficits were identified during this compliance visit that could have resulted in serious consequences.	
T2b	The Monitor may review the accuracy of the Facility's	<u>Observation of Post-Move Monitoring Visit:</u> The Facility had indicated it was achieving some level of compliance in the area of PMM. In order to assess the Facility's assertion	Noncompliance

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	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.	that it had achieved compliance in this provision, the Monitoring Team accompanied the Post-Move Monitor on the 7-day PMM visit for Individual #353. Prior to the visit, the CLDP and accompanying assessments were reviewed. There were a number of concerns regarding the adequacy of the PMM process noted during this monitoring visit. Examples included: • At the beginning of the visit, the Monitoring Team observed a bottle of hydrogen peroxide without a safety cap on a bookshelf in the individual's bedroom and within the individual's reach. The Post-Move Monitor failed to observe this item. The Monitoring Team brought it to the attention of the Post-Move Monitor, but she did not follow-up with staff on it until prompted by the Monitoring Team at the end of the visit. • There was a mixture of staff on hand who had attended the original transition inservice provided by Facility staff as well as newly-hired staff. None had adequate knowledge of the individual's health risks and needs. The Post-Move Monitor failed to probe sufficiently as to the knowledge of the provider staff. She did not ask staff to explain what they knew about the individual's health conditions. For example, the individual had an extensive history of urinary tract issues that had delayed the original transition date and required careful ongoing monitoring. The Post-Move Monitor did not question the staff in this regard. At the conclusion of the visit, the Monitoring Team questioned the lead staff on duty, who indicated she had no knowledge of this health issue. • The CLDP indicated the individual should have only egg substitute and that staff were to be trained to be knowledgeable of his dietary needs. The Post-Move Monitor did ask to see the egg substitute which was not present, and also noted there were eggs in the refrigerator. Provider staff indicated these were just used to cook with. The Post-Move Monitor was not aware of why the individual was to use egg substitute and did not question the advisability of using regular eggs for cooking until prompted by the Monitoring Team, at which time she did call the Facility and discovered egg substitute was to be used for cooking as well. • It was noted by the lead provider staff that she regularly feeds the individual, even though the individual tries to take the utensil to eat independently. The Post-Move Monitor did not question the staff as to the appropriateness of this, given that the individual was both willing and able to eat independently with prompts and monitoring. The Monitoring Team found that there was insufficient attention to detail exhibited in this PMM process, which called into question the level of attentiveness in the process as a whole for all individuals. The Transition Coordinator indicated that the Post-Move Monitor would be attending additional training being offered by DADS at the end of May 2012, which the Monitoring Team supports. The Monitoring Team also recommends	

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		that quality assurance procedures be put into place that include an on-site validity check component on some regular basis. Conclusion: This Provision was found to be not in compliance.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to 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.		Not Applicable
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather tha$_{n\ the}$ provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day	Number and Categories of Alternate Discharges: The Facility reported three Alternate Discharges during the past six months. Two of these were for individuals who moved to other SSLCs within the state, and one was a transition from an acute care hospital to hospice. Compliance with CMS-required Discharge Planning Procedures: The Monitoring Team reviewed the discharge packets for each of the individuals for consistency with CMS-required discharge planning procedures as well as with protocols established in DADS SSLC Draft Policy 019: Most Integrated Setting Practices, undated. The latter policy described a procedure and provided a format for a Discharge Reassignment Summary. Varying degrees of compliance were noted. For one alternate discharge, for Individual #740, the discharge appeared to have been completed in a compliant manner, and provided a thorough assessment of the individual's status. The Transition Coordinator reported that in the other two discharges there were extenuating circumstances that impacted the ability of the Facility to implement the policies as written. • For Individual #52, the individual moved to another SSLC in order to benefit from more intensive behavior intervention, following a negative finding in a CMS survey. The planning process was time-limited by the circumstances and the	Noncompliance

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	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.	needs of the individual as perceived by the Facility. The assessments provided by RSSLC staff did not consistently provide an accurate description of the individual's current needs in order to assist the receiving facility to provide an appropriate plan of supports and services. Examples included: o The Psychological Update, dated 01/26/2012, just three days before the discharge date, provided no detail as to the behavioral crisis that precipitated the transfer. The Summary of Behavior was limited to a single sentence that indicated the individual had a PBSP targeted to aggression to others, leaving without staff permission and inappropriate sexual behavior. The recommendations were only to continue Positive Behavior Supports and to monitor in psychiatric and behavior management clinic. o The QDDP Summary referenced no issues related to inappropriate sexual behaviors. It stated the individual was generally cooperative and got along well with others. It noted the individual tolerated change well, redirected well and responded well to structure. It then indicated the individual needed a program for inappropriate sexual behavior, with no rationale provided. o The Medical Summary was not completed until 2/18/12 and not made available to the receiving Facility until 3/1/12, more than one month after transition occurred. o The Individual Risk Rating was not included in the discharge packet. • For Individual #683, the individual was being treated in an acute care hospital and had been refusing to eat. The individual's family had chosen not to have the individual fed by a pre-existing g-tube. The Facility declined to receive the individual back with this requirement, stating it would provide nourishment by g-tube if the individual continued to refuse to eat. The IDT met several times over the course of a two week period to discuss the situation and determined the individual should be discharged to a sister's care with hospice. The only documentation related to the discharge was a single ISP addendum. No assessments or recommendations were provided as a discharge packet. <u>Conclusion:</u> This provision was found to be not in compliance, as two of the three (66%) discharges did not fully comply with DADS/RSSLC policies on alternate discharges. While there were certain extenuating circumstances, it remained incumbent upon RSSLC to make every effort to ensure ample and current assessment information and recommendations were made available at the point of discharge.	

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

1. The Facility should refine and develop its own critical outcome indicators based on its own strengths, needs and experiences and as new issues emerge and implement monitoring processes that address these. (Self-Assessment)
2. The Facility should develop outcome indicators regarding the IDT review of PMM visits, based not simply on its occurrence, but also on whether it produces the desired results in terms of timely actions that support a successful transition. (Self-Assessment)
3. DADS and the Facility should undertake a process to evaluate the mortality data post-transition across the past three years to gain an understanding of any trends and lessons that may be learned to minimize deaths from preventable causes. (Provision T1a)
4. The Facility should consider developing specific outcome measures related to each of the activities it undertakes for the purpose of encouraging individuals to move to the most integrated setting appropriate to their needs. (Provision T1a)
5. The Facility should ensure that timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Section T1f. (Provision T1c)
6. The Facility should examine its provider inservice training processes to ensure they result in the requisite staff competency. (Provision T1c1)
7. The CLDP should, when appropriate, provide the Post-Move Monitor with the specific criteria the IDT expects as verification of essential and non-essential supports. If the IDT determines that discipline-specific expertise is required to adequately monitor the provision of the support, it should specify this in the CLDP. (Provision T1c1)
8. In addition to continuing to strengthen inter-rater reliability in the use of monitoring tools related to the CLDP, the Facility may need to better define the specific outcomes it must meet to achieve a compliant level. (Provision T1f, Facility Self-Assessment)
9. RSSLC should both develop appropriate action plans to address the significant obstacles identified in its Annual Report, and ensure it implements each of these as planned. (Provision T1g)
10. DADS and the Facility should examine issues related to the accuracy of data related to LAR choice and referrals for community living as reported in its Community Placement Report. (Provision T1h)
11. The Post-Move Monitor should attend additional DADS-sponsored training in May as planned. In addition, quality assurance procedures for PMM should be put into place that include an on-site validity check component on some regular basis. (Provision T2b)
12. RSSLC should ensure ample and current assessment information and recommendations are made available at the point of alternate discharges. (Provision T4)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 51. Richmond State Supported Living Center (RSSLC) Self-Assessment, updated 05/01/2012 52. RSSLC Status Update May 2012 Visit 53. Richmond State Supported Living Center Action Plans, updated 04/27/2012 54. Section U Presentation Book materials 55. DADS Policy 019: Guardianship, effective 3/7/2012 56. RSSLC Policy C.3: Guardianship, dated 3/7/2012 57. The most recent prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and a LAR to render such a decision, dated 04/20/2012 58. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 59. Over the six (6) months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates 60. Rights Assessment form, dated 05/07/10 61. Rights Assessment, Form 6614, dated September 2011 62. Completed Rights Assessments for Individuals #29, #165, #268, #388, #641, #775, and #776 63. Self-Advocacy Minutes for the past six months **People Interviewed:** 1. Jim North, Human Rights Officer (HRO) **Meeting Attended/Observations:** 9. ISPs for Individuals #17, #387, #462, and #508 10. PFA for Individual #429 11. Human Rights Committee
	Facility Self-Assessment: The Monitoring Team reviewed the RSSLC Self-Assessment for Section U, including the Action Plans. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided its assessment of the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Monitoring Team would recommend the Facility consider specific measurable outcome indicators to be reviewed in addition to the fairly subjective process measures in the current Self-Assessment. This might include, for example, an analysis of the competency measures related to training efforts such as that completed during new employee orientation and should include similar outcome measures for any training efforts the Facility plans to initiate in this area when it receives a final policy related to assessment of decision-making capacity. **For Provision U1 and Provision U2**, the Facility indicated it was not yet in compliance and the Monitoring Team concurred. The Facility indicated in both cases that it was just beginning implementation of the new Guardianship policy and that most of the projected Action Steps were not yet started.
	Summary of Monitor's Assessment:

	This Section was not yet in compliance. A summary of noted progress included the issuance of a statewide policy on guardianship and the localization of that policy to RSSLC. The Facility had begun to take some beginning steps toward implementing the requirements of the policy, such as recruitment of members for the Guardianship Committee, and the development of materials to be used for staff training. The Facility also continued to implement activities commended by the Monitoring Team in previous reports, including support for self-advocacy and ongoing training of new employees in guardianship and advocacy. The Facility had also expanded training on these topics to include incumbent employees. Other specific findings for each provision are as follows: **Provision U1:** This provision was found to be not yet in compliance. DADS State Office had issued a new policy, DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits, that provided some guidance to the Facility in the development and maintenance of a prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The Monitoring Team remained concerned that the new policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. RSSLC had begun to take some actions in the past six months to implement the requirements of this provision. The Facility had localized DADS Policy 019 in RSSLC Policy C.3: Guardianship, dated 3/7/2012. The local policy appeared to be internally consistent with the DADS document. The Facility maintained a prioritized 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, but still did not use any standardized process or tool for purposes of making a judgment about such capacity. The list contained some errors, particularly as it reflected a priority status for several individuals who had moved from the Facility more than six months ago, and needed to be updated. **Provision U2:** This Provision was found to be not in compliance. RSSLC continued to provide support for self-advocacy and the Monitoring Team was pleased to see the integration of the office of the Transition Coordinator with self-advocacy in sponsoring a poster contest about what community living means to individuals. The Facility also continued to provide basic staff training on guardianship and advocacy, and additional training was in the planning stages. There was little activity toward the solicitation of guardians for individuals during this review period. It was reported no guardians had been obtained. The Facility had just begun to recruit membership for its Guardianship Committee, as called for in the DADS Policy 019 and RSSLC Policy C.3. As the Facility operationalizes its Guardianship Committee and other components of the new policies toward the solicitation of guardians, it continued to need to ensure it has an appropriate methodology in place to determine the actual need for guardianship.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	Policies and Procedures related to functional capacity to give consent and/nor need for LAR: DADS State Office had issued a new policy DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits. The stated purpose of this new policy was "…to ensure that individuals residing in State Supported Living Centers (SSLCs) and their legally authorized representatives (LARs) and correspondents are made aware of guardianship services available in Texas and to identify those individuals without a LAR who would benefit from having an LAR to help them make decisions regarding treatment and programming." The draft policy did not provide substantial guidance to the Facilities and the IDTs in how to assess an individual's decisional capacities and/or need for guardianship. No standardized tool or process was described for IDTs to use in making these determinations. Rather, the policy stated "… (T)he IDT discusses individual decision-making abilities and guardianship need at the annual IDT meeting for each individual residing in the State Center." In Exhibit A: Procedures, the only guidance to the Facility is that the IDT will review the individual's capacity to make decisions regarding his or her health and welfare at the annual meeting Policy 019 did address other requirements pertinent to Provision U1, including the development and maintenance of a prioritized guardianship list. The policy stated that the "IDT" would prioritize the guardianship list, but also assigns responsibility for "developing, prioritizing and maintaining" the list to a Guardianship Committee. Exhibit A: Procedures also indicated it would be the responsibility of the Committee to make the prioritization. DADS should clarify its intent. The prioritization criteria contained in DADS Policy 019 were identical to the requirements in the SA, 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. The policy indicated that individuals would be assigned to one of three priority levels, depending on the number of factors that pertained to them. Priority I was to be assigned to individuals who met three of four criteria, Priority II to those who met two of four, and Priority III to those who met one of four. Exhibit A: Procedures calls for the Guardianship Committee to consider the following criteria: whether the individual has an actively involved person to advocate for him or her; a pattern of injury, abuse or neglect; receives or is proposed to receive a restrictive program; receives psychoactive medication; has serious, ongoing medical needs; and/or has severely impaired communication. It was not clear how these two sets of criteria were meant to be integrated. DADS should clarify its intent in regard as well. The Monitoring Team remained concerned that the new policy, while requiring IDTs to	Noncompliance

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		make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. It was reported that a workgroup continued to work toward developing such guidance but there was no known projected date for formal issuance of an approved Rights Assessment methodology from DADS. Since the guardianship policy requires the teams to make this capacity determination, it would seem to be essential that the guidance be provided at the same time the guardianship policy is implemented. Otherwise, the Facility runs the risk of inappropriately identifying need for guardianship that, if acted upon, could result in an individual unnecessarily losing rights to make and/or participate in his or her own decisions. The statewide policy also called for the HRO to maintain data, including a list of individuals without an LAR; names and priority levels of individuals referred to the Guardianship Committee; status of the referrals; and dates guardianships were secured. These data were to be entered into a DADS statewide database. In addition, the Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. The Facility had localized DADS Policy 019 in RSSLC Policy C.3: Guardianship, dated 3/7/2012. The local policy was consistent with the DADS document. <u>Maintenance of Prioritized List:</u> The Facility maintained a prioritized list, using prioritization ratings from one (most in need) to three (least in need). The Monitoring Team reviewed the Priority List, dated 04/20/2012, which contained 182 names. The HRO had engaged the Social Work staff to review and provide feedback as to each individual's status and whether changes had occurred that would affect the prioritization. It was not clear this had been adequately completed, as the list still included names of individuals who had moved from the Facility more than six months ago. The Monitoring Team recommends the Facility examine its current list for such errors and complete an update to reflect the necessary corrections. <u>Assessment of Functional Capacity to Render a Decision:</u> The Facility did not routinely use standardized or valid instruments and/or processes to assess functional capacity, so the decision to place someone on the prioritized list was still without a sound basis for	

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		the most part. As a part of its response to the document request, the Facility provided a copy of a draft Rights Assessment it had received from DADS. This Rights Assessment document, Form 6614, dated September 2011, included an expanded section for assessing an individual's ability to provide informed consent, although no instructions were provided for staff as to how to implement the expanded Rights Assessment. Although the HRO was aware that another SSLC was piloting the use of this draft Rights Assessment, he reported he had received instruction from DADS state office to wait for the formal issuance of the policy and tool before proceeding with its use. While awaiting the go-ahead, the HRO was in the process of developing a curriculum and Power Point to be used to provide training for staff. The training is intended to include a competency component, but this had not yet been developed. During the past six months, the IDTs continued to address the ability of an individual to provide informed consent using the annual Rights Assessment dated 05/07/10, but this process was not predicated on any objective criteria. The Monitoring Team requested for review the most recent ISP for each residential unit, including the Rights Assessment. Of the seven ISPs provided in response to this request, six packets included a current Rights Assessment. For six of the six reviewed (100%), the IDT concluded the individual was unable to give informed consent in any of the six areas listed. There was rarely any specific basis offered for this determination in the way of an individualized assessment of the individual's decision-making capacity. In only two of six (33%) instances did the IDT make some attempt to provide a rationale for the determinations, but these were not based on any formal assessment process. In none of the six Rights Assessments (0%) did the IDT document any strategies to improve the individuals' decision-making skills. This finding was borne out in observations made by the Monitoring Team of ISP meetings during the site visit. For zero of four (0%) did the IDT undertake any significant discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent. The Monitoring Team also attended the HRC meeting held during the week of the compliance visit in which the committee reviewed the Rights Assessment for Individual #268 and found the HRC review of the informed consent assessment portion was not yet being implemented in a rigorous manner. The HRC did not question the team representative in any depth as to the assessment and IDT deliberation processes for the informed consent section. It did not require evidence of ISP strategies to enhance decision-making capacity that were relevant to individuals' identified needs in the informed consent areas. The HRC review of informed consent restrictions should be used to help guide IDTs toward providing more training and support for individuals' decision-making capacities. <u>Conclusion:</u> This Provision was found to be not yet in compliance. The Facility did	

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		maintain a list of individuals it deemed to be in need of a guardian that was updated regularly, although some errors were found that were more than six months old. The list was prioritized according to criteria as described in new policy but the determination of need was not predicated on any formal or standardized process or tool.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	<u>Policies and Procedures related to obtaining LARs for individuals in need:</u> DADS Policy 019: Guardianship, effective 3/7/2012, also provided guidance and protocol as to obtaining LARs for individuals who may need one. The Policy designated the Facility HRO to act as the Guardianship Coordinator. Specific duties of the Guardianship Coordinator include the following: • Establishing a Guardianship Committee that meets regularly to discuss guardianship needs at the State Center; • Working with the QDDP Coordinator and QDDPs to develop and maintain a prioritized guardianship list of individuals in need of a guardian; • Providing information to the State Center's Parent/Family Association members regarding alternatives to guardianship and local guardianship programs and resources; • Sharing appropriate information regarding individuals in need of a guardian with local guardianship programs as permitted by law; • Soliciting information from local guardianship programs regarding community supports available to assist with guardianship fees, court costs, and other expenses; and, • Organizing an annual guardianship in-service for individuals, families, staff and other interested parties to discuss guardianship, alternatives to guardianship, the benefits and disadvantages of guardianship, limitations to guardianship, types of guardianship, who can and cannot be a guardian, and other relevant topics. The Policy also required the Facility to develop a Guardianship Committee. According to the policy, the Guardianship Committee is responsible for developing, prioritizing and maintaining the prioritized list as described in Provision U1. Other responsibilities or requirements found in the policy include meeting regularly to discuss guardianship needs at the center and maintaining meeting minutes that include: requests for guardianship services, the date of the meeting, members in attendance, items reviewed and decisions made. It was unclear whether the Guardianship Committee was expected to somehow act on requests for guardianship services, other than in developing and maintaining the prioritized list. The actual responsibilities of the Guardianship Committee should be clarified. RSSLC had localized DADS Policy 019 in RSSLC Policy C.3: Guardianship, dated 3/7/2012	Noncompliance

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		as described in Provision U1. There were no significant differences from the statewide policy as they related to the roles and responsibilities of the Guardianship Coordinator and the Guardianship Committee. Facility Efforts to Obtain LARs: The Facility reported no new LARs had been obtained for individuals living at RSSLC during past six months, nor had there been any significant organized efforts toward appropriately obtaining LARs. New processes prescribed by DADS Policy 019: Guardianship, effective 3/7/2012, were in the very early stages of planning. Findings included: • Guardianship Committee: The Facility had not yet established a Guardianship Committee, as required by the DADS and local policies. The HRO reported recruitment for membership was underway, but only three potential members had been identified thus far. The HRO reported the Facility was in the process of ensuring these proposed members met all of the criteria for membership as described in the policies. • Advocacy Program: RSSLC did not have an active Advocacy Program at this time. The HRO office reported the Facility was awaiting the issuance of an anticipated statewide policy before initiating this program. • Self-Advocacy Program: The HRO was also responsible for providing support for the Self-Advocacy Committee. The Monitoring Team reviewed the minutes of Self-Advocacy meetings held since the last monitoring visit. As the HRO reported, the minutes reflected a declining participation. The HRO was attempting to try differing scheduled meeting times to accommodate individuals' other interests and activities, but reported this had meet with little success thus far. The Monitoring Team suggested that self-advocacy not be seen as just a meeting, but should be incorporated into an ongoing program of active treatment for all individuals. The Monitoring Team also recommended, in support of this concept, the 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 on an ongoing and formative basis. 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. In that same vein, the Monitoring Team was pleased to see the integration of the office of the Transition Coordinator with self-advocacy in sponsoring a poster contest about what community living means to individuals, as this assists individuals to examine their own understanding and preferences about community living and	

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		could contribute to enhancing staff understanding of individuals' awareness and interests in this area. • Other Activities of the Guardianship Coordinator: Other activities included: o The HRO continued to provide inservice on guardianship and advocacy on a monthly basis in new employee orientation. The Facility had also expanded training on these topics to include incumbent employees. The Monitoring Team commends the Facility for these initiatives. o The HRO organized Voter Registration training for both individuals and staff. Conclusion: This Provision was found to be not yet in compliance. As part of undertaking an effective and appropriate large-scale effort to solicit guardians, RSSLC should ensure it has an appropriate methodology in place to determine the actual need for guardianship. DADS should provide guidance through the formal promulgation of such a procedure as part of policy as soon as possible.	

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

1. The Facility should consider developing specific measurable outcome indicators to be reviewed in addition to the fairly subjective process measures in the current Self-Assessment. (Self-Assessment)
2. The actual responsibilities of the Guardianship Committee under DADS Policy 019: Guardianship, effective 3/7/2012, should be clarified. (Provisions U1 and U2)
3. DADS should clarify how the two sets of criteria for prioritization found in DADS Policy 019: Guardianship, effective 3/7/2012, are meant to be integrated. (Provision U1)
4. The Facility should examine its current prioritized list for errors and complete an update to reflect the necessary corrections. (Provision U1)
5. DADS should provide guidance as to the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. Since the guardianship policy requires the teams to make this capacity determination, it would seem to be essential that the guidance be provided at the same time the guardianship policy is implemented. (Provision U1)
6. The HRC review of informed consent restrictions should be more effectively structured so as to help guide IDTs toward providing more training and support for individuals' decision-making capacities. (Provision U1)
7. The HRO should provide ongoing training to QDDPs and other IDT members on the process of assessing an individual's capacity to provide consent and/or participate in decision-making regarding the individual's health or welfare. The training should be competency-based. (Provision U1)
8. The Facility should 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. (Provision U2)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-assessment 5/1/12 2. RSSLC Action Plan 4/27/12 3. RSSLC Presentation Book for Section V 4. DADS Policy #001: Use of Restraint 4/10/12 5. DADS Policy 020.1 Recordkeeping Practices 3/05/10 6. DADS Policy 003.1 Quality Assurance 1/26/12 7. DADS Policy 019: Guardianship, effective 3/7/2012 8. DADS Draft Policy 004.1 Integrated Support Plan Process undated 9. RSSLC Policy A.1 Developing/Revising a Policy or Procedure 2/14/12 10. RSSLC Policy A.6 Recordkeeping 4/10/12 11. RSSLC Policy A.28 Quality Assurance 1/26/12 12. RSSLC Policy B.6 Criminal History Checks: Guidelines for Employment 11/13/11 13. RSSLC Policy B.20 Attending PMAB Training 3/7/12 14. RSSLC Policy C.2 Protection from Harm: Abuse, neglect, & Exploitation 12/20/11 15. RSSLC Policy C.3 Guardianship 3/7/12 16. RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation 11/17/11 17. RSSLC Policy I.15 Actions Following Choking Incident 2/2/12 18. RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 3/19/12 19. RSSLC Policy I.34 Medication Variances 2/27/12 20. RSSLC Policy K.2 Providing Mechanical Supports 2/27/12 21. RSSLC Policy K.3 Providing Adaptive Equipment 2/27/12 22. Policy Approval forms and training documentation for above policies 23. Settlement Agreement policy list undated, provided in email from DADS of 2/6/12 24. Policy and Procedure (P&P) Committee minutes of 12/2/11, 12/7/11, 12/14/11, 1/4/12., 1/18/12, 2/8/12, 2/29/12, 3/7/12, 3/14/12, 4/4/12, 4/11/12, 4/25/12, 5/2/12, and 5/9/12 25. QA/QI Council Meeting Minutes of 12/6/11, 1/3/12,, 3/27/12, and 4/17/12 reporting on formation of the P&P Committee and updates on status and actions 26. Quality Assurance Department Meeting minutes of 3/13/12 27. Training sign-in sheets on the revised RSSLC Quality Assurance policy for the department and the QA/QI Council 28. RSSLC Policy Approval form for Policy A.1 29. Documents regarding training on Policies K2 Providing Mechanical Supports and K3 Providing Adaptive Equipment a. Email from Ping Law of 2/27/12 providing notice of implementation and that staff have ben trained b. Competency quiz

	c. Sign-in sheets 30. Sign-in sheets for training on LOS Policy E1 and samples of completed tests 31. Process for Monitoring Documentation Done by New Employees Following NET (new employee training) and On the Job Training and follow-up documentation from January 2012, and email from Susan Steamer of 3/28/12 32. Active Record Order & Guidelines 6/24/11 33. Table of Contents of Master Record 4/18/12 34. Individual Notebook Equivalent & Guidelines 4/10/12 35. Checklist for Minimum Documents Included in Master Record 36. Draft process for monitoring Overflow 3/21/12 37. Draft instructions for the Virtual Client Folder (VCF) 4/5/12 38. Active records for Individuals #306 and #508 39. Active record, group notebook, and master record for Individual #232 40. Records audit tools a. Settlement Agreement Cross-Referenced with ICF-MR Standards, Section V (the monitoring tool), guidelines form (revised April 2011), and list of definitions/criteria for use of this tool (8/29/11) b. Active Record Order & Guidelines (AROG) revised 3/12/12 c. Individual Notebook and Guidelines revised 3/17/11 d. Interview Tool for use of the Record Guidelines and instructions for implementing the interview 41. Description of process titled Section V-Recordkeeping Internal/External Monitoring 42. Completed audit tools and emails tracking corrective actions required (including Corrections Needed forms) for records audited for Individuals #30, #98, #120, #137, #159, #300, #413, #471, #518, and #798 43. Completed audit tools for audits conducted in April 2012 by Unified Records Coordinators (URCs) for Individuals #24, #76, #184, #354, #358, #375, #612, #714, #729, #792 and by the Program Monitors for Individuals #24, #76, #354, #729, and #792 44. Corrective Action Plan from "QA-QI Meeting: 2-14-12" to train Residential Coordinators, and slides and test used for training 45. Settlement Agreement Provision V.4—Interview Tool for use of the Record, Guidelines, and completed forms for Individuals #24, #120, #358, and #798 46. Interrater Reliability data sheet for Individual #24 47. V—Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 Level of Agreement data report 3/1/12-4/30/12 48. Section V Count of Internal Audits and Count of External Audits 4/1/12-4/30/12 49. Active Record Checklist blank form for records checks done by unit clerks 50. PSP Assessments Tracking Sheet for Individual #789 51. Section V Trend Analysis Report provided to QA/QI Council for months of February 2012 through April 2012, including monthly graphs of compliance by monitoring tool, Data Analysis Report with the findings of 32 audits item-by-item, and Inter-Rater Reliability data sheets for five individuals audited in March 2012, and narrative summary of analysis

	52. Section V Monitoring Tool Facility Random Sampling List for May 2012 53. Monitoring Documentation Done by New Employees After NET (New Employee Training) and On-the-Job Training document and the list of nurses receiving follow-up monitoring in January and March 2012 54. PSP Discipline's Assessments Tracking Worksheet and folders on Virtual Client Folder (VCF) for Individual #789 **People Interviewed:** 1. Group interview of Wanda Hartensteiner, Medical Records Director, and Unified Records Coordinators (URCs) Tracy Stafford and Susan Steamer, and program monitors Andrea Faniel, Suzanne Royer, and Adelia Pavliska 2. Joan Poenitzsch, Director of QA, and Brenda McClendon, Program Auditor 3. Group interview of Program Monitors 4. Carol Agu, QDDP Coordinator, Jacqueline North, QDDP Educator, and Netta Bridgewater, Sherri Zirbes, Crystal Baker, LaTanya Akosede, and Mia Lunn, QDDPs 5. Tran Quan, D.O., Medical Director 6. Ping Law, OTR Director of Habilitation Services 7. Residential Coordinator and direct support professional (DSP), San Antonio D 8. DSP in Leon D **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #462 and #508 2. Records storage in San Antonio D
	Facility Self-Assessment: RSSLC had made considerable revisions to its Self-Assessment, previously called the Plan of Improvement (POI). In the new format, the Facility described, for each provision item, the activities the Facility engaged in to conduct the Self-Assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance, along with a rationale. That was an improvement in the Facility self- assessment activity. For Provisions V1, and V3, the primary activity was the review of active records (the records audits). For Provision V3, the Facility also reviewed data post training to determine if the level of compliance has increased, and developed a quality assurance process to address systemic issues. The Facility reported on specific areas of low compliance, provided inservice on those, and found continuing low compliance in those areas (and reported further training to be done). This indicates that the self-assessment drew from quality assurance data used by the Facility for regular reporting, a positive finding. It also indicated that follow up was done to determine effect of corrective action, also a positive finding. For Provision V4, related to use of records, the Facility used the State Office Section V Interview Tools. Those are useful, but the Facility reported discrepancies between internal and external monitors. However, there should be additional measures of practices that reflect use, or lack of use, of records, such as timely availability of assessments, use in planning meetings of the records or data from the records, and use of the records to guide daily implementation of programs and services.

	For Provision V2, related to development of policies, the Facility reported that 20 policies were implemented or revised between the last compliance visit and 4/4/12, and that a policy that standardized the policy development process had been developed and revised. These are important findings. The Facility also needs to identify which policies still need development in order to implement all the requirements of this Settlement Agreement. The Facility reported that none of the provisions of this Section were in compliance. The Monitoring Team, while recognizing many improvements, concurs. The Facility also provided an Action Plan intended to move toward compliance with provisions of this Section. The Action Steps for Provisions V1, V2, and V3 were, for the most part, sequential. It was clear that gaps in processes had been identified, and that steps had been established to address those. A number of the steps in the Action Plan had already been completed. These plans were well-organized. The Facility might want to identify the outcomes desired, to make clear what the steps are intended to accomplish when completed. The Action Steps for Provision V4 were more general and addressed two different issues—the posting of assessments in the Virtual Client Folder, and the use of records by staff. It would be better for these to be separate actions with their own sets of sequential steps and with some objective to make the desired outcome clear.
	Summary of Monitor's Assessment: RSSLC showed progress in all provisions of this Section. The Facility maintained a unified record for each individual. Since the last compliance visit, the Facility had begun to audit the Group data notebook, in recognition that this notebook is part of the unified record and therefore subject to the audit requirements of Provision V3. For Provision V1, the Facility had policy to guide recordkeeping and that included all requirements of the DADS Recordkeeping policy. An Active 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 binder. Records were accessible to staff, and staff could identify where in the records to find documents. Most, but not all, documents that were required to be in the Active Record were present. Legibility had improved, although the Facility had identified legibility as an area of low compliance and had provided training. Nevertheless, there were a large enough number of documents not present and of other types of errors so that the Facility had not yet reached substantial compliance. Given the continuing improvement and the potential for systemic improvements resulting from audit information, the Facility should be able to resolve continuing issues, minimize errors, and establish a compliant unified record. For Provision V2, there has been continuing development and implementation of policies to address the requirements of the Settlement Agreement. There are still policies that need to be developed or revised at

	both the DADS and Facility levels. Furthermore, continuing efforts must be made to ensure policies are implemented accurately. One action to improve implementation is to identify the training needed and track completion of that training; RSSLC had developed such a process. For Provision V3, there is a robust audit system in place. The audit system had been revised to involve interrater reliability audits between the Unified Records Coordinators and the program monitors. This was a recent change; in the past, the URCs did reliability audits on records audited by the Unit clerks. Unit clerks now do more focused audits, thus providing an additional layer of review. Agreement between the URC and Monitoring Team on one record showed acceptable agreement on the presence of documents but not on the monitoring tool. The Facility will need to revise the instructions and item definitions as the URC/program monitor reliability checks identify disagreements. Nevertheless, this change was a positive step that should help develop compliant audits and compliant records. Corrective actions were taken on errors discovered in audits. The URCs follow up to check on those corrections. The Monitoring Team found that corrections reported to have been made actually were made. Although some of the people responsible for making the corrections notify the URCs when they are done, there is no requirement to do so. The URCs then take time to do checks even for actions that have not been completed. The Monitoring Team recommends that the Facility consider requiring staff responsible for making corrections to notify the URC when the corrections have been completed. For Provision V4, clinical staff report use of information in the record for making decisions. Monitoring Team interviews and observations noted use of the records. However, assessments are not posted timely so they can be reviewed by the IDT in advance of ISP annual meetings and used in making planning decisions. Observations of daily services and supports indicated the information in the records is not used to guide the actual services provided in residential and activity settings. Although no provisions were in compliance, the Monitoring Team recognizes the significant improvements that have been made.

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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.	<u>Policy</u> Recordkeeping was guided by RSSLC Policy A.6 Recordkeeping, which was revised 4/10/12. This policy was consistent with DADS recordkeeping policy and with Appendix D of the SA. In addition, the facility policy contained additional information and notes to operationalize the policy (for example, to identify the specific offices or staff responsible for certain actions and to add requirements such as chart check-out procedures). The policy included an attachment that described disciplinary actions for falsification of records; this attachment included illustrative examples of prohibited practices. The policy was revised since the last compliance visit to reflect change in the records audit process.	Noncompliance

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		Unified Record The Facility maintained a unified record for each individual. The unified record at RSSLC consisted of an Active Record, Master Record, and an individual notebook equivalent section of a Group Notebook, as well as an Overflow record kept with the Master Record in the Medical Records area (and, based on state records retention guidelines, eventually sent to the state contractor for off-site maintenance). The Active Record was the primary document with information about the individual's current status and about the supports and services being provided. 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. The binder for each chart was labeled by volume for ease in finding the correct chart for a specific document (e.g., Chart 1 of 2, Chart 3 of 3); all records reviewed by the Monitoring Team were labeled in this way. The individual notebook equivalent contained information needed by people providing daily service and held the ISP, PNMP, PBSP, communications strategies, and current forms for recording health status and data on PNMP, skill acquisition and behavioral programs. When documents are purged from the Active Record, they are to be sent to Medical Records to be placed in the Overflow Record; the Master Record contains other documents, such as legal documents including birth certificate and guardianship papers. 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 IDT. Other books (the monthly flow notebook, dining book, SAMS book, and Active Treatment book) contained raw data that was not considered to be part of the unified record but was, instead, considered working notes; each month, a progress note summarizing information from these books was entered into the Active Record. Furthermore, active Acute Care Plans were kept in the Care Plan Books on the Units/Homes for ready access. When active problems were resolved the Acute Care Plans were filed in the unified record. The Care Plan Books were not part of the unified records. Also, the original Health Management Plans were maintained in individuals' unified records with working copies placed in the Care Plan Books on the Units/Homes for ready access; there is the potential that individuals' original Health Management Plans may not be updated if the working copies in the Care Plan Books were updated. The Facility should implement a process to ensure documentation that is not part of the Unified Record is consistent with the Unified Record.	

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		Consistency of Unified Records with Policy and Guidelines 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 #232, #306 and #508, as well as the Group Notebook and Master Record for Individual #232. Individual #232 was selected by computerized random selection from among records to be audited in May 2012, so the Monitoring Team could compare its findings with those audited by a URC on the same day; this process and the findings are described in Provision V3. Although records were generally in order and, for the most part, complete and legible, none of the Active and Individual records met all the requirements of Appendix D or of Facility policy. Completeness of Active Record and Group Notebook: For the Active Record, the Monitoring Team checked for the presence of each applicable item on the Active Record Order & Guidelines. Many documents are not applicable in every record. For items that could have many pages or documents (for example, Observation Notes or SPOs), the item was marked not present if the Monitoring Team identified missing documents. The Monitoring Team made an effort through review of other documents in the record to determine whether each 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. Numerous applicable documents were not present in the Active Record. Findings on percent of required documents present in the records reviewed showed, for the documents determined by the Monitoring Team to be applicable: • For Individual #232, 74% of documents were present. • For Individual #306, 75% of documents were present. • For Individual #508, 76% of documents were present. However, one artifact may have caused these percentages to be lower than actually the case. A number of documents are asterisked on the AROG and audit tool; some of these do not appear actually to be required for each record. The Monitoring Team made an effort to determine whether a document was actually required, but if this could not be clearly determined, marked those as applicable (meaning that the lack of that document was considered to make it "not present"). Nevertheless, there were many documents that were clearly required, not asterisked, and not present. The percentages of documents present in these records was relatively consistent with the percentage found at the last compliance visit, but slightly lower.	

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		The Monitoring Team reviewed the individual section of the Group Notebook for Individual #232 at the living unit. A DSP was asked where the Group Notebook would be, and she went directly to the shelf where these were accessible to the DSPs working with individuals and pulled the correct notebook. The Group Notebook was well organized and in good condition. All nine required documents (100%) were present. Furthermore, the residential coordinator, when asked, showed where in the individual section to find the ISP, PNMP, and data sheets. Consistency with Appendix D Requirements: One area of significant improvement was legibility. Except for a few signatures, all documents were legible. This improvement was confirmed by review of numerous other records by the entire Monitoring Team; for example, legibility was reported as an area of improvement in Provision M1. To ensure the ability to track who documented, signatures need to be complete and legible, and documents for which initials are provided need to have an initial legend. The initial legend for MARs was with the MARs themselves. Although the MARs do need to have an initial legend with them, the active record should also have an initial legend so that it is possible to track all entries, especially since nurses are permitted to sign with first initial and last name. Furthermore, some physicians signed their names legibly or printed their names and also signed, and others used a name stamp and also signed, but there were instances in which names were not legible, and the consultation forms are initialed by the Facility physicians who reviewed them; it would be helpful to have an initial legend for physicians and also to have a standard process (print name, use name stamp, or use signature legend sheet) for physician signatures (of course, a legend sheet and also continue to use name stamp or print would be even more useful). There were numerous instances in which documents in the Active Record were not in order. Some documents were filed in the wrong tab or in a different order within a tab than dictated in the AROG. Some documents were not filed in reverse chronological order. Although many of these problems with order of documents were minor issues of placing one document before rather than after a related document, some could have caused problems in finding and using important information. For example: • In the Active Record for Individual #306: o Social Service notes were filed in chronological, rather than reverse chronological order. Client injury reports for this individual were filed out of chronological order, raising the possibility that staff seeking information about injuries as they did assessments might miss a relevant injury report. PSPAs were also filed out of chronological order, raising the possibility of missing ISP revisions that were currently in effect.	

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		o The Safety Plan authorization (HRC addendum) was filed in the Community Programming Resources tab, where it could be missed when reviewing materials for rights assessment. o The Immunization Record was filed in the X-ray tab, which could lead to problems in identifying what immunizations had been provided or were required. • For Individual #508: o Some observation notes were filed in the Community Programming Resources tab following the CLOIP, so information from those observations might not have been noted when needed. o A drug utilization review form was filed in the X-ray tab. • For Individual #232: o Documents in the Social Service tab were filed haphazardly, with contact notes interspersed with other correspondence. A consistent problem was the presence of gaps at the bottoms of pages. These were found in observation notes, IPNs, and physician orders for all three records reviewed. This was confirmed by review of IPNs, as reported in Provision M1. Some documents that should have been purged and sent to the overflow record remained in the Active Record. The Facility has developed and is pilot-testing a process to check and ensure documents that should be purged are sent to the overflow record. As reported in Provision M1 for nursing documentation, approved abbreviations were consistently used with rare exception. Therefore, although the records were generally in compliance with Appendix D requirements, there were enough errors to prevent a finding of substantial compliance. <u>Timeliness and Availability of Documents</u> As reported in Provision L1, there were examples in which documents needed for planning and follow up of treatment were not always filed in the active record timely. For example, for Individual #448, assessment assessment of a pacemaker appeared not to have been done. In fact, it had been done during the week before the compliance visit but not filed in the record. As reported in Provision F1c, assessments were to be posted to the Virtual Client Folder/share drive no later than ten days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. This expectation had recently been changed to 15 days prior to the meeting. The Monitoring Team found, as reported in Provision F1c, that even for the ISPs held	

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		during the week of the compliance visit, not all assessments were available. The Monitoring Team also reviewed the assessments available on the shared drive for a sample of ISPs upcoming over the next ten days. Zero of ten (0%) had all required assessments available and/or posted by the required date. <u>Accessibility and Security of Records</u> Active records were kept at each home in the staff station, which was locked but accessible to all staff. Group Notebooks were kept in each home, in a place accessible to staff but still not open and visible to people who did not need access. The Monitoring Team observed the active records in San Antonio D and the Group Notebooks in San Antonio D and Leon D; at no time during other observations were records noted to be out and visible except when being used. <u>Training of Staff on Documentation</u> All staff are trained on documentation during New Employee Training (NET). Following training, according to report from the Medical Records Director and URCs and a document they provided giving the steps in follow-up monitoring, a sample of at least 20% of employees in each position that is expected to document (including DSPs and clinicians) receives a follow-up assessment in which URCs check documentation and follow-up training as needed. This is an excellent process that should lead to improved documentation. <u>Virtual Client Folder (VCF)/Share Drive</u> 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 IDT. Policy F.5 on PSP documentation requires IDT members to file their assessments and recommendations on the Share drive 10 days prior to the PSP meeting. As reported in Provisions V3 and F1c, 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 ISP, 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 IDT. 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 IDT members. The Facility had developed a draft procedure for the VCF that provides standard procedures for its use.	

#	Provision	Assessment of Status	Compliance
		Conclusion 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. Nevertheless, the lack of improvement in the records since the last compliance visit indicates that these actions have not yet produced improvement. Per interview with the Medical Records Director, URCs, and Program Auditors, there is not yet an expectation that responsibility for improvement in the records belongs to the department heads and unit supervisory staff. While the audit process reported in Provision V3 is robust, the Facility needs to emphasize to those management and supervisory staff that the audits provide them with information that should guide them in acting to ensure improvements in documentation occur.	
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. Local Policies and Policy Development Process Joan Poenitzsch, Director of QA, and Brenda McClendon, Program Auditor, provided information about the process of policy development, revision, and implementation. One improvement was the implementation of RSSLC Policy A1 Developing/Revising a Policy or Procedure. This policy provides a clear process for identification of needed policies and revisions, review of policies at least every three years, assignment of persons responsible for drafting and coordinating development and revision, determination and implementation of notice and training required when a policy is implemented or revised, and approval of new and revised policies by Facility management and a Policy/Procedure Committee. The Facility provided the Monitoring Team with samples of documents that demonstrated notice of revised policies and training (including competency tests). Per interview, a policy approval form includes information for tracking decisions—name of policy, who coordinated development or revision, a summary of the changes made in the policy, and the notice or training that the P&P Committee determines is needed; the program auditor stated she is developing a status sheet that she uses to track receipt of copies of sign=in sheets, curriculum/outline, and tests. The Facility Action Plan includes an action step to develop a process to assess whether new policies are implemented accurately, to be in place by the end of 2012. The Facility had developed or revised numerous policies since the last compliance visit. New and revised policies relevant to implementation of this SA included: • RSSLC Policy A.1 Developing/Revising a Policy or Procedure 2/14/12	Noncompliance

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		• RSSLC Policy A.6 Recordkeeping 4/10/12
		• RSSLC Policy A.28 Quality Assurance 1/26/12
		• RSSLC Policy B.6 Criminal History Checks: Guidelines for Employment 11/13/11
		• RSSLC Policy B.20 Attending PMAB Training 3/7/12
		• RSSLC Policy C.2 Protection from Harm: Abuse, neglect, & Exploitation 12/20/11
		• RSSLC Policy C.3 Guardianship 3/7/12
		• RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation 11/17/11
		• RSSLC Policy F.5 Person Directed Planning & Active Treatment: Completing Personal Support plan Meeting Documentation 11/17/11
		• RSSLC At Risk Individuals Policy, I.08, Effective: 5/11/12
		• RSSLC Policy I.15 Actions Following Choking Incident 2/2/12
		• RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 3/19/12
		• RSSLC Policy I.34 Medication Variances 2/27/12
		• RSSLC Policy K.2 Providing Mechanical Supports 2/27/12
		• RSSLC Policy K.3 Providing Adaptive Equipment 2/27/12
		
		Departments had also developed or revised policies that addressed issues relevant to compliance with the SA, including the following:
		• Chronic Clinical Indicator policy—as reported in Provision L3, this policy was implemented on 10/12/11, and provides an overview of identifying, developing, and implementing core indicators to be used for quality assurance and clinical improvement efforts.
		• Since the last review the Infection Control Nurses had focused their efforts on updating the Infection Control Program's Policies, Procedures, and practices.
		• A RSSLC Integrated Neurology Clinic Policy was implemented 4/17/12
		
		Some policies still needed development. For example:
		• Speech Policy did not exist that provided clear operationalized guidelines regarding, among other things:
		  • Staff responsibilities
		  • Frequency of assessments/updates
		  • Criteria for providing update vs. full assessment
		  • Methods of tracking progress and documentation standards
		• DADS policies for Most Integrated Setting and Rights remain in draft form.
		
		<u>Statewide Policies</u>
		DADS provided a list of policies referenced to the SA. According to this list, Policy 003.1	

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		Quality Assurance had been revised and made effective since the last compliance visit. RSSLC revised its Facility-specific quality assurance policy to reflect DADS policy revisions and provided QA Department Meeting minutes and training sign-in sheets for the department and the QA/QI Council to document training. As reported in Provision U1, DADS State Office had issued a new Policy 019: Guardianship, effective 3/7/2012, with five Exhibits; please refer to Provision U1 for discussion of this policy. RSSLC had revised its local policy to be consistent with DADS policy. The Facility had begun to take some beginning steps toward implementing the requirements of the policy, such as recruitment of members for the Guardianship Committee, and the development of materials to be used for staff training. DADS had recently issued Policy #001: Use of Restraint. This policy included several significant changes in procedure and documentation requirements. The Facility had not yet revised its local policy. This policy was effective 4/10/12 and the training provided to facilities on policy implementation encouraged facilities to convert restraint practices to the new policy requirements in an orderly manner as staff received training. As noted in the spreadsheet provided by DADS of status of policy development, some policies still were in process of development. For compliance, both DADS and the Facility must: • Complete development, revision, and implementation of policies needed to implement all provisions of the Settlement Agreement. • Ensure policies are fully and accurately implemented.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each	At the time of the last compliance visit, the Facility had a robust mechanism in place to do random audits of 15 records per month, done by records clerks, with interrater reliability checks of 10 of those records done by URCs. These audits did not include the individual notebook equivalents in the Group notebooks, nor did they include the other books that the Facility does not consider part of the unified record (the monthly flow notebook, PNMP notebook, or Active Treatment book). In addition, a group of program monitors audited the group notebooks and Chart 1s of about 20 individuals per month, not selected randomly. Although program monitors used a different form for recording audit findings, they reported some of the same kinds of errors found by the records clerks and URCs. This process had undergone significant revision in March 2012, in response to a recommendation from the Monitoring Team to coordinate the two separate audit processes in order to facilitate decision-making on improvement initiatives and to develop a unified corrective action system. Prior to the last compliance visit, a workgroup had begun to meet to look at trends and determine actions to take; the	Noncompliance

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	review to ensure that adequate corrective action is taken to limit possible reoccurrence.	role of this workgroup expanded to discuss the audit processes. <u>Interrater Reliability between URCs and Program Monitors</u> Beginning in March 2012, the URCs and program monitors began to audit the same records using the same format. They now all reviewed a sample of Active Records (all charts) and the group notebooks. Audits done by URCs were referred to as Internal Audits; audits done by program monitors were referred to as External Audits. Under this new process, each URC reviewed five randomly selected records per month, for a total of 10; the program monitors independently reviewed a sample of five of these 10 (a 50% validation sample) at the same time they were reviewed by the URCs, in order to determine interrater reliability. A database maintained by the data management department was used to select the random sample of 10 names from the whole population (not by unit) for URC review. This was done with replacement, so the same individual's record could be selected two months in a row. Program monitors selected one from each unit represented in the random sample and then filled out the rest non-randomly. Audits were done at the same time; records were not available for entries during the audits. They each entered their item-by-item findings for the monitoring tool into the Record Keeping and General Plan Implementation Provisions 1, 3, and 4 database, which calculates agreement. A separate report by individual listed each item on the monitoring tool and the rating or "Y/N/NA" given by the URC and by the program monitor and calculated percent agreement for the individual's record. The Facility provided both the report of data for March and April 2012 and copies of the audits. The Level of Agreement report provided the percentage of agreement between URCs and program monitors for each item on the monitoring tool across all records for which the program monitors did audits. For March through April 2012, the only months for which URC/program monitoring was done, item agreement ranged from 20% (for "If only initials needed, includes legend") to 100%, with 18 of the 29 items having agreement of 80% or 100%. These indicate that the Facility should identify items with low agreement and revise the definitions or provide written examples for specific items of documentation that should be rated "Y," "N," or "NA." The URCs and program monitors reported they discuss the interrater reliability findings after they are entered each month. They discuss why there are differences and try to get an understanding. They do not change any answers. The Monitoring Team recommends that any understandings or changes in definitions must be kept in writing so they can be provided to anyone auditing the records; if this is not done, the definitions may change by agreement of the URCs and program monitors but without any official approval or	

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		permanent record, and the trends data over time may change even if the records themselves do not improve. The new process for determining interrater reliability was thorough and identified areas needing improved definitions. It brought together the URCs, who audit records, with the program monitors, who audit a number of relevant areas in addition to records; this should ensure not only that record audits are accurate but also that information learned through other quality assurance activities can be used to improve audits and to provide management with information needed to train and monitor performance of responsible management and supervisory staff. In addition, the Facility reported that URCs began attending Program Monitors Work Group meetings to discuss program monitoring, issues, and trends; this could provide a venue to identify ways to increase use of the records for both decision-making regarding individuals and for integrating record audit information into overall quality assurance activity. <u>Agreement in Ratings Between URC Audit and Monitoring Team Audit</u> On the Settlement Agreement Cross Referenced with ICF-MR Standards, the Monitoring Team and URC had 67% agreement on 27 items (the Monitoring Team did not score two items--the Interview Tool for V4, which would not yet have been completed for this record, and whether electronic records for this individual are protected through security access or pass codes). Six items marked "Y" by the URC were marked "N" by the Monitoring Team, one marked "N/A" by the URC was marked "Y" by the Monitoring Team, and two marked "N" by the URC were marked "Y" by the Monitoring Team. This does not mean one or the other rated more accurately; instead, it indicates likelihood that better definition for the rating items is needed. Given the much higher agreement between the URC and program monitors, it is likely they have developed understandings of the requirements for items that have not been written in the definitions. The definitions need to continue to be improved; to determine whether the definitions are adequate, it would be good to have an independent auditor who has not been part of the discussions about ratings do a rating periodically. However, on the AROG, agreement between the Monitoring Team and the URC was 82%. Generally, this would indicate an acceptable level of agreement. Twenty of the 30 disagreements involved items for which the URC marked "N/A" but the Monitoring Team marked "Y" or "N"; for 17 of these 20 items (only one of which was an asterisked item), the Monitoring Team marked "N." This raises the likelihood that many, or even all, of these were not actually required documents. If this were clear on the AROG, agreement might actually be much higher. Agreement between the Monitoring Team and URC on the individual section of the Group Notebook was 100%.	

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		In summary, agreement on the presence of absence of documents in the Active Record (as identified on the AROG) and on the Group Notebook was acceptable (and would likely be higher if all items that are not required in each record were asterisked), but agreement on the monitoring tool indicated a need for better definition in order to ensure that review of trends is based on accurate ratings (confirming the findings from agreement ratings between URCs and program monitors). <u>Corrective Actions</u> The Facility reported this process for corrective action following audits: • URC prepares a Corrections Needed form that listed each required correction (using cut and paste from the Active Record Review and Group Notebook Audit) • URC sends email to the responsible Unit Director (UD), department heads of disciplines affected, director of residential services (DRS), Residential Coordinator for the relevant residence, QDDP for the individual, unit clerks, specific clinicians if affected, and all URCs & program monitors. • In two weeks, the URC follows up by going to the record with the correction list and marking off what was completed. If corrections remain to be done, the URC sends another notice. There is no process for people to tell the URCs that corrections are completed, although email streams provided to the Monitoring Team for the audited records show that some staff responsible for making corrections did email such notices when corrected. The Monitoring Team randomly (by computer) selected one record (for Individual #120) audited in March 2012 to review corrective actions identified in the audit and reported as completed. Without prior notice, the Monitoring Team provided the name of the individual; the URC who performed that audit and tracked corrective actions accompanied the Monitoring Team to the living unit. The Monitoring Team checked each item that was reported as corrected and determined that all had been corrected. One item marked as "Not Present" by the URC at the latest review was still not present. The Monitoring Team recommends that the Facility consider requiring staff responsible for making corrections to notify the URC when the corrections have been completed. There are three reasons for this recommendation. First, this would clarify that the responsibility for corrections belongs to the staff who document and who supervise documentation, rather than to the URCs. Second, this would provide a means to document corrections that are important for improvement but would not be made directly on the record (for example, training and increased supervision to improve legibility or to minimize missing data or notes that cannot be changed after the fact).	

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		Third, it might make for more efficient use of URC time and permit more time for planning and implementation of systemic change. <u>Review of Trends and Resulting Systemic Actions</u> The Facility reviewed findings of the audits at the QA/QI Council meetings. The following trend data were reported for the Trend Analysis Report covering February 2012 through April 2012 (as provided to the Monitoring Team): • Bar graphs of overall level of compliance as determined by internal audits and by external audits showing monthly levels of compliance for the three covered months, and for the total for the three months • Bar graph of level of agreement between internal and external audits for the covered three months • Graph of items with less than 80% compliance identified in internal audits, and graph from external audits • Graph of items with greater than or equal to 80% compliance identified in internal audits, and graph from external audits • Graph of overall scores for the periods of 5/1/11-7/31/11, 11/1/11-1/31/12, and 2/1/12-4/30/12 Based on review of findings from audits, the Facility reported it carried out the following improvement activities: • In January 2012, URCs inserviced QDDPs on active record and monitoring tools. • In March 2012, the Facility reported that URCs conducted inservice for Residential Coordinators (RCs) and DSPs to address areas of low compliance found during record audits (legibility, signatures, and gaps between entries). URCs trained RCs (including night) and provided them with a competency test, then had the RCs train the DCPs and give them the tests and return the completed tests to URCs; URCs reported they reviewed them and notified RCs of errors remaining and the need to reinservice individuals who didn't pass. No specific processes were implemented to determine the effectiveness of these training activities. Data from audits through April 2012 did not yet substantiate improvement in documentation, but training was recent, and audits reflect documentation over at least a three-month period. The Monitoring Team recommends that trend data be graphed for a 12-month rolling period to ensure that short-term changes do not lead to inappropriate actions and to show whether gradual change occurs in compliance with required documentation practices.	

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		The Facility also had drafted an audit process to ensure that documents that are purged from the Active Record based on the Maintenance Guidelines are sent to the Medical Records Department for long-term storage. This process was being piloted but was not yet in routine use. The Monitoring Team commends the Facility for taking this step to ensure all documents are purged as required and are kept in a secure location for easy access. <u>Additional Audits by Unit Clerks</u> A new process was developed to replace audits done by unit clerks. Unit clerks no longer audited records but had begun reviewing records using a more focused checklist. The process had been started in March 2012, but notices were first sent out April 27, 2012. Unit clerks are to look for the presence of certain documents and to check the retention guidelines. For use of the checklist, the URCs provide three names from the Make Random List for each unit; unit clerks check a different unit, not their own. This process is to result in 15 extra records monthly that have a level of checking. The unit clerks are to send the completed checklists to URCs and enter results into database; URCs are to send emails with things needing correction to disciplines needing to take action (and to unit clerks); unit clerks are to follow up within a week to check if the corrections were made and are to send URCs by 10th of the next month the status of each of the items on the email. May 2012 would have been the first month to receive the follow-up, but URCs had not yet received these follow-up communications from the unit clerks. <u>Conclusion</u> The Facility had developed a robust and thorough process for audits. The process involved use of statewide monitoring tools, review of active and (recently implemented) the individual section of the Group Notebook. The process to assess interrater reliability had been shifted so this was now done through comparison of independent audits by URCs and program auditors, a process that has the potential to integrate record audit findings into other quality assurance activities; agreement on the monitoring tools was not yet high enough and indicated there was need for further definition of items. The process for notifying staff of the need for corrective actions on individual records was well-organized, and URCs conducted follow-up to ensure corrections were complete; however, there needs to be greater emphasis on the responsibility of staff who document or supervise documentation for accurate completion of documentation. To date, systemic actions and audits had not resulted in compliance with requirements for records, as reported in Provision V1.	
V4	Commencing within six months of the Effective Date hereof and with	The Facility process to evaluate whether records are used in making decisions involved two activities. One was an interview of disciplines that participated on the IDT for two	Noncompliance

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	full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	individuals each month from individuals whose records were randomly audited. The second was review of the IPNs, reports, and assessments for each audited record. Both these resulted in a rating on the monitoring tool. Results of interviews: For the interviews, each URC selected one person each month for IDT interviews; individuals were not selected randomly but were chosen with intent to ensure each living unit received this interview on a rotating basis. The URC interviewed a member of the IDT from each applicable discipline. The URC rated use of the record as "Y" or "N" for each discipline interviewed. Based on these findings, the URC then rated this on the monitoring tool. RSSLC had implemented an interrater reliability process for this; for one individual each month, a program monitor observed the interview and rated independently. This Monitoring Team commends the Facility for beginning this process; the Level of Agreement database reported agreement on the five audits per month reviewed of 80% in March 2012 and 100% in April 2012. The Monitoring Team reviewed the interview forms for Individuals #24, #120, #358, and #798. All included interviews of several disciplines. With only one exception (a vocational staff who reported not using the record), all disciplines identified information they use from the record, including information from other disciplines' reports. Reports of use of the records at meetings was more mixed. In all, the Monitoring Team would agree that these interviews indicated the records were being used for making decisions. The Monitoring Team also interviewed a group of QDDPs and a discipline director. These interviews were general, rather than focused on an individual, but used the same interview form and questions. These interviews substantiated the findings from those conducted by URCs. Information in the record: In addition to rating use of the record based on interviews, the monitoring tool contained one item rating use of the record based on information in the record. The definitions/criteria used for monitoring did not provide any definitions or criteria for rating the item on the monitoring tool that asks whether "review of the record (integrated progress notes) demonstrated use of the record in making decisions. All but one audit completed by both the URCs and program monitors rated "Y." For the record audited for agreement between the Monitoring Team and URC, this was in disagreement, as the Monitoring Team rated it "N" and the URC rated it "Y." The Facility should establish clear criteria for this item. Nevertheless, there were numerous missing or outdated assessments noted in audits of the active records. Disciplines were notified of these as part of the required corrective actions. In at least one case, (Individual #300), an email response to the corrective action	

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		notice stated that the outdated report was on the share drive (VCF), but the corrective action was not considered complete until a signed copy was placed in the active record. Virtual Client Folder (VCF)/share drive: Another measure of use of the record is to determine whether assessments are available for review by all members of the IDT. As noted above, current assessments were not always found in the active record. Another location for these assessments is the share drive. Per policy, assessments were to be posted no later than ten days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. This expectation had recently been changed to 15 days prior to the meeting. The Monitoring Team found, as reported in Provision F1c, that even for the ISPs held during the week of the compliance visit, not all assessments were available. The Monitoring Team also reviewed the assessments available on the shared drive for a sample of ISPs upcoming over the next ten days. Zero of ten (0%) had all required assessments available and/or posted by the required date. This consistent tardiness in the completion of ISP assessments was confirmed by the Facility's own tracking data. Also, the Monitoring Team asked a group of QDDPs to pick one individual whose ISP annual meeting was to be held within 10 days; they selected Individual #789, whose meeting was to be held later that day. Assessments present were audiology, dental, medical, nursing, and pharmacy. Not current were OT/PT and behavioral services, but these were posted to a "To be filed" folder indicating they were completed (but were not in the assessments folder, so IDT members might overlook them or would, at least, have to search other folders to see if they were present). Another folder, the Draft PSP folder—included the SAMS and bedrail assessments. A speech/communication assessment was outdated. The Assessments Tracking Worksheet for this individual showed that as of 10 days prior to the ISP annual planning meeting, no required assessments had been posted, and notifications had been sent out requesting these. Although most assessments were available in the share drive, the Facility did not have a process to determine whether information in the record was used effectively to identify progress or decline in health and behavioral status of individuals for purposes of making treatment decisions. Use of the record at meetings: Another way to assess use of the records in making decisions is to observe whether and how they are used. To verify whether the record was available and used at IDT meetings, the Monitoring Team observed for this at the ISP annual planning meeting for Individuals #462 and #508; the active record was available at both meetings. • At the meeting for Individual #462, the nurse looked in the record to answer	

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		questions from the individual's mother and to ensure accurate information about when the last medical sedation was used and the last mammogram was done, as well as to read an HMP to ensure everyone was clear on what health conditions were to be observed for and reported. • At the meeting for Individual #508, the nurse and dietician provided data and other information from their assessments, which they had at the meeting. The nurse looked in the active record for information from a medical consultation and the resulting physician's order. The Facility did not have a process to determine, evaluate, and identify trends in use of the record to guide implementation of programs. Although staff were able to state where in the Individual Notebook to find documents such as ISPs, PBSPs, and PNMPs, the Monitoring Team noted that these plans were often not followed and did not see examples in which staff referred to them. For example: • Generally, the PNMP was located in the PNMP notebook that followed the individuals 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. • As reported in Sections K and S, the Monitoring Team did not see consistent implementation of either formal or informal skill acquisition training or implementation of PBSPs. Furthermore, as reported in Provision S1, there were only isolated observations of activities that promoted engagement of individuals in functional activities. Given the number of ISPs that include Action Plans to encourage a range of activities, implementation of those action plans would be expected to lead to higher levels of engagement. <u>Conclusion</u> This provision was not in compliance. The Facility has continued interviews of IDT members to assess use of the record in planning and had initiated a process to assess inter-rater reliability, a very positive step. Information from these interviews by the Facility, and interviews by the Monitoring Team, confirmed that IDT members generally use the records and verified that staff can provide examples of how they use the records. However, records need to be used not only for planning meetings but also for daily implementation, and the information must be current in order to be usable. To achieve compliance, the Facility will need to ensure assessments are completed and posted timely so they can be used by the whole IDT in preparing for meetings, and to develop processes to ensure staff understand and implement training goals and other action plans that involve engagement of individuals in functional activities.	

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

1. The Facility needs to emphasize to those management and supervisory staff responsible for documentation that the audits provide them with information that should guide them in acting to ensure improvements in documentation occur. (Provision V3)
2. Implement a process to ensure documentation that is not part of the Unified Record is consistent with the Unified Record. (Provision V1)
3. Identify items with low agreement and revise the definitions in the recordkeeping guidelines and criteria or provide written examples for specific items of documentation that should be rated "Y," "N," or "NA." Then, any understandings or changes in definitions arising from discussions among URCs and program monitors must be kept in writing so they can be provided to anyone auditing the records. (Provision V3)
4. The Monitoring Team recommends that trend data be graphed for a 12-month rolling period to ensure that short-term changes do not lead to inappropriate actions and to show whether gradual change occurs in compliance with required documentation practices. (Provision V3)
5. The Facility should monitor the effectiveness of systemic corrective and improvement actions. (Provision V3)
6. Develop processes to determine whether information in the record was used effectively to identify progress or decline in health and behavioral status of individuals for purposes of making treatment decisions, to comment on missing information needed for decision-making, and to monitor use of the record to guide implementation of programs. (Provision V4)
7. Develop processes to ensure staff understand and implement training goals and other action plans that involve engagement of individuals in functional activities. (Provision V4)

The following are offered as additional suggestions to the Facility:

1. The Facility should consider requiring staff responsible for making corrections to notify the URC when the corrections have been completed. (Provision V3)

List of Acronyms

Richmond State Supported Living Center
May 14-18, 2012 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
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
AS	Action Step(s)
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CAP	Corrective Action Plan
CBC	Criminal Background Check or Complete Blood Count
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
EC	Environmental Control
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
HIM	Health Information Management Department at Rio Grande State Center
HIPAA	Health Information Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMP	Health Management 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
IRR	Integrated Risk Rating
ISP	Individual Support Plan
IT	Information Technology
i.v./IV	Intravenous
LA	Local Authority (formerly MRA)
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/No Direct Contact
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
PBSC	Positive Behavior Support Committee
PBSP	Positive Behavior Support Plan
PBST	Personal Behavior Support Team
PCD	Planned Completion Date
PCP	Primary Care Physician
PDB	Physically Disruptive Behavior
PDP	Personal Development Plan
PFA	Personal Focus Assessment
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
PTP	Psychiatric Treatment Plan

PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMR	Quarterly Medication Review
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
SAP	Skill Acquisition Program
SFA/SFBA	Structural and Functional Assessment/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

WBC/wbc	White blood cell
x/o	Rule out