United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center
November 12-16, 2012

Date of Report: December 21, 2012
Submitted By: Michael J. Davis, Ph.D.
Monitoring Team: Michael J. Davis, Ph.D., BCBA-D
Monitoring Team:
Dwan Allen, RNC, BSN, NP
James Bailey, MCD-CCC-SLP
Rod Curtis, M.D.
Douglas McDonald, Ph.D.
Michael Sherer, M.D.
Scott Umbreit, M.S.
Rebecca Wright, MSW

Table of Contents

Introduction

Background

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

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

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

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

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

Methodology

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

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

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.

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

Organization of Report

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

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

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

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. Although the Facility Director was, at the time of the visit, assigned temporarily as director of another SSLC, the administrative staff remained extremely supportive of the Monitoring Team's activities throughout the week of the compliance visit. 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 Vivian Mahan, Tracey Stafford, Susan Steamer, David Savage, Alice Ramirez, and Brad Hines. 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.

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

General Comments

Population. Population of the Facility at the beginning of the compliance visit was 347 individuals.

Facility Self-Assessment. Richmond State Supported Living Center (RSSLC) provided a self-assessment for each section of the Settlement Agreement. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating. The self-assessment process has become more thorough and objective. In general, improvement was noted in the organization and presentation of the Self-Assessment. A notable attempt had been made to mirror the tools and processes used by the Monitor. However, as indicated in each of the sections of the report below, self-assessments varied greatly across sections of the Settlement Agreement. There was greater use of data in most Sections. For some sections, the Facility used data gathered as part of routine quality assurance and quality improvement activities, which is commendable. In other cases, data were gathered specifically for the self-assessment. In a few cases, data were not gathered at all. In some cases, data that represented positive findings was, and in other cases was not, verified by the observations done by the Monitoring Team. For many provisions, the self-assessment did not cover all essential requirements of the provision. The Monitoring Team provides, in this report, specific reviews of the self-assessments, including recommendations 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

Restraint use at the RSSLC has been steadily increasing over the last two review periods. The Facility attributes this primarily to Individuals who have been recently admitted and have lived at the Facility less than one year. Data supports this. The trend line for restraint use of Individuals who have lived at the Facility more than one year showed a steady decrease. Restraint

documentation had improved as Facility staff had undergone considerable training since the revised State (and RSSLC policy) went into effect in April, 2012.

- Positive Practices and Improvements Made
  - The process of documenting restraints on the Restraint Checklist and Face-to-Face Assessment Debriefing was much improved from that noted in previous reports.
  - No use of prone restraint was identified.
- Improvements Needed
  - The use of crisis intervention restraint at RSSLC increased significantly since the last review period. This is the second consecutive review period with a significant increase in the use of crisis intervention restraint. In both review periods this increase was attributed primarily to difficult new admissions.
  - Many individuals still lack needed plans to reduce the need for pre-treatment sedation.

<u>Abuse, Neglect and Incident Management</u>
The Facility was in substantial compliance with three provisions and with a total of 14 sub-provisions.

- 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.
  - All allegations of physical abuse received a law enforcement referral.
  - DFPS investigation were, for the most part, initiated within 24 hours and completed within 10 days of being reported.
  - DFPS conducts very thorough reviews of allegations when determining to refer an alleged incident back to the Facility as an Administrative 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.
  - The RSSLC convened quarterly joint meetings with DFPS, OIG, and local law enforcement at which any issues of mutual cooperation can be reviewed and resolved.
- Improvements Needed
  - The video surveillance program remained an important administrative tool in detecting abuse and neglect, and in the conduct of DFPS investigations; however, the use of available video surveillance should be expanded in the conduct of Facility investigations of serious incidents.

- Although training for staff on abuse and incident reporting was in place, and all staff was current in that training; however, as noted in the last report, staff knowledge of abuse/neglect reporting requirements needs to improve.
- 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.
- Facility investigations of serious incidents were not always completed within 10 days of being reported.
- Timely reporting of allegations, while improved, remained problematic.

Quality Assurance

The Facility has a new QA Director as of 9/1 and work initiated since her appointment was impressive, including a draft of a comprehensive QA Plan, an expeditious identification of key problem areas in the organization of the Facility QA efforts, and aggressive pursuit of adjustments in organization and task responsibilities. The information presented to the Monitoring Team, particularly in the Presentation Book, demonstrated in a good understanding of QA expectation and the work that lies ahead. The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of the QA system.

- Positive Practices and Improvements Made
  - The development of the data system that consolidated data from multiple sources was impressive. Further refinements in the data systems were also impressive and when finalized should yield important decision-making information to Facility administrators and clinical leaders.
  - The Facility revised trend data to include longitudinal data.
  - The Facility has developed a data library.
- Improvements Needed.
  - 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. While improved from that noted in the last report this is still in a developmental stage.
  - Data items on the monitoring tools have been treated as if they are equally important, so in preparing overall compliance reports the most critical data item counted the same as the most mundane. The Facility needs to review not only overall scores but also patterns of items that are reported as not done, in order to identify what actions are important to take.
  - 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 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 have a method to determine the effectiveness of a CAP.

Integrated Protections, Services, Treatments and Supports

Overall, the Facility had demonstrated some degree of progress in a number of areas, including timeliness of assessments, attendance at ISP annual planning meetings, QDDP facilitation skills and coordination of services. The Monitoring Team commended these efforts, but did not find they had yet yielded substantial progress in the development and implementation of an integrated ISP for each individual that ensured individualized protections, services, supports, and treatments were provided, consistent with current, generally accepted professional standards of care. The Facility is encouraged to continue to build on these recent initiatives.

- Positive Practices and Improvements Made
  - 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, and had recently begun to implement a revision to the ISP process.
  - There was a marked improvement in the organization of meetings observed and there was increased responsiveness to assessment information.
  - The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs and IDT members. The Monitoring Team would particularly like to recognize the creativity and diligence of the QDDP Educator in this regard and encourage the Facility to continue in this direction.
- Improvements Needed
  - The newly revised ISP process, held some promise with the implementation of the Pre-ISP meeting, but the Monitoring Team was concerned the annual planning meeting was so heavily focused on a discussion of problems that it was not conducive to the participation of the individual.
  - Integration of services and supports was still lacking.
  - 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.
  - ISP strategies did not yet adequately address individual's needs, strengths and preferences or reflect encouragement of community participation in any meaningful or purposeful manner.

Integrated Clinical Services

The Facility had continued to make significant progress toward establishing and developing processes to maintain provision of integrated clinical services. Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve; nonetheless, integrating planning and services across disciplines remained a challenge. These processes need to be fully implemented and need to result in more consistent integration of planning and provision of

clinical services in order to reach substantial compliance. Progress had also been made in facility review of consultations by non-Facility clinicians.

- Positive Practices and Improvements Made
  - Although RSSLC did not have one overall policy governing integrated clinical services, several policies addressed areas of integrated services. In general, these policies included requirements or actions that involved collaboration across disciplines.
  - The Integrated Clinical Meeting, Physical and Nutritional Management Team, and Integrated Disciplines Workgroup all provide forums for integrated planning.
  - RSSLC Policy PCP Consultation Letter Policy establishes a process for communication and documentation of medical information from the Primary Care Provider (PCP) to consultants. This policy establishes steps for an initial or follow up consultation letter to consultants and a template for each of these kinds of letters. This policy provides for more complete information to be provided to the consultants as appointments are made.
  - Review of medical and modified barium swallow study (MBSS) consultations verified consistent documentation of review by primary care physicians (PCPs).
- Improvements Needed
  - There was not yet consistent documentation of integrated planning in risk assessment and planning, collaboration at the unit level between physicians and habilitation therapy regarding physical and nutritional interventions, or integration of communication goals into the ISP.
  - Although recent samples provided by the Facility showed referral of consultant recommendations to the IDT for consideration, this was not consistent in the samples reviewed by the Monitoring Team.

<u>Minimum Common Elements of Clinical Care</u>

The Facility has taken significant actions that have resulted in a great deal of improvement in meeting the requirements of this Section. In particular, databases have been developed that make information (including status of clinical indicators) accessible and clear, and that show great promise of improving usefulness of clinical indicators both for decisions on treatments and interventions for individuals, and for improving systems of healthcare for the Facility as a whole.

- Positive Practices and Improvements Made
  - Diagnoses were consistent with the current versions of the DSM and ICD classification systems.
  - The processes to monitor timely provision of medical procedures included use of a database for chronic diseases that included indicators to monitor, implementation of a physician orders flag, and Medical Morning meetings that included on-call reports so PCPs would be aware of any changes in health status.
  - The Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. Many of these indicators had become integrated into the key indicators used by

the Facility for quality review. Others were being used routinely in reviewing health and behavioral status of individuals. Each area of the medical database tracking chronic conditions included clinical indicators to be tracked.
    - The Facility has made tremendous strides in not only identifying clinical indicators useful in providing care to individuals and assessing status of healthcare at the Facility, but developing procedures that make the information readily accessible to providers and administrators through a well-designed database.
- Improvements Needed
    - Timeliness of assessments had improved, but annual assessments for the ISP planning meeting were still not consistently completed on a timely basis. Not all assessments for newly admitted individuals were completed within 30 days following admission. Completion of assessments and evaluations in response to changes in status was variable.
    - Differences in diagnoses for some individuals were found across different documents in the record.
    - For medical services, there were instances in which assessments and results from X-rays, labs, or other tests indicated a diagnosis that was not listed.
    - All information needed for diagnosis and to assess health status must be provided. Some information has not been routinely provided to clinicians for decision making.

<u>At-Risk Individuals</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 9/18/12

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.

- Positive Practices and Improvements Made
    - Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred. Staff understanding of risk assessment policies and procedures had improved.
- Improvements Needed
    - It was not clear that IDTs yet were able to accurately assess levels of risk in an interdisciplinary and collaborative manner. Although considerable training had occurred, there were limited examples of accurate interdisciplinary risk identification, thorough assessments, and effective interdisciplinary risk action plans.

<u>Psychiatric Care and Services</u>
The Monitoring Team rated the Facility in substantial compliance for two of the provisions in this section. The Monitoring Team saw encouraging signs that suggested needed fundamentals are now being put in place that will make it possible for psychiatric care to be consistent with the requirements of the Section.

- Positive Practices and Improvements Made
    - The Facility has employed two psychiatrists, each of whom had the required qualifications and experience.
    - The new psychiatrists brought renewed energy to efforts to clarify an individual's diagnoses so that they properly reflect observable symptoms that are the focus of medication treatments. Much work was being done in the psychiatric clinics toward clarification of diagnoses.
    - Comprehensive psychiatric evaluations (CPEs) have now been done for over 90 percent of individuals who take psychotropic medications, and the Facility has started to do annual updates of those CPEs.
    - It was clear to the Monitoring Team that the Facility was committed to make the fundamental changes needed to support appropriate use of medication. Teams were busy in the PBMC sorting out whether individuals had symptoms that warranted medication treatment, and there were active discussions between psychiatrists and psychologists about the kinds of behavioral data that were needed to support psychiatrists' efforts to provide medication management when it was needed.
- Improvements Needed
    - The Facility needs to establish and improve monthly Facility-level reviews of polypharmacy practices.
    - There had been limited progress made regarding the use of medical restraints. There has been some progress regarding the monitoring for safety during medical restraint, as the new Medical/Dental Restraint Checklist has consolidated vital sign monitoring into one place. Many individuals still lacked needed plans to reduce the need for pre-treatment sedation.
    - In order to complete the work on Reiss screening for psychopathology, psychiatric evaluations must be completed for individuals who failed the Screen, and a Facility protocol is needed regarding the use of Reiss screen for possible change of status of individuals who live at the Facility.
    - Progress was made regarding the use of nurse-administered evaluations for medication side effects, but it was not clear that individuals received all the needed examinations and there was not yet adequate Facility level monitoring for tardive dyskinesia.

<u>Psychological services</u>

In some Provisions, the Facility had demonstrated areas of progress. In Provision K.1, the Facility had continued to hire BCBAs and enroll existing staff in BCBA training programs. The Facility had also developed a checklist to facilitate the peer review of PBSPs required in Provision K.3.

In some areas, the Facility had initiated new procedures or document formats. These efforts suggested the potential for considerable progress toward substantial compliance. Due to the recent implementation of these efforts and the resulting small number of examples, it was not possible to fully assess the Facility's progress. The new PBSP format was substantially

simplified, including only those elements that were necessary for successful implementation of the program. At the time of the site visit, however, only two new SFAs and PBSPs had been completed.

Despite the areas noted for improvement or the potential for improvement, there were several areas in which the Facility had demonstrated little progress.

- Positive Practices and Improvements Made
  - The Facility had continued to hire BCBAs and enroll existing staff in BCBA training programs.
  - Although it was too recent to fully assess progress, the Facility had initiated in one unit a complete redesign of the data graphs and progress notes that allowed for a more clear and detailed presentation of an individual's response to treatment.
  - The Facility had also developed a checklist to facilitate the peer review of PBSPs required in Provision K.3.
- Improvements Needed
  - Even though the number of BCBAs had increased and new peer review procedures had been implemented, SFAs and PBSPs were noted to have several areas of weakness.
  - Few individuals had been provided current intellectual and adaptive skill assessment.
  - Of the individuals receiving counseling or psychotherapy, none had been provided a formal treatment plan.
  - The Facility required a system for assessing staff competence regarding PBSPs and tracking staff participation in training.

<u>Medical Care</u>

The Monitoring Team compliments the Facility for the outstanding work in further developing policies, procedures and system changes that positively affect the provision of medical services at the Facility. Under the leadership of the medical director, the Facility has developed several database systems which enable tracking and trending of important clinical conditions, has developed a comprehensive program to enhance the management of diabetes, and has partially implemented a process that will help ensure improved outcomes following hospitalizations. The medical providers are following up on acute medical conditions promptly, and documenting clinical activities more effectively. In addition, medical providers are following up on all medical consultations and diagnostic studies. Further improvement is necessary for compliance, especially in the area of diagnosing, treating, follow-up, and ensuring that all necessary supports and services are in place for known medical conditions. The Facility must also enhance its medical quality assurance process, and its clinical performance review process.

- Positive Practices and Improvements Made
  - Medical providers are more regularly documenting in SOAP format, and completion of medical summaries has significantly improved. In most cases, for each identified diagnosis on the medical summary, a medical plan was formulated.

- In general, medical providers are addressing acute medical issues more timely, and are following up on acute care issues more closely.
- The Facility is ensuring that individuals are offered screening colonoscopy and mammography.
- There was significant improvement in developing a meaningful process to assess clinical performance of medical providers. The current internal and external medical audit process is performed regularly, and provides good insight into the medical providers adherence to Facility policy, and to documentation standards.
- The Facility has developed several databases for medical care and is continuing to develop additional databases to be used in the context of medical quality assurance.
- The Facility has developed and implemented a nursing diabetic education process, which helps to enable a multidisciplinary approach to the management of diabetes. The Facility has clearly demonstrated its ability to effectively address and ensure quality practice and improved outcome in the area of diabetes.
- The Facility had developed and implemented a robust mechanism to ensure that a hospital discharge planning meeting take place, prior to discharge from the Hospital. The Facility will need to ensure this policy is consistently followed.

- Improvements Needed
  - There is a need to ensure a comprehensive review of underlying medical conditions. For example, individuals were not assertively assessed as to the underlying causes of osteoporosis, and individuals with degenerative spine disease did not have assertive clinical plans developed to ensure that all appropriate supports and services could be provided, to better meet the needs of the Individual.
  - Medical providers must assertively assess all acute conditions.
  - Medical providers should rule out medical conditions that may be manifesting in behavioral issues.
  - Medical providers should responsible to ensure that all clinically necessary supports and services are identified for individuals who reside at the Facility, and that nursing and direct care staff are provided clear, concise monitoring, and reporting parameters for all clinical conditions.
  - Although, as noted above, there was improvement in assessing clinical performance of medical providers, there remains a need to develop and implement a process that assesses performance measures on clinical outcomes, and adherence to acceptable practice standards for medical management that are based on standard of care guidelines.
  - Although the Facility had significantly improved on its mortality review process; however, compliance will require that the Facility develop and implement a process to track and trend mortality review outcome data, implement a process to ensure that a root cause analysis of the medical management of the underlying cause of death is assessed, and develop a standardized approach when conducting a mortality review.

<u>Nursing Care</u>

Overall the Facility had made progress in all provisions except Provision M.5. The lack of progress in this Provision was due to the recently implemented new processes for the Integrated Risk Rating Form and the Integrated Health Care Plan, which had not yet had time to produce enough data to measure compliance.

There was significant progress made in Provisions M.1, M.2, M.3, and M.4 relating to the assessment and documentation of acute changes in health status, annual and quarterly comprehensive nursing assessments and associated care plans. This was no doubt attributable to the increased efforts put forth in training and retraining the nursing staff and increased monitoring of Provision M.1, M.2, and M.3. These efforts significantly moved these Provisions toward compliance.

- Positive Practices and Improvements Made
    - The Nursing Department continued to maintain a highly motivated and stable Nursing Administrative and Management staff. The staffing ratios were reported as consistently being met. No agency nurses were used.
    - The Infection Control Program continued to show improvement with the two Infection Control Preventionist Nurses. The Infection Control Program continued to refine and improve some processes in the areas of tracking, analyzing, and trending infection control data, as described in the report.
    - The Wound Care Nurse continued to provide excellent wound care management in collaboration with other relevant disciplines.
    - The Nurse Educator continued to provide the required nursing annual competency–based refresher training and New Nurse Orientation. The Nurse Educator continued to maintain an excellent tracking system for training to ensure that nurses receive all required and other identified training as needed.
    - 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.
- Improvements Needed
    - The Nursing Department was making steady progress in improving the quality of the Annual and Quarterly Nursing Assessment. The improvements found in the nursing assessments may be attributable to the recently hired RN Case Manager Supervisor and Nurse Educator who had worked aggressively with the RN Case Managers to improve the quality of nursing assessments. The training the Nurse Case Managers received on the State's required Physical Assessment and Documentation Class had made significant improvement in the quality of the physical assessments and documentation. However, the RN Case Managers need continuing improvement on 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.
    - Nursing Policies, Procedures, Processes, and Protocols have not yet been adequately put into clinical practices sufficient to meet individuals' health status needs.

- Recent implementation of new processes for the Integrated Risk Rating Form and the Integrated Health Care Plan, which had not yet had time to produce enough data to measure compliance.
- Nursing staff administering medications continued to need enhanced dysphagia training to better understand and carry out safe medication administration strategies.

Pharmacy Services and Safe Medication Practices

The Monitoring Team noted the exceptional quality of the Facility's DUE process, and the more comprehensive approach the Facility had taken when completing QDRRs. In addition, the Monitoring Team noted some improvement with assessing metabolic syndrome. The Monitoring Team encourages pharmacists to provide meaningful recommendations when issuing a single patient drug intervention, and to the best of their ability, ensure that the medical providers' responses to pharmacy recommendations are clinically appropriate.

- Positive Practices and Improvements Made
  - Medical providers responded to pharmacists' concerns over new medication orders.
  - The Facility maintained a comprehensive database of all ADRs.
  - The Facility had a comprehensive mechanism to review, analyze, and report on ADRs.
  - The drug utilization evaluation process was of high quality.
- Improvements Needed
  - The pharmacist must offer clinical recommendations as appropriate when completing single patient drug intervention reports and ensure there is a response by the physician.
  - QDRRs must be complete, and must appropriately address issues such as polypharmacy and metabolic syndrome.
  - Medical providers and psychiatrists must indicate their review, and agreement or disagreement with recommendations.
  - Medical providers and psychiatrists must follow up on recommendations from pharmacy.
  - Medication variance reports were not fully completed and lacked meaningful review by the department supervisors.

Physical and Nutritional Management

Overall, significant improvement was noted throughout all provisions with the exception of the implementation of plans. The Physical and Nutritional Management Team (PNMT) continued to improve their process as well as their assessments. The Physical and Nutritional Management Plans (PNMPs), while much improved regarding detail, still lacked evidence of review by the entire IDT due to lack of consistent attendance by all relevant parties at the IDT. Staff knowledge as well as proper implementation continued to be a concern of the Monitoring Team. Staff was observed not implementing strategies that were designed to mitigate risk associated with aspiration and choking and therefore were placed at an unnecessary high risk of aspiration and choking as well as other PNM issues such as skin breakdown.

- Positive Practices and Improvements Made
    - Much improvement has been noted with regards to the comprehensiveness of the PNMT assessments, and the discussion during the meetings.
- Improvements Needed
    - There was excessive delay between referral to the PNMT and completion of assessments and sharing with the IDT.
    - While review of an event by the IDT was much improved as well as discussion by the PNMT, there remains concern regarding how these two teams are interacting and sharing information. A new form was developed to help ensure successful transition but this had just been implemented.
    - Although the Aspiration Trigger Sheet was implemented for all individuals who were identified as being high risk for aspiration, Aspiration Trigger data sheets were not consistently completed.
    - PNMPs were not clearly developed with input from the IDT with an emphasis on DSPs, medical/nursing staff, and behavioral staff (if appropriate).
    - 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.
    - Staff were not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being.
    - There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual and that all staff were provided with comprehensive competency based training.
    - A monitoring process had been implemented since the past compliance review but the accuracy and validity of the monitors is questioned secondary to the significant discrepancy between what the Monitoring Team observed and that in which RSSLC reported.
    - There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized identified PNM related risks. There was no detailed comparative analysis of data or assessment findings. Outcomes were reviewed through the risk process but effectiveness of strategies was not.
    - Individuals were not consistently provided with assessments that identified the medical necessity of the tube and pathways to oral intake.

<u>Physical and Occupational Therapy</u>

Overall, there was noted improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at RSSLC. Assessments were much improved and did a respectable job in providing a comprehensive review of the individual. This was especially noted with the most recent assessments that had begun with a new format and with additional staff assistance. While Provision P.1 was considered to be in substantial compliance on this visit, there was some concern by the

Monitoring Team regarding the lack of skill acquisition as part of the assessment. RSSLC was aware of this needed area of improvement through discussion with the Monitoring Team as well as through their self assessment and audit process.

- Positive Practices and Improvements Made
  - Assessments were completed in accordance to the schedule set forth by the Facility and contained the components necessary to identify issues with functional mobility as well as other therapy needs. Although skill acquisition was not a consistent piece of the assessment RSSLC was aware of this need and had established a plan to address the deficiency moving forward.
- Improvements Needed
  - Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.
  - Therapy services were not consistently integrated into the ISP.
  - Justification for continued therapy was not well documented nor was discharge well justified as a result.
  - 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.
  - There was a significant discrepancy between the observations of the Monitoring Team and the Facility monitors, which brings into question the accuracy of Facility monitoring.

<u>Dental Services</u>

There are significant concerns with overall provision of dental services. The Facility had made little progress with the requirements of this Section. The Facility did not provide timely oral health care treatment to individuals who required intravenous or general anesthesia. Documentation practices by the dental office did not adequately communicate oral health care issues to other members of the IDT. The Monitoring Team noted that the dental office did not have an effective means to manage important oral health care database elements.

- Positive Practices and Improvements Made
  - The Facility had developed and implemented a new process to better improve oral hygiene effort at the living areas, called the oral hygiene care plan (OHCP).
- Improvements Needed
  - With two staff on long-term leave, the Facility needs to review staffing of the dental department.
  - Although the Facility had implemented the OHCP, the process was not fully implemented, and there was no documentation to demonstrate that direct support professionals (DSPs) were trained on the individual OHCPs.

- The Facility did not have a meaningful process in place to track and trend dental database elements. For example, the Facility could not readily provide the Monitoring Team with a list of individuals who were assessed, and were pending suctionl toothbrushing.
- There was significant delay in treatment for individuals requiring emergency dental care, because intravenous anesthesia (TIVA) was not readily available.
- Post-TIVA follow-up orders were not individualized by taking into account the Individual's medical and behavioral health care needs.
- The Facility had not improved its ability to track and trend dental appointments and other dental data elements.

Communication

RSSLC showed overall improvement with Section R. Recent assessments were noted to be much more comprehensive and provided a much clearer picture of the individuals' level of functioning. An area of the assessment process that still required improvement was the transfer of the information acquired through the assessment process into functional and meaningful goals that can be applied to a variety of situations. General area communication devices were in the process of being reviewed and implemented in a more functional manner and the Monitoring Team looks forward to seeing how review of these systems impact the lives of the individuals at RSSLC.

Direct and Indirect programs continued to need to be expanded to those Individuals who are most in need. Monitoring of these programs once in place was also an area that was in need of review to ensure appropriateness.

- Positive Practices and Improvements Made
  - RSSLC increased their number of SLPs to six on campus for which one was dedicated to dysphagia.
  - Recent assessments were noted to be much more comprehensive and provided a much clearer picture of the individuals' level of functioning.
- Improvements Needed
  - Presence of SLPs at meetings in which their expertise would be required was inconsistent.
  - 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 consistently implemented.
  - Communication strategies and programs were not consistently integrated into the ISP.
  - DSPs interviewed were not knowledgeable of the communication programs.
  - AAC devices (individualized as well as common area) were not consistently utilized.

Habilitation, Training, Education, and Skill Acquisition Programs

Although no specific provisions were in compliance, there were areas of improvement.

- Positive Practices and Improvements Made
    - In comparison with the previous site visit, the Facility had increased the degree to which individuals were provided the opportunity for functional engagement.
- Improvements Needed
    - Although there had been an increase in engagement, the provision of formal teaching had not substantially increased. Observations did not reveal staff implementing Skill Acquisition Plans (SAPs). Although staff were observed at times providing prompts or praise, these actions were not performed in a systematic manner and did not target specific skills or behaviors.

    - In many cases, neither the ISP nor the SAPs reflected that the needs identified in assessment reports had been targeted for training.
    - Although several SAPs included steps, they did not reflect the use of a task analysis.
    - Discrepancies were noted between data collection sheets, data summaries, and progress notes.
    - There were examples where individuals had continued on the same step of an SAP for well beyond the required number of months despite having demonstrated mastery of the skill.

<u>Most Integrated Setting</u>
The Facility had maintained a relatively high level of referral for community living and transition, but more work remained to ensure those transitions were effectively planned and successfully implemented. Positive developments noted included increased integrated discussion by IDTs and the augmentation of transition staffing to enhance education and awareness of community living options as well as increase the pace of transitions once a referral is made.

- Positive Practices and Improvements Made
    - Fifteen individuals had transitioned to community living and there were 20 active referrals.
    - The Monitoring Team found substantial compliance in Provision T1c2 which addressed the identification of Facility staff responsible for required CLDP actions and the timeframes in which such actions are to be completed.
    - The Facility had made significant progress in the quality of the CLDP integrated discussion by the IDT during this visit, in which discussion was more focused on ensuring the provider staff understood how to implement services and supports rather than on a mere recitation of assessment findings. The Monitoring Team was particularly impressed with the level of specific detail about the individual's characteristics, needs and day-to-day functioning provided in the Positive Behavior Support Plan.

- Improvements Needed

- RSSLC still needed to improve its processes to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options.
- Continuing deficits in assessments also translated to many instances in which the IDT 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, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits were apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living.
- In post-move monitoring, RSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDP.
- Adverse outcomes during this six month period were reported for eight individuals who had transitioned during the past year. The Monitoring Team urges the Facility to use the adverse events to examine how it may improve its own CLDP and PMM processes.

<u>Consent</u>

While new policies on guardianship had been in effect since the last monitoring visit, progress toward implementation since then had been limited. A summary of noted progress included: The Facility had begun to deploy the expanded Rights Assessment and had offered some training in its use. The Facility continued to provide substantial supports for self-advocacy, including a pilot project that trained staff on homes serving individuals with more extensive health care needs to act as self-advocacy mentors.

- Positive Practices and Improvements Made
  - An expanded Rights Assessment was in use and represented an improvement over the previously used process in that it did prompt the team with specific probes in each of seven categories of informed consent.
  - A new DADS policy on Self-Advocacy had recently been issued, and RSSLC did continue to provide commendable support for self-advocacy.
- Improvements Needed
  - DADS policy, while it 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, 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.
  - The expanded rights process was not predicated on any objective criteria or a currently accepted standardized tool for assessing decisional capacity.

- The Facility had provided some training on the expanded Rights Assessment, but there was no discernible difference in the process or outcomes from the previous monitoring visits in which the earlier version had been used. The IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria.
- Many of the requirements of DADS Policy 019, including the Guardianship Committee, were not yet implemented.

Recordkeeping and General Plan Implementation

Progress was evident in all provisions of this Section. Policies had been developed and revised, both for recordkeeping and for other requirements of the Settlement Agreement. Records were generally in order, a robust audit system was in place, and there was evidence that records were being used in making decisions. However, records still were not consistently accurate and complete, the corrective action process for addressing issues identified in the audit had not yet limited recurrence of similar errors, and availability of records did not consistently lead to accurate implementation of supports and services.

- Positive Practices and Improvements Made
  - The Facility maintained a Unified Record with all required components. 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.
  - The Facility had a process in which 10 randomly selected records were audited each month, exceeding the requirement of the Settlement Agreement.
  - Program Monitors performed reliability audits. Interrater reliability appeared adequate to permit confidence in the findings for the monitoring tool and Active Record.
- Improvements Needed
  - Active records contained most required documents, but neither record reviewed in detail by the Monitoring Team included all required documents; data for this small sample was reasonably consistent with the trends data reported by the Facility. Both reviews by the Monitoring Team and audits by the Facility identified a few requirements of Appendix D that were frequently problematic, including gaps in documentation (usually gaps of lines between entries or at the bottom of pages of notes or orders) and legibility.
  - The process for notifying staff of the need for corrective actions for errors found in audits of individual records was well-organized, and the Facility 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. The audit process had not resulted in limiting recurrence of similar errors.
  - Timeliness of completion and posting of routine assessments had improved but there was still some variability, and not all required assessments were posted timely and available for review.
  - Regarding policies, although much progress had been made in development and implementation of policies needed to address requirement of the Settlement Agreement, there were still areas that needed further development. The

Facility needs to develop and implement an organized process for periodic routine review of current policies to determine any need for revision. The Facility is planning to establish a way to track all people who have been trained but have not yet developed a system.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of the Facility. The Monitoring Team hopes the comments throughout this report are useful to the Facility as it continues to work toward meeting the requirements of the Settlement Agreement.

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment 10/30/12 2. RSSLC Action Plan 10/15/12 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 4/10/12 7. PMAB Training Curriculum 8. Facility training materials for restraint monitors 9. Restraint documentation for crisis intervention restraints: Individual #600 6/30 at 8:13am, 7/6 at 6:15am, 7/24 at 9:20am and 9:25am, and 7/29 at 7:35am, Individual #287 7/29 and 9/23 at 6:10pm, Individual #448 6/11 at 11:00am and 9/4 at 9:05am, Individual #142 5/25 at 9:15am and 6/30 at 9:45am, Individual #630 7/16 and 7/24, Individual #624 9/29 at 7:09pm, Individual #306 8/10, Individual #278 9/23, Individual #314 8/5, Individual #151 9/27, Individual #32 6/14, Individual #267 9/11, Individual #511 9/12, Individual #193 5/22 at 6:01pm, Individual #325 7/17, Individual #113 9/7 at 5:10pm, Individual #17 8/24, Individual #346 8/19 at 10:35, Individual #100 6/9, Individual #210 7/23 at 12:08pm, Individual #672 9/26 at 2:50pm, Individual #424 8/21, Individual #798 9/6, and Individual #576 8/20 10. Restraint documentation for medical restraints (refer to Sample J3 in Section J of this report) 11. 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 12. State report "Percent of All Employees Completing Courses of Training Program" 10/17/12 13. Restraint related monitoring/QA forms and reports 14. List of individuals with a Safety/Crisis Intervention Plan (10/10/12) 15. List of individuals injured during restraint (10/11/12) 16. Crisis Intervention Restraint log 5/1/12 to 11/9/12 17. Facility Restraint Trend Analysis 10/31/12 18. Incident Management Team minutes for 7/2, 7/9, 7/16, 7/23, 7/30, 8/6, 8/13, 8/20, 8/27, 9/3, 9/10, 9/17, 9/24, 10/1, 10/8 and 10/15, 2012 19. List of staff approved as Restraint Monitors (undated) 20. Restraint Monitors training transcripts (23) 21. Direct Support Professional (DSP) training transcript for a sample of 24 employees **People Interviewed:** 1. Bobby Buckner, Director of Behavioral Services 2. Pat Newell, Psychology Assistant

	Meetings Attended/Observations: 1. Incident Management Team (IMRT) 11/13/12 2. Sabine Unit Morning Meeting 11/13/12 3. Quality Assurance/Quality Improvement (QA/QI) Council 11/13/12 4. Restraint Elimination Committee 11/13/12
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section C. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Specific elements of the self-assessment are presented in each Provision. The Facility self-assessment relied almost exclusively on a review of recent QA/QI Monitoring Tool data. The self-assessment did not provide any data collected from the Behavioral Services Department. In the last review, the Facility reported it had a process to compare audit results from the QA Auditor with audit results from the Behavioral Services Department. It was unclear if this was still the case as no inter-rater reliability data was presented in the self-assessment. The self-assessment reported substantial compliance with Provision C.2 and noncompliance with the other seven Provisions in Section C. The Monitoring Team determined that Provision C.2 and C.6 were in substantial compliance. The self-assessment for each provision has been copied below into the assessments of the status of each provision in order to facilitate comparison of Facility findings to the findings of the Monitoring Team. The Facility's Action Plan that accompanied the self-assessment was overly vague and non-specific. The Action Plan for most provisions was a similar four step set of actions: 1) train staff in xyz, 2) monitor xyz, 3) report monitoring data to the QA/QI Council quarterly, and 4) develop corrective action plans. This generic nonspecific approach to describing Action Plans to the Monitoring Team is unlikely to lead to the improvements needed to reach compliance with the Settlement Agreement (SA).
	Summary of Monitor's Assessment: Restraint use at the RSSLC has been steadily increasing over the last two review periods. The Facility attributes this primarily to Individuals who have been recently admitted and have lived at the Facility less than one year. Data supports this. The trend line for restraint use of Individuals who have lived at the Facility more than one year showed a steady decrease. Restraint documentation had improved as Facility staff had undergone considerable training since the revised State (and RSSLC policy) went into effect in April, 2012. 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 confirmed compliance. In addition, the Monitoring Team found compliance with Provision C.6 which addresses, primarily, supervision of Individuals while in restraint.

	The use of crisis intervention restraint at RSSLC increased significantly since the last review period. This is the second consecutive review period with a significant increase in the use of crisis intervention restraint. In both review periods this increase was attributed primarily to difficult new admissions. The process of documenting restraints on the Restraint Checklist and Face-to-Face Assessment Debriefing was much improved from that noted in previous reports. The State office released a new restraint policy in April which included several significant changes in procedure and documentation requirements. The Facility had revised its restraint policy to incorporate requirements in the State policy. Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records and minutes of the Incident Management Team (IMRT), no use of prone restraint was identified. Most crisis intervention restraint use at the RSSLC was highly restrictive (basket-hold, horizontal side-lying, or four- point mechanical). The Facility reported that an injury occurred to the restrained Individual during 15% of restraints. Data related to staff training was sufficient to demonstrate substantial compliance with the training requirements in Provisions C.3 and C.5. The restraint monitoring process at the Facility was deficient in important areas. The Facility practices needed to ensure a substantive clinical and administrative review of each restraint episode were defined well in policy but not fully operationalized. Video surveillance tapes that had recorded a restraint episode are available for review, including the events immediately preceding the restraint and the events immediately following release from restraint; however, this had only been used twice since the last review. There has been some progress regarding the monitoring for safety during medical restraints, as the new Medical/Dental Restraint Checklist has consolidated vital sign monitoring into one place. Many individuals still lack needed plans to reduce the need for pre-treatment sedation. Improvements in both areas are needed for the Facility to come into compliance with the requirements of the provision.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Conducted a review of the most recent Section C QA/QI Audit results which included audits of 99 of 185 restraints from 3/1/12 to 8/31/12 to ensure that	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	restraints were only used: because the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures was 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 and that only restraint techniques approved in the SSLCs policies were used. From its self-assessment the Facility determined that: 2. Section C audit results indicated that: in 100% of restraints, the individual posed an immediate and serious risk of harm to him/herself or others; in 100% of restraints, restraint was used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner; in 100% of restraints, restraint was used only for reasons other than as punishment; in 88% of restraints (n=87), restraint was used only for reasons other than for convenience of staff; in 100% of restraints, restraint was not used in the absence of or as an alternative to treatment; and, in 100% of restraints, an approved technique was used and no prone restraint was used. Based on findings of this self-assessment, the Facility determined this provision was not in substantial compliance because only 88% of Section C audit results clearly demonstrate that the restraint was used for reasons other than convenience of staff and according to written policies and procedures. Monitoring Team note: if the Facility determined that 12% of restraint use occurred for the convenience of staff it is possible these restraints also occurred in the absence of or as an alternative to treatment. The Facility self-assessment did not address this. The self-assessment also did not note the significant revisions to the Facility's policy that governs the use of restraint and any staff training that occurred in its implementation. <u>Monitoring Team findings</u> DADS issued a substantial revision to its statewide Restraint Policy on 4/10/12. Instructions and training material were provided to each Facility. Facilities were encouraged to phase in implementation of the requirements of the new policy in an orderly manner as staff was trained. Consequently, there was not a firm implementation date from which the Monitoring Team could assess compliance with the new policy. The RSSLC revised its restraint policy (J.1) to meet the requirements of the revised State policy with an effective date of 4/10/12. Consequently, for this review restraints were reviewed against the requirements of the new policy.	

#	Provision	Assessment of Status	Compliance
		The major changes represented in the new policy included: 1. Replacing one Restraint Checklist with three (one for crisis intervention restraint, one for medical/dental restraint, and one for protective mechanical restraint for self-injurious behavior). 2. Adding a psychology department review component to the Face-to-Face Assessment/Debriefing form. 3. Establishing a requirement for an ISP Action Plan, which is intended to decrease and ultimately eliminate the use of restraint for the individual. Action Plans (or review of an existing plan) are required when: a. There have been more than three crisis restraint episodes in a rolling 30-day period. b. There is a consistent pattern of injuries to the individual or others as restraint procedures are carried out. c. Restraint use has not decreased over time and is likely to continue unless an ISP action plan is implemented or an adjustment is made in the current ISP action plan. d. The characteristics of the individual (e.g., strength, size, etc.) or changes in contraindications require that standard restraint procedures be adapted to meet his or her specific needs. e. An individual has persistent self-injurious behavior, and intensive supervision and implementation of the PBSP have not sufficiently reduced the potential for imminent physical harm. f. An individual's behavior is making it difficult if not impossible to provide needed medical or dental treatment or is inhibiting or undoing medical or dental treatment. g. The ISP action plan has been effective in greatly reducing the use of restraints, and thus the plan, including staff instructions on the use of restraint procedures, needs revision. 4. Establishing a new restraint category for "protective mechanical restraint for self-injurious behavior" which is described in the policy as "a type of mechanical restraint applied prior to the individual engaging in self-injurious behavior for the purpose of preventing or mitigating the danger of the self-injurious behavior". 5. Establishing a requirement for a "Protective Mechanical Restraint Plan for Self-Injurious Behavior" which is described in the policy as a component of the ISP action plan and provides instructions for staff on how to effectively and safely apply the protective mechanical restraint, including a description of the individual's self-injurious behaviors, and instructions on when to apply and remove the restraint. The plan must identify: (1) any low-risk situations when the restraint may be safely removed and what staff should	

#	Provision	Assessment of Status	Compliance
		do during those situations to continue to protect the individual from harm; and (2) adjustments in staff instructions as progress is made for gradually eliminating the use of the restraints. 6. Establishing detailed operational requirements associated with the use of protective mechanical restraints for self-injurious behavior. The Facility reported that much of its work activity since the last review was associated with training staff on the new policy, initiating implementation steps, and monitoring implementation. The Facility conducted routine auditing of restraint documentation, using standardized monitoring tools, which provided the necessary data to identify practice and documentation discrepancies requiring administrative follow-up. The data resulting from this monitoring was also used by the Facility to determine, in part, its self-assessment rating. From information provided to the Monitoring Team it appears most of, if not all, of this monitoring was done by Facility QA staff. The use of crisis intervention restraint at the Facility had increased significantly. The Facility reported this was due to a number of new admissions with particularly difficult behavioral issues. As noted below crisis intervention restraint was used 222 times with 26 different Individuals from 5/1/12 through 10/31/12. In the previous six month period (November 2011 through April 2012) crisis intervention restraint was used 168 times. This was an increase of 32%. The Restraint Trend Report provided by the Quality Assurance Department for the time period ending 9/30/12 included data separating new admission Individuals (those living at the Facility less than one year) from other Individuals. These data showed 56% of crisis intervention restraint used since May were attributable to Individuals who had lived at the Facility less than one year. Additionally, the trend line for restraint use with Individuals living at the Facility longer than one year showed a steady decrease in restraint utilization. **Type of Restraint** / **Date Range** 5/1/12 to 10/31/12 / **Date Range** 11/1/11 to 4/30/12 Physical restraints used during a behavioral crisis: 200 / 168 Chemical restraints during a behavioral crisis: 2 / * Mechanical restraints during a behavioral crisis: 20 / * TOTAL restraints used in: 222 / 168	

#	Provision	Assessment of Status	Compliance

behavioral crisis		
TOTAL individuals restrained in behavioral crisis	26	*
Of the above individuals, those restrained pursuant to a Safety/Crisis Intervention Plan	11	*

*data not reported on the Facility Trend Report

RSSLC had improved its restraint documentation practices from that observed at the last review. For example, in its last report the Monitoring Team noted that none of the crisis intervention restraint documentation files contained the "Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint" and most did not contain documentation that the Incident Management Review Team (IMRT) reviewed the restraint episode. This was noted to be much improved. In its last report the Monitoring Team expressed concern that there did not appear to be sufficient internal controls to ensure the use of restraint occurred within the parameter of defined policy and procedure. This too had improved.

The Facility reported it had spent considerable effort since the last review training staff on the new Facility policy on restraint. This policy was effective 4/10/12 and mirrored the new State policy. The Monitoring Team was able to confirm the Facility's assertion that implementation of the new policy improved record-keeping, restraint practices, and associated documentation.

In its last report the Monitoring Team noted that the use of crisis intervention restraint had increased significantly (+43%) since the prior period. This was reported to be primarily attributable to issues presented by several new admissions. This upward trend in the use of crisis intervention restraint had continued. As reported above, the Facility had experienced a 32% increase since the last review, again attributing this to new admissions. Since May, 56% of crisis intervention restraint use was attributable to Individuals who have lived at the Facility less than one year. This trend is of concern to the Monitoring Team and raises questions as to Facility practices with respect to pre-admission planning, initial assessments, IDT decision-making, ISP implementation, and staff training and competencies. These topics are discussed in various other sections of this report. The Facility needs to determine areas in need of improvement and work aggressively on improvement plans.

#	Provision	Assessment of Status	Compliance
		In its last report the Monitoring Team noted the Facility had expanded the Restraint Trend Report to include key data tracked longitudinally, which enabled the Monitoring Team (and the Facility) to review six-month trends and note that crisis intervention restraint was primarily the result of Individuals being aggressive towards staff and that most restraints occurred in the afternoon. Restraint trend reports presented to the Monitoring Team for this review were not as detailed and did not present data related to the reason for restraint such as aggression to staff, aggression to others, elopement, self-injurious behavior, etc. This is important data to facilitate interdisciplinary problem solving. The Facility also reported the Restraint Elimination Committee had not met since the last review because so much attention was devoted to implementation of the new restraint policy. This was unfortunate, especially in light of the increased use of crisis intervention restraints and associated issues described above. The Restraint Elimination Committee did meet during the week of this review. Crisis intervention restraint used at the RSSLC continued to be highly restrictive. From the Monitoring Teams sample of 32 restraints, 29 (91%) were basket-hold, horizontal side-lying, chemical, or four-point mechanical. The restraint Trend Analysis Report did not include data on restraint type but should include such data. This pattern of use of highly restrictive restraint techniques was noted by the Monitoring Team in its last two reports. This is of concern to the Monitoring Team and raises questions as to Facility practices with respect to ISP planning, assessments, IDT decision-making, ISP implementation, active treatment engagement, and staff training and competencies. These topics are discussed in various other sections of this report. The Facility needs to determine areas in need of improvement and work aggressively on improvement plans. Treatment plans that inadvertently overly rely on restraint use are not acceptable and should be addressed through program planning, staff training, and implementation. The Monitoring Team assembled two samples of restraint use at the RSSLC. 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 request. These samples were: 1. Restraint documentation for 32 crisis intervention restraints: Individual #600 6/30 at 8:13am, 7/6 at 6:15am, 7/24 at 9:20am and 9:25am, and 7/29 at 7:35am, Individual #287 7/29 and 9/23 at 6:10pm, Individual #448 6/11 at 11:00am and 9/4 at 9:05am, Individual #142 5/25 at 9:15am and 6/30 at 9:45am, Individual #630 7/16 and 7/24, Individual #624 9/29 at 7:09pm, Individual #306 8/10, Individual #278 9/23, Individual #314 8/5, Individual #151 9/27, Individual #32 6/14, Individual #267 9/11, Individual #511 9/12, Individual #193 5/22 at 6:01pm, Individual #325 7/17, Individual #113 9/7 at 5:10pm, Individual #17 8/24, Individual #346 8/19 at 10:35, Individual #100 6/9, Individual #210 7/23 at 12:08pm, Individual #672 9/26 at 2:50pm,	

#	Provision	Assessment of Status	Compliance
		Individual #424 8/21, Individual #798 9/6, and Individual #576 8/20. 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 were represented. This sample represented 20% of the 160 crisis intervention restraints since the last review reported on the Facility log. 2. Restraint documentation for medical restraints this sample is described in Section J of this report (Sample J3). To assist in the review of restraint documentation the Monitoring Team asked that the Facility prepare a documentation file for each restraint episode selected for the above samples. This was to include the Restraint Checklist, Face-to-Face Assessment/Debriefing, any medical orders, any physician-specified monitoring schedule, any standard facility protocol for monitoring restraint, documentation of review activity, and any other information that might be helpful in understanding the circumstances associated with the restraint use such as the individual's Positive Behavior Support Plan. The expectation of the Monitoring Team was that the Facility would provide all documentation it had that it felt would demonstrate compliance with Section C of the Settlement Agreement (SA). <u>Prone Restraint</u> Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records and minutes of the Incident Management Team (IMRT), no use of prone restraint was identified or the subject of any discussion in meeting minutes. Many 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. In its last report the Monitoring Team recommended 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. The Facility did not provide any evidence that restraint review procedures considered this suggestion. Additionally, the Facility had not as yet fully implemented use of video review of restraint episodes. Use of this would further demonstrate compliance with this requirement of the SA. <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.	

#	Provision	Assessment of Status	Compliance
		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: 1. All 32 records (100%) included documentation showing that the Individual posed an immediate and serious threat to self or others. The Face-to-Face Assessment and Debriefing (FFAD) asks "person's behavior an immediate and serious risk of harm to self or others?" In each case the response was "yes." This was supplemented with a narrative comment. The data on the FFAD was corroborated by narrative information on the Restraint Checklist (RC). Some documentation was unclear and contained apparently conflicting information. For example, for Individuals # 600 on 6/30, #210 on 7/23, and #424 on 8/23 the Restraint Checklist reported event code 3 (yelling/screaming) as the behavior of the Individual at the time the restraint began. Narrative information on the first page of the RC was more descriptive and likely more accurate. Presumably a person would be engaged in behavior more intense than yelling and screaming when a determination to apply restraint is made. 2. All 32 records (100%) included documentation showing that the restraint monitor could validate that restraint was used for the appropriate reason (not for the convenience of staff or as punishment). This documentation is contained in the FFAD. Some documentation was unclear and contained apparently conflicting information. For example, as noted above for Individuals # 600 on 6/30, #210 on 7/23, and #424 on 8/23 the Restraint Checklist reported event code 3 (yelling/screaming) as the behavior of the Individual at the time the restraint began. Narrative information on the first page of the RC was more descriptive and likely more accurate. Using restraint in response to an individual yelling and screaming could be interpreted as being done for the convenience of staff. 3. All 32 records (100%) included documentation showing that preventative strategies and interventions were attempted prior to restraint. There was limited information recorded in restraint documentation that addressed the effectiveness of preventative interventions and strategies. Section II of the Debriefing document, completed by a psychologist, should be more descriptive. In many instances the response to what might be considered a thought provoking point of inquiry was simply recorded as a "yes" or "no". 4. Only 26 of 32 (81%) restraint records included documentation that the Interdisciplinary Team (IDT) reviewed the restraint episode. Those that did not were restraints for Individuals #142 (5/25 and 6/30), #448 (6/11), #325 (7/17), #32 (6/14), and #424 ((8/21). IDT review of restraint episodes is an important part of the ISP process.	

#	Provision	Assessment of Status	Compliance
		5. Thirty-one of 32 (97%) records included documentation validating Unit Morning Meeting review of the restraint episode. Restraint for Individual #142 (5/25) did not. Much of this documentation consisted of entries on the RC and FFAD. The Facility was asked to provide meeting minutes to further validate compliance and was able to do so in only 19 (59%) cases. Those that did not were restraints for Individuals #142 (5/25), #100 (6/9), #600 (6/30), #630 (7/24), #287 (7/29), #306 (8/10), #346 (8/19), #113 (9/7), #511 (9/12), #278 (9/23), #287 (9/23), #151 (9/27), and #624 (9/29). Nearly all minutes were devoid of substantive comments, ordinarily just providing a record that the restraint occurred. 6. Thirty of 32 (94%) records included documentation validating IMRT Meeting review of the restraint episode. Much of this documentation consisted of entries on the RC and FFAD. The Facility was asked to provide meeting minutes to further validate compliance and was able to do so for 28 of the 30 cases. The two records that did not include data to support IMRT review were restraints for Individuals #142 (6/30) and #630 (7/24). The Facility needs to continue to improve its restraint review process (Provision C.8) to ensure documentation is complete, accurate, and any conflicting or apparent contradictory data is reconciled. <u>Medical Restraint Use - Rates Of Use Of Pre-Treatment Sedation</u> The dental clinic provided data that showed that between April and October the average monthly number of sedations used for dental clinic appointments for completed appointments was 144. Per the Facility's report, anesthesia was used for an average of 10.6% of all completed appointments, and oral pre-treatment sedation was given for 13.4% of completed appointments. Data was not provided by the Facility for rates of medical pre-treatment sedation. <u>Monitoring For Safety During Medical Restraint</u> There were two protocols for nurse monitoring for safety. When oral pretreatment sedation was used for medical or dental appointments, a nursing protocol for pretreatment and post sedation monitoring was used. The protocol called for vital sign assessment at baseline (prior to the administration of the medication). After that, vital signs were obtained every 30 minutes until the procedure started. After the procedure, monitoring continued every 30 minutes for one hour, then every two hours for four hours, then every four hours for twenty-four hours. Following TIVA anesthesia, the post anesthesia recovery protocol was used. The protocol was vital signs during recovery every 15 minutes for an hour, then every 30 minutes until an adequate level of arousal was assessed via a REACT sedation of at least 8. Vital signs were then assessed every two hours for a total of four hours, then every shift for 72 hours.	

#	Provision	Assessment of Status	Compliance
		To assess monitoring for safety, the Monitoring Team selected 10 examples of medical restraints. These included oral pre-treatment sedation for medical procedures (three examples), oral pre-treatment sedation for dental procedures (four examples) and TIVA sedation for dental care (three examples). Results were as follows: • Oral pre-treatment sedation for dental procedures: Medical orders were provided for the day of the procedure. REACT scores were provided followed by Integrated Progress Note (IPN) documentation of vital sign monitoring for the required duration of time. • Oral pre-treatment sedation for medical procedures: Medical orders were provided for the day of the procedure. Vital sign documentation for safety was provided (although in one of the three cases, the medical restraint form was not used). In each of the three cases there was significant deviation from the acute care protocol. In two cases there was significant deviation from the required frequency for monitoring. In one case there was a twelve hour hiatus in monitoring; in a second, vital signs that should have been done with a hiatus of two hours were done after four hours. In the third case documentation of vital sign monitoring was provided for 13 hours although the protocol required 25 hours. • 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 each case. Overall, the introduction of the new Medical/Dental Restraint Checklist appears to have simplified the recording of vital signs at the intervals specified by the nursing protocols. In at least one case, however (Individual #318) the form appears to have been used incorrectly: The form indicated that vital signs were needed at specified time points after completion of the procedure, in that case at two and four hours. That would have led to a two hour interval between the measurements. Instead, the nurse doing the monitoring took the vitals with intervals of two and then four hours. As a result, what should have been an interval of two hours became four. Further training on the use of the new checklist may be needed. <u>Status of Development of Plans to Minimize the Need for Pre-Treatment Sedation:</u> The Facility reported that there were plans to minimize the need for pre-treatment sedation for 10 of 61 (16%) of individuals who received oral pre-treatment sedation, for 47 of 80 (58%) of individuals who received dental pre-treatment sedation, and 87 of 110 (79%) individuals who received TIVA. Plans to minimize the use of pre-treatment	

#	Provision	Assessment of Status	Compliance
		sedation were provided for two of ten (20%) individuals in Sample J4. The Monitoring Team reviewed these two plans. • For Individuals #318 and #120, the purpose of the plan was to increase the individual's ability to participate in periodic medical procedures. This was done by a graduated approach. Data sheets were provided for each individual, verifying participation in three sessions of training. There has been some progress regarding the monitoring for safety during medical restraints, as the new Medical/Dental Restraint Checklist has consolidated vital sign monitoring into one place. Many individuals still lack needed plans to reduce the need for pre-treatment sedation. Improvements in both areas are needed for the Facility to come into compliance with the requirements of the provision. The Facility, while demonstrating improvement, continued to experience difficulties in administrating the use of restraint in accordance with all applicable written policies, procedures, and plans governing restraint use, as required by the SA. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: conducted a review of the most recent Section C QA/QI Audit results which included audits of 99 of 185 restraints from 3/1/12 to 8/31/12 to ensure that 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: Section C audit results indicated that in 99% of restraints (n=96), restraint was terminated as soon as the individual is no longer a danger to him/herself or others. Based on findings of this self-assessment, the Facility determined this provision is in substantial compliance because 99% of restraints reviewed were terminated as soon as the individual was no longer a danger to him/herself or others. <u>Monitoring Team findings</u> Thirty-two crisis intervention restraints were included in Sample C.1. From data recorded on the RC and the FFAD in all (100%) restraint release occurred when 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: Documentation of restraint review described in Provision C.1 by the Unit Team (missing 19% of the time) and the IMRT (missing 6% of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		the time) needs to improve. One purpose of these reviews is to ensure that data recorded on the RC and the FFAD reviewed by the Restraint Monitor 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 including 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.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the current RSSLC restraint policy to ensure that policies 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. 2. Reviewed the most recent Section C QA/QI Audit results which include audits of 99 of 185 restraints from 3/1/12 to 8/31/12 to assess whether restraint documentation indicated that restraint was used only after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner, the restraint used was the least restrictive intervention necessary to manage behaviors, and that staff responsible for applying the restraint techniques had successfully completed competency-based training on PMAB. From its self-assessment the Facility determined that: 1. Current restraint policies 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. 2. Since Section C audit results indicate that in 100% of restraints, restraint was used only after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner, it is determined that in 100% of restraints, the restraint used was the least restrictive intervention necessary to manage behaviors. Section C audit results indicate that in 98% of restraints (n=95), staff responsible for applying the restraint techniques had successfully completed	Noncompliance

#	Provision	Assessment of Status	Compliance
		competency-based training on PMAB. Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance because in 4 of the 99 restraints reviewed, there was no clear documentation to indicate that staff had received proper training. Monitoring Team note: this Provision also includes elements of policy implementation. The Facility only considered the staff training component of policy requirements. <u>Monitoring Team findings</u> 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 24 staff training records (selected by picking the fourth name of a direct care 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 training transcripts for all 23 DCPs in the sample confirmed completion of the above classes 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:	

#	Provision	Assessment of Status	Compliance
		• 98% RES0105 Restraint: Prevention and Rules for Use at MR Facilities • 98% RES0110 Applying Restraint Devices • 98% PMA0320 – PMAB Basic • 98% PMA0400- PMAB Restraint • 98% PMA0700 –PMAB Prevention • 98% 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. 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 the most recent Section C QA/QI Audit results which include audits of 99 of 185 restraints from 3/1/12 to 8/31/12 all restraints, other than medical restraints, are limited to crisis interventions, no restraint was used that is prohibited by the individual's medical orders or Interdisciplinary Team, and that if medical restraints are required for routine medical or dental care for an individual, the Individual Support Plan for that individual shall include treatments or strategies to minimize or eliminate the need for restraint. 2. Reviewed a list of all individuals requiring restraints for routine medical or dental care to determine if the individual has a Medical or Dental Support Plan. From its self-assessment the Facility determined that: 1. Section C audits indicated that in 100% of restraints other than medical restraints, the restraint was implemented in response to a crisis. Section C audits indicated that in 100% of restraints other than medical restraints, the restraint used was not prohibited by medical orders or the individual's IDT. 2. All individuals needing a plan to minimize or eliminate the need for restraint have one; however, only 40% of Dental and Medical Support Plans have measurable objectives against which to monitor progress Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance due based upon the lack of empirical evaluation of the	Noncompliance

#	Provision	Assessment of Status	Compliance
		effectiveness of Dental and Medical Support Plans and known issues with the implementation of Dental Support Plans. Monitoring Team note: The Facility self-assessment did not address the component of the Provision "no restraint shall be used that is prohibited by the individual's medical orders or ISP." Future self-assessments should address this. <u>Monitoring Team findings</u> Based on a review of 32 crisis intervention restraints (Sample C.1), in all (100%) there was evidence documenting that restraint was used as a crisis intervention. The Facility used a RSSLC form titled "Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint" to address the SA requirement that restraint not be used that is prohibited by the individual's medical orders. This form was present in 28 of the 32 (88%) documentation files prepared for the Monitoring Team. Those that did not include this form were restraints of Individuals #314, #287 (2x), and #151. In the 28 instances where this form was present, the physician noted for 10 Individuals (36%) "based on the medical conditions identified above the IDT should consider the risk/benefit in determining if restraint should be used and put into place any safeguards to minimize the risk(s)." IDT follow-up was intended to be documented on a form entitled "Special Considerations" which included a template heading "Restraint Techniques/Mechanical Devices Limitations". This documentation was insufficient in six (60%) of the ten instances. In two instances the Facility was unable to produce the Special Considerations form (Individuals #278 and #511). In four instances the Special Considerations form contained information or statements of fact without reference to its implications for safe use of restraint.; for example, "fragile bone precaution" or "reflux with hiatal hernia." This was the case with Individuals #798, #100, #346, and #672. Sufficient information reflecting due consideration by the IDT was reflected on the Special Considerations form for Individuals #113, #630, #17, and #424. In the 28 instances where this form was present, the physician noted "no restrictions" for seven Individuals (25%). Five of these seven (71%) Individuals had conditions cited in the Active Problem List section of the Annual Medical Summary that on their face suggested a need for thoughtful consideration in contemplating restraint limitations and safety. For example, these included medical conditions such as scoliosis, PTSD, obesity, ADHD, hypothyroidism, and seizure disorders. In summary, there were 28 instances where the form was present. In 10 instances the physician referred the consideration of risk/benefit to the IDT (which as noted above didn't always act), in seven instances the physician noted no restrictions to the use of restraint (which as noted above may not	

#	Provision	Assessment of Status	Compliance
		have carefully considered all potential medical risk), and in 11 instances the physician described specific limitations with respect to the safe use of restraint with the Individual. No documentation was provided that would address the additional requirement that prohibitions against restraint other than medical considerations, such as information in a functional assessment indicating that restraint serves as a reinforcer, or a history of physical abuse involving physical restraint, were assessed, considered, and noted in an Individual's ISP. It is important that 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. <u>Status of Development of Plans to Minimize the Need for Pre-Treatment Sedation:</u> The Facility reported that there were plans to minimize the need for pre-treatment sedation for 10 of 61 (16%) of individuals who received oral pre-treatment, for 47 of 80 (58%) of individuals who received dental pre-treatment sedation, and 87 of 110 (79%) individuals who received TIVA. Plans to minimize the use of pre-treatment sedation were provided for two of ten (20%) individuals in Sample J4. These two plans were reviewed by the Monitoring Team. • For Individuals #318 and #120, the purpose of the plan was to increase the individual's ability to participate in periodic medical procedures. This was done by a graduated approach. Data sheets were provided for each individual, verifying participation in three sessions of training. 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 Provision 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	<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
	months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed 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.	assessment: conducted a review of the most recent Section C QA/QI Audit results which included audits of 99 of 185 restraints from 3/1/12 to 8/31/12 to assess whether staff trained in the application and assessment of restraint conducted and documented a face-to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint, that a licensed health care professional monitored and documented vital signs and mental status of the 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, whether in extraordinary circumstances, with clinical justification, the physician ordered an alternative monitoring schedule, and whether a licensed health care professional checked and documented vital signs and mental status of the individual within 30 minutes of the individual's return to the SSLC for restraints away from the facility and whether in each instance of a medical restraint, the physician specified the schedule and type of monitoring required. From its self-assessment the Facility determined that: 1. Section C audits indicated: a. 95% of restraints (n=93), staff conducting the face-to-face assessment was trained in the application and assessment of restraint. b. 88% of restraints (n=87), the assessment was completed within 15 minutes from the start of the restraint. c. 66% of restraints (n=65), vital signs were monitored and documented every 30 minutes from the start of the restraint. d. 71% of restraints (n=67), mental status was monitored and documented every 30 minutes from the start of the restraint. e. Section C audits indicated no restraints resulted in an individual needing an alternative schedule of monitoring. f. There were no restraints away from the facility and no medical restraints are included in the sample. Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance due to: the assessment was completed within 15 minutes from the start of the restraint in only 88% of restraints reviewed, vital signs were monitored and documented every 30 minutes from the start of the restraint in only 66% of restraints reviewed, and in only 71% of restraint, mental status was monitored and documented every 30 minutes from the start of the restraint. Monitoring Team note: the Facility self-assessment did not address the specific training required for staff serving as Restraint Monitors (against which compliance would be measured) and should in the future.	

#	Provision	Assessment of Status	Compliance
		Monitoring Team findings 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 Monitoring Team reviewed the training transcripts for the 23 staff who acted as a restraint monitor for the 32 restraints in Sample C.1. 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 restraint monitor training All 23 staff who acted as a restraint monitor for the 32 restraints in Sample C.1 were current with all required training. Based on a review of 32 restraint records for restraints that occurred (30 at the Facility and two off-campus) Sample C.1, there was documentation that a licensed health care professional: ▪ Conducted monitoring at least 15 minutes from the initiation of the restraint in 18 (56%) of the instance of restraint. Those that did not included: o Individual #142: 6/30/12 at 9:45 a.m. o Individual #448: 6/11/12 at 11:00 a.m. and 9/4/12 at 9:05 a.m. o Individual #306: 8/10/12 at 7:08 a.m. o Individual #624: 9/29/12 at 7:09 p.m. o Individual #630: 7/24/12 at 2:59 p.m. o Individual #151: 9/27/12 at 1:35 p.m. o Individual #287: 7/29/12 at 12:40 p.m. o Individual #32: 6/14/12 at 2:45 p.m. o Individual #346: 8/19/12 at 10:35 p.m. o Individual #511: 9/12/12 7:30 p.m. o Individual #193: 5/22/12 at 6:01 p.m. o Individual #600: 7/6/12 at 6:15 a.m. o Individual #17: 8/24/12 at 12:00 p.m.	

#	Provision	Assessment of Status	Compliance
		▪ Monitored and documented vital signs at least every 15 minutes from the start of the restraint until released in 12 (38%). Records that did not contain documentation of this included: o Individual #142: 6/30/12 at 9:45 a.m. o Individual #306: 8/10/12 at 7:08 a.m. o Individual #151: 9/27/12 at 1:35 p.m. o Individual #600: 7/6/12 at 6:15 a.m., and 7/24/12 at 9:20 a.m. o Individual #32: 6/14/12 at 2:45 p.m. o Individual #511: 9/12/12 at 7:30 a.m. o Individual #630: 7/24/12 at 2:59 p.m. o Individual #287: 7/29/12 12:40 p.m. o Individual #448: 9/4/12 at 9:05 am o Individual #314: 8/5/12 at 12:07 a.m. o The vital signs were documented as refused on the following Individuals: ▪ Individuals 448: 6/11/12 at 11:00 a.m. ▪ Individual #624: 9/24/12 at 7:09 p.m. ▪ Individual #267: 9/11/12 at 11:30 a.m. ▪ Individual #100: 6/9/12 at 8:45 a.m. ▪ Individual #193: 5/22/12 at 6:01 p.m. ▪ Individual #424: 8/21/12 at 4:00 p.m. ▪ Individual #314: 8/5/12 at 12:07 a.m. ▪ Individual #142: 5/25/12 9:15 a.m. ▪ Monitored and documented mental status at least every 15 minutes from the start of the restraint until released in 18. Records that did not contain documentation of this included: o Individual #142: 6/30/12 at 9:45 a.m. o Individual #306: 8/10/12 at 7:08 a.m. o Individual #151: 9/27/12 at 1:35 p.m. o Individual #600: 7/6/12 at 6:15 a.m., and 7/24/12 at 9:20 a.m. o Individual #32: 6/14/12 at 2:45 p.m. o Individual #511: 9/12/12 at 7:30 a.m. o Individual #630: 7/24/12 at 2:59 p.m. o Individual #287: 7/29/12 12:40 p.m. o Individual #448: 9/4/12 at9:05 a.m. o Individual #314: 8/5/12 at 12:07 a.m. o Individual #193: 5/22/12 at 6:01 p.m. o The mental status was documented as refused or unable to assess on the following restraint episodes: ▪ Individual #448: 6/11/12 at 11:00 a.m. ▪ Individual #624: 9/29/12 at 7:09 p.m.	

#	Provision	Assessment of Status	Compliance
		▪ Three of 32 (10%) restraint episodes were documented on the outdated Restraint Checklists, 06032010R. Records included: o Individual #142: 5/25/12 at 9:15 a.m. o Individual #193: 5/22/12 at 6:01 p.m. o Individual #100: 6/9/12 at 8:45 a.m. The Facility should purge the outdated Restraint Checklist form, 06032010R, and ensure that the revised Crisis Intervention Restraint Checklists form, SSLC001A, is used. The Monitoring Team noted documentation on the Restraint Checklists of numerous refusals by the Individuals to allow the nurses to complete the required vital signs monitoring. In the future, if an individual frequently refuses to allow the nurses to complete the required monitoring, this may indicate a need to do something different with the ISP, skill acquisition plan, or safety plan. For two of the restraint episodes, the nurses' document that the individuals either refused or they were unable to assess their mental status. However, the nurses' should be able to assess and document mental status through observation. The Nursing staff should be re-trained on the RSSLC Use of Restraint, Policy Number: J.1 to ensure the required monitoring and documentation occurs at least every 15 minutes from the start of the restraint until released, as required by policy. Based on documentation provided by the Facility, two restraints had occurred off the grounds of the Facility in the last six months. The Monitoring Team reviewed both. A licensed health care professional: ▪ Conducted monitoring within 30 minutes of the individual's return to the Facility in two of two (100%). ▪ Monitored and documented vital signs in both. ▪ Monitored and documented mental status in both. ▪ In one of two (50%) restraint episodes, the results of assessment by a licensed health care professional indicated an injury was sustained during the restraint episode. Injuries to Individuals as a result of restraint are of concern to the Monitoring Team. The Facility reported 27 injuries had occurred since the last review during the use of restraint. This represents fifteen percent of restraint episodes. The Facility needs to ensure restraint review closely examines restraint practices and consider additional staff training specific to restraint application of specific Individuals to ensure safety. Video review would likely be helpful in this regard. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with	

#	Provision	Assessment of Status	Compliance
		this provision of the SA.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activity to conduct its self-assessment: conducted a review of the most recent Section C QA/QI Audit results which included audits of 99 or 185 restraints from 3/1/12 to 8/31/12. From its self-assessment the Facility determined that: Section C audits indicated that in 98% of restraints (n=97), the individual was checked for restraint-related injury. Section C audits indicated that in 100% of restraints (1 of 1), the individual was given opportunities to exercise restrained limbs. Section C audits indicated that in 100% of restraints (1 of 1), the individual was permitted to eat at as near meal times as possible. Section C audits indicated that in 50% of restraints (1 of 2), the individual was offered the opportunity to drink fluids. Section C audits indicated that in 50% of restraints (1 of 2), the individual was offered the opportunity to use a toilet or bedpan. Section C audits indicated that in 100% of restraints, the individual was provided with continuous one-to-one supervision or enhanced supervision (for medical restraints). Based on findings of this self-assessment, the Facility determined his provision is not in substantial compliance due to audits not demonstrating sufficient documentation that the individual was checked for restraint related injury, that food was offered, and that opportunity to toilet was offered. <u>Monitoring Team findings</u> A sample (Sample C.1) of 32 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: • In all 32 (100%) continuous one-to-one supervision was documented. • In all 32 (100%) the date and time restraint was begun was documented. • In all 32 (100%) the location of the restraint was documented. • In all 32 (100%) information about what happened before, including the change in the behavior that led to the use of restraint was documented. • In all 32 (100%) the interventions taken by staff prior to the use of restraint were documented and were adequate for post restraint review. • In all 32 (100%) the specific reasons for the use of the restraint were documented. • In all 32 (100%) the method and type (e.g., medical, dental, crisis intervention) of restraint were indicated on the restraint checklist. • In all 32 (100%) the names of staff involved in the restraint episode were indicated on the restraint checklist. Twenty-one (66%) of the restraints in the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		sample included use of the horizontal side-lying technique. In all 21 at least two staff were listed as applying the restraint. • The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint. The recorded activity and events were consistent with policy requirements in all 32 (100%) cases. • In all 32 (100%) the specific behaviors of the individual that required continuing restraint were noted. • Six of the 32 restraints (19%) reviewed were 15 minutes or longer. There was sufficient documentation on the RC for six of six (100%) 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 all 32 (100%) the level of supervision provided during the restraint episode was recorded on the restraint checklist. • In all 32 (100%) the date and time the individual was released from restraint was recorded on the restraint checklist. • In nine of 32 (28%) the results of assessment by a licensed health care professional indicated minor injuries were sustained during restraint episodes. The Restraint Checklists for Individual #142 on 6/30/12 at 9:45 a.m. and Individual #630 on 7/24/12 at 2:59 p.m., did not include documentation to indicate whether or not they sustained injuries during restraint episodes. In one instance the restraint monitor was not present within the required 15 minutes. This was the case with restraint of Individual #142 (6/30). The restraint monitor is reported to have arrived 18 minutes after the start of the restraint. None of the 32 crisis intervention restraint records in the sample had an alternative physician-ordered monitoring schedule. In its last report the Monitoring Team noted little evidence of continued improvement in restraint documentation since the last review. There was a significant improvement in restraint documentation noted during this review. The Monitoring Team has determined this Provision to be in substantial compliance. The sample reviewed by the Monitoring Team (N=32) did not detect problems in documentation as did the Facility self-assessment (N=99); this is not especially surprising given that the sample for this review was smaller than the self-assessment sample, and the self-assessment sample found high compliance except for two issues for which samples were very small (two individuals each). Additionally, the Facility has maintained a process to review restraint documentation, identify problems, and correct problems, primarily retraining of staff.	

#	Provision	Assessment of Status	Compliance
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	According to Facility documentation, during the six-month period prior to the on-site review, a total of 11 individuals were placed in restraint more than three times in any rolling thirty-day period. A sample of 11 of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met. The following documents were reviewed • ISPs, • ISP addenda, • PBSPs, • PBSP progress notes, • Restraint documentation • Psychological Evaluations and Updates The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. Of the 11 individuals who were restrained more than three times in a rolling thirty-day period, four individuals (36%) had at least one instance when the criteria for review were met but when no review of restraint was provided at any time. Two of these four individuals, Individuals #142 and #278, (18% of the individuals who met this criterion) had circumstances where criteria were met but no review was provided. For Individual #142, these circumstances had occurred in late May and June, which was early in the review period. For Individual #278, the circumstances that did not result in review occurred in September, which was much later in the review period. The remaining two from these four individuals (18%) experienced multiple circumstances in which criteria for restraint review were met, but only a portion of these circumstances resulted in review. For example, Individual #630 met the criteria for review on 5/8/2012, but none of the restraint applications involved was ever reviewed. Restraint applications that occurred following this point, however, were reviewed when criteria were met. It was also important to note that that for three individuals who met this criterion (27%), reviews of the restraint applications did occur but were conducted substantially after criteria were met. For these three individuals, the average delay was 29 days with a minimum delay of 24 days and a maximum delay of 35 days. Of these 11 individuals, eight individuals (64%) were provided with a review for restraint use for every instance in which criteria were met requiring review. In several	

#	Provision	Assessment of Status	Compliance
		circumstances, as described below, the review process provided by the Facility did not meet all elements of an adequate review.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For four of the individuals in the sample (36%), the interdisciplinary team (IDT) provided some review of the individual's adaptive skills. The following is an example of an individual for whom this was done appropriately:: • For Individual #113, the provided review thoroughly examined adaptive skills. The review revealed that the individual possessed well-developed adaptive skills, did not consider himself to be a good fit for RSSLC, and disliked living at the Facility. The following is an example of where teams failed to do this adequately: • For Individual #32, restraint reviews were lacking in detail. Although the review stated that no adaptive skill issues were identified, no specifics regarding adaptive skills were provided. For four of the individuals in the sample (36%), IDT provided some review of the biological, medical and psychosocial factors. The following is an example of an individual for whom this was done appropriately: • For Individual #600, multiple reviews were conducted that often overlapped with previous reviews. Each review provided detailed discussions for biological, medical, and psychosocial factors. As a result, factors affecting restraint applications were often given consideration at least twice. The following is an example of where teams failed to do this adequately: • A review of restraint was provided for Individual #448 on 9/5/2012 even though criteria for review were not met. The fact that the IDT implemented a review was positive. The review itself, however, did not contribute to the understanding of the restraint application. The review attributed the use of restraint to the death of a dog, but offered little explanation of how the death contributed to the need for restraint. Although the death of a dog could be a rare event, grief is a response associated with many different events. The review did not reflect that the IDT addressed the issue of grief or recommended supports such as counseling for this or future circumstances.	Noncompliance
	(b) review possibly contributing environmental conditions;	For four of the individuals in the sample (36%), the IDT provided some review of the possibly contributing environmental conditions. The following is an example of an individual for whom this was done appropriately: • Individual #624 was provided a review of restraint use on 9/28/2012. This review indicated that the use of restraint was predicated by the lack of	Noncompliance

#	Provision	Assessment of Status	Compliance
		opportunities to smoke. The individual became frustrated by the inability to smoke and did not respond to less restrictive efforts that included redirecting his attention and providing alternate activities. The following is an example of where teams failed to do this adequately: • Individual #287 was provided a restraint review on 10/17/2012. This review stated that no environmental factors could have contributed to the use of restraint as the individual was being provided 1:1 supervision. There was no indication of how such supervision would have prevented the environment from influencing the individual's behavior or the need for restraint.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For three of the individuals in the sample (27%), a structural assessment was conducted or the IDT provided some review of an existing structural assessments of the behavior provoking restraints. The following is an example of an individual for whom this was done appropriately: • For Individual #600, multiple reviews were conducted that often overlapped with previous reviews. Each review provided detailed discussion of the structural/functional assessment (SFA). As a result, it was evident that the adequacy of the SFA was routinely considered by the IDT. The following is an example of where teams failed to do this adequately: • Individual #306 was provided with restraint reviews on 5/5/2012, 6/13/2012, 7/2/2012, 7/5/2012, 7/30/2012, and 8/13/2012. In each of the restraint reviews it was indicated that a structural/functional assessment (SFA) was either in development or, later, had been completed. Despite the acknowledgement of an SFA, no details regarding findings were provided. Furthermore, although an SFA is intended to provide details regarding how the environment influenced behavior, the restraint reviews consistently indicated that no environmental factors were involved with the behavior that resulted in restraint. It should also be noted for Individual #306 that the primary emphasis of treatment involved psychiatric services or changes in the psychotropic drug regimen. Despite this emphasis, there was no indication that the SFA involved behaviors related to symptoms of mental illness.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	The Facility combined the structural and functional assessment process. As a result, comments offered in Sections C.7.c also apply to this section.	Noncompliance
	(e) develop (if one does not exist)	For eight of the individuals in the sample (73%), the individual had a PBSP. Of the eight	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	individuals in the sample who had PBSPs, the following was found: • Three (38%) were based on the individual's strengths; • Seven (88%) specified the objectively defined behavior to be treated that led to the use of the restraint; • Six (75%) specified a potential alternative, positive adaptive behavior to be taught to the individual to replace the behavior that initiates the use of the restraint. Only three (38%) included replacement behaviors identified through an adequate SFA. • Eight (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The following is an example of an individual for whom an adequate PBSP was in place: • Individual #287 was provided a comprehensive PBSP that was based upon an adequate SFA. It should be noted, however, that although the PBSP was adequate, it was not completed until five months after the individual came to live at the Facility. Considering that the individual required restraint numerous times during that five month period, the Facility did not act with prudent speed in addressing the individual's behavioral needs. The following is an example of an individual who had an inadequate PBSP: • For Individual #624, the restraint review indicated that an SFA had been completed. The individual's chart, however, did not contain an SFA and there was no indication that an SFA had been completed since the individual had been admitted to RSSLC in April 2012. Furthermore, the individual had been provided only a Behavior Assessment Plan since admission to the Facility rather than a PBSP. Four of the individuals in the sample (36%) had a current Safety/Crisis Plan in the chart. The Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In four out of four of the individuals for whom Safety/Crisis Plans had been provided (100%), the type of restraint authorized was delineated; • In four out of four of the individuals for whom Safety/Crisis Plans had been provided (100%), the maximum duration of restraint authorized was specified; • In four out of four of the individuals for whom Safety/Crisis Plans had been provided (100%), the designated approved restraint situation was specified; and • In four out of four of the individuals for whom Safety/Crisis Plans had been provided (100%), the criteria for terminating the use of the restraint were specified.	

#	Provision	Assessment of Status	Compliance
	(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	The Facility reported that efforts to determine treatment integrity were not conducted frequently or consistently. As a result, for none of the individuals reviewed (0%), was their evidence that showed that the PBSP was implemented with a high level of treatment integrity.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Restraint Reviews, and ISP Addenda were reviewed to determine if PBSPs had been assessed. In seven of the records in the sample (64%), there was documentation that that the IDT had reviewed the status of the PBSP. In each of these seven records, the IDT determined that no revision was necessary. Evidence available in the progress notes and data graphs for each of the seven individuals reflected that progress was being achieved, supporting the decision of the IDT. For example, for Individual #448, the IDT did not recommend revisions to the PBSP and data did not reflect the need for any revisions to the PBSP. The following are examples of where teams failed to review PBSPs adequately: • Individual #624 had been provided only a Behavior Assessment Plan since admission to the Facility in April 2012. The individual had required the application of restraint on several occasions in August and September of 2012, yet no SFA had been initiated and a PBSP had not been developed. As a result, there was no indication that the Facility had acted prudently to assess behavior and provide the necessary behavior interventions. • For Individual #278, no restraint review had been completed. For Individual #314, a restraint review on 10/4/2012 stated that the individual's SFA and PBSP would be reviewed for revision "soon". A restraint review on 11/5/2012 offered the same statement. There was no indication that a review had been initiated at the time of the site visit. • For Individual #32, the PBSP was over a year old at the time of the fourth restraint application in 30 days. The IDT did not address the need for review as part of the restraint review process. At the time of the current site visit, documentation did not reflect that the PBSP had been reviewed or revised.	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	<u>Facility self-assessment:</u> The Facility reported it had engaged in the following activity to conduct its self-assessment: conducted a review of the most recent Section C QA/QI Audit results which included audits of 99 restraints from 3/1/12 to 8/31/12.	Noncompliance

#	Provision	Assessment of Status	Compliance
	take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	From its self-assessment the Facility determined that: Section C audits indicated that in 99% of restraints (n=98), restraint review took place within three business days of the start of the restraint, other than medical restraint. In no instance was it recommended by the team that the ISP be revised. Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance because the required IDT reviews and subsequent ISP revisions did not consistently occur. Monitoring Team note: it is important that future self-assessments not only measure whether or not the event(s) occurred but also assess the substance of the review content and the appropriateness if the IDT response and subsequent ISP revision, if any. <u>Monitoring Team findings</u> If an Individual does not have a Crisis Intervention Plan, RSSLC policy for the review of crisis intervention restraints requires that the IDT meet and review each use of restraint 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 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 was deficient in a number of areas. 1. Only 26 of 32 (81%) restraint records included documentation validating the Interdisciplinary Team (IDT) reviewed the restraint episode. Those that did not were restraints for Individuals #142 (5/25 and 6/30), #448 (6/11), #325 (7/17), #32 (6/14), and #424 ((8/21). 2. Thirty-one of 32 (97%) records included documentation validating Unit Morning Meeting review of the restraint episode (restraint of Individual #142 5/25 did not); however, in many instances this documentation did not include unit morning meeting minutes. Typical documentation consisted only of entries on the RC and FFAD. The Facility was asked to provide meeting minutes to further validate compliance and was able to do so in only 19 (59%) cases. Those that did not were restraints for Individuals #142 (5/25), #100 (6/9), #600 (6/30), #630 (7/24), #287 (7/29), #306 (8/10), #346 (8/19), #113 (9/7), #511 (9/12), #278 (9/23), #287 (9/23), #151 (9/27), and #624 (9/29). Nearly all minutes were devoid of substantive comments, ordinarily just providing a record that the restraint occurred. The Monitoring Team observed one unit morning meeting that reviewed restraint of Individual #287. This review was, for the most part	

#	Provision	Assessment of Status	Compliance
		thorough and comprehensive. The Facility needs to ensure unit morning meeting minutes provide information to reflect the substance of the review discussion. 3. Thirty of 32 (94%) records included documentation validating IMRT Meeting review of the restraint episode. Much of this documentation consisted of entries on the RC and FFAD. The Facility was asked to provide meeting minutes to further validate compliance and was able to do so for 28 of the 30 cases. The two records that did not include data to support IMRT review were restraints for Individuals #142 (6/30) and #630 (7/24). The Facility needs to improve its restraint review process to ensure documentation is complete and accurate. Additionally, the review of each restraint episode conducted by a psychologist and recorded in Section II of the FFAD should be more descriptive. In many instances the response to what might be considered a thought provoking point of inquiry was simply recorded as a "yes" or "no". In its last report the Monitoring Team noted that the Facility had initiated a process whereby video surveillance tapes that had recorded a restraint episode can be reviewed, including the events immediately preceding the restraint and the events immediately following release from restraint. This had not as yet become a routine part of restraint review. It was reported this had only occurred twice, and those were very recent. The Facility had developed a protocol for these video reviews, including a checklist to record observations from the review. According to information provided by the Facility, injuries occurred during the use of restraint in 15% of the cases. Most restraints in Sample C.1 (28 of 32 or 88%) were of the type (basket-hold, horizontal side-lying, and four-point mechanical) where injury can be an inadvertent consequence. The Facility needs to intensify its restraint review practices, including the use of video when available. Restraint practices at the Facility included monthly preparation of the Restraint Trend Analysis Report, which included narrative explanation of data and recommendations for new actions to address concerns raised by these data. This report also tracked the status of previous recommendations. Additionally, restraint monitoring data (using the standard SA monitoring tool) occurred quarterly at the Facility's QA/QI Committee. Prior to this visit, the Facility had not convened the Restraint Elimination Committee since the last review, reporting that it had focused all its attention on implementing the new restraint policy, especially training of staff. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision of the SA.	

#	Provision	Assessment of Status	Compliance

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. Closely monitor the process that is in place 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. When an injury to an Individual occurs during restraint use, the review of the restraint episode should closely examine restraint application and identify and provide additional staff training specific to restraint application of specific Individuals to ensure safety. Video review would likely be helpful in this regard.
7. Effective pre-admission planning and initial ISP planning needs to occur to ensure newly admitted Individuals are not subjected to unnecessary restraint. Facility practices with respect to ISP planning, assessments, IDT decision-making, ISP implementation, active treatment engagement, and staff training and competencies need to be thoroughly reviewed. (Provision C.1)
8. Restraint trend reports need to be more detailed and present data related to the reason for restraint such as aggression to staff, aggression to others, elopement, self-injurious behavior, etc. Use compliance monitoring/audit data to isolate problem areas, e.g. by home/shift and use this analysis to target resource application. (Provisions C.1, C.2, and C.3)
9. The Facility needs to fully implement use of video review of restraint episodes. (Provision C.8)
10. Information recorded in restraint documentation needs to address the effectiveness of preventative interventions and strategies. Section II of the debriefing document, completed by a psychologist, needs to be more descriptive. (Provisions C.1 and C.8)
11. Unit meeting and IMRT minutes need to include substantive commentary regarding the review of the restraint episode, not just provide a record that the restraint occurred. (Provision C.8)

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 10/30/12 2. RSSLC Action Plans 10/15/12 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 9/19/12 11. RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 9/19/12 12. RSSLC Policy D.8 Completing/Routing Client Injury Report 9/11/12 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 5/1/12 to 11/9/12 16. Log of serious injuries 5/1/12 to 11/9/12 17. Log of serious incidents 5/1/12 to 11/9/12 18. Log of witnessed Injuries 5/1/12 to 11/9/12 19. Log of discovered Injuries 5/1/12 to 11/9/12 20. Log of peer to peer injuries 5/1/12 to 11/9/12 21. CMS 2567's surveys since the last review 22. Incident management meeting minutes for Incident Management Team minutes for 7/2, 7/9, 7/16, 7/23, 7/30, 8/6, 8/13, 8/20, 8/27, 9/3, 9/10, 9/17, 9/24, 10/1, 10/8 and 10/15, 2012 23. Administrative Review Team minutes for 8/1, 8/8, 8/15, 8/29, 9/12, 9/19, 9/27, 10/3, and 10/17, 2012 24. Individual training records for RSSLC investigators 25. Individual training records for DFPS investigators 26. Documentation of volunteer background checks 27. Documentation of employee background checks 28. RSSLC Criminal Background Checks report 10/12 29. Training curriculum for Abuse, Neglect, and Exploitation 30. Acknowledgement of Reporting signed forms for 25 randomly selected employees 31. Log of Department of Family Protective Services (DFPS) cases 5/1/12 to 11/9/12 32. DFPS investigation reports and related documentation for cases 42357920, 42406367, 62698020, 42417276, 42425806, 42427017, and 42455406-Sample D.1 33. DFPS investigation administrative referrals 42167014, 42180134, 42212857, 42316796, 42329812,

	and 42335220 34. Other DFPS investigation reports and related documents for cases 42399251, 42359524, 42359153, 42359556, 42347572, and 42316795. 35. DFPS/OIG/RSSLC coordination meeting minutes 8/15/12 36. OIG case log 5/1/12 to 11/9/12 37. Document prepared by RSSLC describing the audit process to detect underreporting of injuries 38. Materials used to educate individuals, LARs, and family members on Abuse, Neglect, and Exploitation 39. DADS report MHMR0102 Percent of All Employees Completing Course of Training 10/17/12 40. Incident Information Report (E.17) and related documents for Individual #184 (9/14 at 3:35pm), Individual #351 (6/3 at 6:15am), Individual #346 (8/22 at 7pm), Individual #60 (9/5 at 6:49am), Individual #225 (7/16 at 3:45pm), and Individual #181 (8/18 at 8:30pm and 10:27pm) 41. RSSLC investigations of serious injuries for Individual #535(9/3), Individual #112 (8/11), Individual #164 (9/20 at 1:45pm), Individual #287 (9/9), Individual #579 (9/9), and Individual #382 (8/18) – Sample D.2 42. UIRs 12-177, 239 13-034, 037, 038, and 041 43. List of employees/dates placed in No Direct Contact status (undated) 44. Staff Training Records (24 randomly selected employees) 45. Abuse/neglect quiz used by campus administrators (undated) 46. Self-Advocate meeting minutes 7/11/12, 7/25/12, 8/3/12, 08/17/12 and 9/5/12 47. Employee roster 10/18/12 48. RSSLC Trend Reports 10/31/12 **People interviewed:** 1. Robert Muhammad, Acting Incident Management Coordinator 2. Brenda McClendon, QA Program Auditor 3. Tim Weatherby, Interim Facility Director 4. Kali Schmidt, DFPS Investigator 5. Maria Butler, DFPS Investigator 6. Omar Akmal, OIG Investigator 7. Eight Direct Support Professionals at Lavaca home **Meetings attended/Observations:** 1. Incident Management Team Meeting (IMRT) 11/13 & 14/12 2. Four Rivers Unit Morning Meeting 11/14/12 3. Sabine Unit Morning 11/13/12 4. Quality Assurance/Quality Improvement (QA/QI) Council 11/13/12 5. Administrative Review Team 11/14/12 6. PSP meeting for Individual #165
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

	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 14. 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 reported to be in substantial compliance in the Facility self-assessment, and the Monitoring Team confirmed this. In some Provisions the Facility's self-assessment process was overly general and 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 accompanied 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 often lacked detail, was overly general, or did not target specific problems identified in the self-assessment. For example, no Action Step was directed at increasing timely reporting of serious incidents, a significant problem acknowledged in the Facility self-assessment and validated by the Monitoring Team. 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 or achieve compliance with a requirement. Additional action steps will need to be developed to address issues identified by the Monitoring Team that are not sufficiently addressed in the current Facility Action Plan.
	Summary of Monitor's Assessment: As noted in the Facility Self-assessment summary above, the RSSLC self-assessment reported substantial compliance with 19 of 22 Provisions in Section D of the Settlement Agreement. The Monitoring Team determined substantial compliance with 14. 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 reported to be in substantial compliance in the Facility self-assessment, and this was confirmed by the Monitoring Team. Five Provisions rated as in compliance by the Facility self-assessment were determined to be noncompliant by the Monitoring Team. These were: 1. Provision D.2.a, which addresses timely reporting requirements. 2. Provision D.2.i, which addresses injury auditing. 3. Provision D.3.e, which addresses timely initiation and completion of investigations. 4. Provision D.3.f, which addresses investigation report content. 5. Provision D.3.g, which addresses Facility review of investigation reports 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 policies governing abuse/neglect and incident management had been updated since the last review, in part to correct omissions in content pointed out by the Monitoring Team. 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 remained an important administrative tool in detecting abuse and neglect, and in the conduct of DFPS investigations; however, the use of available video surveillance should be expanded in the conduct of Facility investigations of serious incidents. The Monitoring Team did not find any instances of lack of cooperation between 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, as noted in the last report, staff knowledge of abuse/neglect reporting requirements needs to improve. All allegations of physical abuse received a law enforcement referral. 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. DFPS investigation were, for the most part, initiated within 24 hours and completed within 10 days of being reported. DFPS conducts very thorough reviews of allegations when determining to refer an alleged incident back to the Facility as an Administrative Referral. Facility investigations of serious incidents were not always completed within 10 days of being reported. 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 known, the AP was immediately placed in no contact status. Timely reporting of allegations, while improved, remained problematic at the RSSLC, as 33% of investigations (DFPS and Facility investigations of serious incidents) in the Monitoring Team's samples were not reported within one hour of discovery as required by policy. Employee and volunteer background checks were completed in accordance with State policy.

	The RSSLC convened quarterly 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. 2. Reviewed monitoring system to ensure reporting ANE posters remained in place. 3. Reviewed number of trained investigators to ensure an investigator is onsite 24 hours a day seven days a week. 4. Reviewed staff training compliance with ANE. 5. Reviewed 20 results of A/N/E Reporting Obligations and Procedures Quiz from (8/21/12 to 9/11/12). From its self-assessment the Facility determined that: 1. The policy, C.02 - Protection from Harm: Abuse. Neglect, & Exploitation, that addresses ANE included the commitment to zero tolerance. 2. 100% of the posters were in place in the residential and programing areas. 3. RSSLC Investigators were trained and one Investigator is on-site or on-call 24 hours a day. 4. Staff compliance for A/N/E was no less than 98% from 7/1/12 to 9/3/12. 5. 100% (20 of 20) of staff quizzes reviewed passed the A/N/E Reporting Obligations Quiz. Based on the findings from the self-assessment, the Facility determined this provision remained in substantial compliance because the local policies address the commitment of zero tolerance of ANE. <u>Monitoring Team findings</u> The Facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The Facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. In practice, the Facility appeared committed to ensure that abuse and neglect of individuals was not tolerated, and encouraged staff to report abuse and/or neglect, as illustrated by examples provided throughout this Section D of the report. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report. This Provision was in substantial compliance.	
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 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	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed 25 of 81 (31%) Unusual Incident Reports (UIRs) (included ANE and serious incidents) from 7/1/12 to 9/30/12 to determine if they were reported to the facility director or designee according to policy. 2. Reviewed 15 Incident Management minutes 7/1/12 to 9/30/12 (five randomly from each month) to determine if UIRs of ANE and Serious Incidents were reviewed and discussed during Incident Management Meeting to address any reporting problems or concerns. 3. Reviewed Policy C.01-Incident Management, C.02-Protection From Harm-Abuse, Neglect and Exploitation and D.8-Completing/Routing Client Injury Reports for reporting requirements including reporting serious injuries immediately, within one hour, to the facility Director/designee. From its self-assessment the Facility determined that:	Noncompliance

#	Provision	Assessment of Status	Compliance
	report these and all other unusual incidents, using standardized reporting.	1. Reviewed 25 UIRs from (7/1/12) to (9/30/12). 15 UIR's were DFPS Investigations and 10 UIRs were Facility Investigations. 22 of 25 (88%) UIRs were reported within one hour. 2. Reviewed Incident Management minutes. 100% (28 of 28) of UIRs were discussed in Incident Management Meeting. 3. Revised polices C.01, C.02 and D.8 to include reporting serious injuries immediately, within one hour to the Director/designee. Based on the findings from the self-assessment, the Facility determined this provision is in substantial compliance as staff report 100% of deaths, ANE and other serious incidents using a standardized process. Monitoring Team note: The Facility self-assessment determined substantial compliance because all incidents are reported "using a standardized process." While a SA requirement, this requirement is secondary to the primary requirement of the Provision, that being timely reporting of incidents. The conclusions reached from the self-assessment should address the frequency of timely reporting and whether the compliance rate is sufficiently high to merit a self-assessment rating of compliance. Data reported in the self-assessment was unclear. In one section 25 UIRs were reported as having been reviewed, in another 28. Were these different UIRs (a total of 53) or is this merely a typo? Upon interview this was described as two separate samples although little information was provided in the self-assessment with respect to the sample of 28. The self-assessment conclusion is incomplete as it does not address timeliness of reporting. Greater care needs to be taken in describing self-assessment activity and reporting data. Additionally, throughout the self-assessment a "review of 25 UIR's" is reported. Presumably these are the same 25 UIRs reported above. In future self-assessments if a sample is going to be used more than once please assign it an identifying number (e.g. SA Sample D.1, or SA Sample D.2) and refer to this when referencing data used, and conclusions reached, from each respective sample. <u>Monitoring Team findings</u> RSSLC Policy's C.01 Incident Management (9/19/12), C.02 Protection From Harm – Abuse, Neglect, and Exploitation (9/19/12), and D.8 Completing/Routing Client Injury Report (9/11/12) 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 was corrected. All three	

#	Provision	Assessment of Status	Compliance
		policies had been updated since the last review, in part to correct omissions in content pointed out by the Monitoring Team. The Facility provided data to the Monitoring Team for a six month reporting period of 5/1/12 through 10/31/12. During this six month period allegations reported to DFPS were as follows: • 141 abuse allegations. The disposition by DFPS of these 141 allegations was: Five were substantiated, 69 were unconfirmed, 14 were inconclusive, and 34 were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. Nineteen were listed as disposition pending. • 51 neglect allegations. The disposition by DFPS of these 51 allegations was: Two were substantiated, 21 were unconfirmed, four were inconclusive and 16 were referred back to the Facility as the allegation did not meet DFPS criterion for investigation. Eight were listed as disposition pending. • No exploitation allegations. 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 noted that a number of allegations of abuse and neglect 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 six of these administrative referrals (42167014, 42180134, 42212857, 42316796, 42329812, and 42335220). 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 conducting staff interviews, interviews with the alleged victim, and reviewing selected facility documentation/records before reaching the conclusion that the allegation did not meet the DFPS requirements for investigation. These mini investigations took as long as ten days 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. The Monitoring Team was impressed with the thoroughness of review in this regard. In reporting allegations the Facility used a standardized reporting system. Two samples of investigations were selected for review. These included: • Sample D.1 of seven DFPS investigations of abuse, neglect, and/or exploitation between 5/19/12 and 9/30/12. This sample included the following DFPS investigation reports: 42357920, 42406367, 62698020, 42417276, 42425806,	

#	Provision	Assessment of Status	Compliance
		42427017, and 42455406. This represented a nearly 20% sample of 36 investigation cases included in the log provided in response to the Monitoring Teams document request. The sample included 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 physical abuse). • Sample D.2 of six facility investigations of serious injuries. RSSLC provided a report entitled Serious Injury Report, which listed serious injuries to individuals from 5/19/12 to 9/30/12. From this report the Monitoring Team was able to determine the RSSLC had 28 serious injuries during this time period. From these 28, six (21%) were selected for Sample D.2 to assess the adequacy of the facility investigation process. Four were noted on the Facility log as discovered injuries. In reviewing Sample D.1 (DFPS case reports) three of the seven investigations (43%) noted a date and time the incident occurred (the other four noted the time of the incident as unknown). Two of the three (67%) 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 42455406 and 42425806. The Facility self-assessment also detected issues with late reporting; however, the data presented in the self-assessment did not delineate late reporting between DFPS cases and serious incidents (not involving abuse or neglect) required to be reported to the Facility Director. In reviewing Sample D.2 (serious injuries) five of six (83%) were reported immediately (within one hour) to the Facility Director/designee. UIR 12-245 was not. In this case the serious injury was not reported until the Facility physician had classified it as a serious injury even though a nurse assessment four hours earlier described the injury as "bruising to the left eyelid, hematoma above the left eyelid, and a cut with swelling and a small amount of bleeding on the left lip." Although DADS policy allows for the time period for reporting to begin when a clinician codes the injury as serious, an injury with characteristics such as these should be immediately reported as serious to the Facility Director in order to ensure client protection measures have been assessed and put in place. If Facility (or State) policy requires that a physician officially classify an injury as serious before requiring it be reported, strict adherence to that policy undermines the intent of immediate and timely reporting. Apparent serious injuries should be reported to ensure client protection measures (including protecting evidence) are enacted as soon as possible. To test staff knowledge of abuse/neglect reporting responsibilities the Monitoring Team met with four randomly selected DSP staff from the morning shift and four randomly selected DSP staff from the afternoon shift at one home. The staff was selected by the Facility and were all staff available at the time. All were asked to respond to the following	

#	Provision	Assessment of Status	Compliance
		question: from the training you've received if you witness, or suspect, abuse what are you supposed to do?" The response from five (63%) included calling DFPS (most often noting "call the 1-800 number"). Three responses were "report it" without reference to whom. One response was "stop it seek medical attention." It is of concern that 37% of the respondents did not include calling DFPS or the 1-800 number in their response. Staff knowledge of abuse/neglect reporting requirements needs to improve. The Facility had initiated an Abuse, Neglect, and Exploitation Quiz to test staff when various administrators made rounds. While an impromptu staff quiz is a good idea the three true/false questions asked were too elementary and too leading. For example, "if you see a co-worker yelling at an individual and punching him in the stomach, you should intervene." Another question is "the 1-800 phone number for DFPS is located on the back of your RSSLC employee badge." It would seem highly unusual that any staff would answer anything but "true." The correct answer for all three questions is true. The Facility would be better served to revise the questions so that staff needs to give more thought to their response. For example, "if you see abuse who do you call and where do you find the phone number?" Timely reporting of allegations had improved since the last review but remained problematic. The Facility self-assessment sampled 25 cases (both DFPS and Facility UIRs) and found the one-hour reporting compliance rate to be 88%. As noted above, the Monitoring Team, in its sample of DFPS cases, found one-hour reporting compliance to be lower (67%). In its sample of Facility investigations the Monitoring Team also found the one-hour reporting compliance rate to be lower (83%). Since the last review the Facility had established a tracking log of late reporting. This log can serve as an effective management tool. In its present form it does not do this. In reviewing the log with Facility staff there was considerable confusion as to what constituted late reporting and what data displayed on the report actually meant. This was particularly the case in instances where an incident is discovered and reported within one hour of discovery but may have occurred much earlier but the investigation found staff who were aware or should have been aware of the incident at the time it occurred and should have reported. The log reviewed by the Monitoring Team reported 67 instances of late reporting. Twenty-six of the 67 were reports made by Individuals living at the RSSLC who alleged abuse or neglect well after the alleged act(s) took place. (therefore, according to the log provided by the Facility there were 41 other instances of late reporting). The Facility should continue to be proactive in educating Individuals on abuse/neglect reporting including the benefit of reporting it as soon as possible. In many other cases the reporter was listed as unknown. In only two cases was the late reporter noted to be staff. The	

#	Provision	Assessment of Status	Compliance
		Facility needs to better define terminology used on this log to ensure it fairly separates late reporting attributable to variables under its administrative control from other types of late reporting. Certainly staff are expected to report timely, and pursuant to Provision D.2.e the Facility is to take proactive measures to encourage Individuals, family members, and Legally Appointed Representatives (LARs) to report suspected abuse and neglect. Evidence of late reporting was further validated by DADS regulatory in a survey completed on 8/2/12. DADS regulatory reported on an incident that occurred on 6/3/12 but was not reported to DFPS until 6/5/12. The Facility was cited for being in violation of federal Medicaid standards because the "Facility staff did not immediately report to the state's investigation agency an allegation of physical abuse." An additional element of properly reporting allegations of abuse and neglect is the investigation of non-serious discovered injuries 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 reported 1,062 discovered injuries classified as non-serious from 5/1/12 to 11/9/12. The Monitoring Team reviewed five non-serious discovered injuries to assess whether Facility investigation/review was sufficient to rule out abuse or neglect as a cause or contributing factor to the injury. The Client Injury Report used by the Facility includes a section labeled "Administrative Follow-up." This serves to document the determination regarding the suspicion of abuse or neglect and is completed by unit administrative staff. If abuse or neglect is suspected the injury is referred to the Incident Management Coordinators (IMC) office so that a trained investigator can conduct a more thorough investigation. None of the five injuries reviewed by the Monitoring Team included a determination of suspicion of abuse or neglect. The Facility uses its Administrative Review Team (ART) to review every Client Injury Report and E.17 Incident Information Report. Minutes of ART meetings note the results of this review with entries such as "OK", "could be more measurable", "how is bruise related to friction", "not all information is included in the packet", or "incomplete information on the CIR". In the Monitoring Teams small sample of discovered non-serious injuries similar issues were identified. For example, the E.17 Incident Information Report which is considered a primary source of information for the unit review is not always signed and dated. The administrative follow-up section of the injury report (referenced above) does not report the name of the administrator completing this section of the injury report. Unit reviews do not always draw logical conclusions which result in some injuries not being referred to the IMC office. For example, one injury (Individual #60, 9/5/12) was reported as "multiple small scattered bruises to the	

#	Provision	Assessment of Status	Compliance
		buttock region." These injuries were attributed to "plopping down in a rocking chair" with no further information as to how plopping down in a rocking chair could cause multiple small scattered bruises to the buttock region. It does not seem logical that plopping down in a rocking chair would cause small scattered bruises. Another injury (Individual #346 8/22/12) was reported as "multiple bruises to the arm, armpit, and chest." These injuries were attributed to the Individual scratching himself with no further information as to how this scratching would result in bruising. The circumstances associated with both injuries should have been investigated further to rule out abuse or neglect. It is of concern that these injuries had been reviewed by the Facility's Administrative Review Team (ART) and if determined to be insufficiently thorough and/or incomplete were not amended or corrected. The review 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 compliance with this provision.	
	(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 15 DFPS Investigations from 7/1/12 to 9/30/12 for list of alleged perpetrators (APs) and compared the list to the log of APs reassigned to determine if reassignment to non-client contact occurred until the completion of the investigation. 2. Reviewed 25 UIRs from07/1/12 to 9/30/12 for documentation that adequate additional action, including nursing assessments and treatment, were rendered, as appropriate and emotional assessments of victim trauma were conducted by psychology staff. From its self-assessment the Facility determined that: 1. 100 % of the alleged perpetrators returned to duty after the completion of the investigation. 2. 100 % (25 of 25) of UIRs had adequate actions taken and documentation for the individuals. Based on the findings from this self-assessment, the Facility determined this provision is in substantial compliance because RSSLC staff takes immediate and appropriate action to	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		protect the individuals involved, including removing alleged perpetrators, until the investigation is finished; nursing assessments and treatment were rendered, as appropriate; and emotional assessments of victim trauma were conducted by psychology staff. Monitoring Team findings Based on a review of the seven investigation reports included in Sample D.1, in every instance where an alleged perpetrator (AP) was known 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 5/1/12. 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. As noted in the last report, the Facility should understand the relationship between late reporting (refer to Provision 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 seven 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 seven 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.	
	(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	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 7/1/12 to 9/30/12. 2. Reviewed results of A/N/E Reporting Obligations and Procedures Quiz from 8/21/12 to 9/11/12.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	completion of such training.	From its self-assessment the Facility determined that: 1. Reviewed the staff training compliance report from CTD and the results were: • 7/12 - 99% • 8/12- 98% • 9/12- 98% 2. 100% (20 of 20) of staff quizzes reviewed passed the A/N/E Reporting Obligations Quiz. Based on the findings from this self-assessment, the Facility determined this provision remains in substantial compliance because of the percentages for the above months listed reflecting compliance rate of 98% and 99%. <u>Monitoring Team findings</u> 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 24 staff training transcripts (Sample C.2) showed that all 24 (100%) had completed competency-based training on abuse and neglect and unusual incidents within the last 12 months. Additionally, the Monitoring Team reviewed the DADS report MHMR0102 Percent of All Employees Completing Course of Training (10/17/12) which reported a 99% compliance rate for staff completion within the last 12 months for ABU0100 and for UNU0100. As reported in Provision D.2.a staff knowledge of abuse/neglect reporting responsibilities is variable. This may suggest the effectiveness of the training should be further probed by the Facility through quality assurance monitoring.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision. This is because Facility practices address the requirements of this Provision that the training be competency-based, that staff complete the training, and that documentation of training completion is maintained. As noted in its last report the Monitoring Team suggests the Facility 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 neglect.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed copies of the DADS Form 1020 Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation for staff hired in July and August, 2012. 2. Reviewed a random sample of 10 employees for completion of DADS Form 1020. From its self-assessment the Facility determined that: 1. 97% (36 of 37) were signed and acknowledged by the staff person selected. 2. 100 % of employees sampled signed the acknowledged by the staff person DADS 2010 form. Based on the findings from the self-assessment, the Facility determined this provision remains in substantial compliance because 97% of staff has signed Acknowledgement forms Monitoring Team 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 September and October, 2012, and, for a random sample of 24 employees. Form 1020 is required by State policy. The 42 new hires and 24 sampled employees all (100%) had completed and signed the 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. Two instances of late	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		reporting were noted in Provision D.2.a of this report. These were identified by the Facility through its investigation report review process and the employees were retrained on reporting responsibilities. 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 concurs with the Facility's self-assessment of substantial compliance with this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the annual Interdisciplinary (IDT) meeting for five Individuals from (7/1/12) to (9/30/12) for a formal discussion on assisting family members in reporting ANE. 2. Reviewed documentation in five active records for documentation that materials were provided to primary correspondents/LARs prior to each individual's IDT meeting by the Social Worker. 3. Reviewed minutes from five Self-Advocacy meetings from (7/1/12) to (9/30/12) for discussion that addressed ANE. From its self-assessment the Facility determined that: 1. The reviews of the Annual Planning Meetings from 7/1/12 to 9/30/12 for a formal discussion on assisting family members in reporting ANE indicated that three of five (60%) meetings reviewed listed a discussion on steps for reporting ANE with the individual/family member present. 2. Review of five active records for documentation that materials were provided to primary correspondents/LARs in reporting ANE indicated that three of five (60%) primary correspondents/LARs received information from the Social Worker. 3. Minutes from five self-advocacy meetings dated 7/11/12, 7/25/12, 8/3/12, 08/17/12 and 9/5/12 recorded discussion that addressed ANE. Based on the findings of the self-assessment, the Facility determined this provision is not in compliance because the discussion on the steps of reporting ANE is not documented in all the Annual Individual Service Plan Meetings with the individual/family member present. Monitoring Team note: future self-assessments should be more complete in describing sampling methodology. For example, five records were reviewed. Were they all from one unit"? Or one QDDP? Or one each from five units? Were they selected randomly?	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team findings ISP meetings attended by the Monitoring Team did not include presentation of information on, or discussion of, abuse and neglect identification and reporting procedures. ISP documents reviewed by the Monitoring Team did not consistently include 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 ISP 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. The Facility reported that effective 10/1/12 the ISP template had specific prompts to ensure this discussion takes place. The Monitoring Team believes this should lead to compliance with this Provision. 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 all meetings that addressed abuse, neglect, exploitation, or rights material. In its last report the Monitoring Team noted that 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.	
	(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: reviewed results of audits from Social Workers and Human Rights Officer 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: 137 audits reflected that the individual rights poster and reporting ANE posters were posted and in good condition. Based on the findings from this self-assessment, the Facility determined this provision	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		remains in substantial compliance because 100% of the posters were visible in each living unit and program area. Monitoring Team findings A review was completed of the postings the Facility used. The Facility used two posters. Both posters had been revised since the last review and are very well done – colorful and eye-catching. Both are displayed in English and in Spanish language. 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. 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.	
	(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: reviewed 15 A/N/E cases from 7/1/12 to 9/30/12 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: 100 % of the cases reflected that law enforcement and/or OIG were notified in all ANE cases reviewed. Based on the findings from this self-assessment, the Facility determined this provision is 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 received a law enforcement referral. All allegations of physical abuse, if substantiated, may represent some form of assault or	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 six 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.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: reviewed 25 cases (random sample) from 7/1/12 to 9/30/12 for potential retaliation. From its self-assessment the Facility determined that: review indicated that zero of 25 cases did not have retaliation reported. Based on the findings from this self-assessment, the Facility determined this provision remains in substantial compliance as there were no reports of staff expressing fears of retaliation to DFPS. Monitoring Team note: future self-assessments should be more comprehensive. Consideration should be given to including this topic in the quarterly meeting with DFPS and OIG and/or informal conversation with outside investigators. Consideration should also be given to interviewing (post investigation) a sample of staff who were witnesses in cases that resulted in confirmed findings to determine if any activity occurred which could have been construed as retaliatory in nature. <u>Monitoring Team findings</u> Based on interviews with Facility administrative staff, including the Interim Facility Director, 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		DFPS and OIG investigators reported they did not discover any situations of real, or perceived, retaliation in the course of conducting their investigations. The Interim Facility Director reported one instance of reported retaliation. The reported retaliation was investigated and the perpetrating employee was discharged. 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. 3. Reviewed the top 10 individuals with the most non-serious injuries from 4/1/12 to 9/30/12 to determine if any of the injuries were unusual types of injuries. From its self-assessment the Facility determined that: 1. The audit reports of the Campus Coordinator Log and Home Shift Log from 7/1/12 to 9/30/12 to verify all discovered injuries were reported, documented and investigated. • 7/12 – 98 % • 8/12 – 100 % • 9/12 – 100% 2. The audit reports completed by the Campus Investigators' for reporting injuries to individuals for the period of 8/1/12 to 9/30/12 were: • 8/12 – 90% Non-serious injuries were reported. • 9/ 12 – 100% Non-serious injuries were reported. None of the injuries did not reflect [sic] suspicion of ANE or were coded as serious and not reported. 3. 100 % of the injuries were not unusual types of injuries such as bruises to the buttocks, breast or genitals area.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on the findings of this self-assessment, the Facility determined this provision remains in substantial compliance because the percentage averages above for the listed months reflect over 90% or better for each month in reporting non-serious injuries and completing investigations. Monitoring Team note: as reported in its last Monitoring Team report, the Facility self-assessment did not describe any methodology for determining whether or not Facility auditing discovered any unreported injuries, and if so whether or not they were subsequently reported for investigation. <u>Monitoring Team findings</u> One element of the provision requires the Facility to identify significant injuries that should have been reported for investigation and validate that they had. To accomplish this, the Facility review process should: • Determine whether or not an issue identified by a program auditor is representative of a "significant injury". A significant injury may not necessarily be a serious injury as defined in DADS or Facility policy. For example, issues identified in the audits could involve incidents/injuries such as cuts requiring treatment and injury in the area of the eye (client protection issue). This could be considered "significant" and may merit closer review in the context of this Provision. • Determine whether or not an issue identified by a program auditor was (or should have been) reported for investigation. • Determine that if the issues identified by a program auditor should have been reported for investigation, and were not, that discovery of this fact resulted in subsequent initiation of an investigation. The procedures in place at RSSLC that were presented to the Monitoring Team addressed many aspects of these three elements but needs further refinement. For example, the current auditing process does not determine whether an injury was significant. The Monitoring Team was provided with a written description of the review activity associated with this Provision and through interview gathered information on sampling, review activity, and how the review activity was documented. Every three months each Facility investigator reviews documents related to two Individuals. This results in 12 Individuals being reviewed every three months. The purpose of the review is to determine if any serious injuries had not been reported for investigation. Documents reviewed included health care progress notes, physician orders, observation notes, and the campus coordinator logs. Each review is documented on an Internal Investigative Report. This review activity determined that all serious injuries had been reported for	

#	Provision	Assessment of Status	Compliance
		investigation. These review activities are necessary but not sufficient to meet the SA requirement of an "audit" at least semi-annually. As noted in its last report the Monitoring Team suggested the 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. The Facility had over 2,200 non-serious injuries between 5/1/12 and 11/9/12. 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.	
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	<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 if all required training was completed by staff conducting investigations per state and local policy. 2. Reviewed DFPS investigator's staff training records to determine all DFPS required training was completed by investigators assigned to RSSLC. 3. Reviewed supervisory responsibilities of the IMC department to determine if there would be a direct line of supervision of anyone subject to investigations.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	supervision of the alleged perpetrator.	From its self-assessment the Facility determined that: 1. On 10/1/12, 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 attended investigator training provided by Labor Relations Alternatives the week of 4/23/12. 2. All DFPS Investigators assigned to RSSLC have the required training. 3. The IMC Department who reports to the Quality Assurance Director did not have any direct line of supervision of anyone that was investigated. Based on the findings from this self-assessment, the Facility determined this provision remains in substantial compliance because all IM staff that conducts investigations received the training required by state and local policy and do not have any direct line of supervision of anyone subject to investigations. <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 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	

#	Provision	Assessment of Status	Compliance
		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 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.	

#	Provision	Assessment of Status	Compliance
		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. 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.	
	(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 15 cases from 7/1/12 to 9/30/12 to determine if staff cooperated with outside entities during investigations. 2. Reviewed potential issues during quarterly meeting between facility, DFPS, OIG, and Ft. Bend County Sheriff's Dept. during meeting on 8/15/12. From its self-assessment the Facility determined that: 1. Review of 15 cases indicated 15 of 15 (100%) showed that staff cooperated with outside entities during ANE investigations. 2. No issues were identified. The facility was commended by the Department of Aging and Disability Services- Regulatory Services for cooperating with the investigations by scheduling appointments, securing evidence and identifying factors that may contribute to the case. Based on the findings from this self-assessment, the Facility determined this provision remains in substantial compliance because there were no instances of staff not cooperating with outside entities during investigations. Monitoring Team note: the self-assessment notes a commendation from DADS regulatory but does not provide any information on this subject that may have been shared by DFPS or OIG investigators. These are the two agencies with primary responsibility for investigating allegations of abuse and neglect. <u>Monitoring Team findings</u> The Monitoring Team did not detect any instances of lack of cooperation in its review of the seven DFPS investigations in Sample D.1.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The Facility convenes periodic joint meetings with DFPS and OIG at which any issues of mutual cooperation can be reviewed and resolved. The Monitoring Team reviewed the minutes of this meeting which was held on 8/15/12. Additionally, both DFPS and OIG investigators interviewed reported receiving excellent cooperation from Facility staff in the conduct of their investigations. 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 7/1/12 to 9/30/12 (random sample) to determine that if there were any interference with investigations by other entities during investigations by law enforcement. 2. Reviewed potential issues during quarterly meeting between facility, DFPS, OIG, and Ft. Bend County Sheriff's Dept. during meeting on 8/15/2012. 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. 2. No issues were identified. The facility was commended by the Department of Aging and Disability Services- Regulatory Services for cooperating with the investigations by scheduling appointments, securing evidence and identifying factors that may contribute to the case. Based on the findings from this self-assessment, the Facility determined this provision remains in substantial compliance because all of the reviewed cases were coordinated appropriately. Monitoring Team note: the self-assessment notes a commendation from DADS regulatory but does not provide any information on this subject that may have been shared by DFPS or OIG investigators. These are the two agencies with primary responsibility for investigating allegations of abuse and neglect. <u>Monitor Team findings</u> 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 seven of seven (100%) investigation records from DFPS (Sample D.1) no evidence of interference by one agency or the other was identified. Of the six investigation records from the Facility (Samples D.2.), there was no suspicion of abuse or neglect, and therefore these 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.	
	(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, C.01-Incident Management, to ensure it supported the safeguarding of evidence. 2. Reviewed 25 UIRs completed by DFPS and the facility to determine if physical evidence was safeguarded when needed. 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. 2. 96% (24 of 25) UIRs determined that physical evidence was safe guarded. In the one case where evidence was not safeguarded, it was related to blood being cleaned up before facility investigator arrived on scene. Based on the findings from this self-assessment, the Facility determined this provision remains in substantial compliance because evidence is safeguarded as per policy.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team note: the self-assessment reports the Facility "reviewed 25 UIRs completed by DFPS". This is most likely a typographical error but is an indication that greater care should be taken in preparing the self-assessment document. <u>Monitoring Team findings</u> 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. Investigators from DFPS and OIG were interviewed during this review. Neither reported any issues with the safeguarding of evidence. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with this provision.	
	(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 25 of 81 (31%) UIRs (included ANE and serious incidents) from 7/1/12 to 9/30/12 to determine if all investigations of incidents commenced within 24 hours. 2. Reviewed 25 of 81 (31%) UIRs (included ANE and serious incidents) from 7/1/12 to09/30/12 to determine if all investigations of incidents were completed within 10 calendar days unless the facility Superintendent (Director) or Adult Protective Services Supervisor granted a written extension. 3. Reviewed 25 of 81 (31%) UIRs (included ANE and serious incidents) from 7/1/12 to 9/30/12 to determine if all investigations of incidents resulted in a written report, including a summary of the investigation, findings, and as appropriate, recommendations for corrective action. From its self-assessment the Facility determined that: 1. Review indicated that 24 out 25 (96%) UIRs commenced within 24 hours. 2. Review indicated that 24 out of 25 (96%) UIRs were completed within 10 calendar	Noncompliance

#	Provision	Assessment of Status	Compliance
		days. Only 1 case did not have written approval. 3. Review indicated that 25 of 25 (100 %) UIRs resulted in written report, including a summary of the investigation, findings, and as appropriate, recommendations for corrective action. Based on the findings from this self-assessment, the Facility determined this provision is in substantial compliance because UIR investigations commenced within 24 hours; were completed within 10 calendar days and resulted in a written report. <u>Monitoring Team findings</u> The Monitoring Team reviewed the DFPS document provided by DADS which was 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. These guidelines did not require DFPS presence at the Facility within 24 hours of an incident being reported except in instances of Class I physical abuse and sexual abuse allegations. Very few allegations are classified as Class I even though it appears many could be because the definition of Class I includes abusive acts that "could have" resulted in serious injury. It appears that in practice only abusive acts that did result in serious injury are classified as Class I although there are very limited examples of this occurring. No allegations at the RSSLC were reported to be Class I violations. 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 did not address the protection of testimonial evidence from witnesses and alleged perpetrators. Almost always testimonial evidence was the primary evidence used in DFPS investigations in reaching investigation conclusions. The Monitoring Team believes the initial plan for investigations (which must be done within the first 24 hours) should include an assessment of the need to protect testimonial evidence. If this assessment determines that protection of testimonial evidence is critical to the investigation, then DFPS and the Facility should be expected to agree on any special administrative efforts the Facility or DFPS should undertake to accomplish this. DFPS had modified its report format to more clearly summarize investigatory activity undertaken by DFPS within 24 hours of an allegation being reported. Typical activity reported in case reports included telephone contact with the Facility's Incident Management Coordinator or Campus Coordinator to ensure the individual who is the subject of the report is safe (and if injured has received appropriate medical care) , that any known APs were placed in NDC status, the identification of any collateral witnesses, that the Facility has (or is) gathering all relevant documentation, that any physical	

#	Provision	Assessment of Status	Compliance
		evidence is secure, a determination if there is likely video surveillance evidence to review, and the development and review of a preliminary investigation plan. All seven (100%) cases in Sample D.1 documented these type of activities took place within the first 24 hours. All seven (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are presented in Provision D.3.f of this report. DFPS concerns and recommendations for corrective action were included in three investigation reports and were appropriate to address issues identified by the DFPS investigation. 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 seven DFPS investigations in the sample: All (100%) 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. In all cases, the Facility placed alleged perpetrators (AP) in non-direct care status immediately after an allegation and ensured they were closely supervised while on shift. Six (86%) were completed within 10 calendar days of the report of the incident. Investigation 42426998 was not. The initial DFPS notification was on 8/18/12 and the report was completed on 9/6/12. The appropriate approved extension request was not provided by the Facility. Following review of a draft of this report, the Facility stated an Extension Request was submitted and approved because witnesses were not available for interviews. The Monitoring Team accepts that this was the case, but information to this effect was not provided at the time of the compliance visit. All seven (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	

#	Provision	Assessment of Status	Compliance
		for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In all seven (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)</u> The following summarizes the results of the review of Facility investigations of serious incidents: All six (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. Three of six (50%) were completed within 10 calendar days of the incident, including sign-off by the supervisor (IMC). Those that were not included UIRs 12-245, 13-001, and 13-020. This was determined by comparing data reported in the Intake Information (No. 2) of the UIR with the Review/Approval dates at the end of each UIR. None contained direct evidence that an extension had been requested and approved. All six (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis stated for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. All six (100%) included recommendations for corrective action. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision of the SA. Five of 13 (39%) investigations were not completed in 10 days and no evidence of an approved extension was provided to the Monitoring Team.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: reviewed 25 of 81 (31%) UIRs (included ANE and serious incidents) from 7/1/12 to 9/30/12 to determine if all cases included: • a clear basis for conclusion • a separate report in a standardized format	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• the name(s) of all witnesses • the name(s) of all alleged victims and perpetrators; • the names of all persons interviewed during the investigation • an accurate summary of topics, a recording of the witness interview or a summary of questions posed, and a summary of material statements made discussed for each person interviewed • 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 • the investigator's reasons for his/her conclusions. From its self-assessment the Facility determined that: • 25 of 25 (100%) UIRs included a clear basis for conclusion. • 25 of 25 (100%) UIRs had a separate report in a standardized format. • 21 of 25 (84%) UIRs had the names of all witnesses interviewed. • 15 of 15 (100%) A/N/E UIRs had the names of all alleged perpetrators. • 21 of 25 (84%) had the names of all staff interviewed during the investigation. • 25 of 25 (100%) UIRs had an accurate summary of topics, a recording of the witness interview or a summary of questions posed, and a summary of material statements made discussed for each person interviewed • 24 of 25 (96%) UIRs had all documents reviewed during the investigation. • 25 of 25 (100%) UIRs had all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency • 25 of 25(100%)UIRs included investigators findings • 25 of 25 (100%) UIRs included the investigators reasons for his/her conclusion. Based on the findings from this self-assessment, the Facility determined this provision is in substantial compliance because the elements in the provision were at 84-100% compliance. <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	

#	Provision	Assessment of Status	Compliance
		separately. DFPS Investigations 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 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 seven (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 seven (100%), each serious incident or allegations of wrongdoing; o In seven(100%), the name(s) of all witnesses; o In seven (100%), the name(s) of all alleged victims and perpetrators; o In seven (100%), the names of all persons interviewed during the investigation; o In seven (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 seven(100%), all documents reviewed during the investigation; o In seven (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 seven (100%), the investigator's findings; and o In seven (100%), the investigator's reasons for his/her conclusions. Facility Investigations Facility investigations (UIRs) did not always clearly document the names of all persons	

#	Provision	Assessment of Status	Compliance
		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. For example, in UIRs 12-240 and 13-009 it is not possible to determine if the data collected describing the events associated with the reported incident was collected via staff interview, written statement, or essentially hearsay, meaning, for example, a home supervisor reported what other staff told her. In neither case was information presented in the UIR that served to verify the accuracy of what was reported. This was a common theme in all UIRs reviewed by the Monitoring Team. UIR information needs to be more descriptive using language such as "Investigator John Doe interviewed DCP Bill Doe on (date & time) who reported…..", or "Investigator John Doe obtained a written statement from DCP Bill Doe dated xyz. This statement was collected by home supervisor Joe Doe." The following summarizes the results of the review of Facility investigations: • In none of the investigations reviewed (100%) were the contents of the investigation report sufficient to provide a clear basis for its conclusion. This was primarily due to the issues related to presentation of evidence described above, and, the failure to include video review when available. For example, in UIR 12-240 the serious injury (suture to the forehead requiring five staples to close) occurred in the hallway so video evidence should have been available. The incident was reported as being witnessed. Nevertheless, video review could have confirmed what the witness reported (accidental fall) rather than other possible causes such as being pushed or tripped by another Individual or staff. It appears the Facility does not consider video review of witnessed injuries. In the event of a serious injury the investigation should determine if video evidence exists, and if so it should be reviewed. • The report utilized a standardized format that set forth explicitly and separately: o In six (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, these data do not differentiate between staff on duty and those in a position to potentially have witnessed the incident. If they all are considered to be potential witnesses they are not always all interviewed. For example, in UIR 13-009 five DSP's were noted as being on duty in Section 5. Two were interviewed and no explanation is provided to explain why only those two were interviewed. o In six (100%), the name(s) of all alleged victims and perpetrators.	

#	Provision	Assessment of Status	Compliance
		o In six (100%), the names of all persons interviewed during the investigation but as noted above in some cases there may have been people who should have been interviewed and were not.. 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. Because of ambiguous language, in reviewing a UIR it was not possible to determine if the facts being reported resulted from an interview with the staff person, a written statement provided by the staff, or a third party account of what the staff person reported to the third party. If the facts recorded on the UIR did come from an interview in no case was a summary of topics discussed presented. o In six (100%), all documents reviewed during the investigation. o In six (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 six (100%), the investigator's findings. o In six (100%), the investigator's reasons for his/her conclusions. In its last report the Monitoring Team noted that the Facility needed 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. This still needs to occur. Improvements in the facility investigation process, and accurate documentation related to facility investigations, will be required to achieve compliance with this provision. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: reviewed 25 of 81 (31%) UIRs (included ANE and serious incidents) from 7/1/12 to 9/30/12 to determine if the QA Department reviewed each report and other relevant documentation to ensure that the investigation is complete and meets all requirements of the SA and the report is accurate, complete and coherent and that any further inquiries or deficiencies are addressed promptly. From its self-assessment the Facility determined that 25 out of 25 UIRs (100%) were	Noncompliance

#	Provision	Assessment of Status	Compliance
	or areas of further inquiry in the investigation and/or report shall be addressed promptly.	reviewed by the QA Auditors and the IMC to ensure that cases were accurate, answered questions and provided corrections needed. Based on the findings from this self-assessment, the Facility determined this provision is in substantial compliance because adequate supervisory review is occurring for all cases reviewed. Monitoring Team note: As reported in the last Monitoring Team report the Facility's self-assessment was incomplete as it did not address all required elements of the provision; 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: • Six of seven (86%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. This was not the case for investigation 42406367; however, the Facility did not provide the Monitoring Team with the last page of the investigation and the supervisor approval may have been on that page. • All seven (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 six investigation files reviewed there was evidence that IMC (the supervisor) had conducted a review of the investigation report. • There was limited evidence that the review had resulted in changes being made to correct deficiencies in the report as reported in Provision D.3.f. Important information in Facility investigation reports was often unclear without making gross assumptions such as an account of an event being derived from an interview when this is not specifically noted in the report. Staff tasked with reviewing Facility investigations need to be more critical to ensure investigation reports present clear, accurate, and documented information that does not	

#	Provision	Assessment of Status	Compliance
		repeatedly require clarifying information or use of assumptions in order to be understandable. Improvements in the facility investigation process, and accurate documentation related to facility investigations, are needed to achieve compliance with this provision. The Facility must review each report and other relevant documentation to ensure that: 1) the investigation is complete and meets all requirement of the SA; and 2) the report is accurate, complete and coherent and that any further inquiries or deficiencies (necessary to address requirements of the SA) are addressed promptly. The Monitoring Team does not concur with the Facility's self-assessment of substantial compliance with this provision.	
	(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: reviewed 25 of 81 (31%) UIRs (included ANE and serious incidents) from 7/1/12 to 9/30/12 to determine that a written report exists that contained relevant documentation to ensure that the investigation was completed and met all requirements of the SA and the report was accurate, complete and coherent and that any further inquiries or deficiencies were addressed promptly From its self-assessment the Facility determined that 25 out of 25 cases (100%) had written reports that contained relevant documentation to ensure that the investigation was completed and met all requirements of the SA and the report was accurate, complete and coherent and that any further inquiries or deficiencies were addressed promptly. Based on the findings from this self-assessment, the Facility determined this provision is not in substantial compliance because more time is needed to ensure that compliance is sustained. Monitoring Team note: As reported in the last Monitoring Team report 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> This Provision requires a written report documenting the review of the written investigation reports referenced in Provision D.3. g. The written report prepared pursuant to this Provision needs to reflect the substance of the Facility review of each investigation, e.g. "ensure that the investigation is thorough and complete and that the	Noncompliance

#	Provision	Assessment of Status	Compliance
		report is accurate, complete, and coherent" and, "any deficiencies or areas of further inquiry…. shall be addressed promptly". The RSSLC used a form "DFPS Investigation Cover Sheet Allegation and Final Report", dated 2/6/12, to document review of each DFPS investigation report. This form was presented to the Monitoring Team for only one of seven (14%) investigations. The Facility also has an Administrative Review Team (ART) that reviews DFPS investigation reports. The form used to document these reviews was not presented to the Monitoring Team for any of the seven investigations in Sample D.1. The information contained in the DFPS Investigation Cover Sheet Allegation and Final Report is intended 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 deficiencies. The Monitoring Team concurs with the Facility's self-assessment of noncompliance with this provision.	
	(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: reviewed UIR Tracking Log and actual UIR Folder to ensure that disciplinary and/or programmatic actions to correct the situation and/prevent recurrence were implemented promptly and thoroughly, and tracked and documented including corresponding outcome. From its self-assessment the Facility determined that: reviewed cases from 7/1/12 to 9/30/12 (random sample) indicated that 18 out of 25 cases (72%) had all disciplinary and/or programmatic actions documented and included. Based on the findings from this self-assessment, the Facility determined this provision in not in compliance because all disciplinary and/or programmatic actions are not tracked and documented with corresponding outcomes. Monitoring Team note: As reported in the last Monitoring Team report 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>	Noncompliance

#	Provision	Assessment of Status	Compliance
		Follow-up actions, persons responsible, and target dates, relative to DFPS and Facility investigations are noted in each UIR. In reviewing documentation provided by the Facility for both Sample D.1 and D.2 evidence of completed follow-up actions was variable. This finding is consistent with the Facility self-assessment. In its last report the Monitoring Team noted that 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 outcomes of disciplinary or programmatic actions corrected a situation and/or prevented recurrence. For example, staff training was often a recommendation. The Facility did not engage 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. This observation by the Monitoring Team is still valid. 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: evaluated the facility's records and record area for easy accessibility. From its self-assessment the Facility determined that: after evaluation of record area, it was concluded that the current area/system was efficient and met 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 from this self-assessment, the Facility determined this provision is 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 been the subject of prior investigations. In past reviews, it was noted that file storage in the IMC's office was organized and up-to-	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		date. For this review the Facility had a difficult time accessing documents requested by the Monitoring Team. Documentation files for DFPS cases were identified by the Monitoring Team 10 days before the review providing the Facility with sufficient time to assemble all relevant information. Initial documentation files prepared for both Facility and DFPS investigations were often incomplete or not provided for the case requested. The Facility was afforded the opportunity to provide supplementary information, which it attempted to do. In many instances the final documentation files reviewed by the Monitoring Team still did not have all relevant documents. In some cases, files were prepared for cases that were not asked for instead of cases that were requested. It did not appear the Facility was diligent in preparing documents for the Monitoring Team and this may be indicative that records are not consistently maintained in a manner that permits easy access. The Monitoring Team expects to see improvement in the next review. The Monitoring Team, with some reservation, concurs with the Facility's self-assessment of substantial compliance with this provision.	
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: reviewed revised Trend Reports to ensure that all unusual incidents were tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation; in addition they included a comparison from 12 months prior for each month and a 90 day data review. From its self-assessment the Facility determined that the Trend reports from 6/1/12 to 8/30/12 reflected the above data changes including longer term trends and information and corrective action. Based on the findings from this self-assessment, the Facility determined this provision is 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> Facility data reports a significant increase in the number of DFPS allegations from 62 in the six-month period of 11/11 through 4/12 to 87 in the six-month period of 5/12 to 10/12. The trend line for confirmed cases was showing fewer confirmed cases.--from 13	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		to five in these six month periods. The Facility had made improvements in its Trend Report, most notably in tracking data longitudinally. In its last report the Monitoring Team noted areas still in need of improvement, including 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 (by type of case) is increasing or decreasing. This still needs to occur. This is important because (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. Some additional data in this regard had been added to the Facility Trend report but further refinement is needed in content and presentation such that it can display trends in certain key areas, such as those enumerated above. Particularly with respect to confirmed cases of abuse and neglect it would be useful to track and trend data by the location of the incident that resulted in the confirmed finding, and, by the shift that the incident occurred during. This would presumably contribute to a data based understanding of when and where abuse and neglect has occurred. Trend data should be presented in a manner that lends itself to useful discussion and decision-making. At the present time the Facility's Incident Management Department did not use much of the available data to analyze client protections at the Facility. Its use of data was limited to management oversight activity within the Department such as tracking IMRT directed follow-up. This is necessary but should not be the only focus of data utilization. There were no examples presented to the Monitoring Team that demonstrated analyses of data leading to subsequent substantive decision-making. The Monitoring Team concurs with the Facility self-assessment of substantial compliance but in order to maintain compliance with this Provision the Facility needs to not only track the results of investigations of incidents and allegations but also present data in a manner that lends itself to useful discussion and decision-making. The Facility must also demonstrate it is using these data to assess operational performance, to improve deficient practices, to improve client protections, and to improve services.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: initial and annual checks with Employee Misconduct Registry, the Nurse Aide Registry, the Client Abuse and Neglect Reporting System, and the Federal Bureau of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	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 all of the (1318) 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 no staff 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 provision is 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 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. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 24 employees and nine volunteers confirmed that their background checks were completed. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. The most recent check was completed in October, 2012 and provided to the Monitoring Team. Employees were subject to a one-time fingerprint check during the month of October, 2011. Once the fingerprints were entered into the system, the Facility receives 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. Facility policy requires employees to self-report encounters with law enforcement that may impact their continued eligibility for employment. The State also provided similar	

#	Provision	Assessment of Status	Compliance
		information to the Facility as cross-matches routinely occur between state employee records and background check databases. This process identifies employees who did not self-report law enforcement encounters. The Facility Director confirmed this process, as described, is in place at the Facility. The Monitoring Team has determined that the RSSLC was in substantial compliance with this provision.	

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 review of non-serious discovered injuries is needed. (Provision D.2.a)
4. Additional steps to educate individuals and guardians regarding abuse/neglect identification and reporting need to be initiated. (Provision D.2.e)
5. The audit process to determine under-reporting of injuries and other incidents needs improvement. (Provision D.2.i)
6. 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)
7. 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 10/30/12 2. RSSLC Action Plan 10/15/12 3. RSSLC Section E Presentation Book 4. DADS Policy 003.1-Quality Assurance 1/26/12 5. RSSLC Policy A.28 Quality Assurance 3/13/12 6. RSSLC Quality Assurance Plan 10/12 7. RSSLC Quality Assurance Plan Draft Revisions 9/12 8. Summary Report – Active Databases (undated) 9. RSSLC Corrective Action Plan Process (undated) 10. CAP sample reports 11. Facility Trend Reports 10/31/12 12. QA monitoring tools used by the QA department 13. QA monitoring tools used by discipline departments 14. QA/QI Council Meeting Minutes for 5/15, 6/12, 6/26, 7/10, 7/24, 8/7, 8/21, 9/4, 9/18, 10/2, and 10/16, 2012 **People interviewed:** 1. Stacey Burdue, Director of Quality Assurance 2. Alice Ramirez, Data Analyst 3. Brad Hines, Data Analyst **Meetings attended/Observations:** 1. Quality Assurance/Quality Improvement (QA/QI) Council 5/15/12 2. Administrative Review Team 5/16/12 3. Restraint Reduction Committee 5/16/12
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The Facility self-assessment was comprehensive and reviewed policies, plans, and administrative practices being used at the Facility as part of its QA process. Through this process the Facility identified several important areas in need of improvement including improving inter-rater reliability between internal and external QA auditors, database improvement including clarification of the purpose and intended use of each database, improvements in Corrective Action Plans and incorporating measurable outcomes, and improvements in tracking systems. The self-assessment reported that the Facility is not yet in compliance with any of the five provisions of Section E of the Settlement Agreement (SA). The Monitoring Team concurs. The Monitoring Team observed continued improvement in the development of the administrative

	processes associated with QA activity. Under new leadership, 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: The Facility has a new QA Director as of 9/1 and work initiated since her appointment was impressive, including a draft of a comprehensive QA Plan, an expeditious identification of key problem areas in the organization of the Facility QA efforts, and aggressive pursuit of adjustments in organization and task responsibilities. The information presented to the Monitoring Team, particularly in the Presentation Book, demonstrated in a good understanding of QA expectation and the work that lies ahead. The Monitoring Team was able to determine that at least some 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. Further refinements in the data systems were also impressive and when finalized should yield important decision-making information to Facility administrators and clinical leaders. 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 primarily SA monitoring tools supplemented with Facility-developed 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 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. While improved from that noted in the last report this is still in a developmental stage. Data items on the monitoring tools have been treated as if they are equally important, so in preparing overall compliance reports the most critical data item counted the same as the most mundane. The Facility needs to review not only overall scores but also patterns of items that are reported as not done, in order to identify what actions are important to take. The QA activity in place at RSSLC directed at the identification of systemic issues had expanded from that

	observed at the last review. The Facility is to be commended for its work in creating and maintaining 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 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 have a method to determine the effectiveness of a CAP. The work effort observed during this monitoring visit demonstrated continued improvement in the development and implementation of the QA system.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed data inventory lists – one for the facility and one for all data collected by QA – for accuracy and completeness. 2. Reviewed QA Plan to determine that it accurately reflects ongoing monitoring 3. Reviewed QA monitoring tools used to track compliance, 4. Reviewed QA data bases 5. Reviewed QA tracking systems. 6. Reviewed Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes to determine that the Council meets at least monthly. From its self-assessment the Facility determined that: 1. The data inventory list is utilized as a way to know what databases we are currently using to trend data. The list were updated to include the following: • Guardianship Priority list • CAP Tracking database • Data library • Restraint trend report • Reduction of Polypharmacy Medications • Work Refusals • Medical follow-ups – revised 2. The QA Plan needed revisions to describe the quality assurance system in terms of: • Organizational structure,	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Functional responsibilities of management and staff, • Lines of authority, and • Required interfaces for those planning, implementing, assessing, monitoring, and improving all activities conducted. 3. QA monitoring tools needed improved levels of agreement between: • Internal and • External auditors 4. QA databases needed the following: • Clean-up the databases, • Archive unused databases • Clarify purpose of databases in use 5. The tracking systems needed to track: • How it is being monitored • When it is being monitored • What evidence of monitoring • Who is held accountable 6. Since the May monitor visit, the QA/QI Council met three times in May, twice in June, July August September, and October Data was reviewed according to the QA/QI schedule during 12 of the 13 (92%) meetings. The 5/29/12 meeting included discussion and development of team leads to address six desired outcomes. Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance because the data analyzed and trended does not include sufficient longitudinal data to identify trends in all areas identified in this provision; lacks effective monitoring tools and tracking systems. <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; □ Pharmacy and Therapeutics Committee;	

#	Provision	Assessment of Status	Compliance
		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 had revised its QA policy (A.28) to incorporate State requirements. A new QA Director was appointed on September 1st and had initiated several important and significant administrative improvements. The Facility also hired an additional data analyst who, along with the experienced data analyst, are refining and expanding data systems and associated reporting, including corrective action planning data, to be more useful to front line managers at the Facility. These improvements were characterized as recently initiated and still under development and refinement. These included: • Development of a narratively described comprehensive QA plan. The draft plan, still under development and refinement, contained detailed descriptions of: the organizational structure of the QA process (including descriptions of individual roles and responsibilities); the purpose of the QA program and the role of outside (discipline) departments; the continuous quality improvement process; performance improvement reports; plan implementation procedures, including data collection, reliability assessments, corrective action tracking, and performance measurement; and the role of the QA/QI Council in guiding the entire process. When this document is completed it will represent a comprehensive description of the QA process at the Facility. The Facility is to be commended for initiating such a document. • Formalization of a data library for the 62 databases already in use that collect and assemble data related to the QA process. These databases address many sections of the Settlement Agreement and more are in development. • Establishment of an integrated disciplinary workgroup that operates as somewhat of a subcommittee of the QA/QI Council focusing on the interdisciplinary operational details needed to address issues detected through routine QA monitoring. This group meets at least monthly. • Establishment of a quality engagement support team (referred to as QuEST).	

#	Provision	Assessment of Status	Compliance
		This interdisciplinary group met for the first time in October and will be concerning itself with the quality of engagement between DSPs and Individuals, directing its attention first to Individuals with identified special circumstances such as PICA, peer to peer aggression, specific medical conditions, and restraint use. • Creation of a series of on-screen data reports designed with the end user in mind. Those demonstrated for the Monitoring Team contained a series of drop down selection boxes making data available and sorted in different configurations that can quickly produce information needed relative to a specific Individual, or a group of Individuals, a specific clinical condition or group of clinical conditions, a specific disease process, infections in general or specific infections, etc. The Monitoring Team looks forward to its next visit and opportunity to observe these new initiatives in action. The Facility continued to produce the trend analysis reports required by DADS. These produced data related to restraint use, unusual incidents, allegations of abuse and neglect, and injuries. The Facility also continued to implement SA monitoring tools and produced data reports, including trend data, relative to the results of this monitoring. Additionally, the Facility had expanded its tracking and trending to include incidents of peer to peer aggression, medication variances, community placement obstacles, and bedrail corrective actions. The Facility reported it intends to expand the topics covered with trend reports as the QA process, and plan implementation, evolves. Much of the trend data included the presentation of longitudinal data. There are still additional refinements that should be considered. Detailed longitudinal data may be useful in detecting systemic problems, or in concluding a particular problem appears to be limited in scope (as opposed to Facility-wide). For example, if the Allegations Trend Report reported the day of the week, shift, and hour of the day for allegations over an extended period of time as it could have implications for staffing, supervision, and activity levels of individuals. If allegations are disproportionally represented on certain days of the week, certain shifts, or in clearly delineated time windows, it is conceivable that activity schedules, staffing ratios, or supervisory presence may need to be examined. At a minimum these data, when reviewed longitudinally, should give clues as to administrative and programmatic processes that may need to change because data is pointing to a systemic problem. A similar approach to data presentation and analysis would be appropriate for injury trending and many other aspects of client protection, nursing care, and clinical activity, and clinical outcomes. The Facility also prepared reports presenting data gathered from monitoring reports	

#	Provision	Assessment of Status	Compliance
		administered by both the QA Department and the discipline department under review. These reports provided information regarding inter-rater reliability and displayed data by each question on the monitoring tool. As reported in the Facility self-assessment there is an acknowledged need to improve inter-rater reliability to ensure data collected through QA activity and used for decision-making was as accurate as possible. The Facility needs to use these data to ensure that future quality assurance activity leads to interdisciplinary decision making that focuses on improving the quality of services, supports, and outcomes for the 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 report packages also include narrative analysis of key data. The work of the QA/QI Council is organized so each provision of the SA is reviewed at least quarterly. In addition to reviewing data the QA/QI Council receives reports and updates from Facility committees such as the Restraint Elimination Committee, Physical Nutritional Management Team (PNMT), Behavior Support Committee, Infection Control Committee, and Performance Improvement Teams. 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. 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 was beginning to change. The Monitoring Team, in its review of the Corrective Action Plan (CAP) process noted CAPs that targeted systemic issues. For example, CAP 123 targeted the systemic issue of pre-ISP assessments not being reviewed prior to an ISP, and, CAP 122 targeted the	

#	Provision	Assessment of Status	Compliance
		systemic problem of developing dental support plans. The CAP database now requires the initiator of the CAP to identify the issue being addressed as systemic (system wide) or an individual/department issue. It appeared those CAPs identified as systemic all would involve multiple departments/disciplines working together in an interdisciplinary manner to correct the issue the CAP addressed. The Facility is to be commended for beginning the process of using data to identify issues which appear to be systemic in nature and initiating a CAP that requires interdisciplinary work and cooperation to address. Each CAP also identifies the primary section of the SA affected by the issue being addressed by the CAP. This should help the Facility better understand the scope of issues related to compliance with each section, and the resources that may be necessary to reach compliance. The Facility may want to further refine its coding of CAPs so that similar types of planned corrective actions (such as staff training) can be reviewed together. In the example of staff training this type of data review could be used to measure the effectiveness overall of staff training and whether or not competencies being taught remain relevant. Reviewing all CAPs that include additional or different types of training could point to a systemic problem associated with the design, content, and type of training offered at the Facility. Trending of injuries, medication variances, infection control related data, 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 monthly reports related to these topics and others and a multitude of reports related to the use of SA Monitoring Tools. The Facility had taken important steps in the very recent past to improve its QA program. QA staff was obviously excited and enthusiastic about these changes. The Monitoring Team looks forward to reviewing the continued development, refinement, and implementation 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	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed random data summaries and analysis from QA/QI, 17/37 (46%) 2. Reviewed QA information to be presented to QA/QI Council 3. Reviewed QA/QI Council minutes to determine if corrective action was made a result of data review/discussion.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	4. Reviewed CAPs tracking log for timely implementation and completion of corrective action or modification as necessary. 5. Reviewed CAPs for measurable outcomes to assess effectiveness. From its self-assessment the Facility determined that: 1. Random samples of data summaries/analysis were reviewed. 17/37 (46%) and determined initially the focus was only on level of agreement. 2. The information presented to QA/QI by QA via individual section reports and revealed there is a gradual move from focusing primarily on level of agreement between internal and external audits to a more meaningful focus on the data analysis which will ultimately drive the corrective action plans. 3. Review of the QA/QI meeting minutes determined that data was reviewed during 11 of the 12 (65%) meetings and according to the QA/QI schedule. • Recommendations for corrective action were noted in the meeting minutes • No effective tracking system • Tracking system did not track when discussed at QA/QI • CAPs need to include the data, when data-driven • In 9 of 11 QAQI meetings CAPs were discussed/ recommended a result of data review/ discussion. (81%) • The 5/29/12 QA/QI meeting included discussion and development of team leads to address six desired outcomes. 4. Review of the CAPs tracking log revealed • Review revealed that 20 CAPs were implemented in the past 6 months • There was timely implementation of CAPs. • The CAP tracking log is ineffective in that it didn't capture all CAPs. A new tracking system to track and monitor CAPs is just in the early development stages. • During the 10/2/12 QA/QI meeting, it was announced that revisions will be made to the CAPs form, procedures written and training will be provided for CAPs written effective after the implementation of the training. 5. The CAPs tracking log reflects • 0 of 20 (0%) CAPs contain measurable goals. • 7 of 20 CAPs contained data information which prompted the CAP (35%) Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance because the facility is moving from data summary towards data analysis; there is not an effective CAPs tracking system, and the CAPs do not include measurable outcomes. <u>Monitoring Team findings</u>	

#	Provision	Assessment of Status	Compliance
		Please refer to Provision E.1 for a description of data collection and analysis processes in use at the RSSLC. An important element of this Provision is using data to develop and implement Corrective Action Plans (CAPs) to address problems identified through the quality assurance process. The Facility produced a great deal of data which demonstrated its process for data collection, data assembly, report preparation, report presentation to the QA/QI Council, and a report format from which a Corrective Action Plan could be prepared and submitted the QA Department. The use of these data to identify issues that might need a CAP was limited. The Facility reported that since 5/1/12 twenty CAPs had been initiated. Eight (40%) were initiated after 9/1/12. It is apparent that the Facility administrative QA processes were just beginning to develop Corrective Action Plans correlating to the analysis of performance data. For example, the Presentation Book prepared for the Monitoring Team did not include any examples of CAPs to document compliance with Provision E.2. 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. As reported in Provision E.1 the Facility has recently taken important steps in this regard. The use of the CAP process is better organized and had expanded to additional departments/disciplines since the last review (primarily since 9/1/12) where it was noted to be in place primarily in the nursing area. During this review at least one CAP was in place that addressed issues in 11 different sections of the SA (F, M, E, S, T, Q, D, L O, R, and P). This is a good start as multiple departments are beginning to get involved in the process of data review and analysis that leads to the development of a CAP. As suggested in the Facility self-assessment this is just the beginning stage of a Facility-wide CAP process. None of the 20 CAPs developed contained measurable outcomes and only seven sufficiently defined the problem (using data) the CAP was intended to correct. Nevertheless, the Facility is to be commended for its recent progress in implementing a procedural framework for CAP development. Please refer to Provision E.1 for additional information that effects compliance with this Provision. There are still improvements needed in the overall design of the monitoring system that will eventually produce the trend data used in formulating correction action plans. Data items on the monitoring tools have been treated as if they are equally important, so in preparing overall compliance reports the most critical data item counted the same as the	

#	Provision	Assessment of Status	Compliance
		most mundane. The Facility needs to review not only overall scores but also patterns of items that are reported as not done, in order to identify what actions are important to take. Most of the data reviewed by the QA/QI Council came from the monitoring tools that are used for each provision of the SA. The Monitoring Team was able to determine that there was some evidence that corrective action plans were initiated when monitoring discovered specific deficient practices and this was reviewed at the QA/QI Council. This was reflected in QA/QI Council meeting minutes. As the Facility continues to develop and refine its QA system it will need to use its extensive library of data to develop problem/issue statements in CAPs that, after implementation, can measure effectiveness in addressing the originally identified problem(s). Data analysis needs to be sufficiently robust to enable the Facility to proactively identify homes, day/vocational programs, and/or departments that require improvement, issues for whom the corrective solutions are inter-departmental in nature, as well as to identify systemic issues requiring attention. The work effort observed during this monitoring visit, particularly that which was initiated by the new QA Director, 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: reviewed CAPS tracking system to ensure all CAPs implemented within the past 6 months have been disseminated to all responsible parties. From its self-assessment the Facility determined that the tracking system indicated that 100% of the CAPs were disseminated to the responsible party. However, other than the tracking system which lists the responsible person, there is no evidence other than the CAP itself to verify that all responsible parties received the CAP. Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance because it cannot be verified in a systemic manner that all parties responsible for the implementation of the CAPs have received copies of the CAPs identifying their responsibilities.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team findings As reported in the Facility self-assessment the Facility does not as yet have an effective system to ensure, and document, correct dissemination of CAPs. 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 CAPS tracking system. 2. Reviewed QA/QI minutes to determine regular review of CAP data analysis with recommendations for corrective action made. 3. Reviewed data based on the results of CAPs monitoring. 4. Reviewed data related to CAPs revised due to ineffectiveness. From its self-assessment the Facility determined that: 1. Review revealed that 20 CAPs were implemented in the past 6 months. 2. Review of QA/QI meeting minutes revealed that CAPS related to Outcome Measures (identified at the 5/29/12 QA/QI meeting) were further discussed at 4 of 6 (67%) QA/QI meetings since their implementation date of 6/15/12. The dates of the QA/QI discussions were: • 7/24/12 • 8/07/12 • 8/21/12 • 9/04/12 3. Review of the data of CAP monitoring revealed a need • For a new tracking system • Improved follow through and • Accountability for ensuring CAPs are completed, monitored, reported systemically at QA/QI. 4. Review of the tracking log did not indicate that any were revised due to ineffectiveness; however • discussions with leads indicate that some were revised without updating the log • QA/QI minutes reflect that revisions had been made (5/15/12 and 10/2/12) Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance because not all CAPs are written in measurable terms, tracking and monitoring needs improvement.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team findings As reported in Provision E.2 the initiation of CAPs is a relatively new process at the RSSLC and none contained measurable outcome measures. As a result the Facility could not determine effectiveness and need for modification. Anecdotally, CAPs were discussed at QA/QI meetings and this discussion was recorded in meeting minutes; however, this discussion did not usually include presentation and review of objective data related to the intended outcome of the specific CAP. This is not surprising since none of the CAPs identified measurable outcomes. 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 was revised if not effective. 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: 1. Reviewed data related to CAPS revised due to ineffectiveness. 2. Reviewed data related to outcome of CAPS and continuation of the implemented corrective action. From its self-assessment the Facility determined that: 1. Review revealed that 20 CAPs were implemented in the past 6 months 2. CAPs data log revealed that • 0 of 20 CAPs were revised due to ineffectiveness • log had not been updated 3. CAPS log reflects a need for a method to document continued monitoring of corrective actions following completion of the CAPS. Based on findings of this self-assessment, the Facility determined this provision is not in substantial compliance because there is not any evidence of continued monitoring of corrective actions following the completion of CAPs. Monitoring Team findings 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 to identify patterns of data items on monitoring tools that are not being met, so actions can be taken 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. (Provision E.1)
4. Develop a methodology to define and identify staff who should receive CAPs, and that ensures CAPs actually are disseminated to those staff for action. (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 10/30/12 2. Richmond State Supported Living Center Action Plans, updated 10/15/12 3. Richmond State Supported Living Center Settlement Agreement Presentation, dated 11/9/12 4. Section F 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 Individual Support Plan Meeting Documentation, revised 03/27/12 10. RSSLC Policy F.11: Staff Responsibilities Regarding Daily Schedules, revised 07/13/12 11. RSSLC Policy F.13: Implementing & Documenting Active Treatment Programs, revised 05/04/12 12. RSSLC Policy F.18: Completing Personal Focus Assessment, effective 12/14/11 13. RSSLC Policy F.20: Completing the 3rd Quarterly Review Meeting, revised 04/18/12 14. Annual Assessments Filed Within 10 Days, for meeting dates of 5/1/12-9/30/12 15. List of ISPs and Attendance Tracking, Meeting Dates of 5/1/12-9/30/12, dated Thursday, October 11, 2012 16. 30-Day ISPs and Assessments for Individual #787 17. ISP Assessments for Individuals #148, #511, #544, #552, and #582 18. Sample of recent Individual Support Plans (ISPs) for Individuals #31, #156 #165, #465, #661, #746, and #760 19. Sample of Preferences and Strengths Inventory (PSI) for Individuals #31, #265, #251, #465, #511, and #746 20. Sample of Monthly/Quarterly Reviews for Individuals #23, #173, #180, #216, #382, #484, #552, #574, #579, #600, and #758 21. Section F Monitoring Tool 22. F.A.T City training curriculum and trainee evaluations 23. Planning My Future curriculum, revised 9/13/12 **People Interviewed:** 1. Jacqueline North, QDDP Educator and Interim QDDP Coordinator 2. Cynthia Fannin, Director of Education and Training 3. Stacey Burdue, Director of Quality Assurance 4. David Savage, QA Auditor 5. Cynthia Newton, Transition Coordinator 6. QDDP for Individual #251 **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #165 and #465 2. Pre-ISP meeting for Individual #251 3. F.A.T City training session

	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. 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. 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. For Section F, in conducting its self-assessment, the Facility did use monitoring/auditing tools, including the Section F Monitoring Tool. The data upon which the self-assessment was predicated in many instances indicated much different findings than those of the Monitoring Team. For example, the Facility reported the following data that were inconsistent with findings by the Monitoring Team: • 100% (10 of 10) ISPs indicated that CLOIP information was shared with either individuals and /or LAs annually; • 70% (7 of 10) ISPs had identified obstacles to community living with action plans to overcome identified obstacles; • 100% (10 of 10) ISPs included supports needed and encouraged community participation; and, • 98% of the ISPs reviewed included documented supports and services that were practical and functional. The Facility noted significant concerns with inter-rater reliability, so it was not yet likely this information provided a sound basis for evaluation. The Facility reported, in Provision F2g, that it was in the process of re-thinking its quality management strategies, including the use of new tools. As it examines these strategies, the Monitoring Team suggested this process should incorporate a review of the details of, and examples in, the compliance reports for Section F to ensure the auditors assigned have a clear understanding of how these items are being evaluated by the Monitoring Team. The Monitoring Team also reviewed the Action Plans. Overall, many of the Action Plans were thoughtful and included a set of steps likely to lead to compliance with the requirements of this Section if fully implemented. There did need to be a clearer plan for measuring the outcomes of each of these and include this in the Evidence column in addition to the paper compliance evidence found there. In some cases, Action steps were designated as completed, but evidence found during this monitoring visit would suggest the desired outcomes had not been achieved. For example, the Action Plans included a step to re-train QDDPs on the identifications of obstacles to community placement which had been completed, but the evidence during this monitoring visit suggested IDTs were not yet proficient in doing so; the Action Plan listed no further actions to build on the completion of retraining and improve identification of obstacles and then to ensure ISPs include not only accurate statements of obstacles but also plans to address them. Positive outcome indicators regarding proficiency should be used to determine whether a step is completed, not simply a copy of a training roster.
	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 had demonstrated some degree of progress in a number of areas, including timeliness of assessments, attendance at ISP annual planning meetings, QDDP facilitation skills and coordination of services. The Monitoring Team commended these efforts, but did not find they had yet yielded substantial progress in the development and implementation of an integrated ISP for each individual that ensured individualized protections, services, supports, and treatments were provided, consistent with current, generally accepted professional standards of care. The Facility is encouraged to continue to build on these recent initiatives. Additional 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, and had recently begun to implement a revision to the ISP process. This process held some promise with the implementation of the Pre-ISP meeting, but the Monitoring Team was concerned the annual planning meeting was so heavily focused on a discussion of problems that it was not conducive to the participation of the individual. A two hour discussion focused on risks and problems did not set a stage for developing a plan based on an individual's personal goals, preferences and strengths. The Monitoring Team recommends the State and Facility reconsider how the current process could be modified in part to focus more planning time on preferences, strengths and personal goals, while retaining the overall structure and improvements found in this new format. On the whole, there was a marked improvement in the organization of meetings observed and there was increased responsiveness to assessment information. Integration of services and supports was still lacking, however, as described throughout this section. 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. **Provision F2:** The Monitoring Team found there were some examples of improved coordination of services at the Facility as well as a degree of improvement in integration observed in planning meetings, but these were not yet sufficient to result in outcomes required for this Provision. For example, ISP strategies did not yet adequately address individual's needs, strengths and preferences or reflect encouragement of community participation in any meaningful or purposeful manner. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs and IDT members. The Monitoring Team would particularly like to recognize the creativity and diligence of the QDDP Educator in this regard and encourage the Facility to continue in this direction. Some improvements were noted in meeting facilitation and in functional engagement; but, overall, staff did not demonstrate competence to implement the ISP programs or provide active treatment on an ongoing basis. There also continued to be a significant incidence of failure to provide timely development and implementation of an ISP for each individual.

#	Provision	Assessment of Status	Compliance

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
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 20 QDDPs. Six had been hired during the past six months. The Facility also had a QDDP Educator who was serving as the interim QDDP Coordinator as well after the retirement of the incumbent. RSSLC reported that six QDDPs had been deemed competent in the Q Construction Facilitation skills, although one of these had recently taken a position as a Transition Specialist. 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. On the whole, there was a marked improvement in the organization of meetings observed, and there was increased responsiveness to assessment information. Integration was still lacking, however, as described throughout this section. 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 and F2d. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, as described in Provision F2e below, an effort the Monitoring Team commends. <u>Conclusion:</u> This provision was found to be not in compliance.	Noncompliance
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT	<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 ISPs and Attendance Tracking, Meeting Dates of 5/1/2012-9/30/2012, dated Thursday, October 11, 2012, the overall compliance for attendance by the required disciplines during this period was 97.6%. Participation ranged from 83% to 100%. The Monitoring Team did note concerns related to IDT participation, both in annual planning meetings and Community Living Discharge Plan meetings, As reported in Provision R1, Speech/Language Pathologist (SLP) participation at meetings in which their expertise would be required was	Noncompliance

#	Provision	Assessment of Status	Compliance
	meetings shall be dictated by the individual's preferences and needs.	inconsistent, but improvement was expected as a result of RSSLC obtaining full staffing in that discipline. The two new ISPs and a Pre-ISP meeting held during the monitoring visit were well-attended, but it was noted that the SLP did not participate in the CLDP or offer an adequate assessment, and the team physician did not stay for that entire meeting. <u>Extent of Individual participation in ISP:</u> Meaningful participation by individuals themselves remained very limited, as reported in previous assessments by the Monitoring Team. However, at the annual ISP planning meeting for Individual #165, the individual participated actively in some portions of the meeting (although the individual left for part of the meeting and then returned); the QDDP actively encouraged this participation, and the IDT responded respectfully to the information and concerns the individual expressed. As observed in previous reports, individuals with intellectual disabilities benefit from repeated and ongoing experiential activities in this area, as with many others, as opposed to once or twice a year. The State and Facility were urged to consider how the PSI process might be expanded onto be an ongoing process that truly supports individuals to be active participants in their own planning. A newly revised Preferences and Strengths Inventory (PSI) process, as described in DADS Policy 004: Individual Support Plan Process, was not robust enough to facilitate an individual's real understanding and participation. The Monitoring Team recommended that the Facility implement a curriculum for "planning my future" that would be incorporated into the overall active treatment program on an ongoing and regular basis. Such a planning process might include, for instance, many opportunities across the year for staff to assist each individual to create pictorial representations of the things that matter to them. Using photographs, drawings, pictures from magazines and books, for example, each individual could develop a poster portfolio of such things as "Important People in My Life," Things I Want to Do," Places I Want to Go," What My Ideal Home Looks Like," "Things I am Good At," etc. These posters could then be placed on the walls to begin the PSI 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 PSI areas with the individual. The portfolio could then be revised for the ISP meeting based on the PSI results. This would make the ISP a much more comprehensible, participatory and positive experience. The Facility had developed such a staff curriculum entitled Planning My Future, revised on 9/13/2012. It focused primarily on how to develop a Planning My Future notebook for each individual and included proposed materials and participant testing. There was not a formal plan for how individuals would be engaged in the process at this point. In addition, the Monitoring Team did not view any notebooks in actual use at RSSLC at this time, so it was not able to assess whether this strategy was consistent with the	

#	Provision	Assessment of Status	Compliance
		recommendations in the previous paragraph The Monitoring Team commends the Facility for its initiative in this area and looks forward to reviewing the implementation and outcomes at future visits. The Facility should continue to implement and broaden its "planning my future" strategies such that this activity that is incorporated into the overall active treatment program on an ongoing and regular basis During this site visit, the Monitoring Team observed two ISP annual planning meetings in the newly revised format and process. While the Monitoring Team appreciated the intent of completing the Integrated Risk Rating Form (IRRF) at the beginning of the meeting, it found this process was so heavily focused on a discussion of problems that was it not conducive to the participation of the individual. Both meetings began with a brief review of an individual's preferences from the PSI, including in one instance some related pictorial display on an easel, but this was immediately followed by the IRRF discussion, which in both cases consumed the next two hours. This discussion was not held in such a way as to be meaningful or comprehensible to the individual, and was in no way related back to individual goals and preferences. A two hour discussion focused on risks and problems did not set a stage for developing a plan based on an individual's personal goals, preferences and strengths. The Monitoring Team recommends the State and Facility reconsider how the current process could be modified in part to focus more planning time on preferences, strengths and personal goals, while retaining the overall structure and improvements found in this new format. <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.	Policy DADS Draft Policy #004 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the "Action Plans" section of the ISP." In Section II.E, the policy stated: "IDT members prepare for the ISP meeting by: • Completing the recommended and required assessments and placing them on the facility computer shared drive for the IDT to review no later than five (5) working days prior to the initial ISP meeting; and • Reviewing all assessments for the initial ISP to be prepared for a comprehensive, integrated discussion during the ISP meeting." For annual ISP planning meetings, this policy requires in Section III.C that assessments	Noncompliance

#	Provision	Assessment of Status	Compliance
		be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting. Facility policy required assessments to be in the shared drive no later than fifteen days prior to the annual ISP planning meeting. <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. For example, for Individual #165, the Facility provided 11 assessments in response to a request for all assessments to be used for the ISP. Of these, four were not for the current year, including medical, psychological, nutrition and OT/PT. 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 five (0%) had all required assessments available and/or posted by the required date, although there was progress noted since the previous monitoring visit. For example, the Shared drive folder for Individual #552 was opened on 11/14/12 to determine the status of assessments due in preparation for the individual's upcoming ISP annual planning meeting on 11/20/12. Of 25 assessments listed in the folder as required, 24 (96%) were present. Of those 24, 23 (96%) had been posted 10 or more days prior to the scheduled ISP meeting, a significant improvement. These trends toward the timely completion of ISP assessments were confirmed by the Facility's tracking data. . The Monitoring Team reviewed the Annual Assessments Filed Within 10 Days, for meeting dates of 5/1/2012-9/30/2012 which tracked assessments by residence and by discipline. By residence, the overall percentages of timeliness ranged from 72%-89%. While there was significant variability among and within the disciplines as to timeliness, it was noted there had been some improvement in the timeliness of the Nursing Summary since the previous monitoring report. One that stood out in these data as frequently being submitted late was the Speech Assessment. The Monitoring Team also noted during this review that some behavioral assessments were not available at the time of ISP planning meetings, including those for Individuals #787 and #165. Other examples of the failure to complete assessments routinely included: • It was reported in Provision S1 that only one individual in the sample of Skill Acquisition Plans (SAPs) had been provided a formal assessment of adaptive skills within the year prior to the ISP. For the nine remaining individuals in the sample, neither the reviewed ISPs nor the corresponding Psychological Assessments included specific information regarding adaptive skills. Although	

#	Provision	Assessment of Status	Compliance
		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. • It was also noted that DADS policy calls for the PSI 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. This process was being phased in with the new Pre-ISP meeting portion of the new-format ISP and, while progress was noted since the last monitoring visit, the PSI was not yet consistently available in the prescribed timeframe. <u>Extent to which assessments are conducted in response to significant changes:</u> There were still many instances in which assessments were not updated when the need arose. Examples included: • As reported in Provision O2, there was an excessive delay in which reports related to the PNMT assessment process were completed, with only one of seven completed within 30 days. More than half took over three months. Delay in getting the assessments completed results in an increased risk due to the team not receiving the needed feedback in a timely manner and therefore being unable to implement any needed strategies in an efficient manner. • As reported in Provision O1, zero of five individuals 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. <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 M2, the RN Case Manager had developed and implemented a Quality Peer Review process and a standardized Monitoring Tool for Annual and Quarterly Nursing Assessments in addition to the Nursing Care Monitoring Tool for Annual Quarterly Nursing Assessments. A random sample of 18 nursing assessments was completed in August and September 2012 with an overall compliance of 87%. Overall, assessments were still not routinely of sufficient quality to reliably identify the	

#	Provision	Assessment of Status	Compliance
		individual's strengths, preferences and needs. In particular, the Monitoring Team found that the PSI 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: • As reported in Provision S1, none of the ISPs included in the sample (0%) involved formal assessment of preferences or reinforcers. Anecdotal information about preferences was presented in most ISPs. This information was obtained through the Preferences and Strengths Inventory (PSI), however, rather than a widely recognized procedure or tool for identifying preferences. As the PSI lacked an evidence base and standardized administration, the weaknesses associated with anecdotal assessment were likely to be more pronounced with the PSI. 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. • The Analysis Section of the PSI was intended to synthesize the findings of the PSI such that they could be used to provide the team with guidance and insight in the development of the ISP. This section was typically was summary of preferences, but without any synthesis as to how the team might use them to support the individual's future, even though the template prompted such an analysis. The Monitoring Team did observe the PSIs for the two new format ISPs, which did seem to take a somewhat more in-depth approach, so this was an encouraging sign. • Very few PSIs devoted any attention to work exploration or opportunities. • The Monitoring Team attended one Pre-ISP meeting during this monitoring visit and found the PSI was not available at the meeting. It had been completed, but the QDDP did not bring it to the meeting, nor was there a discussion of its findings. The Monitoring Team found additional limitations in the current processes related to assessment processes. Examples included: • As reported in Provision R2, 24 of 39 (61%) individuals had comprehensive assessments that contained each of the elements considered to reflect standard of practice. Those assessments that were not considered to be comprehensive did not include the manner in which strategies, interventions, and programs should be utilized throughout the day or addressed Factors for Community Placement. • As reported in Provision U1, the Facility did not routinely use standardized or valid instruments and/or processes to assess functional decisional capacity. The new Rights Assessment was an improvement over the previously used process in that it did prompt the team with specific probes in each of the seven	

#	Provision	Assessment of Status	Compliance
		categories of informed consent but it was still not predicated on any objective criteria, nor implemented in such a manner as to result in any discernible difference in the deficient process or outcomes from previous visits. • The Facility typically did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2, a very small proportion of individuals living at RSSLC had opportunities to tour community living options, and the annual CLOIP process was not meaningful for most. For example, the Monitoring Team found that only 12 of a sample of 26 individuals (46%) were allowed by the LAR to participate in the CLOIP. <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 still not consistently completed in time for IDT members to review each other's assessments prior to the ISP meeting, nor were assessments completed with sufficient thoroughness. Even when the results of this 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. As reported in Provision S1, a sample of two SAPs was selected from each home at RSSLC. The Facility was asked to provide for each SAP the most recent ISP, Functional Skills Assessment (FSA), preference assessments, and assessment reports from each discipline, as well as the data sheets and progress notes for the SAP. Based upon the sampled SAPs and related materials, there was no indication that assessment information was used in the development of skill acquisition programs. There were indications that assessment data had been reviewed during the ISP process for several individuals. None of the reviews documented in ISPs in the sample, however, included information specific to the SAPs, such as assessment findings or documentation that IDT discussions had encompassed skills targeted by the SAPs. Other examples of failure to incorporate assessment findings in the development of the plan included: • As reported in Provision S1, in none of the ISPs or SAPs reviewed, were there FSA findings discussed in the ISP that corresponded with the specific skills	Noncompliance

#	Provision	Assessment of Status	Compliance
		targeted by the SAPS. • For Individual #787, the ISP documented the important personal preferences identified in the PSI included interest in computer use and writing, both potentially valuable work skills. In addition, the SLP had suggested to the IDT in the Pre-ISP meeting that a SAP could be developed to address behavioral concerns through written language. Neither of these was incorporated into the ISP. <u>Conclusion:</u> This provision was found to be not in compliance.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. The Monitoring Team attended two ISP annual planning meetings and reviewed five recent ISPs as measures of how this process may have affected the IDTs' implementation of this requirement of the SA. The IDT was expected to indicate the most integrated setting appropriate to an individual's and, if they chose not to make a referral, indicate the reason(s) for that choice. In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. For the two new-format ISPs, the Monitoring Team found there were some indications of progress, but the required determination was still not being consistently provided. • For Individual #165, there was some progress observed in identifying the most integrated setting appropriate to an individual's needs noted during the ISP annual planning meeting for this individual. The QDDP went around to all the professionals, as well as to the DSP, the representative of the Local Authority (LA) and Disability Rights Texas representative and asked for an independent decision on the appropriateness of movement to a more integrated setting. Each person gave an opinion and some rationale from the person's clinical area or other knowledge of the individual. There was then a robust discussion before an IDT decision was finalized. This information was not consistently present in the discipline assessments, however. The Facility provided 11 assessments in response to a request for all assessments to be used for the ISP. Of these, four were not for the current year, including medical, psychological, nutrition and OT/PT. Only four of the current assessments provided a professional determination as to the most integrated setting. Overall only 36% of assessments for Individual #165 provided a current determination of most integrated setting. • For Individual #465, six assessments were provided. Each (100%) had a template statement indicating the individual could be served in a community	Noncompliance

#	Provision	Assessment of Status	Compliance
		setting, but only two (33%) included any specific recommendations about what those services should be. The IDT members were polled as to their professional opinions, which generally supported the assessment the individual could be appropriately served in a community setting, but there was no recommendation made by the team as a whole as to the most integrated setting that would be appropriate to her needs, or discussion as to how these opinions were reconciled with the decision not to make a referral. The Monitoring Team commends the improvement noted in the IDT meeting, particularly as it was intended to demonstrate how the new ISP process would be implemented in the future. That the portion of the directive for each discipline to include recommendations regarding the most integrated setting and supports/services needed in that setting was not yet fully implemented at the Facility was further evidenced by a review of assessment packets for five individuals with upcoming ISPs. 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 38 discipline specific assessments related to the five ISPs reviewed. Of these 23 (60%) provided such a determination. Other findings included: • In most cases, the assessments did include a statement that the individual's needs for supports and services could be met in a community setting. These often took the form of a template statement that was not individualized. Only rarely was the statement accompanied by any statements regarding services and supports specific to needs in a community setting. • In most cases, the template statement indicated that the professional opinion was based on the current services and support being provided at the Facility; it did not take into account that any different services might be needed in the community. In Provision T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such obstacles. In summary, the Facility was not yet effectively identifying or addressing obstacles. For example, none of four (0%) of the recently completed ISPs reviewed, in which a referral was not made, evidenced proficiency in identification and addressing of obstacles. In none of the four (0%) that identified LAR or individual choice as the barrier were there specific action plans developed to address the barriers. This review of the recently completed ISPs indicated IDT members continued to need additional training in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs. These data were also inconsistent with the Facility's self-assessment that 70% (7 of 10) ISPs had identified obstacles to community living with action plans to overcome identified obstacles.	

#	Provision	Assessment of Status	Compliance
		As it relates to this provision, there was little overall progress demonstrated in the ability of the IDTs to identify the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. This was observed to continue to be true in the new ISP process and may be attributed in part to a sequence that did not ask the team to actually determine the most integrated appropriate setting until after the individual's services and supports had been identified. This tended to perpetuate the tendency of the teams to focus primarily on the supports and services currently being provided at the Facility. While such an array may include many essential services and supports, it does not take into adequate consideration the varied needs that may be needed for successful transition and community living. The IDT must identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported. The identification of needed services and supports is also pre-requisite to assisting the team to identify and address potential obstacles. <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,	<u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u> The ISP process relies heavily on the PSI process to identify preferences and strengths. As described further in Provision S1, it was noted that none of the ISPs included in the sample (0%) involved formal assessment of preferences or reinforcers. Anecdotal information about preferences was presented in most ISPs. This information was obtained through the Preferences and Strengths Inventory (PSI), however, rather than a	Noncompliance

#	Provision	Assessment of Status	Compliance
	identifies the supports that are needed, and encourages community participation;	widely recognized procedure or tool for identifying preferences. As the PSI lacked an evidence base and standardized administration, the weaknesses associated with anecdotal assessment were likely to be more pronounced with this instrument. As a result, there was only limited information to suggest that services and supports, including SAPs and other supports to overcome barriers to movement to a more integrated setting, were based upon the preferences of the individuals or used reinforcers selected through structured assessment. See Provision F1c for a further description of the limitations of the PSI in this regard. In addition, as documented in Provision F1d, even when strengths and preferences were identified, the ISP was not consistently built around these. <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 five (0%) recent ISPs reviewed were barriers clearly identified and addressed, as further detailed in Provisions F1c and T1b1. <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. Examples included: • In a review of five recent ISPs, zero of five (0%) evidenced any meaningful community integration strategies; this finding was inconsistent with the self-assessment, which found 100% (10 of 10) ISPs encouraged community participation. Instead, each had community objectives that were typically limited to stating the individual would have opportunities to participate in various community outings on an "ongoing" or an "annually or as needed" basis. 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, including use of community settings to teach skills that would support successful community living or integrate preferences identified by and for the individual into SAPs. • At the time of the current site visit, the Facility indicated that only money management SAPs were being implemented in the community. No money management programs were included in those made available by the Facility for the Section S review**.** 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. • As reported in Provision T1b2, the Facility did not yet succeed in developing individualized plans for community education and awareness. There was little	

#	Provision	Assessment of Status	Compliance
		progress observed in the sample of five recent ISPs reviewed. For zero of the five (0%) recently completed ISPs was there an individualized plan for increasing awareness of community living options that took into account the learning needs of the individual. There was some progress noted in the discussion of this topic in one of two (50%) new format ISPs, for Individual #165, and this was encouraging. The Monitoring Team looks forward to reviewing the plan developed from this discussion and its implementation. As recommended in Provision T1b2, the Facility's IDTs should develop an individualized community participation 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. <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 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;	<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 requisite essential components of skill acquisition programs such as operational definitions of teaching targets needed to allow measurable goals/objectives, or clearly specified strategies such as discriminative stimuli, consequences, and teaching instructions. <u>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:</u> Identifying 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 Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of five (0%) recent ISPs reviewed evidenced proficiency in this regard. Also see Provision F1e above.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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, and inclusion of or consistency with risk action plans. 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, learn the names of foods and make choices that are consistent with any health care risks; 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. For example, a pre-ISP meeting was held for Individual #251 during the monitoring visit. The IDT reviewed the current programs and discussed continuing programs such as hand-washing . The speech therapist also indicated she would be working on a tactile schedule that would help the individual be more aware of daily activities, which the Monitoring Team found to be a practical and functional approach. The IDT had no discussion as to how the tactile schedule could be integrated into the remaining programs, such as being used to indicate it's time to wash hands. The Monitoring Team provided technical assistance to the QDDP, who seemed very receptive and saw the value in this integrated approach. The Monitoring Team looks forward to reviewing its implementation at the time of the next monitoring visit. Overall, additional and extensive training was still 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 an area of need and/or preference. 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: • As reported in Provision O3, a review of the 11 individuals' ISP attendance	Noncompliance

#	Provision	Assessment of Status	Compliance
		sheets found medical, dental, SLP and Registered Dietitian attendance at the meetings were all less than 50%. The absence of these professionals impacted the discussion related to the integration of PNMP and dining plans into the ISP, risk assessment, and multiple support plans. In addition, the absence of dental staff as well as the other professionals impacted the ability of the IDT to adequately review and integrate an individual's PNMP into the ISP. • As reported in Provision R2, three of six (50%), communication assessments and PBSPs reviewed addressed the connection between the PBSP and the recommendations contained in the communication assessment. Three of six (50%) communication assessments reviewed contained evidence of review of the PBSP by the SLP. • 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 P2, the interventions contained as part of the PNMP were in place, were well documented, and had established measurable and functional goals that were included as part of the OT/PT assessment; however, findings were often not integrated into the ISP. Recommendations other than the PNMP were often not included and there was limited to no evidence of therapist-designed SAPs in general or related to direct therapy services. <u>Conclusion:</u> This provision was found to be not in compliance.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Extent to which ISP identifies:</u> <u>Methods for implementation:</u> There was some evidence of progress in this area, including that, as reported in Provision M3, which reported 11of 11 (100%) Acute Care Plans' instructions for the direct care professionals were appropriate and sufficient to meet individuals' needs and were written in terms they could easily understand. Also, Provision O4 reported that, in most cases, pictures were available with the Physical and Nutritional Management Plans (PNMPs) related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. However, findings in Provision S1 that indicated the methods of implementation were not yet compliant included: • The similarity across 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. In addition to the similarity of task analyses, documentation for only six of 10 individuals (60%) in the sample provided by the Facility included at least a task analysis protocol. It was also	Noncompliance

#	Provision	Assessment of Status	Compliance
		noted, for those individuals for whom a task analysis was provided, that the steps in the task analysis protocol often did not match the steps for training included in the SAP. • 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 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. • For training to be effective there must also be a consequence for an incorrect 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 or offer prompting. 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. • Staff did not identify the training methodology best suited to the behavior or skill being taught. All skill acquisition programs that were reviewed at RSSLC were described as using either forward chaining or backward chaining teaching methodologies. Although chaining procedures can be very effective, they are not appropriate for all skills and all circumstances. It was also not clear that program authors understood the concepts of forward and backward chaining, or when each should be used. Furthermore, as reported in Provision R3, recommendations were limited to how individuals who did not have individualized AAC devices could utilize the common area devices; when recommendations were provided they were vague and did not provide clear direction as to how and when individuals would utilize such devices. <u>Timeframes for completion:</u> There was not a consistent approach to providing timeframes for completion. ISP Action Plans typically documented an implementation date, and sometimes a projected timeframe for the first objective, but there was not usually an overall projected completion date, although the Action Plan templates had a column for this purpose. Two Action Plan templates were in use in the recent ISPs reviewed. One provided for an indication of the frequency of implementation and one did not. <u>Responsible Staff:</u> The ISPs typically indicated by position who would be responsible for documentation and data review. All Action Plan templates had a column that indicated "Persons Responsible for Implementation/Documentation." Each template also had	

#	Provision	Assessment of Status	Compliance
		columns for the "Person Responsible for Plan Development" and "Person Responsible for Reviewing for Progress and Effectiveness." Conclusion: 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	Extent to which interventions, strategies, and supports are practical and functional: As reported in Provision S3a, 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. Also due to the numerous limitations in the skill acquisition programs described in Provision S1, it was not possible to determine that SAPs were practical or functional. Observations reflected, and SAP data sheets supported, that formal programs were seldom implemented. In many instances, staff failed to demonstrate accurate and skillful implementation of SAPs. As reported in Provision R3, a review of the ISPs for 27 individuals indicated the ISPs did not consistently integrate communication supports, strategies or interventions. Examples included: • In 16 of 27 ISPs reviewed (59%), the type of AAC and/or communication supports was identified. • In 16 of 27 ISPs reviewed (59%) a description of how the individual communicated, including the AAC system if they had one, was included. • Four of 27 ISPs reviewed (14%) included how communication interventions were to be integrated into the individual's daily routine. • Fourteen of 27 ISPs reviewed (51%) contained skill acquisition programs to promote functional communication. The Monitoring Team's findings did not support the Facility's self-assessment data that indicated 98% of the ISPs reviewed included documented supports and services that were practical and functional. Conclusion: 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 frequency of data collection in order to permit the	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: The Monitoring Team found the Facility did not yet consistently identify the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress. Examples included: • SAPs reviewed for Section S typically did specify the frequency of data	Noncompliance

#	Provision	Assessment of Status	Compliance
	objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	collection, although the frequency was not high enough to permit the objective analysis of the individuals' progress, usually no more than once or twice per week. There were some SAPs that specified multiple trials per session but data sheets only allowed for the entry of a single score. • As reported in Provision M3, fifty six of 78 (72%) HMPs included the frequency for assessments and documentation and where to document actions/intervention in the unified record. However, frequently found on the plans was the requirement for the Nurse Case Managers to document on the plan quarterly. This was not adequate for periodic assessment of individuals' problems related to the identified health problems. <u>Extent to which ISP identifies the persons responsible for the data collection and the persons responsible for data review:</u> The SAPs reviewed for Section S did not specifically indicate who was responsible for data collection or who was responsible for data review. The ISP Action Plans did identify responsibility by position, but not by specific name. <u>Conclusion:</u> 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.	<u>Extent to which goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP:</u> 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: • As reported in Provision O1, members added to the PNMT since the previous compliance visit included a physician and a QDDP. The physician consulted with the PNMT regarding medical diagnoses and other issues, and the QDDP served as the primary liaison to the other QDDP and IDTs. The addition of these two members should assist in the development of a comprehensive review as well as improved communication between all relevant teams. • As reported in Provision J8, examples reported were the integrated clinical meetings that took place on Wednesdays, the integrated care sessions in the neurology clinic (planned but not yet in place) and the expanded use of the PBMC. The Monitoring Team observed the beginnings of the latter process during two PBMCs. The meetings were attended by the psychiatrists, psychologists, nurse case managers and others. Psychiatrists were attentive to issues of diagnosis and enquired about symptoms that were the basis for existing diagnoses. Psychologists explained PBSPs, and DSPs provided critical examples from day-to-day living. Discussions were good, but it was simply too	Noncompliance

#	Provision	Assessment of Status	Compliance
		early in the process to tell whether the PBMCs have been transformed from medication management clinics to a place where meaningful integrated care was developed. The Monitoring Team commends the Facility for these initiatives to promote staff coordination in the development and monitoring of supports and services. Overall, however, coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP continued to be lacking, as described throughout this Section F. Conclusion: 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.	Extent to which ISP is accessible to staff: Staff generally reported that the ISP was accessible. The ISP was placed in the individual's section of the Group Notebook. Extent to which ISP is comprehensible to staff: 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 Provision O4, staff were observed not implementing interventions and recommendations outlined in the PNMP and/or Dining Plan, which continued to be a concern of the Monitoring Team. Observations on San Antonio, Leon, and Trinity demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to prevent swallowing difficulties, increased risk of aspiration, or contractures and skin breakdown. • As reported in Provision S2, there was some recent improvement in functional engagement, but there were also multiple examples in which individuals were not provided opportunities for choice or learning. The Monitoring Team was encouraged to observe abundant examples of functional engagement that included training in vocational training activities. In this area, staff were observed to use frequent reinforcement and were diligent in ensuring opportunities for meaningful activity. Overall, however, functional engagement of individuals observed in multiple sites was less than 50%. Conclusion: This provision was found to be not in compliance.	Noncompliance
F2d	Commencing within six months of	Monthly review of progress:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	The Monitoring Team also requested Monthly/Quarterly Reviews for the past six months for 11 individuals. In most instances, the Facility provided either the Monthly Progress Notes or, more often, the Quarterly Review completed by the QDDP. The Monitoring Team found for only one of the 11 individuals (9%) was there evidenced any meaningful review in which actions were taken based on documented progress or lack thereof. In most cases, the reviews documented the same basic assessment, such as "Progress" and plan "Continue" over and over. In at least one instance, the Quarterly Review appeared to be identical for two quarters in a row. In some instances, the Facility provided recent monthly or quarterly reviews in response to the request for the last six months for only five of the 11 (45%) individuals. For example, for Individuals # 552 and #758, the Facility only provided monthly/quarterly reviews for March through May 2012 and February through April 2012 respectively. Overall, the Monitoring Team found that Monthly/Quarterly Reviews were not consistently completed in a way that provided for meaningful evaluation of progress or program revision. In addition to these findings, the Monitoring Team found other concerns related to monthly review of progress: • As reported in Provision S1, staff lacked the expertise necessary to compile training data, organize those data into graphs, and determine when progress has occurred. For several individuals there were errors such as graphs not matching data sheets, historical data changing from month-to-month, statements of progress when no progress had been made, and SAPs continuing at the same step for several months despite documented mastery. As a result, it was difficult to determine whether an SAP was facilitating learning for any individual. • Another example of failure to assess progress or take appropriate action was reported in Provision O7. A review of 10 individuals found 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. <u>Extent to which ISPs are modified as appropriate:</u> The failure to complete timely or meaningful 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. As noted above, it was not clear the Facility had even completed all monthly reviews for six individuals in the sample since more than six months ago. Absent those reviews, no meaningful modification could have taken place. In another example, for Individual #484, the individual consistently met criteria from February 2012 through October 2012, but the monthly review provided for October simply stated "Made Progress" and "Continue in Program."	

#	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 when 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 provided training in facilitation skills using the Q Construction curriculum. The Facility had begun to implement a structured approach to assessing competencies in the Q Construction skills, which the Monitoring Team commends. Training sessions for QDDPs and other IDT members responsible for development of ISPs also included ongoing training on the implementation of the revised ISP process, including the Pre-ISP meeting and the revised Risk process. Additional training topics had included Program Writing, Integration of Assessments and Services Discussion Worksheet and RSSLC Policy F.11: Staff Responsibilities Regarding Daily Schedules. Extent and adequacy of competency-based training for staff responsible for implementation of ISPs: The Monitoring Team was pleased to have the opportunity to review a curriculum entitled F.A.T City that was being implemented by the QDDP Coordinator/Educator, including a portion of a training session. This curriculum focused on heightening staff sensitivity to how individuals with intellectual disabilities experience learning and how the style of staff interventions may or may not support learning as well as a supportive climate in general. Between 07/02/2012 and 11/01/2012, 279 staff had completed the training. Based on a review of participant evaluations, this training appeared to be very effective in causing staff to reflect on their own interactional styles and to identify changes they would like or planned to make. The Monitoring Team was impressed with these results and encourages the Facility to continue to provide such experiential training opportunities. The Facility continued to work towards other competency-based training for staff responsible for implementation of ISPs. Examples included: • As reported in Provision O5, RSSLC had developed Physical and Nutritional Management Core Competency Training since the last compliance visit. Once staff completed the classroom based training, they were then required to complete competency/skill verification checklists. • Nurses were scheduled to receive PNM related Medication Administration training but that had not occurred as of this review. • As reported in Provision M4, six New Nurse Orientation trainings were conducted since the last compliance review using competency-based, formalized	Noncompliance

#	Provision	Assessment of Status	Compliance
		lesson plans from the Nurse Educator's Handbook. • As reported in Provision R3, RSSLC had recently developed "Core Competency" Training that was intended to improve hands on training with many aspects of care including communication. As of this compliance review, only 6.3 % had yet received this new training class. Overall, however, the Monitoring Team found staff were not yet adequately provided with competency-based training. This was confirmed in some cases by the Facility's own assessment. As reported in Provision K12, for example, the Facility continued to report that no system was in place to track staff training or ensure that staff were competent in regard to PBSPs. In other instances, the Facility reported it was implementing competency-based training, but the competency evaluation upon which the assertion rested was flawed in that it did not test actual competency in the execution of the skills that were to have been learned. This finding was also influenced 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: • As reported in Provision O5, there was no formal 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. • As reported in Provision O4, observations on San Antonio, Leon, and Trinity demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to prevent swallowing difficulties, increased risk of aspiration, or contractures and skin breakdown. In only two of 11 (18%) observations, were staff following mealtime plans. In only two of 5 (40%) observations were staff following positioning instructions. 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. • As reported in Provision K11, in an attempt to ensure that all PBSPs were easily read and interpreted by staff, RSSLC required that the staff instructions section of each PBSP be written in simple English, and had demonstrated progress in this area. Observations of failures to implement intervention strategies, there was no indication that RSSLC had acted to ensure that PBSPs were routinely and accurately implemented by staff. The lack of a system to track training on PBSPs made it impossible to assess whether the failures to implement the PBSPs resulted from lack of competency-based training, lack of monitoring of	

#	Provision	Assessment of Status	Compliance
		implementation to ensure continuing competency, or some other reason. <u>Conclusion:</u> This provision was found to be not in compliance.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	<u>Extent to which ISPs are developed within 30 days of admission:</u> RSSLC reported three admissions in the last six months, only one of which had exceeded 30 days since admission. The Monitoring Team reviewed the ISP and assessments for Individual #787. The ISP annual planning meeting was held within 30 days of admission. Assessments had generally been completed on a timely basis, but there was no written input from the psychologist or behavior analyst provided with the assessment packet. This was significant as the individual had behavioral considerations, to the extent that the ISP began with an introductory statement that the individual's methods of communication were "effective" and included hitting, biting, kicking and screaming "no." The Monitoring Team first questions whether this was the intent of the introduction section. It would be appropriate that the focus should be on how an individual communicates as it may affect his or her participation in the ISP annual planning meeting. The aforementioned statement did not contribute to the individual's participation and may have, in fact, negatively impacted it. The introduction then indicated the behavior analyst and speech therapist were "working on" a behavior plan. As described in Provision F1e above, related deficits were noted in this ISP. For example, there had been a recommendation by the SLP in the Pre-ISP meeting to consider how the individual's strengths in written communication could be used to support positive behavior, but this was not referenced in the ISP. Important preferences were also not incorporated. As a result of these findings and the lack of necessary assessments, this ISP could not be said to adequately address the individual's needs. The IDT should meet again to develop an ISP that addresses the communication and behavioral concerns, as well as the individual's strengths and preferences in an integrated manner supported by adequate assessment. . <u>Extent to which ISPs are revised annually and as needed and put into effect within thirty days of preparation:</u> RSSLC Policy F.5: Completing Individual Support Plan Meeting Documentation, revised 03/27/12, required the ISP be filed within 30 days of the ISP meeting. The Monitoring Team reviewed a list of ISP dates provided by the Facility, dated Friday, October 19, 2012. Despite an apparent overall compliance with annual meeting dates, the Facility still did not actually consistently complete or implement ISPs within 30 days of preparation, as reported in the previous monitoring report. A review of the Facility's own data indicated, for example, that for the first 31 names on a list of ISPs by date, nine (29%) had not been "filed" within 30 days. Of these, six were delayed well beyond the 30 day requirement, ranging from almost two months to almost seven months.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Conclusion: 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 provisions of this section.	The Monitoring Team had recommended during the previous visit that 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. The Facility had received confirmation that they could individualize the use of the Settlement Agreement Monitoring Tools and was considering how they might do so. No significant action had been taken in this area since then. A new QA Director had been appointed about two months prior to this monitoring visit, however, and planning was currently underway. In terms of Section F requirements, the Facility was implementing and/or evaluating the following processes: • The Facility continued 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. The external validation of a random sample of three to five of the completed tools by a QA Auditor had not been occurring as previously described, due in part to the Auditor acting as interim QA Director for a period of time. The Facility acknowledged that there was no current confidence in the level of inter-rater reliability. • The Facility had received a new Section F Monitoring Tool from DADS State Office on November 6, which it will be required to complete and then enter resulting data in the statewide POI (Plan of Improvement) database. The Monitoring Team reviewed the tool. It was comprised of 35 questions, many of which were broad and subjective, but for which the answers were to be Yes, No or NA. For example, questions included: "Are plans practical and functional in a community setting?" and "Does the plan include individualized observable and measurable objectives based on the individual's goals?" Developing inter-rater reliability in the face of the level of subjectivity will be a challenge. It is also recommended the Facility incorporate a review of the details of, and examples in, the Monitor's reports for Section F to ensure the auditors assigned have a clear understanding of how these items are being evaluated by the Monitoring Team. • RSSLC had also reviewed the ISP Monitoring Tool developed by Denton State Supported Living Center (DSSLC) and was considering how it might make use of this tool in conjunction with the DADS monitoring tool for Section F. The Facility was scheduled to hold a meeting on November 19, 2012 to evaluate the options and develop a plan. It was projected that a new approach would be operational by early 2013.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 develop a clearer plan for measuring the outcomes of its Action Plans and include this in the Evidence column in addition to the paper compliance evidence found there. Positive outcome indicators regarding proficiency should be used to determine whether a step is designated as completed. (Self-Assessment)
2. In order to make the ISP a much more comprehensible, participatory and positive experience for individuals the Facility should continue to implement and broaden its "planning my future" strategies such that this activity that is incorporated into the overall active treatment program on an ongoing and regular basis. (Provision F1b)
3. The State and Facility should reconsider how the new ISP process can be modified to better support a plan that focuses more planning time on preferences, strengths and personal goals. (Provision F1b)
4. 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)
5. The IDT should ensure that all ISPs address individuals' strengths and preferences in an integrated manner supported by adequate assessment. When they do not, as for Individual #787, the Facility should ensure the IDT reconvenes to address the concerns as soon as possible. (Provision F2f)
6. The Facility should incorporate a review of the details of, and examples in, the Monitor's reports for Section F to ensure the QA auditors assigned for Section F have a clear understanding of how these items are being evaluated by the Monitoring Team. (Provision F2g)

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 11/2/12 2. RSSLC Action Plan 10/15/12 3. RSSLC Presentation Book for Section G 4. DADS Draft Policy 005 Minimum and Integrated Clinical Services 1/12/10 5. RSSLC Policy I.29 Integrated Clinical Meeting 9/7/11 6. RSSLC Policy Pre-Hospital Discharge Planning Policy (no number) 9/6/12 7. RSSLC Policy I.08 At Risk Individuals 5/11/12 8. RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 1/30/12 9. RSSLC Policy K.01 Physical Nutritional Management 3/21/11 10. RSSLC Policy Integrated Neurology Clinic Policy (no number) 4/17/12 11. RSSLC Policy PCP Consultation Letter Policy (no number) 7/2/12 12. RSSLC Policy I.12 Routing of Of-Campus Consultations 1/6/11 13. RSSLC Policy I.13 Routing of On-Campus Consultations 1/6/11 14. RSSLC Policy I.34 Medication Variances 2/27/12 15. RSSLC Policy K.01 Physical Nutritional Management 9/21/12 16. RSSLC policy regarding integration of care between members of the behavioral health team (untitled) 9/13/12 17. RSSLC Form 8529 Consultation Report, July 2012 18. RSSLC database screenshots for Medical Follow-Ups 19. Integrated Clinical Meeting Minutes of 5/16/12, 6/13/12, 7/17/12, 7/18/12, 8/8/12, 10/10/12, and 10/24/12, 20. Psychiatry and behavior management clinic report of 8/30/12 for Individual #17 21. Integrated Progress Notes (IPN) of 9/25/12 and 9/27/12 regarding SIRE/PATH therapeutic horse riding program meeting with the RSSLC Medical Staff 22. Diabetes Trend Analysis Report of 8/31/12 23. Diabetic Training for Individuals/Family Members handouts and in-service signing sheet for guardians 24. Sample of medical consultation reports for Individuals #7, #125, #148, #159, #161, #268, #429, #558, #649, #711, #724, #767, #787 25. For each Primary Care Physician (PCP), one example of documentation of consultation, including for that example: 26. The consultation report form 27. The IPN or the date the report form was entered into the IPN 28. The PCP's documentation into the medical database regarding this consultation 29. Documentation of review by the IDT 30. Attendance sheet for annual ISP planning meeting for Individual #165 31. ISPs, CLDPs, and other documents reviewed by the Monitoring Team **People Interviewed:**

	1. Tran Quan, D.O., Medical Director and Raj Thakur **Meeting Attended/Observations:** 1. ISP Annual Planning Meeting for Individual #165 2. Integrated Clinical Meeting 11/14/12 3. Integrated Disciplines Workgroup 11/14/12 4. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section G, dated 10/30/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. In conducting its self-assessment, the Facility: • Identified specific indicators relevant to the requirements of the individual provisions. These included, among others, data: o On whether there was active participation by multiple disciplines in Integrated Clinical Meetings as evidenced by physician orders corresponding to the discussion identified through review of minutes o On ISP attendance o From a new ISP addendum audit process that was recently started o On documentation on consults forms of accepting or declining non-facility clinician's recommendations o On documentation of consultation results in ISP records • Presented data in a clear way, identifying the number of documents reviewed, whether that was a sample or the total, and the number or percent meeting the standard. • Did not assess all the essential features of the requirements of the provisions. o Review of active participation in Integrated Clinical Meetings and of attendance at ISP meetings are appropriate means to assess integrated planning but are not sufficient. The Facility should develop a process to evaluate whether planned services and supports show evidence of integrated planning. The new ISP audit process may provide a means to do so, and the Facility might keep that in mind when assessing the implementation and usefulness of that process. o Although the self-assessment for G2 reports an activity of reviewing ISP records to ensure recommendations of the consultation are integrated into the IDT discussion (an essential requirement), it states instead that 10 of 10 ISP records documented consultation results, rather than reporting on whether there was integration of the recommendations with existing supports and services. Reporting results to the IDT is not equivalent to discussion, as needed and appropriate, resulting in decisions on recommendations and integration with existing supports and services (or revisions of those supports and services). Although recent samples provided by the Facility did show such integration, reviews of a number of consultations throughout the review period did not consistently find such documentation. The Facility should carry out and report the results of the

	activity as stated--to assess whether recommendations of the consultation are integrated into the IDT discussion rather than simply whether there was documentation of reporting of consultation results. The Facility determined that it was not in compliance with Provision G1 but was in compliance with Provision G2. The Monitoring Team determined that the Facility was not in compliance with either provision. Although recent examples of consultation reports and related documents provided by the Facility do indicate that they may now have compliant processes in place, the documents for other consultations reviewed by the Monitoring Team did not yet show consistent integration of consultant recommendations into the ISP. The Facility provided an Action Plan that reported actions being taken to achieve compliance. Nearly all actions were reported as "complete" with two listed as "in process"; the Monitoring Team verified several of these through observation, review of documentation, or interview, including development of a policy and a database to track medical consultations (the consultation database). However, although these actions might have resulted in progress to date, they do not provide a set of further actions and initiatives to integrate clinical services to the point that the Facility achieves substantial compliance with this Section. The Facility should review the current report, identify its own criteria and measures of integrated clinical services and of integration of consultant recommendations with existing services and supports, determine the gaps between current performance and its own criteria, and establish plans to address those gaps to the point that criteria are fully met.
	Summary of Monitor's Assessment: The Facility had continued to make significant progress toward establishing and developing processes to maintain provision of integrated clinical services. Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve; nonetheless, integrating planning and services across disciplines remained a challenge. These processes need to be fully implemented and need to result in more consistent integration of planning and provision of clinical services in order to reach substantial compliance. Progress had also been made in facility review of consultations by non-Facility clinicians. Although RSSLC did not have one overall policy governing integrated clinical services, several policies addressed areas of integrated services. In general, these policies included requirements or actions that involved collaboration across disciplines. DADS policy remained in draft. The Monitoring Team identified examples of both integration of clinical services and opportunities for greater integration. The Integrated Clinical Meeting, Physical and Nutritional Management Team, and Integrated Disciplines Workgroup all provide forums for integrated planning. There was not yet consistent documentation of integrated planning in risk assessment and planning, collaboration at the unit level between physicians and habilitation therapy regarding physical and nutritional interventions, or integration of communication goals into the ISP.

	The use of a consultation database and a new consultation letter that gave more information to the consultant provided a means to ensure consultations occurred timely, were followed up, and responded to the needs of the individual and the information needed by the Facility clinician. Documentation showed improvement in the involvement of the IDT but did not yet show this was consistent enough to establish compliance. RSSLC Policy PCP Consultation Letter Policy establishes a process for communication and documentation of medical information from the Primary Care Provider (PCP) to consultants. This policy establishes steps for an initial or follow up consultation letter to consultants and a template for each of these kinds of letters. This policy provides for more complete information to be provided to the consultants as appointments are made. Although consultation requests typically involve medical issues, there may be other types of clinical consultations, so this policy might be revised also to address situations in which a clinician requests a consultation that does not require PCP approval. Review of medical and modified barium swallow study (MBSS) consultations verified consistent documentation of review by primary care physicians (PCPs). Although recent samples provided by the Facility showed referral of consultant recommendations to the IDT for consideration, this was not consistent in the samples reviewed by the Monitoring Team. The new procedure for use of the consultation database, inclusion of the documentation in the IPN, and IDT review are in place. As this was found for a requested sample but not as completely for the general samples (for which referral to the IDT and documentation available to the IDT through the IPNs were not consistently found), the Monitoring Team expects that documentation using these procedures will be more evident at the next compliance visit and may demonstrate compliance at that time.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility had continued to progress toward providing clinical services in an integrated manner. Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve. Nevertheless, integrating planning and services across disciplines remained a challenge, and this provision was not yet in compliance. <u>Policy</u> Although RSSLC did not have one overall policy governing integrated clinical services, several policies addressed areas of integrated services. In general, these policies included requirements or actions that involved collaboration across disciplines. • RSSLC Policy I.29 Integrated Clinical Meeting establishes an Integrated Clinical Meeting held weekly to have a collaborative discussion on individuals. • RSSLC Policy Pre-Hospital Discharge Planning Policy (no number) provides a process for discharge planning before an individual returns from an acute care	Noncompliance

#	Provision	Assessment of Status	Compliance
		hospital. This process is, among other actions and requirements, to include several disciplines, identify changes in clinical status and in assessments and supports required after discharge, identify follow up needed after discharge, and identify the appropriate risk rating based on the hospitalization. • RSSLC Policy I.08 At Risk Individuals requires the IDT to work collaboratively to address individual risk factors and to develop a plan to identify actions and supports to minimize identified risks. • RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies establishes a process intended to ensure individuals receive timely medical treatment and intervention. It requires the use of a consultation database, identifies who will enter and track information, and how information will be communicated across disciplines and to the IDT. • RSSLC Policy Integrated Neurology Clinic Policy (no number) identifies which clinicians will attend the neurology clinic (including direct care staff, primary care physician, psychiatrist when an individual is on both psychotropic and antiepileptic medication, and clinical pharmacist) and how documentation will be done so the IDT will have access to the assessment and plan. • RSSLC Policy K.01 Physical Nutritional Management, among other things, establishes a physical and nutritional management team (PNMT) that includes a number of disciplines. • RSSLC policy regarding integration of care between members of the behavioral health team (untitled) 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. <u>Activities and Examples</u> Through observations, interviews, and reviews of documentation, the Monitoring Team identified examples of both integration of clinical services and opportunities for greater integration. Examples of integration included: • The Monitoring Team observed the Integrated Clinical Meeting of 11/14/12. Numerous disciplines participated, including PCPs, psychiatrist, psychology and behavior analysis, nursing, occupational therapy, physical therapy, dietitian, pharmacy, and direct support and the QDDP for the individual being discussed.	

#	Provision	Assessment of Status	Compliance
		They physician presented extensive information about the individual, the diagnoses and active problems, relevant history, and lab and imaging results. Information was provided to provide background meaningful to all participants. Participants were given an opportunity to ask questions, some of which were answered by the direct support professional (DSP). Other discipline staff added relevant information, including recommendations from the PNMT. Extensive discussion occurred, with participation by several disciplines. The Medical Director summarized the discussion and recommendations made, and indicated that this would be provided to the IDT. Review of minutes of other Integrated Clinical Meetings, each of which addressed one individual, showed a similar process, with some meetings focusing discussion and recommendations more narrowly on medical conditions and others including behavioral, psychiatric, and habilitation issues and recommendations. • The Integrated Disciplines Workgroup provided a means to bring together program monitors (who audit several areas of program, documentation, and services) with Unit Directors to talk about follow up to identified issues, share information, and resolve concerns. At the meeting observed during the compliance visit, one particular issue related to integrated clinical services; there was discussion that there was a mismatch between risk ratings and use of bedrails. In some cases, individuals at low risk for injury (for example, with history but now low risk of seizures) have a high-risk support (bedrails to prevent falling out of bed). Discussion was held of the need for IDTs, including clinicians, to discuss address these mismatches as part of the Integrated Risk Rating process. • A positive practice that continued to be noted was participation by PNMT in the medical morning meetings as well as participation during rounds at the infirmary thus allowing for the increased sharing of issues between multiple committees. • In the area of integration of behavioral healthcare, there was an excellent addition to the SFA section, which addressed the differentiation of function between psychiatric and psychological treatment. It cannot alone provide all the needed answers but it was evident that the Facility is moving in the right direction for quality of integrated behavioral care. • Psychiatry and Behavior Management Clinic (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 Professionals (QDDPs), Direct Support Professionals (DSPs), and habilitation therapists. The key place where psychiatric diagnoses were made was in the PBMC. This was because it was a venue that was shared by the various behavioral healthcare professionals, and a place where good	

#	Provision	Assessment of Status	Compliance
		interdisciplinary discussion could take place. Note, however, although this was a positive practice that allowed for integrated planning, missing from this was the PCP, who is an important participant in decisions about medications because of both side effects and interactions with other medications. Decisions about medications based on discussions at this meeting must involve documented participation of the PCP, at the meeting or through another process. • For a number of individuals, including Individuals #500, #523, and #585, a comprehensive PNM assessment provided input from medical services/PCP, nursing, dietary, and habilitation therapy. • Discussion during the ISP planning meeting for Individual #165 included the attempt by the psychiatrist to collaborate with the PCP in trying to match dose of a psychotropic medication to changes in dose of a medication as recommended by endocrinology. Examples in which integration could have been improved included: • As reported in Provision I3, based on a review of 16 records for individuals determined to be at risk, there was documentation that the Facility showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs in four records (25%). • As reported in Provision O1, zero of five individuals (Sample #6) who had a MBSS that recommended an upgrade or downgrade in diet texture had the findings of the study reviewed and discussed by the IDT. 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. • Although, as noted above, participation by the PNMT in the medical morning meetings and infirmary rounds allowed sharing of issues, this still did not reflect active collaboration at the unit level between the physicians and the PNMT and/or IDT regarding their caseload. • In one of 11 records reviewed for samples #1, #2, and #3 (9%), PNMPs were clearly developed with input from the IDT with an emphasis on DSPs, 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. • Individuals #302 and #379 had communication goals that focus on the use of manual signs as a method to improve expressive and receptive language. There was no integration of this type of communication into the PBSP. The Monitoring Team reviewed documents that provided information on attendance at annual ISP planning meetings and observed the planning meetings for Individual #165	

#	Provision	Assessment of Status	Compliance
		and #465. The Facility tracked the attendance of IDT members at annual ISP meetings. According to a document provided for review, entitled List of ISPs and Attendance Tracking, Meeting Dates of 5/1/2012-9/30/2012, dated Thursday, October 11, 2012, the overall compliance for attendance by the required disciplines during this period was 97.6%. Participation ranged from 83% to 100%. This is excellent attendance and would permit integrated planning. As reported, though, in Provision O3, attendance sheets showed attendance of several disciplines at ISP meetings for the sampled reviewed for that provision indicated much more variable levels of attendance. Due to the sample drawn, that information included several ISP meetings that were more than six months in the past. It is possible that attendance had increased significantly since the last compliance visit; the Monitoring Team will review that at the next compliance visit. As reported in Provision F1b, the two new ISP annual planning meetings and a Pre-ISP meeting held during the monitoring visit were well-attended by appropriate disciplines, individuals and direct support professionals. For example, attendance and participation at the annual ISP planning meeting for Individual #165 were appropriate. All disciplines relevant to planning for the individual were present except dental and pharmacy services. There was extensive discussion of risks and of need for vocational services. In summary, the Facility made significant progress toward establishing and in developing processes to maintain integrated clinical services. As noted in the examples in which improvement was needed, these processes need to be fully implemented and need to result in more consistent integration of planning and provision of clinical services in order to reach substantial compliance.	
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.	<u>Policies</u> The following Facility policies addressed aspects of consultation and review of recommendations from non-Facility clinicians. • RSSLC Policy I.29 Integrated Clinical Meeting 9/7/11 • RSSLC Policy Pre:Hospital Discharge Planning Policy (no number) 9/6/12 • RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 1/30/12 • RSSLC Policy Integrated Neurology Policy (no number) 4/17/12 • RSSLC Policy PCP Consultation Letter Policy (no number) 7/2/12 • RSSLC Policy I.12 Routing of Of-Campus Consultations 1/6/11 • RSSLC Policy I.13 Routing of On-Campus Consultations 1/6/11 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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" 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." RSSLC Policy PCP Consultation Letter Policy dated 7/2/12 establishes a process for communication and documentation of medical information from the Primary Care Provider (PCP) to consultants. This policy establishes steps for an initial or follow up consultation letter to consultants and a template for each of these kinds of letters. These letters are to be printed and attached to the required consultation form prior to scheduling an appointment. The letter is to remain with the consultation form and returned to the Facility along with the consultation form completed by the consultant. The PCP is then required to review the consultation and document acknowledgement on the back of the consultation form. This policy also requires unit RN case managers to review the consultations and update the Medical Follow Up database (although it does not indicate how the unit case manager receives this information, Policies I.12, I.13, and I.33 state the PCP is to provide the signed consultation to the Unit Nurse Manager); the unit case manager is also required to inform the IDT of the PCP's assessment and plan for the consultation. This policy provides for more complete information to be provided to the consultants as appointments are made. It could be improved by 1) clarifying how the unit case managers receive the information, and 2) addressing the responsibility of the PCP to identify issues requiring IDT review, and especially addressing situations in which the PCP should participate with the IDT in such review (such as when clinical information may need to be interpreted to non-clinicians, or when a significant risk/benefit issue arises that requires decisions by the IDT and/or individual/LAR and that may need PCP involvement in discussion). Although consultation requests typically involve medical issues, there may be other types of clinical consultations, so this policy might also address situations in which a clinician requests a consultation that does not require PCP approval. Because there is overlap across policies, it might be wise to review all the relevant policies and ensure they are consistent throughout, or perhaps consolidate into fewer policies. For example, Policy I.12 requires the unit case manager "to present to the unit morning meeting that "contains most members of the PST and will determine if a formal	

#	Provision	Assessment of Status	Compliance
		PST is needed based on the consultation." The PCP Consultation Letter policy merely requires the unit case manager to "continue to inform" the IDT of the PCP's assessment and plan. The Medical Director reported that the Nurse Case Manager takes the information from the consultation report to the unit morning meeting, and the PCP has the option of referring to the IDT. 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. The Consultation Report form had been revised in July 2012 to direct the consultant to "See PCP Consultation Letter" for the reason for the requested consultation. 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 informed the Monitoring Team that documentation by the PCP will be in the consultation database. To avoid double-documentation, there is no longer an expectation that PCPs will enter integrated progress notes into the active record; the PCP is to enter acknowledgement of the consultant's recommendation and plan of care into the consultation database (although, as described below for a sample of recent documentation, IPNs are being entered, and these seem to be useful additions to the information on the consultation database and are easily accessible to the IDT). According to Policy I.33, the Unit Case Manager is responsible for printing and filing a copy of the database report into the IPN. <u>Review of Consultations by Facility Clinicians</u> The Monitoring Team reviewed a sample of 17 consultation reports for 13 individuals; 12 reports for eight individuals were for medical consultations (Individuals #7, #148, #159, #161, #558, #649, #724, and #787), and five reports for five individuals were for modified barium swallow study (MBSS) consultations (Individuals #125, #268, #429, #711, and #767). For each, there was documentation of review by the PCP. Twelve medical consultations (100%) and two MBSS consultations (40%) had documentation on the consultation form of review by the PCP. For medical consultations, in addition to documentation on the consultation reports, five consultations (42%) also had documentation in the integrated progress notes (IPNs); for MBSS consultations, the three	

#	Provision	Assessment of Status	Compliance
		that did not have documentation on the consultation report did have documentation in the IPNs. For the medical consultations, the PCP documented acceptance of recommendations for 11 (92%); for the 4/3/12 GI consultation for Individual #649, documentation of acceptance, rejection, or referral to the IDT was not found. For the MBSS consultations, the PCP documented acceptance of all recommendations (100%). Documentation of referral to, and discussion by, the IDT was found only for one consultation (8%), the 10/4/12 GI consultation for Individual #148. In addition to this sample, the Monitoring Team requested, for each PCP, one recent example of documentation of consultation, including for that example the consultation report form, the IPN or the date the report form was entered into the IPN, the PCP's documentation into the medical database regarding this consultation, and documentation of review by the IDT. This information was provided for eight individuals (one each for four PCPs and four for another PCP); the Monitoring Team reviewed the first provided for one PCP and the single example provided for each of the others, Individuals #17, #70, #287, #551, and #716. Five of five (100%) showed documentation of review on the consultation report form, with four of five (80%) documenting acceptance of the consultant recommendation and one of five (20%, Individual #287) documenting rejection and referral to the IDT along with rationale for rejection. Five of five (100%) included at least one IPN. Five of five (100%) included documentation in the consultation database. Four of five (80%) included documentation of review by the IDT in the form of an ISP Addendum; there was no documentation for Individual #551. In addition to the case in which the consultant recommendation was rejected, the IDT determined the need for a second opinion in the case of Individual #17, which resulted in a different recommendation that was accepted by the PCP. These documents demonstrate that the new procedure for use of the consultation database, inclusion of the documentation in the IPN, and IDT review are in place. As this was found for a requested sample but not as completely for the general samples (for which referral to the IDT and documentation available to the IDT through the IPNs were not consistently found), the Monitoring Team expects that documentation using these procedures will be more evident at the next compliance visit and may demonstrate compliance at that time.	

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

1. Fully implement, and monitor to assure implementation, the new policies and procedures for integrated clinical services. (Provision G1)
2. Review all policies related to consultations and consider whether to consolidate policies or otherwise ensure they are consistent throughout. (Provision G2)
3. Ensure referral of consultant recommendations is made to the IDT as appropriate and that documentation is made of IDT decisions. (Provision G2)

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 10/30/12 2. RSSLC Action Plans 10/15/12 3. Presentation Book for Section H 4. DADS Draft Policy 006.3 At Risk Individuals 7/13/12 5. DADS Draft Policy 004.1 Individual Support Plan Process 6. RSSLC Policy I.26 Physician Quarterly Review 2/18/11 7. RSSLC Policy Pre-Hospital Discharge Planning Policy (no number) 9/6/12 8. RSSLC Policy I.31 Chronic Clinical Indicators 10/12/11 9. RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 1/30/12 10. RSSLC Medical Department DSM and ICD Medical and Psychiatric Diagnosis Update Policy 1/12/12 11. Annual Assessments Filed Within 10 Days, for ISP planning meeting dates of 5/1/12-9/30/12 12. SSLC At-Risk Process flowchart 6/21/12 13. Annual Integrated Risk Rating Form (IRRF) 5/31/12 14. Annual ISP Meeting IDT Attendance Indicators 9/7/12 15. Pre-Hospital Discharge Discussion Summary Planning Meeting blank agenda/form 16. Pre-Hospital Discharge Discussion Summary for Individuals #99, #113, #259, #477, #564, #577, #649, #700, #745, and #783 17. RSSLC database screenshots for Diabetes I/II, Osteoporosis, Neuromotor/Musculoskeletal Disorder, and Preventive Healthcare Screening 18. RSSLC database screenshots for Medical Follow-Ups 19. List of Chronic Clinical Indicators from Databases 20. Sample Daily Sick Call Logs with IPNs 21. Diabetes Trend Analysis Report 8/31/12 22. Osteoporosis Trend Analysis Report 1/12/12 23. Medical Department Orientation materials 24. Training materials for Observing and Reporting Clinical Indicators of Health Status Change 25. ISPs, CLDPs, Integrated Progress Notes, and other documents reviewed by the Monitoring Team **People Interviewed:** 1. Tran Quan, D.O., Medical Director and Raj Thakur **Meeting Attended/Observations:** 1. Annual ISP Planning Meeting for Individual #165 2. Integrated Clinical Meeting 11/14/12 3. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section G, dated 10/30/12. In its Self-Assessment, for each

	sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. In conducting its self-assessment, the Facility: • Identified specific indicators relevant to the requirements of the individual provisions. These included, among others: o Numbers of PNMT evaluations were done, pre-hospital discharge meetings were held, and new policies were written. o Percentages of documentation that included specific requirements, such as whether Annual Medical Summaries showed documentation of routine and preventive health care services, whether Physician Quarterly Reviews showed PCPs documented a set of checked components, and whether Daily Sick Call Log IPNs addressed routine issues and response time was noted to be less than 24 hours from the onset of symptoms. o Clinical indicator data from trend analyses for the diabetes database that could be used to evaluate and comment on quality of care, such as number of individuals at the Facility with diabetes mellitus who were at treatment foal for diabetes and blood pressure control, and the average HgA1c, along with an assessment of a plan of action. o Percentage of sampled Integrated Progress Notes and Psychiatric Assessments for which diagnoses clinically fit the ICD-9 and DSM standards. • Generally provided data in a clear way that would allow assessment of status. However, there were a few items on which data provided in the results section did not match the description of the activities engaged in. Examples are provided to assist the Facility in continuing to improve the use of data in assessing compliance with requirements of the Settlement Agreement. o For Provision H4, the activity described was to review the Medical Follow-up Database and Chronic Clinical Indicator Database to ensure that clinical indicators were efficacious and clinically justified. The results provided a report of data from a trend analysis for the diabetes database. The trend analysis data would be useful in evaluating quality of care and are excellent data to report as outcomes that relate to the quality of health care the Facility provides, and the listing of specific indicators shows that, for at least one condition, appropriate indicators have been identified. However, it does not show the status of determining clinically justified indicators in general or that they are used in care of individuals. o For Provision H5, the activity was to review randomly selected records from the Medical Follow-up Database to ensure there was a system in place to maintain effective monitoring of the health status of individuals, but the results provided data only on missed medical appointments. While an important measure, this does not give adequate information to judge whether there was an effective health status monitoring system in place. • Did not fully assess all the essential features of the requirements of the provisions. The two examples above involve useful data that should be included in the self-assessment but do not fully assess the requirements of the relevant provisions. Other examples of requirements not assessed included:

	o For Provision H2, although consistency with diagnostic manuals was assessed, there was no assessment of the other requirement of the provision—that diagnoses "clinically fit the corresponding assessments or evaluations". o For Provisions H4 and H6, the provision of data regarding the trend analysis, and evaluation and action plans from the data, were very useful and important to include, they did not provide all information needed to assess whether, overall, clinical indicators of the efficacy of treatments and interventions were determined in a clinically justified manner, or whether treatments and interventions were modified in response to clinical indicators. o Did not, for all provisions as appropriate, assess status of compliance for clinical disciplines other than medical services (with some exception such as PNMT minutes and evaluations). The Facility determined that it was not in compliance with any provision of Section H. The Monitoring Team concurs. Nevertheless, the Monitoring Team recognizes significant action taken by the Facility that has resulted in improvement that shows promise of achieving compliance for several provisions. The Facility provided an Action Plan that reported actions being taken to achieve compliance. Most actions were reported to be completed, with the rest "In Process." Many, perhaps most, of the actions are relevant to development of a database that will capture diagnoses, track medical consultations and significant diagnostic studies, and track and trend clinical indicators for chronic diseases—a high-priority and very valuable set of activities. To some extent, these activities have been sequential; they begin with developing a system, then a policy for the system, then train staff, then monitor the system, and finally evaluate trends generated from the database. These are listed as completed, but there is a need to expand the database. Furthermore, there needs to be a set of further actions to make sure the database is used to meet the requirements of this Section.
	Summary of Monitor's Assessment: The Facility has taken significant actions that have resulted in a great deal of improvement in meeting the requirements of this Section. In particular, databases have been developed that make information (including status of clinical indicators) accessible and clear, and that show great promise of improving usefulness of clinical indicators both for decisions on treatments and interventions for individuals, and for improving systems of healthcare for the Facility as a whole. Timeliness of assessments had improved, but annual assessments for the ISP planning meeting were still not consistently completed on a timely basis. Not all assessments for newly admitted individuals were completed within 30 days following admission. Completion of assessments and evaluations in response to changes in status was variable. Diagnoses were consistent with the current versions of the DSM and ICD classification systems. For psychiatric services, careful and substantive diagnostic practices were in place. However, differences in diagnoses for some individuals were found across different documents in the record. The Facility reported it was working on a process to address this concern. For medical services, there were instances in which

	assessments and results from X-rays, labs, or other tests indicated a diagnosis that was not listed. The Facility had continued processes to ensure medical procedures were initiated timely. However, there were not yet procedures in place to ensure other treatments and interventions were initiated timely. The processes to monitor timely provision of medical procedures included us of a database for chronic diseases that included indicators to monitor, implementation of a physician orders flag, and Medical Morning meetings that included on-call reports so PCPs would be aware of any changes in health status. The Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. Many of these indicators had become integrated into the key indicators used by the Facility for quality review. Others were being used routinely in reviewing health and behavioral status of individuals. Each area of the medical database tracking chronic conditions included clinical indicators to be tracked. The database format is exemplary. The Facility has made tremendous strides in not only identifying clinical indicators useful in providing care to individuals and assessing status of healthcare at the Facility, but developing procedures that make the information readily accessible to providers and administrators. Additional conditions should be added so the database can provide a means to track individual status and services for a wider range of individuals and conditions. It will also be important to ensure all information needed for diagnosis and to assess health status is provided. Some information has not been routinely provided. Two specific areas in which information has not consistently been provided at bowel monitoring and the Aspiration Trigger Data Sheet. To achieve compliance, not only will the areas for which clinical indicators are routinely and accurately gathered and evaluated need to be expanded, but also there must be documentation that verifies that indicators are used in making decisions on treatments and interventions, and on improvements in clinical services.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	This report contains, in the various sections, information on the required assessments and evaluations. Following is a summary of findings. <u>Timeliness of regular assessments and evaluations</u> As reported in Provision F1c, timeliness had improved, but annual assessments for the ISP planning meeting 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 reviewed the Annual Assessments Filed Within 10 Days, for	Noncompliance

#	Provision	Assessment of Status	Compliance
		meeting dates of 5/1/2012-9/30/2012, which tracked assessments by residence. Although most assessments were posted timely, there was significant variability among and within the disciplines as to timeliness. 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 five (0%) had all required assessments available and/or posted by the required date, although there was progress noted since the previous monitoring visit. However, for Individual #552, whose annual ISP planning meeting was scheduled for the week following the compliance visit, 96% of required assessments had been posted timely. As reported in Provision K2, 95% of individuals had a psychological evaluation completed within the prior 12 months. Only 13 of those reports, however, included findings from a current intellectual or adaptive skill assessment, addressed changes in mental illness and behavior, and offered specific recommendations. For new admissions, no psychological assessment had been completed by the Facility within 30 days following admission. As reported in Provision M2, the Monitoring Team selected a sample of records to review from each unit for the Admission, Annual, and/or Quarterly Comprehensive Nursing Assessments completed over the past six months. The Monitoring Team found progressive improvement over time in the quality and comprehensiveness of the nursing assessments reviewed, with the most notable improvements were found in those nursing assessments completed since August 2012. Therefore, the overall improvements found in review of the nursing assessments over the past six months may not reflect the most recent improvements. Findings regarding timeliness of assessments showed improvement for new admissions and annual ISP meetings and included: • Four of four (100%) Admission Comprehensive Nursing Assessment were completed within 30 days of admission as required. • Six of six (100%) Annual Comprehensive Nursing Assessments were completed within 10 days of the annual ISP meeting. • Nineteen of 22 (86%) Quarterly Comprehensive Nursing Assessments were completed according to the ISP schedule. As reported in Provision P1, individuals in Samples #1, #2, #3, and #4 were provided annual assessments in accordance with general standards of care and per state and RSSLC policy. As reported in Provision S1, only one individual in the sample of SAPs, Individual #600, had been provided a formal assessment of adaptive skills within the year prior to the ISP. There was no indication in the ISP document that this assessment had been considered	

#	Provision	Assessment of Status	Compliance
		in the development of the SAPs. For the nine remaining individuals in the sample, 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. As reported in Provision J2, there had been improvement in completing comprehensive psychiatric evaluations (CPEs). A small number of individuals who were prescribed psychotropic medications still needed CPEs. In addition, CPEs were needed for a number of individuals who had scores above the clinical cutoffs for the Reiss Screen (a screening assessment for psychopathology) and were not seen in the PBMC. <u>Assessments and evaluations in response to changes in status</u> Completion of assessments and evaluations in response to changes in status was variable. • As reported in Provision J1, the Monitoring Team requested and received a list of the changes in diagnosis that took place during the review period. There were 24 such changes. All took place between August and October, during PBMC clinics conducted by the two Facility Psychiatrists. The Facility provided the Monitoring Team with copies of the clinic notes during which the changes were made. The notes make clear that careful and substantive diagnostic practices were in place. • As reported in Provision M2, from the sample of records reviewed from each unit the Monitoring Team found that the quarterly Comprehensive Nursing Assessments were not consistently updated when there was a significant change in health status. • As reported in Provision O2, there was an excessive delay in which reports related to the PNMT assessment process were completed, with only one of seven completed within 30 days. More than half took over three months. The PNMT nurse assessed four of four (100%) individuals from Sample #1 who returned from the hospital, and six of six (100%) from Sample #1 were discussed at the PNMT meeting. Another form of review noted by the Monitoring Team was discussion by the IDT in response to a hospitalization. Four of four individuals (100%) diagnosed with pneumonia from Sample #1 were reviewed by the IDT. This was noted to be an improvement since the last compliance visit, which showed only 33% of individuals receiving the needed review and/or assessment. The problem noted was that while the IDT did meet in response to an individual's anticipated return from the hospital, the meetings offered inconsistent evidence of investigation into the root cause of the issue. The primary topic of the IDT meeting was stating that the person would be returning	

#	Provision	Assessment of Status	Compliance
		and that a referral would be made to the PNMT but as stated above, there was a significant delay in getting the assessment completed; therefore, there were many times in which the individual was home for more than 2 months with little intervention provided post hospitalization. • As reported in Provision P1, individuals in Samples #1, #2, #3, and #4 were provided interim assessments as indicated by a change in status in accordance with general standards of care and per state and RSSLC policy in addition to annual assessments. There had clearly been improvement in providing timely annual assessments for most disciplines. While there was also improvement in providing timely assessments when there was a change of status, this was not as consistent as it needs to be, and further improvement is needed. Quality of assessments, while improved for most disciplines, continues to need improvement. The issue of quality is addressed in other sections of this report.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Diagnoses were consistent with the current versions of the DSM and ICD classification systems. It is positive that the RSSLC Medical Department DSM and ICD Medical and Psychiatric Diagnosis Update Policy requires: • Training of medical and psychiatric staff annually on DSM and ICD standards; • The Primary Care Provider (PCP) to update the Active Problem List (APL) annually during the Annual Medical Summary, and the APL to have diagnosis consistent with DSM and ICD; • The APL to be submitted to Medical Records for entry into a database; and • The PCP or Psychiatrist to update the medical chart when there is a new medical or psychiatric diagnosis for an individual by documenting in the Physician Order Section and entering a progress note. The Monitoring Team did not review to determine that training the annual had been done. As reported in Provision J2, the APL is updated annually during the Annual Medical Summary. However, diagnoses are changed during the Psychiatry and Behavior Management Clinic (PBMC) meetings. The Monitoring Team requested and received a list of the changes in diagnosis that took place during the review period. The Facility provided the Monitoring Team with copies of the clinic notes during which the changes were made. The notes make clear that careful and substantive diagnostic practices were in place.	Noncompliance

#	Provision	Assessment of Status	Compliance
		However, perhaps due to updating the APL annually, to the need to complete comprehensive psychiatric evaluations (CPEs), or to the system for tracking diagnoses, there were differences in the diagnoses across documents. The Monitoring Team reviewed the 18 records of Sample J1 (see Section J). For each individual the Monitoring Team compared the diagnosis of record in PBSP, the PBMC clinic, and the APL. For 13 of 18(72%) individuals, there was at least one difference between those sections of the record. The Facility reported it was working on procedures to address this. Furthermore, as reported in Provisions J3 and J6, there were still individuals receiving psychotropic medications who had NOS or no diagnoses, and further work was needed in the area of diagnostic justification. In addition, as reported in Provision L1, there were instances in which assessments and results from X-rays, labs, or other tests indicated a diagnosis that was not listed. For example: • For several individuals, including Individuals #500 and #99, the type of epilepsy was not indicated or classified in the annual medical summary. • For Individual #760, multiple spinal conditions were not listed as a diagnosis or on the active problem list, although cervical spine disease was delineated in the individual's medical history, and gait abnormalities indicated a need for further evaluation. • For Individual #382, whose past medical history included a diagnosis of spina bifida and annual medical summary indicated a diagnosis of multilevel degenerative lumbar spine disease, and who had an x-ray indicating spina bifida and multilevel lumbar spine disease, the diagnosis of spina bifida was not listed. Although improvements had occurred in assessment, diagnosis, and diagnostic justification for both medical and psychiatric diagnoses, continued improvement is necessary. The Facility's plan to develop a process to ensure consistent documentation of diagnoses is appropriate and could be designed to help ensure both that all diagnoses are listed and also that diagnostic justifications are adequate.	
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 continued processes to ensure medical procedures were initiated timely. However, there were not yet procedures in place to ensure other treatments and interventions were initiated timely. The processes for medical procedures included us of a database for chronic diseases that included indicators to monitor, implementation of a physician orders flag, and Medical Morning meetings that included on-call reports so PCPs would be aware of any changes in health status.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility provided Sick Call Logs for 11/5/12 for all five units, along with associated IPNs for each individual recorded as seen. The logs noted the name of the individual, the chief complaint, and the morning vitals. IPNs were all completed on the same day by the PCP. The IPNs were written in SOAP format (refer to Section M for additional information) and therefore included a plan of care. 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 in conditions and appropriate treatments as well as to identify areas for systemic improvements in health care. <u>Timeliness of implementation</u> Medical and healthcare: In general, implementation of treatments was timely based on assessments and diagnoses (although, as noted below, there were instances in which assessment did not identify the need for additional assessment and possibly more assertive treatment, or in which treatment did not match the assessment or diagnosis). However, some individual and systemic issues of lack of timely intervention still occurred. • Constipation: As reported in Provisions L1 and M2, lack of reporting regarding bowel movements likely contributed to delays in treatment of constipation. Intervention for constipation goes beyond simply providing medication and includes such actions as providing adequate hydration; instructions to carry out such interventions were not always clear. • As reported in Provision L1, Individual #760 has known severe cervical spine disease, as delineated in his medical history, and a history of spinal surgery on the lower spine for disc disease; however, the annual medical summary, dated 9/19/12, did not list the multiple spinal conditions as a diagnosis, or on the active problem list, and there was no medical plan to follow-up on these conditions. Similarly, Individual #773 has a diagnosis of degenerative cervical spine disease, as indicated on the annual medical summary; however there was no medical plan developed for this condition. Additional examples were reported in Provision L1. • As reported in Provision M1, records reviewed for assessments and documentation associated with several individuals who had acute changes in health status found significant improvement in the quality and of the follow-up as required, with few exceptions. Integrated Progress Notes more consistently contained documentation that Acute Care Plans were established; appropriate Nursing Protocols (Antibiotic Therapy, Vomiting, Head Injury, When Contacting	

#	Provision	Assessment of Status	Compliance
		the PCP, and PICA), and/or medical monitoring were initiated. • As reported in Provision Q1, Individual #483 was seen for an urgent dental visit for dental pain. Nursing staff evaluated, and triaged the individual appropriately to the dental office. Definitive treatment, for a dental abscess and extraction, did not take place for three weeks. Behavioral and psychiatric: There were several issues related to lack of timely assessment and intervention. • Psychiatric evaluations were needed for 16 individuals who had scores above the clinical cutoffs for the Reiss Screen (a screening assessment for psychopathology) and were not seen in the quarterly Psychiatry and Behavior Management Clinic (PBMC). Although comprehensive psychiatric evaluations had been done for several people whose scores exceeded the cutoff, this number remained to be done. Therefore, it is unclear whether these people will need psychiatric care that they are not yet receiving. • For newly admitted individuals with significant behavior problems, a Behavioral Assessment Program (BAP) is to be initiated while behavioral assessments are being completed in preparation for developing a Positive Behavior Support Program (PBSP). For nine individuals, the behavioral treatment programs were Behavioral Assessment Programs (BAPs) that were initial and incomplete PBSPs, and that been in place for more than 90 days. <u>Clinical Appropriateness</u> As reported in Provision L1, there have been improvements in medical services, including timeliness of addressing acute medical issues and the inclusion of a medical plan for each diagnosis in medical summaries. The Monitoring Team did note areas that continue to need marked improvement, especially in the area of ensuring a comprehensive review of underlying medical conditions. For example, individuals were not assertively assessed as to the underlying causes of osteoporosis, and individuals with degenerative spine disease did not have assertive clinical plans developed to ensure that all appropriate supports and services could be provided.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. Many of these indicators had become integrated into the key indicators used by the Facility for quality review. Others were being used routinely in reviewing health and behavioral status of individuals. Each area of the medical database tracking chronic conditions included clinical indicators to be tracked. These included lab values, presence of complications, and medications prescribed. The databases provided reports that flagged individuals for whom clinical indicators met criteria for review as well as listing individuals whose	Noncompliance

#	Provision	Assessment of Status	Compliance
		values were within accepted levels. Graphs were also available that showed trends across the Facility, such as a graph of HgbA1c averages for all individuals with diabetes I/II by month for the 12 months prior to the compliance visit. Continuing to expand these databases to cover common and serious chronic conditions (as well as to pick up some recurring acute conditions such as UTIs) would have the potential to greatly improve health care by both providing medical care providers with timely and valuable information, and by making clear areas of healthcare that could be improved facility-wide. The Monitoring Team would like to compliment the Facility on the development of what promises to be an outstanding tool. The Facility provided a list of chronic clinical indicators from databases. These included indicators of outcomes (such as HgA1c and T-Scores) as well as processes (such as missed consultation appointments and medications/supplements). These indicators were to be used to track health status of individuals. Data were not provided to show how the indicators were used in assessing quality of health care at the Facility. However, as noted below for diabetes mellitus, information from the clinical indicators had led to actions to improve health services. At the time of this review, the Facility had developed and implemented the diabetes mellitus database, osteoporosis, and a medical follow-up database. The Facility was developing a developmental disability healthcare screening database, and a database for neuromotor, and musculoskeletal database. Review of the trends analysis, and policies for the diabetes mellitus, osteoporosis, and a medical follow-up databases, demonstrated the functionality, and benefit of tracking and trending clinical outcome data, and the Monitoring Team is supportive of such efforts. As an example, the diabetes Trend Analysis Report of 8/31/12 recorded a discussion of what the database tracks; which individuals were above goal for HgA1C and what has been done to respond; and similar information for some individuals with high blood pressure or elevated microalbuminuria to creatinine ratio. The Trend Analysis Report did not include data on the status across all individuals, which would provide a set of information that would be useful in determining the status of health care across the Facility. However, such data were reported in the Self-Assessment for this provision, including data on HgA1c, percent of individuals with diabetes mellitus at treatment goal, percent at goal for blood pressure control, % at goal for microalbuminuria, and % at goal for LDL cholesterol control. These appear to be appropriate clinical indicators that can be used both for determining the efficacy of treatments and interventions and for assessing the quality of diabetes care at the Facility; a similar approach should continue to be developed for common and serious conditions that occur among the individuals who reside at the Facility. The list of chronic clinical indicators provided by the Facility also included the indicators for which the self-assessment provided data, as well as	

#	Provision	Assessment of Status	Compliance
		additional information such as complications including neuropathy and procedures such as medications and surveillance exams. Provision L3 reports on the Nursing diabetic education program; according to report of the medical director, this was developed in response to a finding in the trend analysis that identified that diabetes control was not incompliance when individuals when home or out to eat with their families. This provided an example of integrated clinical planning to address an issue identified through review of clinical indicators. Similarly, the Osteoporosis Trend Analysis Report of 11/2/12 recorded a discussion among medical staff. There was discussion of the meaning and cautions surrounding DEXA scores for the individuals who are served at the Facility, as well as of treatment options. The list of chronic clinical indicators did include a number of indicators such as T-scores and instances of osteonecrosis of jaw, and measures of process such as calcium and vitamin D supplement. No data were provided to indicate how these were tracked or how information was used, other than for individual review as indicated by the osteoporosis database. Examples of the use of, or need to improve use of, clinical indicators for monitoring health status included: • As reported in Provision I3, based on a review of 16 records for individuals determined to be at risk there was documentation that the Facility included the clinical indicators to be monitored and the frequency of monitoring in five (31%) cases. • 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. The 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" • 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). Measurable outcomes were included as part of	

#	Provision	Assessment of Status	Compliance
		the PNMT evaluation but there was no evidence of integration of these outcomes into the nursing care plans to allow for monitoring whether these issues occurred. • As reported in Provisions L1 and M2, recording of bowel movements, a key clinical indicator for individuals at risk of or diagnosed with constipation, was frequently not done, or there was no documentation of bowel movements, for extended periods up to several days. The Facility has made tremendous strides in not only identifying clinical indicators useful in providing care to individuals and assessing status of healthcare at the Facility, but developing procedures that make the information readily accessible to providers and administrators. For compliance with this provision, the Facility should expand these indicators and procedures to additional conditions (including medical conditions but also including conditions addressed by other clinical disciplines, such as behavioral/psychiatric issues, physical and nutritional management, and habilitation therapies). The Facility also must ensure that the information is used to make decisions on 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 Facility had continued to use and expand several systems to monitor the health status of individuals, including the database for several conditions, the related process to use the database to track chronic care and to respond to clinical indicators that show need to consider revision to the current treatment, and review through the daily Unit Incident Risk Management Team Meetings, morning medical meeting, and Integrated Clinical Meeting. The database 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. The diabetes database and resulting diabetes education program exemplified a process in which regular review systemwide can be integrated with individual management of a chronic condition. At the time of this review, the Facility had developed and implemented the diabetes mellitus database, osteoporosis, and a medical follow-up database. The Facility was developing a developmental disability healthcare screening database, and a database for neuromotor, and musculoskeletal database. The Monitoring Team looks forward to seeing further expansion as well as to learning about how it helps in effectively monitoring health status of individuals. Review of the trends analysis, and policies for the diabetes mellitus, osteoporosis, and a medical follow-up databases, demonstrated the functionality, and benefit of tracking and trending clinical outcome data, and the Monitoring Team is supportive of such efforts.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The databases provide a structure for monitoring chronic conditions routinely. There remains a need to ensure clinical indicators of changes in health status are reported. The Facility had developed a set of training materials on observing and reporting clinical indicators of health status change. The training plan and materials appear to focus clearly on the need to report changes in status, provide information on the types of changes of status that are important to look for, and provide examples of proper documentation. The Monitoring Team did not determine when or to whom this training had been provided. Nevertheless, this training addresses important issues in a clear and concise manner, and is an excellent starting point for improving reporting of changes in health status. It could possibly serve as a model also for training on reporting of changes in status relevant to other clinical disciplines and as a supplement to objective data used to measure progress, such as behavioral status. Several nursing processes also provide means to monitor health status of individuals. As reported in Provision M1, these processes include the following: • The RN Case Managers attended the daily Unit Incident Risk Management Team Meetings. • The Nursing Administrative Nurses and Nurse Managers met daily and reviewed the Units' Nursing 24 Hour logs. • Pre-Hospital Discharge Planning Meetings were a positive step forward in identifying individuals' health status, change in needs for supports and services, and staff training needs prior to discharge, which should improve the quality of care when individuals return home. In the area of physical and nutritional management (PNM), as reported in Provision O8, all individuals who were enterally fed were to receive at a minimum annually an Aspiration Pneumonia/Enteral Nutrition Evaluation (APEN). This tool monitored clinical indicators related to aspiration; however, completion of APENs was inconsistent in both frequency and quality. In addition to the chronic care database described above, the Facility had implemented or was in the process of creating other databases that would make it easier to monitor health status of individuals. These include: • A Consultation Database that improved tracking of consultations, identified missed appointments and prompted re-scheduling, and documented recommendations from consultants and resulting treatment plans. • The creation of an enhanced hospital database that will provide the clinical disciplines and IDT with more real time data regarding individuals' hospital course, as well as the capacity for the Hospital Liaison Nurse and other clinical disciplines to document observation and assessment notes.	

#	Provision	Assessment of Status	Compliance
		• A database to track improvement in skin integrity issues. In past compliance reviews the status of pressure ulcers and/or wounds was included in the minutes of the Skin Integrity Committee Meeting minutes. Thus, there was not a system in place for tracking longitudinal data. It would be good to include additional data on whether decubiti were hospital or facility acquired. As reported in Provision I1, the Facility's risk review process still needed improvement in assessing risks related to health status. Although IDTs were attempting to incorporate clinical data and indicators into the process—and improvement the Monitoring Team supports—there continued to be a tendency to be imprecise. DADS had recently established a revised integrated risk review process. The Monitoring Team looks forward to reviewing whether this process improves the ability of IDTs to monitor and address risks related to health status.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	As noted above, the development of clinical indicators had continued. Not only were clinical indicators listed for a number of conditions, but also a database had been developed for a few chronic conditions that made data and other information readily accessible for decision-making. In addition, a training program was developed on reporting changes in health status; in this training, a number of clinical indicators were presented to assist in determining what objective information to report (although, appropriately, the training repeatedly advises staff to report any significant change in an individual). It was not yet as clear whether information on clinical indicators was used routinely in modifying treatments and interventions. As reported in Provision H3 and in several Sections of this report, there were instances in which treatments and interventions were not timely. Provision H4 provides examples in which data on clinical indicators was not routinely documented or used, such as the lack of bowel monitoring documentation for individuals with diagnosed constipation. The requirements of this provision related also clinical disciplines other than medicine. In addition to the clinical pathways and clinical indicators being developed, identification and tracking of clinical indicators are important for making decisions about a wide range of interventions. For example, clinical indicators should provide one source of information used in assessment of risk, planning of interventions for behavioral services, and modification of PNMPs, among other clinical services. Throughout observations and reviews of documentation, the Monitoring Team found many examples of treatment and intervention that were appropriate to clinical	Noncompliance

#	Provision	Assessment of Status	Compliance
		indicators. However, there were also examples in which modifications did not occur in response to changes in clinical indicators, or in which review of indicators did not occur timely. For example: • As reported in Provision L1, out of five individuals with constipation whose records were reviewed, the bowel records for monitoring bowel movements by direct care staff was fully complete in only one out of the five cases (20%), while the remained had several days of omitted documentation; and the Quarterly Drug Regimen Reviews (QDRRs) documented a review of the efficacy of anti-constipation medications in only one out of five cases (20%). • As reported in Provision R3, documentation of review of progress by Speech Language Pathologists did not consistently contain information regarding whether the individual showed progress with the stated goal. Therefore, treatments and interventions were not modified in response to clinical indicators of progress or lack of progress. • As reported in Provision S1, some SAPs continued at the same step for several months despite documented mastery. For example, Individual #574 continued at the same step for over six months at 100% mastery. This prevented movement to learning additional skills. Thus, although the Facility had made significant progress in identifying and tracking clinical indicators of health care, two issues remained. The first is that there remained many examples in which either clinical indicators did not lead to decisions about treatment and intervention. The second is that at least some clinical indicators were not consistently documented.	
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.	Several Facility policies were relevant to requirements of this Section, including: • RSSLC Policy I.26 Physician Quarterly Review 2/18/11 • RSSLC Policy Pre-Hospital Discharge Planning Policy (no number) 9/6/12 • RSSLC Policy I.31 Chronic Clinical Indicators 10/12/11 The Facility had made progress on procedures to implement requirements, including expansion and use of the chronic care database, as well as the use of the Pre-Hospital Discharge process to integrate planning and provide timely treatment for people returning from hospital. DADS policy remained in draft. A draft DADS state policy was available that addressed Provisions G and H together. The policy was not yet completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the Facility with some guidance and direction. It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of Section H.	Noncompliance

#	Provision	Assessment of Status	Compliance
		For provision item H1, the policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). DADS Policy 009.1 Medical Care had been revised in September 2012. This policy addresses responsibilities of physicians regarding acute and chronic conditions, medical orders, consultations, responsibilities of the physician and pharmacist for new drug orders and drug regimen reviews, hospitalizations, infection control, vaccinations, and documentation. It lists a small number of clinical indicators but does not clearly define what data will be collected.	

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

1. Develop a process or initiative to identify standards for contents and quality of assessments and to monitor that standards are met. (Provision H1)
2. As the Facility develops a process a process to ensure consistent documentation of diagnoses, it should consider including processes to help ensure both that all diagnoses are listed and also that diagnostic justifications are adequate. (Provision H2)
3. When documenting review of trends in clinical indicators, the Facility should consider developing a standard process to include data into the reviews and into the documentation of the reviews. (Provision H4)
4. DADS should complete development of policy guiding minimum elements of clinical care; this policy should address all clinical areas of care. (Provision H6)

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 10/30/12 2. RSSLC Section I Action Plan 10/15/12 3. RSSLC Section I Presentation Book 4. DADS At Risk Policy 006.1 (2/18/11) 5. RSSLC Policy I.08 At-Risk Individuals (9/18/12) 6. RSSLC Policy D.23 Using Bed Rails (8/22/12) 7. Record reviews Section O Sample #1: Individuals #386, #404, #701, #711, #745, and #783 8. Record reviews Section O Sample #2: Individuals #23, #500, #523 and #584 9. Record reviews Section O Sample #3: Individual #787 10. Record reviews Section O Sample #4: Individuals #120, #398, #404, #548, #577, #701, and #792 11. Record reviews Section O Sample #5: Individuals #16, #99, #106, #185 and #259 12. Record reviews Section O Sample #6: Individuals #125, #268, #429, #711, and #767 13. Records reviews for compliance analysis for Individuals #386, #745, #701, #783, #404, #711, #600, #448, #165, #630, #25, #152, #613, #709, #24, and #31 14. Integrated Risk Rating Form and accompanying Risk Action Plan for Individuals #70, #694, #31, #161, #743, #24, #152, #613, #364, #709, #340, and #25 15. Client Injury Report and Incident Information Report for Individual #351 16. List of Top 10 individuals causing injury to peers 17. List of Top 10 injured individuals. 18. List of individuals supported with bedrails 19. List of individuals injured from bedrails **People Interviewed:** 1. Ping Law OTR Habilitation Therapies Director 2. David Taylor OTR 3. Sally Martinez PNMT RN 4. Brandie Rabe PNMT SLP 5. Jean Cuevo PNMT PT 6. Dana Hatter QDDP/PNMT 7. Ten DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meetings Attended/Observations:** 1. Physical and Nutritional Management Team (PNMT 11/13/12 and 11/15/12) 2. Observations at living units during meals, transition and leisure times--San Antonio, Trinity, Leon, Three Rivers, and Four Rivers 3. ISP Annual Meeting for Individuals #165 and #465
	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.

	The Facility policy for implementation of the DADS-directed at risk policy was revised as recently as 9/18/12. RSSLC's monitoring/auditing of this section of the SA reported significant implementation issues. For example, for Provision I.1 monitoring done by staff external to the QA Department reported an overall compliance rate of 85%. Monitoring done by the QA Department reported an overall compliance rate of 10%. The self-assessment noted this discrepancy represented a "significant competency gap of understanding and utilization of the section I audit tool." These compliance ratings were much lower than that noted in the previous report, particularly with regard to QA Department monitoring where the average compliance score decreased from 39% to 10%. 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. Most action steps were intended to start 11/1/12, for example, nearly all action steps directed at compliance with Provisions I.2 and I.3. 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 9/18/12. 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 collaborative manner.

#	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: 1. Reviewed the local Policy I.08 At Risk Individuals on the risk screening, assessment and management process to determine if the policy addresses risk screening, assessment and management system to identify individuals whose health or well-being is at risk. 2. Reviewed revised integrated at risk assessment process, including integrated health care plan, status change integrated at risk assessment and status change health care	Noncompliance

#	Provision	Assessment of Status	Compliance
		plan to determine if the revised process has been implemented to identify individuals' health risk. 3. Reviewed official list of individuals with pneumonia to trace its assessment and management system. 4. Reviewed database on individuals at various risks to trace its risk rating assessment and management system. 5. Reviewed the section I audits of 79 (76 internal & 3 external audits) out of facility census of 355 from 4/1/2012 through 8/31/12 for outcome of provision compliance. 6. Reviewed 3 inter-rater monitoring (external audit) completed in September, 2012 to determine competency gap. The results of the self-assessment: 1. Current Policy I.08 At Risk Individuals was approved and implemented on 5/11/12. The policy revealed a process of screening and assessment to identify individuals with health risk to meet the requirement of this provision I.1. 2. The facility has recently implemented (September 7) the revised integrated at risk process in two homes. The rest of the facility was trained on the general at risk process and is implementing part of the risk assessment process. 3. The facility presented with one official list of individuals with pneumonia in Avatar. Hospital Liaison communicated with medical director and reconciled the hospital admission log diagnosis. However, conflict of diagnoses was found among official list, hospital admission log and infirmary admission log. The assessment and management system are not consistent. 4. The facility maintains a database of individuals whose health risk is rated at low, medium or high. The risk levels were determined by IDT in its risk rating. However, an external audit found 0 out of 3 risk assessment provided rationale for the determined risk levels and did not meet the assessment requirement. 5. The section I audit from 4/1/12 through 8/31/12 revealed the level of compliance to requirements of all provisions as the following: Internal audit (conducted by QDDPs) – 84.6% External audit (conducted by QA personnel) – 9.8% 6. The inter-rater monitoring was implemented in September which was part of external audit. The compliance level is 9.8% which indicated significant competency gap of understanding and utilization of the section I audit tool. <u>Self-rating</u> Based on the results of the self-assessment for this provision, the Facility determined it is not in substantial compliance. The results indicate that the Facility met criteria #1. The section I inter-rater audit presents a large discrepancy of agreement. Many processes	

#	Provision	Assessment of Status	Compliance
		were either in the process of implementation or had only been implemented for a short period of time. <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 9/18/12. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred since the last review, 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. Staff understanding of risk assessment policies and procedures had improved since the last review, 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 using the statewide monitoring tool reported an overall compliance rate of 85%. 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 just 10%. The review completed by the Monitoring Team suggests that the QA Department monitoring is likely more reflective of actual performance than 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 collaborative manner. There was still a tendency to over rely on the guidelines for each 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. The Monitoring Team did observe that in some instances the IDTs were attempting to incorporate clinical data and indicators into the process, but there continued to be a tendency to be imprecise in that attempt. For example, for Individual #465, the team noted the individual had "had some coughing" during meals and recommended a repeat MBS, but did not discuss how many times the coughing had been reported or whether this represented an increase over a baseline. The team also failed to note an episode of emesis in the record, instead reporting that none had occurred. It is essential that precise and accurate clinical indicators be used by the IDTs to make appropriate risk assessments.	

#	Provision	Assessment of Status	Compliance
		ISP meetings did not always have the relevant staff to properly consider risk assessment and planning. For example, review of the 11 individuals' ISP attendance sheets in Samples #1, #2 and #3 from Section O found: • Medical attendance was 45% (5 of 11 meetings); • Nursing attendance was 100% (11 of 11 meetings); • Dental staff attendance was 0% (0 of 11 meetings) • Occupational Therapist attendance was 72% (8 of 11 meetings); • Physical Therapist attendance was 72% (8 of 11 meetings): • Speech Language Pathologist attendance was 45% (5 of 11 meetings); • Registered Dietician attendance was 18% (2 of 11 meetings); and • Direct support professional attendance was 100% (11 of 11 meetings). The absence of these professionals impacted the discussion related to the integration of services and supports into the ISP, risk assessment, and multiple support plans. In addition, the absence of dental staff as well as the other professionals impacted the ability of the IDT to adequately review and integrate an individual's PNMP into the ISP. For many Individuals the PNMP is the cornerstone of their risk action plan. 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. 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	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the section I audit report (79 audits from 4/1/12 through 8/31/12) to determine if the assessment process is interdisciplinary. 2. Reviewed the same section I audit report to determine if the assessments were initiated within 5 working days of the individual being identified as at risk as required by the state policy. 3. Reviewed the section audit report to determine if rationale were adequately provided for the risk levels. 4. Reviewed the section audit report to determine if action plans were established for high and medium risks. 5. Reviewed Section O audit report (sample of 20) to determine if comprehensive	Noncompliance

#	Provision	Assessment of Status	Compliance
	days of the individual being identified as at risk.	physical and nutritional management supports were in place for individuals with identified risks. 6. Reviewed PNMT referral list and completed assessments to determine if the referred individuals were being followed. From its self-assessment the Facility determined that: 1. The Section I internal audit did not indicate if the assessment process was interdisciplinary. 2. The same audit revealed 84 out of 97 (87%) assessments were initiated within 5 working days. 3. However, no rationale was included in the risk rating to support its risk level. 4. 82 out of 97 (85%) of Section I audit included action plans but it is not known if they covered both high risk as well as medium risk. 5. 20 out of 20 (100%) Section O audit (May through July 2012) included physical and nutritional management plan. The PNMP appeared comprehensive. 6. Zero out of 12 PNMT assessments was completed in a timely manner (within 30 days) from April through September. Based on the results of the self-assessment for this provision, the Facility determined it is not in substantial compliance. The results indicate only criteria #4 was met. <u>Monitoring Team findings</u> Review of 11 records for individuals determined to have had a change in condition meriting risk assessment review by the IDT (Individuals #152, #600, #448, #165, #630, #386, #745, #701, #783, #404, and #711) 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 three (27%) of the 11 Individuals. These were Individuals #745, #783, and #404. Based on a review of records of a sample of six individuals (Individuals #25, #152, #613, #709, #24, and #31) 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 six 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 six 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. For example, Individual #613 was identified as medium risk for constipation/bowel obstruction but did not include clinical data to support the risk rating.	

#	Provision	Assessment of Status	Compliance
		Based on a review of records of an additional sample of six individuals (Individuals #386, #&45, #701, #783, #404, and #711) for whom assessments had been completed to address the individuals' at risk conditions, five (83%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. The assessment for Individual #701 did not. Based on a review of records of four individuals (Individuals #600, #448, #165, and #630) 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. The work of the PNMT is critical to risk assessment identification and planning. A problem noted with the PNMT assessment process was the excessive delay in which the reports were completed. For the individuals in Samples #1 and #2 (Section O) who received a PNMT evaluation (seven individuals): • Four out of seven (57%) took over three months to complete following referral. • Two out of seven (29%) took over two months to complete following referral. • One out of seven (14%) took over one and a half months to complete following referral. Delay in getting the assessments completed results in an increased risk due to the team not receiving the needed feedback in a timely manner and therefore being unable to implement any needed strategies in a timely manner. Observations on San Antonio, Leon, and Trinity demonstrated that staff did not always implement interventions and recommendations outlined in the PNMP and/or mealtime plans that were developed as part of the risk assessment/planning process. For example, in only two of 11 (18%) observations were staff following mealtime plans and in only two of five (40%) observations were staff following positioning instructions. Examples of where staff did not implement interventions and recommendations outlined in the Risk Action Plan/PNMP and/or mealtime plan included: o Individuals #598 and #776 were not provided with cues to alternate liquids and solids. o Individual #230 was observed taking large bites when the plans called for small	

#	Provision	Assessment of Status	Compliance
		bites, thus increasing risk of choking and/or aspiration. o Individual #471 was observed with staff initially attempting to assist. When it appeared the individual was not being cooperative, the staff moved to another table to help someone else. At this point, the individual began taking large bites, eating at an unsafe rate and not taking liquids as recommended on the dining plan. o Individual #212 was observed with no pillow under her right lower leg or between knees, resulting in increased scissoring of legs and pressure on the right leg. o Individual #623 was observed in bed with no folded sheets between her knees resulting in poor positioning. Implementation of risk action plans associated with PNMPs had not improved from that noted in the last review. Additional examples of deficient practices are presented in Section O of this report. As reported in Provision L1, there were examples in which risks were rated below what would have been called for by diagnoses and incidents. • Individual #146 was rated to be at low risk for falls and fractures, despite having a known diagnosis of severe osteoporosis, spastic movements, cataracts, dementia, cerebral palsy, and the need for physical support for all transfers. The individual was reported to have sustained a supracondylar fracture of the left knee on 5/5/12 that was reported to be "severe and displaced". The Individual was hospitalized, and was later suspected of having two additional fractures, involving the pelvis. Furthermore, an addendum to the ISP dated 5/7/12 indicated that the Facility believed that the individual's spastic movements and osteoporosis may have caused the knee fracture because such movements predisposed the Individual to fracture by hitting objects. The assessment did not take into consideration the two suspected fractures of the pelvis, and the explanation of the Individual hitting her leg on a table would not be an adequate explanation. • For Individual #596, who was noted on the annual medical summary, dated 6/27/12 to have had a past surgery for foreign body, and a diagnosis of pica, and chronic constipation, medical recommendations did not provide information on potential risks of constipation; although the medical plan identified the need to provide anti-constipation medications, and free water, there were no specific instructions provided to staff on the quantity of water, and what signs and symptoms to monitor for worsening constipation. Furthermore, the ISP dated 5/7/12 indicated that the Individual was at low risk for constipation even though the Individual has a known diagnosis of constipation, is on pro-	

#	Provision	Assessment of Status	Compliance
		constipating medications, and takes medication daily for constipation. As reported in Section M of this report, a review of 6 recently completed Integrated Risk Ratings for Individuals #25, #709, #152, #613, #31, and #24 revealed that zero of six (0%) Risk Action Plans adequately provided an integrated Risk Action Plan for each of the risk rating categories. There was no appreciable improvement from the last compliance review. Since individuals' Integrated Risk Rating Forms and Risk Action Plans were completed on the previous form, future risk ratings and plans of care using the new IRRF and IHCP processes along with additional training of the IDTs should show improvement. Additional findings and comments regarding risk assessment can be found in Section M of this report. As reported in Provision L1, regular screening for certain health conditions was done appropriately, including mammograms for females over the age of 40, and colonoscopy for individuals aged 50 and older. Information from these screenings is available for identifying level of risk. 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 when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	<u>Facility self-assessment</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the section I audit report (4/1/12 through 8/31/12) to determine if action plans are implemented within 14 days. 2. Reviewed action plans to determine if the plans included preventive interventions to minimize the condition of risk. 3. Reviewed the section I audit report to determine if immediate action was taken when there was change of individual's risk condition. 4. Reviewed ISP to determine if the action plans (with functional and measurable objectives) were integrated in the individual's ISP. 5. Reviewed clinical indicators for monitoring and frequency of monitoring. From its self-assessment the Facility determined that: For the same time frame of review (4/1/12 through 8/31/12), 1. 64 out of 71 (90%) internal audits indicated action plans were implemented within 14 days. 2. 60 out of 71 (85%) internal audits indicated the plans included preventive	Noncompliance

#	Provision	Assessment of Status	Compliance
		interventions to minimize the condition of risk. 3. 63 out of 69 (91%) internal audits indicated that the plan was updated as necessary when changes in risk condition occurred. 4. 64 out of 72 (89%) internal audits indicated that the action plans were integrated in the individual's ISP. 5. 57 out of 68 (84%) internal audits indicated the plans included clinical indicators to be monitored and identified the frequency of monitoring. Based on the results of the self-assessment for this provision, the facility is not in substantial compliance. While the internal audit presented high percentage of compliance, the external audit indicated a significant competency gap of understanding the section monitoring tool. In addition, the total sample size of 79 is small compared to the total facility census of 354. <u>Monitoring Team findings</u> Based on a review of 16 records for individuals determined to be at risk (Individuals #386, #745, #701, #783, #404, #711, #600, #448, #165, #630, #25, #152, #613, #709, #24, and #31), 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 four (25%)) cases. Records that contained documentation of this included Individuals #745, #783, #404, and #711. • Implemented a plan that met the needs identified by the IDT assessment in four (25%) cases. Records that contained documentation of this included Individuals #745, #783, #404, and #711. • Included preventative interventions in the plan to minimize the condition of risk in seven (44%) cases. Records that contained documentation of this included Individuals #745, #783, #404, #709, #24, #31 and #711. • When the risk to the individual warranted, took immediate action in four of 10 (40%) cases. Records that contained documentation that this did not occur included Individuals #600, #448, #165, #630, #386, and #701. • Integrated the plans into the ISPs in five (31%) cases. Records that contained documentation of this included Individuals #745, #783, #404, #711, and #31. • In four (25%), 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 #745, #783, #404, and #711. • In six (38%) appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. Records that contained documentation of this included Individuals #745, #783,	

#	Provision	Assessment of Status	Compliance
		#404, #152, #31, and #711. • Included the clinical indicators to be monitored and the frequency of monitoring in five (31%) cases. Records that contained documentation of this included Individuals #745, #783, #404, #152, and #711. • Four (25%) of the risk plans reviewed by the Monitoring Team were adequate to meet the Individual's needs. Records that contained documentation of this included Individuals #745, #783, #404, and #711. In addition to risk plans, routine treatment and intervention plans must be designed and implemented to reduce unnecessary risks. For example, physical and nutritional management plans (PNMPs) must be well designed and must be implemented accurately. As reported in Section O, implementation was not always accurate. Staff did not refer to the plans when providing services, and may DSPS could not describe the plans. Triggers were not reported on a form specifically designed for such reporting, the Aspiration Pneumonia/Enteral Nutrition Evaluation. Failure to recognize triggers places the individuals at an unnecessary risk as these triggers have been identified through assessments and observations to be clinical warning signs of increased risk. 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:	**Documents Reviewed:** 1. RSSLC Self-assessment (10/30/12) 2. RSSLC Action Plans (10/15/12) 3. Facility Presentation Book for Section J 4. DADS Policy and Procedures 007.2 Psychiatry Services (8/30/11) 5. DADS Policy and Procedures 007.3 Psychiatry Services (draft) 6. DADS Procedure 001.1 Use of Restraints (4/10/2012) 7. DADS Nursing Protocol Post Anesthesia Care (6/2010) 8. DADS Nursing Protocol Pre-treatment and Post Sedation Monitoring (6/2010) 9. DADS Medical/Dental Restraint Checklist (4/ 2012) 10. An alphabetical list of all individuals who receive psychiatric care, including the current psychiatric diagnosis, the name of the treating psychiatrist, the psychotropic medications given to the individual, and the date of the most recent Comprehensive Psychiatric Diagnosis (CPE) 11. A list of individuals for whom psychiatric diagnoses have been revised since the last visit, 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) 12. For individuals who experienced more than three episodes of restraint in 30 days, relevant psychiatric re-assessments, any Interdisciplinary Team (IDT) meetings held to review the circumstances of the multiple episodes of restraint, and physician orders involving changes in psychiatric treatment including medication changes 13. For the past six months, minutes of the Pharmacy and Therapeutics Committee (P&TC), and the committee that addresses polypharmacy 14. A list of individuals prescribed intra-class polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 15. A separate list of individuals for whom each of the following are prescribed a. Anticonvulsant medications being used only for psychiatric indications b. Anticonvulsant medications being used only for neurological indications c. Anticonvulsant medications being used for both neurological and psychiatric indications c. Lithium d. Tricyclic antidepressants e. Trazodone f. Beta blockers being used as a psychotropic medication g. Clozaril/clozapine h. Mellaril i. Reglan j. Anticholinergic medications k. Benzodiazepines 16. A list of individuals who have medical support plans and dental support plans, to reduce the need for pre-treatment sedation 17. The number and percentage of individuals who had dental procedures, who also received pre-

	treatment sedation (oral or total intravenous anesthesia (TIVA)). 18. For the past six months, an alphabetical list of individuals who have received pre-treatment sedation medication or TIVA for medical or dental procedures that includes the date the pre-sedation was administered, the name dosage, the route of the medication, and an indication of whether a plan is in place to minimize the need for the use of pre-treatment sedation medication 19. A list of all individuals screened for tardive dyskinesia with Dyskinesia Identification System (DISCUS) evaluations. 20. A list of all individuals screened with Monitoring of Side Effect Scale (MOSES) evaluations 21. A spreadsheet with results of DISCUS and MOSES evaluations done since the last compliance review. 22. Copies of DISCUS forms done over the past year that were rated "5" or higher 23. Copy of the Active Problem Lists (APL) for each individual diagnosed with tardive dyskinesia 24. Copies of all Reiss screens (both data and scoring sheets) done since the last review 25. A list of all Reiss screens (screen + scoring sheet) that reached or exceeded cut-off values per instrument guidelines 26. Sample J1: Individuals #19, #24, #27, #91, #101, #151, #200, #232, #316, #378, #429, #513, #530, #555, #568, #584, #723, and #764. The sample was comprised of individuals considered by the Facility to be stable on their medications, individuals who had experienced acute difficulties, and individuals who had experienced recent updates of Comprehensive Psychiatric Evaluation (CPEs). Materials reviewed were: a. Social History b. Most recent Psychiatric Evaluation (Appendix B format if done) c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review d. Most recent Positive Behavior Support Plan and Structural and Functional Assessments (SFA) e. Most recent Individual Support Plan (ISP) f. Most recent Annual Medical Summary g. Most recent Active Problem List h. All Psychiatry and Behavior Management Clinic (PBMC) notes for the past six months i. All MOSES/DISCUS Side Effects Screenings for the past six months j. All Quarterly Drug Regimen Reviews (QDRRs) for the past six months k. Most recent Health Risk Assessment Rating – tool and team meeting sheet l. 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) m. Medical and/or dental plans to increase cooperation/participation and reduce the need for pre-treatment sedation n. Most recent Annual Nursing Summary o. Most recent Neurology Consultation 27. Sample J2: Individuals #19 (Wellbutrin, Clonidine), #210 (Depakote, Clozaril), #264 (Depakote), #287 (Seroquel), #306 (Depakote), #314 (Abilify, Zyprexa), #363 (Haldol), #404 (Trazodone), #513 (Prozac), #529 (Cogentin), #545 (Haldol, Benadryl), #555 (Trazodone, Melatonin), #576 (Abilify), #596 (Melatonin, Trazodone), #600 (Depakote), #672 (Abilify), #726 (Seroquel, Depakote), #798 (Wellbutrin). These were individuals who had psychotropic medications approved by the Behavior Support Review Committee (BSRC) and the Human Rights Committee (HRC) during the last six months.

	Materials reviewed included: Information from the clinical record (e.g. progress notes, psychiatric treatment reviews, ISPAs) that helped the Monitoring Team understand the reasons/clinical rationales for choice of the medication, consents for the use of psychotropic medication, revised Positive Behavior Support Plan (PBSP) 28. Sample J3: Individuals #31 (10/11/12), #57 (10/01/12), #120 (09/27/12), #142 (09/06/12), #207 08/28/12), #260 (10/09/12), #273 (08/30/12), #318 (09/20/12), #324 (08/30/12), #479 (08/30/12). These were individuals who had episodes of medical restraint. Each episode was reviewed for safety during the procedure: Materials reviewed included medical orders; physician specified monitoring schedules, restraint checklists, pre and post sedation nursing checklists, integrated progress notes, (IPNs) and dental clinic notes that documented medical monitoring for safety during the procedures. Each episode was also reviewed for plans to minimize the need to use medical restraint: Materials reviewed included individual ISP and Individual Support Plan Addenda (ISPA) information regarding the need for pre-treatment sedation and the development and implementation of such plans, including completed data sheets if a program was developed and implemented **People Interviewed:** 1. Bobby Buckner, MS, BCBA, Chief Psychologist 2. Stacey Burdue, Director of Quality Assurance 3. Sylvia Ikes, Pharm D., Clinical Pharmacist 4. Roger Joe, MD, Lead Psychiatrist 5. Ugo Nweke, RN, Nurse Educator 6. Hugh Pharies, MD Staff Psychiatrist 7. Franca Uzuejba, RN Nurse Case Manager Supervisor 8. Damola Olatoregam, Psychiatry Assistant **Meetings Attended/Observations:** 1. PBMC clinics, 11/13/12 and 11/15/12 2. Integrated Care meeting, 11/14/12 3. P&TC meeting, 11/14/12
	Facility Self-Assessment: The Facility submitted a self-assessment for Section J, dated 10/30/12. In its self-assessment for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment 2) the results of the self-assessment and 3) a self-rating. For Section J, the Facility did not use monitoring/auditing tools. Instead, the Facility used other relevant data sources to conduct the self-assessment. Many of the items used by the Facility for the self-assessment were cited for more than one provision item. The various sources are listed below, arranged by topic. <u>For Psychiatric Diagnosis</u> 1. The Facility reviewed records for all individuals at the Facility receiving psychotropic medications [154 individuals], to (a) determine if all had been evaluated and diagnosed in a clinically justifiable manner, via a completed Comprehensive Psychiatric Evaluation (CPE) and to (b) determine the appropriateness

	of the psychiatric diagnosis/behavioral pharmacological hypothesis. 2. The Facility reviewed a sample [10] of annual psychiatric summaries of individuals, who had their psychiatric summary updated after September, 2011. <u>For Medication use and Polypharmacy</u> 1. The Facility reviewed the P&TC and Patient Medication Review Panel minutes. 2. The Facility reviewed PBMC Clinic notes for individuals who had the prescriptions of two or more psychotropic medications from the same general class and prescriptions of three or more psychotropic medications monthly in PBMC. 3. The Facility also reviewed the results of the Clozaril Utilization review for all individuals on Clozaril at the Facility. <u>For Reiss Screen Use</u> 1. The Facility reviewed the list of individuals to determine whether all individuals had a Reiss Screen annually. <u>For Informed Consent</u> 9. The Facility reviewed 4 of 40 (10%) of consents for psychoactive medications that were submitted to the Human Rights Committee (HRC) between 04/01/2012 to 09/30/2012 to ensure that consents included any limitations on the use of the medications or restrictive procedures and identified associated risks. <u>For Side Effect Monitoring</u> 1. The Facility reviewed spreadsheets for the timely completion of DISCUS and MOSES assessments. <u>For Psychiatrist Participation in Facility Activities</u> 1. The Facility reviewed psychiatrist attendance at IDT meetings. 2. The Facility reviewed psychiatrist(s) attendance at Neurology Clinic to coordinate the use of medications. The materials reviewed provided some degree of understanding about where the psychiatry department stood in reference to matters which are key to the SA. However, the utility of the self-assessment process was limited. Absent the use of monitoring/auditing tools or a more detailed description of how records were reviewed and determinations were made, it was difficult to get more than a broad overview of progress made. The self-assessment also described a number of Psychiatry Department initiatives. These included a process for revision of CPEs to conform to the Appendix B requirement. The self-assessment reported that these had been completed for 45 of 154 (29%) of the records. A process was also underway to resolve differences between CPE and PBMC diagnoses, as well as differences between APLs and the new Medical and Psychiatric problem list in the medical order section of the record. These initiatives responded to needs identified by the Monitoring Team in prior reviews.

	In some cases the self-assessment did not follow-up on specific areas of concern mentioned by the Monitoring Team. For example, the May 2012 report of the Monitoring Team identified that there were 22 individuals who had Reiss Screen scores above the clinical cutoffs and who needed follow-up psychiatric evaluations (see discussion for Provision J7). The self-assessment for the provision on Reiss Screen did not address that matter. The Facility has also not yet provided estimates for the amount psychiatric time that is needed to provide services required by the SA (see discussion for Provision J5). The self-assessment cited a number of Facility databases that were in place to assist in the self-rating process. These include a spreadsheet for tracking of completion of CPEs, a spreadsheet for key data for individuals supported by psychiatry (current diagnosis, treating psychiatrist and psychotropic medications), a tracking of most recent PBSPs, and a listing of medical and dental support plans. There was also a spreadsheet of medical and dental plans that were in place. The spreadsheets were helpful but in some cases they were not sufficiently detailed since they did not address specifics identified as necessary by the Monitoring Team. For example, the Monitoring Team had identified that individuals who need pre-treatment sedation needed to have plans to reduce the need for such pre-treatment sedation. The plans that are in place and that were cited in the self-assessment included many different dental needs, including the need for general oral hygiene. Such plans may or may not address the issue of pre-treatment sedation. A matter addressed in the current report is that the spreadsheet for key information for individuals supported by psychiatry did not include the requested listing of the psychotropic medications prescribed for individuals. The absence of the needed information made discussions with the pharmacy about psychiatric polypharmacy unnecessarily difficult, since the pharmacy does not track psychiatric polypharmacy separately from overall polypharmacy that includes somatic medications. It would be very helpful for the Department of Psychiatry spreadsheet to be expanded to include the needed information on psychiatric medications. In many cases, the monitoring information provided by the Facility did not include adequate indicators that would have allowed the Facility to determine compliance with the SA. During the visit the Monitoring Team's encouraged that Facility to consider the use of clinical indicators that would help determine compliance. The Facility also provided an Action Plan that reported actions being taken to achieve compliance. Several items were listed as not started, including key items such as a joint review of PBSPs with other departments (Provision J3) and the need to develop a process to verify consistency in data collection (Provision J2). Many provisions were reported as "in process" or "complete and ongoing." Because the self-assessment did not clearly identify specific improvements needed, it was difficult to assess whether the Action Plan addressed such needs for improvement. Examples were Provisions J4, J12, and J14. The Monitoring Team also noted that a key initiative of the Psychiatry Department was not part of the Action Plan. That was the effort to convert CPEs to conform to the Appendix B requirement and to resolve differences between CPE and PBMC diagnoses, and between APLs and the new Medical and Psychiatric problems list that was developed by the Medical Department.

	With the above in mind, the Monitoring Team found that while the self-assessment contained useful information, the Facility needed to: • Better utilize available auditing and monitoring tools • Include all relevant activities in the Action Plan • Provide more input from departments other than psychiatry for the section J self-assessment • Better utilize the Facility QA process and the services of the QA Department • Improve the use of the Facility Action Plan In the absence of the processes and information sources discussed above, the self-assessment materials presented by the Facility did not include adequate indicators to allow the Monitoring Team to determine compliance with the Settlement Agreement (SA). The Facility rated itself as being in compliance with the following five provisions of Section J: Provision J.1, Provision J.5, Provision, J.11, Provision J.12, and Provision J.14. This was not consistent with the Monitoring Team's findings. The Monitoring Team agreed with the Facility about Provisions J1 and J11 and found the Facility in substantial compliance on those provisions. For Provision J5 the Monitoring Team was not yet able to determine whether there was adequate staffing to fulfill the requirement of the SA. For Provision J12, the Monitoring Team found that not all individuals received the screens they needed. For Provision J14, our review looked at the quality versus the mere presence of indicators and found that more individualized information was needed for risk vs. risk information and treatment alternatives.
	Summary of Monitor's Assessment: The Monitoring Team rated the Facility in substantial compliance for two of the provisions in this section. Nonetheless, the Monitoring Team saw encouraging signs that suggested needed fundamentals are now being put in place that will make it possible for psychiatric care to be consistent with the requirements of the SA: • The Facility has employed two psychiatrists, each of whom had the required qualifications and experience. The new psychiatrists brought renewed energy to efforts to clarify an individual's diagnoses so that they properly reflect observable symptoms that are the focus of medication treatments. Much work was being done in the psychiatric clinics toward clarification of diagnoses. CPEs have now been done for over 90 percent of individuals who take psychotropic medications, and the Facility has started to do annual updates of those CPEs. • In the area of the appropriate use of psychotropic medications, it was clear to the Monitoring Team that the Facility was committed to make the fundamental changes needed to support appropriate use of medication. Teams were busy in the PBMC sorting out whether individuals had symptoms that warranted medication treatment, and there were active discussions between psychiatrists and psychologists about the kinds of behavioral data that were needed to support psychiatrists' efforts to provide medication management when it was needed. The Facility remained in compliance for the provision on polypharmacy, but to maintain that rating improvements are needed in the area

	of monthly Facility-level of polypharmacy practices. • In the area of integration of behavioral healthcare, there was an excellent addition to the SFA section, which addressed the differentiation of function between psychiatric and psychological treatment. It cannot alone provide all the needed answers but it was evident that the Facility is moving in the right direction for quality of integrated behavioral care. However, psychiatry reengagement with neurology is needed to restore the provision of neurological and psychiatric care to its previous rating of compliance. The Monitoring Team reviewed ongoing Facility efforts to bring various provisions into compliance. The Monitoring Team found that there had been limited progress made regarding the use of medical restraints. There has been some progress regarding the monitoring for safety during medical restraint, as the new Medical/Dental Restraint Checklist has consolidated vital sign monitoring into one place. Many individuals still lacked needed plans to reduce the need for pre-treatment sedation. In order to complete the work on Reiss screening for psychopathology, psychiatric evaluations must be completed for individuals who failed the Screen, and a Facility protocol is needed regarding the use of Reiss screen for possible change of status of individuals who live at the Facility. Progress was made regarding the use of nurse-administered evaluations for medication side effects, but it was not clear that individuals received all the needed examinations and there was not yet adequate Facility level monitoring for tardive dyskinesia. The Monitoring Team has requested that the Facility provide estimates of the time required to provide services required by the SA. At this point the Monitoring Team cannot state that the Facility has a sufficient number of FTE psychiatrists to ensure the provision of required services.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications and Experience of the Psychiatrists</u> Since the last visit of the Monitoring Team, two psychiatrists have joined the staff at the Facility. Roger Joe, MD joined the staff in July 2012. He is employed by the Facility on a full-time basis and is the Lead Psychiatrist for the Facility. Dr. Joe is a 2006 graduate of the St Matthew University School of Medicine in Orlando, Florida and he completed his psychiatry residency in 2011 at the Department of Psychiatry, University of Arizona in Tucson. He completed a fellowship in forensic psychiatry in 2012 at the Louisiana State University in Shreveport. Dr. Joe gained experience in intellectual disability when he worked at the Pinecrest Facility in Louisiana, as part of his fellowship. Dr Joe has been board certified in psychiatry since 2011. Dr. Hugh Pharies also joined the staff during summer 2012. He a 1967 graduate of the University of Texas at Galveston School of Medicine, and he completed his psychiatry residencies in adult and child psychiatry at the Department of Psychiatry, Baylor University School of Medicine, in 1997 and 1999, respectively. For ten years he worked as an Assistant Professor at Baylor, and then he then joined the staff of the Mental Health and Mental Retardation Authority (MHMRA) of Harris County,	Substantial Compliance

		Texas. Dr. Pharies worked there from 1993 until 2012. Dr. Pharies had prior experience in intellectual disability psychiatry as part of his overall clinical responsibilities at the MHMRA. He also worked as a contractor for another DADS facility for three months, prior to coming to RSSLC. Dr. Pharies has been board certified in psychiatry since 1987. He is employed by the Facility on a full-time basis. <u>Monitoring Team's Compliance Rating</u> The Facility psychiatrists have appropriate credentials and experience and the Facility is in substantial compliance with the requirements of this provision.	
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> 154 of 347 (44%) individuals who lived at the Facility took psychotropic medications. <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 Professionals (QDDPs), Direct Support Professionals (DSPs), and habilitation therapists. Psychiatrists also examined individuals in the context of other scheduled IDT functions such as ISP meetings, and when 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, and information about laboratory data and side effects screening. In the Facility self-assessment the Lead Psychiatrist made clear that the key place where psychiatric diagnoses were made was in the PBMC. This was because it was a venue that was shared by the various behavioral healthcare professionals, and a place where good interdisciplinary discussion could take place. 2. In response to the requirements of the SA, the Facility continued to provide CPEs to both existing and new referrals to the psychiatry service. Over the past three years, CPEs have been provided to 145 of 154 (94%) of the individuals who lived at the Facility and took psychotropic medications. Of these, 33 individuals had CPEs done since the last visit. Based on these numbers, there were nine individuals who took psychiatric medications and still needed CPEs. As reported under Provision J7, psychiatric evaluations were also needed for 16 individuals who had scores above the clinical cutoffs for the Reiss Screen (a screening assessment for psychopathology) and were not seen in the PBMC. At the time of the compliance visit CPEs were in place for five of these individuals. Combined, there were 26 individuals who lived at the	Noncompliance

		Facility, who needed CPEs, but did not have them in place (15% of a total of 170 people who would need a CPE—those taking psychotropic medications or with Reiss Screen scores above cutoff). A new development at the Facility was that the Psychiatry Department had started to provide annual updates to the CPEs. This was a positive development. Among other things, annual updates of the CPEs will provide psychiatrists with a place to document significant developments that have taken place during the year in a document that will remain readily available for future reference. To date, there have been nine individuals who have had CPE updates, all done prior to their annual ISP meetings. The Monitoring Team requested and received a list of the changes in diagnosis that took place during the review period. There were 24 such changes. All took place between August and October, during PBMC clinics conducted by the two Facility Psychiatrists. The Facility provided the Monitoring Team with copies of the clinic notes during which the changes were made. The notes make clear that careful and substantive diagnostic practices were in place. Examples were: • For Individual #239 the psychiatrist noted that concurrent diagnoses of dysthymia and major depression were not needed and removed the diagnosis of dysthymia. • For Individual #459 the psychiatrist added the diagnosis that cited brain trauma, on the basis of the documented history of traumatic brain injury with loss of consciousness for 24 hours. • For Individual #179 the diagnosis of obsessive compulsive disorder was removed as unwarranted. • For Individual #200 the diagnosis of schizophreniform psychosis was changed to schizophrenia on the basis of the Diagnostic and Statistical Manual (DSM) criteria. • For Individual #101 the diagnosis of sleep disorder was discontinued and autism added. In this case more detail will be needed at the time of the annual update to substantiate the diagnosis of autism. Autism was diagnosed in the notes on the basis of "rocking, spinning, and self stimulation and insistence on sameness. He has only moderate interest in socializing with others, and although he was nonverbal during the interview the staff reports that he does talk to them some." These details are consistent with the diagnosis but do have sufficient detail to justify the diagnosis, for example over a less specific diagnosis of pervasive developmental disorder. The fuller documentation can be provided at the time of the annual update of the CPE. • For individual #645 autism was diagnosed on the basis of "qualitative impairment in social interaction, failure to develop peer relations and lack of social or emotional reciprocity. Qualitative impairments in communication are manifested by lack of development of spoken language, and restrictive stereotyped and repetitive movements." This covered all the key requirements for the diagnosis and notes in the record provided the needed details. <u>Facility efforts to resolve differences between CPE and PBMC diagnoses</u> As described above, there have been two parallel processes in place to generate psychiatric	

		diagnoses. As described in prior reports, there were many instances where different places in the record of a given individual provide different diagnoses. In the self-assessment the Facility stated that these differences will be resolved during annual CPE updates. However, the process of annual updates of CPEs had just begun. <u>The system in place to track changes in diagnosis.</u> The Monitoring Team reviewed with the psychiatry assistant how changes in diagnosis were tracked. When a change in diagnosis was made by the psychiatrist in the clinic, the change in diagnosis was reflected in the psychiatrist's dictation for the individual reviewed. The psychiatry assistant made the needed change in the departmental spreadsheet for diagnoses and the psychologist completed a form known as a DG1 that updated the AVATAR system which in turn maintained that database accessed by the Primary Care Physician (PCP) for the next annual medical review. This was needed since the APL printout for the chart was done annually at the time of the annual medical evaluation. The psychiatry assistant also notified the PCP so that the APL in the chart could be manually updated. During the PBMC of 11/13/12, there was an exchange about updates of diagnoses between the psychiatrist and other team members. For several individuals, the psychiatrist noted that the changes in diagnosis he had made during previous clinics had not been reflected in documents brought to the meeting. It emerged that there has been a backup in dictations so that team members had to bring old and outdated forms to the meeting, likely then propagating new errors. <u>Adequacy of the process to track diagnoses and diagnostic update</u> As described in the paragraphs above, efforts were underway at the Facility to resolve conflicting diagnosis cited in different part of the clinical record. To assess the current status of such efforts, the Monitoring Team reviewed the 18 records of Sample J1. For each individual the Monitoring Team compared the diagnosis of record in PBSP, the PBMC clinic, and the APL. For 13 of 18(72%) individuals, there was at least one difference between those sections of the record. Overall, the system in place for tracking diagnoses seemed complex. It was not clear to the Monitoring team whether it would be adequate, once the process of sorting which of the competing diagnoses in the records was completed. <u>Monitoring Team's Compliance Rating</u> The two psychiatrists now working at the Facility have brought renewed energy to efforts to clarify individual's diagnoses so that they properly reflect observable symptoms that are the focus of medication treatments. Much work was being done in the psychiatric clinics toward clarification of diagnoses, CPEs have now been done for over 90 percent of individuals who take psychotropic medications, and the Facility has started to do annual updates of those CPEs. Nonetheless, in many cases individuals still had different diagnoses in different sections of the record. In addition, systems that kept track of diagnoses did not keep pace with the changes in diagnosis made by psychiatrists. Further progress on these matters is needed in order to achieve a rating of substantial	

<table>
<tr><td></td><td></td><td>compliance.</td><td></td></tr>
<tr><td>J3</td><td>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.</td><td><u>Behavioral Treatment Program for Medicated Individuals</u>
Psychotropic medications were given to 154 of the 347 individuals (44%) individuals who lived at the Facility. The provision required that medications should not be used as a substitute for a treatment program, such as a behavioral treatment program. The Monitoring Team compared a list of individuals who took psychotropic medications and a list of individuals who had behavioral treatment programs. These indicated that 153 of 154 (over 99%) of the individuals who were treated with psychotropic medications had behavioral treatment programs. However, for nine individuals the behavioral treatment programs were Behavioral Assessment Programs (BAPs) that were initial and incomplete PBSPs, and that been in place for more than 90 days. It is best for full PBSPs to be in place no later than 90 days after their development is started. The above analysis did not include two individuals who admitted to the Facility just before the visit and for whom the psychotropic medications prescribed at the time of admission were continued while BAPs were developed.

<u>PBSP Information on Psychiatric Diagnoses and treatment needs</u>
The Monitoring Team reviewed the records of 18 individuals in Sample J2. PBSPs for 18 of 18 (100%) of the individuals contained psychiatric diagnosis or diagnoses, in the DSM format. PBSPs also contained a section titled “rationale for current intervention.” That section identified the reason that behavioral supports were needed for challenging behaviors, but it typically did not address the psychiatric component of the overall program.

<u>Information about Psychiatric Medications and Symptoms linked to the Medications</u>
PBSPs contained a section that described the psychotropic medications that were given to the individual. Medication information was provided in a table that typically followed the following format:

<table>
<tr><td colspan="5">Drugs for Behavior Management</td></tr>
<tr><td>Medication</td><td>Date begun</td><td>Current dose</td><td>Maximum Daily Dose</td><td>Potential Adverse Side effects</td></tr>
</table>

The five columns of information in the table of medications did not provide the writer with an opportunity to discuss the diagnosis that was linked to the medication, or the symptoms to be assessed for medication efficacy. That is needed for substantial compliance. Please note that the needed information was included in the presentation for individual #151 below.

During previous visits and reports, the Monitoring Team discussed the need for more information about psychiatric medications, and the information about new medications that are listed in Provision J13 of the SA are also paralleled in the DADS requirements for PBSPs. During the current</td><td>Noncompliance</td></tr>
</table>

visit the Monitoring Team learned from the Chief Psychologist about pending plans to provide more information, which will be part of a new format for the SFA. In the 18 records reviewed, additional psychiatric information was provided in a variety of ways. These were:

- In many case some of the needed information was given, as part of the entry for "medication." For example, for Individual #530 the entry for "medication" was "Seroquel XR (Quetiapine) for treatment of psychosis and depressed mood secondary to Schizoaffective Disorder, Bipolar Type."
- In three of 18 (17%) records the table of information on medication was followed by a description of behaviors that should trigger review of the medication. For Individual #24, diagnosed with schizophrenia and treated with Risperdal, the entry was "impulsivity, restlessness, agitation, sleep disturbance, change in appetite, and or weight will be monitored as indicators for medication adjustments." For Individual #101 diagnosed with personality change secondary to anoxia and treated with Depakote: "The behaviors that will be monitored as indicators for medication adjustments (are) abdominal pain, anorexia, rash, back pain and tremor." It is possible that in the latter case the authors focused on signs of medication toxicity.
- In three of 18 (16%) records a table was added that had columns for "Medication Change" and "Behavioral Response. " For example, Individual #90 diagnosed in the PBMC with psychosis, NOS (as erroneously listed in the PBSP as having no DSM Axis 1 diagnosis) a medication change on 2/08/11 was listed as having a behavioral response of "targeted behaviors decreased."
- In five of 18 (27%) records the medication table was followed by a section called "Behavioral Symptoms to be monitored." For example for Individual #568, diagnosed with Bipolar Disorder and treated with Seroquel, the entry was "symptoms of mania manifested as aggression toward other and the environment and agitation." For Individual #27, diagnosed with dysthymia and treated with Zolpidem and Seroquel, the entry was "(the individual) has a history of displaying anger, aggression (SIB, physical aggression toward others), irritability, rate of aggression, weight and mood will be monitored …"
- In one of the records, (Individual #151, admitted in 2012) the table of information about medications was altered: The five columns of information about medication shown above were replaced by three columns on the medication, the diagnosis, and the target symptoms, as follows. In this case the presentation format was the one that has been used for a number of years in the PBMC.

Psychoactive Medication	Psychiatric Diagnosis	Target Behaviors/Symptoms
Depakote 7500 mg BID (sic)	Admitted w/DX dysthymia disorder, Psychosis and Mood Disorder	Mood, Aggression
Seroquel 100 mg TID and 300 mg qHS	Admitted w/DX dysthymia disorder, Psychosis and Mood Disorder	Psychosis, Mood and Aggression

Celexa 20 mg QAM	Admitted w/DX dysthymia disorder, Psychosis and Mood Disorder	Depression

This presentation was clear. The psychiatric diagnoses needed to be revisited, since there was no reason to have both a diagnosis of dysthymia and mood disorder. By adding the words "admitted with Dx" (Dx is an abbreviation for diagnosis), the psychologist writing the PBSP indicated an understanding that the diagnoses were tentative. Overall, the presentation reflected the best information that was available to the treatment team at the time the document was written, soon after admission. The presentation format provided a linkage of each medication to the relevant psychiatric diagnosis and it identified – at least in general terms – what each medication was intended to treat.

In summary, there was no single way in which PBSPs presented information about psychotropic medication. Overall, the Monitoring Team's impression was that for many individuals cited above, the choice of psychiatric symptoms to be monitoring could be improved. However, the examples showed that the authors were thinking about the topic of the symptoms that could be treated with medication, and that was positive. The Chief Psychologist shared with the Monitoring Team that in the coming months a standard format for presentation will be deployed.

Assessment of Medication Treatment Efficacy

As described above, PBSPs had some, albeit limited, information about how objective data and an individual's response would be reported and assessed. At the Facility, medication treatments were typically reviewed at the PBMC. In the past, the table of medication information in the format listed in #5, above, was included in the psychiatrists' report from the PBMC. For this review period, the PBMC reports changed and the table of information was not included in the psychiatrist's note. As a result, it was not possible from the PBMC notes requested by the Monitoring Team to know what data was presented at PBMCs for the individuals in Sample J1.

During the visit the Monitoring Team attended PBMCs, and noted that behavior analysts did bring with them the traditional PBMC data sheets. The data sheets included a table about medications that included psychiatric target behaviors/symptoms to be monitored. For the individuals seen in the PBMC clinic on 11/15/12, the Monitoring Team therefore compared the symptoms designated for monitoring per each individual's PBSP, the symptoms to be monitored, per PBMC medication table that was on the psychologist's, and data actually presented at the PBMC. Results were as follows:

Individual	Diagnosis	Symptoms to be monitored, per PBSP medication table	Psychiatric target behaviors/symptoms to be monitored, per PBMC medication table	Data presented at PBMC
#17	Bipolar	Any significant	Mood lability,	Aggression and self

	disorder with psychotic features	change in mood, sleep appetite and/or weight	restlessness irritability, somatic complaints suicidal threats, homicidal threats self injurious behavior, physical aggression	injury Threats
#137	Schizoaffective Disorder	Any significant change in delusional speech, sleep, appetite, and or weight	Paranoid delusions, high energy, response to internal stimuli, mood lability	Aggression, delusions
#322	Cyclothymia	Irritability, anger, and happiness that alternate with depressive symptoms, with no reports of mania or psychosis. Sleep, irritability (aggression) weight, mean refusals and mood will be monitored as indicators for medication adjustments	Sleep, Mood , hyperactivity, loud pressured speech	Aggression and sleep
#487	Bipolar Disorder	Noncompliance and sleep	None	Noncompliance and sleep
# 779	Cyclothymia	Sleep	Mood swings, hypomanic symptoms	sleep

The above shows that there is there was recognition in PBMC that behavioral data was needed and some details were spelled out. Nonetheless, the above table also showed that much work remained, as follows:

- Not all individuals in the PBMC had a PBMC table that identified what clinic participants

		thought was needed for medication tracking. For example the medication table for individual #487 was blank. • There were significant differences between what has been identified in the PBMC clinic as needed for medication monitoring, and what was reported in the PBSP. In the table, this was most evident for Individual #779. • The tables that described medication tracking in the PBSP and tables that described the same information in the PBMC clinic used different templates. It is not clear why. • The information identified in the PBMC table and the information identified in the PBSP table was not the same. Over time, the differences should be resolved. Overall, it appeared that the Facility had yet to develop a system for reporting psychiatric data. The table made clear that data presented at PBMC was still largely data on the challenging behaviors that were already in place based on the needs for tracking challenging behaviors. In informal discussions with the Monitoring Team the Facility suggested that observable behavioral characteristics of psychiatric disorders will be defined for each individual in the same manner that this is done for existing behavioral targets, and data will be reported accordingly. This process was still in its infancy. <u>Appropriate Use of Medication</u> As mentioned for Provision J2, the Monitoring Team assessed various aspects of the clinical process, by observation of the psychiatrists' day-to-day work in the various settings and meetings where individuals were seen and their care discussed. The primary place where these took place was the psychiatric clinic and the PBMC reviews. The process was observed by the Monitoring Team during the PBMCs that took place on 11-13 and 11-15. The time scheduled to review each individual was 30 minutes, and in many cases the reviews lasted 45 minutes or longer. As discussed under Provision J2, the clinical process during PBMCs was good. Behavior analysts presented behavioral information for the preceding period. Nurses presented information about each individual's physical well being and reported on any side effects noted; MOSES and DISCUS reviews were presented, discussed and signed by the psychiatrist. When applicable, QDRRs were reviewed. The clinical pharmacist provided excellent guidance about laboratory monitoring, drug-drug interactions, and related pharmacological information that was relevant to the care of the individual, and good clinical discussion followed. <u>Medications used for staff convenience</u> The Monitoring Team addressed whether medication was used for staff convenience by examination of the records, and by observations made during PMRs and other activities during the visit, and by interviews with staff. There was no evidence that medications were used for staff convenience. <u>Medications used for punishment</u> To determine whether this was ever done, the Monitoring Team considered observations made during the tour, and reviewed the records of the 18 individuals in Sample J1. There was no evidence	

		that medications were used for punishment. Chemical Restraint There were two uses of chemical restraints during the review period. The first episode was for Individual #600 on 7/24/12. During the episode the psychiatrist worked closely with the treatment team during and after the period of restraint. Although the psychiatrist had just started working at the Facility, he went beyond attending to the immediate circumstances around the use of a chemical restraint and its safety. In addition, he also gathered the clinical team on the same day to explore what could be done to modify the individual's treatment prospectively, to minimize the possibility of recurrence. Changes in the psychiatric treatment were made, and as described in the Monitoring Team's report for Section C, there has since been a gradual reduction in the need for restraints. Overall the intervention by the psychiatrist represented good psychiatric practice. The post chemical restraint review form for the episode that took place on 7/24/12 was requested but not received, and it is possible that it was not done. The review form is needed for each episode of restraint. It is possible that it was not done on that date since the psychiatrist had just started work at the Facility and may not have been familiar with the requirement. There is no question that a substantive review did take place. The second episode of chemical restraint took place for Individual #137 on 10/05/12. The appropriate clinical protocols were followed, and the psychiatrist completed the required post chemical restraint review, along with the clinical pharmacist. Monitoring Team's Compliance Rating There has been limited improvement in the way that information about medication was presented in the PBSP. For example, in all cases there is now information about the psychiatric diagnosis of the individual and there is information on possible side effects of the medications. In many cases, however, PBSPs did not specify the psychiatric symptoms or behavioral characteristics that were the focus of medication treatment. As a result, the treatment team could not be informed about changes in behavior that could have been the result of medication treatments. Absent such information, the Monitoring Team could not state that medications were used properly, as part of an overall treatment program. Although progress was limited, it was clear to the Monitoring Team that the Facility was committed to making the fundamental changes needed to support appropriate use of medication. Teams were busy in the PBMC sorting out whether individuals had symptoms that warranted medication treatment, and there were active discussions between psychiatrists and psychologists about the kinds of behavioral data that were needed to support psychiatrists' efforts to provide medication management when it was needed. The Monitoring Team's rating of noncompliance reflects the existing situation, but the Monitoring Team was encouraged by the overall direction of efforts to introduce data-based support for medication management.	

J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	<u>Rates of use of pre-treatment sedation</u> The dental clinic provided data that showed that between April and October the Facility dental clinic had an average of 144 completed appointments per month. Per the Facility's report, anesthesia was used for an average of 10.6% of all completed appointments, and oral pre-treatment sedation was given for 13.4% of completed appointments. Data was not provided by the Facility about the rates of use of pre-treatment sedation for medical appointments. <u>Monitoring for safety during medical restraint</u> There were two protocols for nurse monitoring for safety. When oral pretreatment was used for medical or dental appointments, a nursing protocol for pretreatment and post sedation monitoring was used. The protocol called for vital sign assessment at baseline (prior to the administration of the medication). After that, vital signs were obtained every 30 minutes until the procedure started. After the procedure monitoring continued every 30 minutes for one hour, then every two hours for four hours, then every four hours for twenty four hours. Following TIVA anesthesia, the post anesthesia recovery protocol was used. The protocol was vital signs during recovery every 15 minutes for an hour, then every 30 minutes until an adequate level of arousal was assessed via a REACT sedation of at least 8. Vital signs were then assessed every two hours for a total of four hours, then every shift for 72 hours. To assess monitoring for safety, the Monitoring Team selected 10 examples of medical restraints. These included oral pre-treatment sedation for medical procedures (three examples), oral pre-treatment sedation for dental procedures (four examples), and TIVA sedation for dental care (three examples). Results were as follows: • Oral pre-treatment sedation for dental procedures: Medical orders were provided for the day of the procedure. REACT scores were provided followed by Integrated Progress Note (IPN) documentation of vital sign monitoring for the required duration of time. • Oral pre-treatment sedation for medical procedures: Medical orders were provided for the day of the procedure. Vital sign documentation for safety was provided (although in one of the three cases, the medical restraint form was not used). In each of the three cases there was significant deviation from the acute care protocol. In two cases there was significant deviation from the required frequency for monitoring. In one case there was a twelve hour hiatus in monitoring, in a second vital signs that should have been done with a hiatus of two hours were done after four hours. In the third case documentation of vital sign monitoring was provided for 13 hours although the protocol required 25 hours. • 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 each case. Overall, the introduction of the new Medical/Dental Restraint Checklist appears to have simplified the recording of vital signs at the intervals specified by the nursing protocols. In at least one case,	Noncompliance

		however (Individual #318) the form appears to have been used incorrectly: The form indicated that vital signs were needed at time points of two hours and then four hours after the procedure. Instead, the nurse doing the monitoring took the vitals at intervals of two hours and then four hours later, and the resulting time point were two hours and then six hours after the procedure. Further training on the use of the new checklist may be needed. <u>Status of Development of Plans to Minimize the Need for Pre-Treatment Sedation:</u> The Facility reported that there were plans to minimize the need for pre-treatment sedation for 10 of 61 (16%) of individuals who received oral pre-treatment, for 47 of 80 (58%) of individuals who received dental pre-treatment sedation, and 87 of 110 (79%) individuals who received TIVA. Plans to minimize the use of pre-treatment sedation were provided for two of ten (20%) individuals in Sample J4. These two plans were reviewed by the Monitoring Team. • For Individuals #318 and #120, the purpose of the plan was to increase the individual's ability to participate in periodic medical procedures. This was done by a graduated approach. Data sheets were provided for each individual, verifying participation in three sessions of training. <u>Monitoring Team's Compliance Rating</u> There has been some progress regarding the monitoring for safety during medical restraints, as the new Medical/Dental Restraint Checklist has consolidated vital sign monitoring into one place. Many individuals still lack needed plans to reduce the need for pre-treatment sedation. Improvements in both areas are needed for the Facility to come into compliance with the requirements of the provision.	
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.	<u>Psychiatric Staffing</u> The Facility employed two psychiatrists, Drs. Joe and Pharies. The two psychiatrists provided a combined level of effort of 80 hours per week or 2.0 FTEs. Ongoing psychiatric support via PBMC appointments was provided by psychiatrists to 154 of 347 (44%) of individuals who lived at the Facility. The psychiatrists were assisted in the work by three individuals. Damola Olatoregum gathered information for writing psychiatric evaluations, prepared paperwork for clinics (past clinic notes, medication profiles, problem lists, and symptom checklists); assembled QDRRs and MOSES/DISCUS for review during the clinic. He tracked changes decided upon during the clinic and entered the data into Department of Psychiatry databases, he maintained Department of Psychiatry spreadsheets for diagnoses, and he attended the polypharmacy and morning medical meetings. Mr. Olatoregum also served as the Interim Lead Psychiatrist after the departure of the previous lead psychiatrist. Mr. Olatoregum was conscientious and thorough in his work. He was well organized and he supported the PBMC clinic with timely provision of needed materials. He is an excellent team member, and the Facility is fortunate to have his services. Denese Daniels was responsible for scheduling psychiatric	Noncompliance

		consultations. Rajesh Thakur was responsible for transcribing the psychiatric summaries and other dictations, compiling reports submitted by behavior analysts, nurse case managers, QDDPs and social workers, and he maintained automated forms with an individual's demographics for daily use by the psychiatry department <u>Determination of Required FTEs</u> To assess compliance with this provision it was necessary to establish how much psychiatric time was needed to complete the tasks required by the various sections of the SA. During a previous visit the Monitoring Team requested that the Facility provide an estimate for the number of hours needed to provide adequate staffing that would enable psychiatrists to provide services to support the psychiatry clinic and other clinical responses needed across the campus, provide admission evaluations and quarterly/annual assessments, attend to administrative issues, and participate in meetings where the psychiatrists' participation was required. The Facility's estimates were not received during this visit, and the need for the information was reviewed with the Lead Psychiatrist. Some guidance on how much psychiatric time was needed could be obtained by comparing the number of individuals at RSSLC who received ongoing support from each FTE psychiatrist and to compare that number with staffing levels at other DADS facilities. At RSSLC psychiatrists now provided ongoing services to 77 individuals for each FTE psychiatrist. That was higher than some other DADS facilities. <u>Team's Compliance Rating</u> At this point the Monitoring Team could not state that the Facility had a sufficient number of FTE psychiatrists to ensure the provision of required services, and the provision remained in noncompliance.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	<u>Appendix B Evaluations</u> The Monitoring Team reviewed Appendix B evaluations for the 18 individuals who were part of Sample J1. The Appendix B evaluations reviewed were informative and detailed. The length of the evaluations ranged from six to eleven single typed pages. The presentations were detailed, and useful information about treatment over the years was included. Among other things, the compilation of information about what treatments have been tried and which treatments were and were not effective would help guide future interventions. There were a number of improvements in the ways CPEs were completed. These were: • <u>Consistent use of the Appendix B format</u>: First, the Facility appeared to have been responsive to the feedback from the Monitoring Team during the May 2012 compliance visit. In the report for that visit, the Monitoring Team noted in some cases CPEs unnecessarily deviated from the guidelines of the Appendix B format. In response, the Facility noted in the 10/30/12 self-assessment for Provision J6 that charts were now being updated and converted into the required Appendix B format. Evidence for this was noted in the psychiatric evaluations that were reviewed. During the previous visit the Monitoring Team noted that in bio-psycho-social case formulations (Sections XIII of the Appendix B	Noncompliance

		CPE) were replaced in a number of cases. In contrast, in all 18 cases reviewed during the current visit, case formulations followed the required format. • Reductions in NOS diagnoses: Facility psychiatrists worked to minimize the use of not-otherwise-specified (NOS) diagnoses. The guidelines for appendix B are that all NOS diagnoses should be resolved in a timely manner. In past reports the Monitoring Team clarified that NOS diagnoses should be used only when there is no other viable clinical diagnosis available. The Monitoring Team also clarified that it did not expect pervasive developmental disorder NOS to be resolved when the criteria for that disorder were met and when the criteria for autism were not. This was because in that situation there may be no other available diagnoses. In the current review of 18 evaluations, the Monitoring Team noted only one use of an NOS diagnosis. Elsewhere in this report, (e.g. discussion for Provision J3) however, the Monitoring Team cited examples of individuals who had NOS diagnoses or no diagnosis at all (despite receiving psychiatric medication). The Appendix B guidelines called for resolution of NOS diagnoses within six months. • The initiation of annual updates to CPEs: An additional area of improvement was the initiation of annual CPE updates, for individuals supported in the PBMC. As outlined in more detail under Provision J2, such updates would provide a place to track important clinical developments from year to year, in order to build the best ongoing understanding of the individual and the supports from which he/she benefits. These updates were just started, and they have now been provided for none of 154 (6%) individuals supported in the PBMC. Although there were improvements, further work was needed in the area of diagnostic justification. As outlined in the discussion for Provision J2, there was a need to provide good diagnostic justification for the diagnoses that were offered, and whenever possible to support the diagnoses with details of observable behavioral characteristics of the diagnosed disorders. The latter was important, not only since it provided support for the diagnoses that were made, but also since it helped provide possible "targets" for new and ongoing treatments. To provide guidance regarding the expectations of the Monitoring Team for diagnostic justification, examples were provided below from CPEs of individuals in Sample J1. Examples were provided for both good diagnostic practices and for instances where more was needed. • For Individual #19, there was a good case formulation. However the Monitoring Team questions the use of the diagnosis of intermittent explosive disorder in the presence of severe mental retardation. Per the guidance of the Diagnostic Manual for Intellectual Disabilities (DMID), it is very difficult to make the diagnosis of intermittent explosive disorder with that level of ID. Also, the CPE reported that "behavioral staff reports some evidence of psychosis where (the individual) was seen speaking to people who were not there." The diagnosis of psychosis in a person with severe ID is also difficult, but the evidence cited by the psychiatrist should be explored. It was helpful that the psychiatrist noted the symptoms of aggression, noncompliance, property destruction and intermittent self injury by head banging, but these were very non specific symptoms in regard to the	

		psychiatric diagnosis. The Monitoring Team noted the concurrent diagnosis of pervasive developmental disorder. It might be helpful to flush out more details of that disorder, and it was possible that it was the only diagnosis needed. If so, exploration of the functional analysis of the symptoms that overlap between psychiatry and psychology might help better guide medication targets. • For Individual #584, the diagnostic justification for schizophrenia was not provided. • For Individual #513, the psychiatrist reported symptoms of depression including reports of tearfulness and weight gain. There were also reports of auditory and visual hallucinations in the past. It would be helpful for the psychiatrist to review the evidence for hallucinations and to comment on whether they are credible. There needed to be comments about why schizoaffective disorder was favored over other forms of affective illness. • For Individual #316, the CPE provided symptoms to support the diagnosis of OCD per guidance of the Diagnostic Manual for Intellectual Disabilities (DMID). This was an example of good diagnostic practice. • For Individual #555, the diagnostic impression section of the 10/23/12 CPE provided a detailed justification for the diagnosis of Bipolar Disorder, and provided a nuanced appreciation of the data upon which the diagnosis was made. As such, it provided what was required by the provision. It would nonetheless be helpful to spell out the details of the "disturbed functioning that is observable by others," so as to establish the preferred behavioral characteristics for medication treatment monitoring. • For Individual #723 the justification for the diagnosis of Obsessive Compulsive Disorder (OCD) focused on the use of the diagnosis due to the individual's inability to self-report obsessions. The DMID offered guidance on this matter and offered diagnostic adaptatations for individuals with ID. The diagnostic justification should have included a discussion of why the symptoms that were the basis for OCD could not be subsumed by the concurrent diagnosis of autism. It was not clear why both diagnoses were needed. • For Individual # 151, the diagnosis of psychosis NOS should be used only if there was no other clinically viable diagnosis – see guidelines of the Appendix B format. <u>Appendix B evaluations Use Across the Campus</u> CPEs were needed, not only for individuals followed in the PBMC but also for psychiatric evaluations done elsewhere in the Facility. During the May 2012 visit, the Facility and the Monitoring Team identified 22 individuals who needed CPEs on the basis of Reiss Screen results. Sixteen of those had yet to be completed. CPEs were also done as part of change of status evaluations for individuals who lived at the Facility, who were not supported by the PBMC, and who developed new psychiatric symptoms. There were two such evaluations during the review period. They were reviewed under Provision J7 and they were done well. <u>Monitoring Team's Compliance Rating</u> As outlined above, progress was made. Continued efforts were needed to bring Provision J6 into full compliance, particularly in the area of diagnostic justification.	

J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Reiss Screens for Individuals who Lived at the Facility</u> 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. At the last compliance visit 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. At the time of the last compliance tour there were twenty-two individuals who had Reiss screen scores that reached or exceeded the designated cutoffs, but had not yet received psychiatric evaluations. During the current visit the Facility provided psychiatric evaluations for Individuals #235, #322, #378, #526, #559, and #770. Psychiatric evaluations were not yet available for Individuals #52, #95, #109, #112, #124, #199, #266, #412, #462, #615, #634, #748, #772, #780, #794, and #797. <u>Reiss Screens for Recent Admissions</u> The Monitoring Team reviewed Reiss Screen information for the four individuals admitted since May 2012. Reiss screens were done and did not reach the clinical cutoff for Individuals #787 and #576. Reiss screens were not done for two recent admissions, Individuals #352 and #588, who were undergoing psychiatric evaluations at the time of the visit. <u>Change of Status Evaluations</u> There were two referrals of individuals who lived at the Facility for psychiatric consultations during the review period. They were for Individuals #604 and #649. The consultations were done using the Appendix B format. In each case the consultation responded to the consultation question. <u>The Role of Reiss Screen for Ongoing Screening for Psychopathology and for Clinical Change of Status Evaluations</u> 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 not yet made a final decision on a policy on this matter. <u>Monitoring Team's Compliance Rating</u> The Facility had not yet achieved compliance since psychiatric evaluations had not been completed for individuals whose screens exceeded the designated cut-offs, and there was yet no agreed upon policy for change of status evaluations. Once the latter was decided, the Monitoring Team would also need to review the policy and if found adequate, proper implementation would need to be verified.	Noncompliance
J8	Commencing within six months of the Effective Date hereof and with full implementation within	<u>Venues for Integrated Behavioral Care</u> RSSLC Psychiatry Policy 1.00d (revised 08/30/2011) made clear how integrated behavioral care must be provided, by stating that "*RSSLC must develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined case analysis*	Noncompliance

	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.	*and case formulation."* The Facility made clear that it has a commitment to integrated care, and that was evident for several activities that involve psychiatry. Examples were the integrated clinical meetings that took place on Wednesdays, the integrated care sessions in the neurology clinic (planned but not yet in place) and the expanded use of the PBMC. The latter was a setting that was evolving. For many years it was a clinic that was managed by a consultant, often on weekends. The use of the PBMC as an activity that was staffed in part by a full time psychiatrist and integrated into the overall care system had been in place for less than two years. The deployment of PBMCs as the main venue for routine psychiatric care throughout the campus by full-time psychiatrists was entirely new. The Facility self- assessment for Provision J8 emphasized that the system for integrating pharmacological with behavioral and other interventions though combined assessment and case formulation would be anchored by the PBMC. During the visit the Monitoring Team saw the beginnings of that process during the two PBMCs attended by the Monitoring Team on 11/3 and 11/15. The meetings were attended by the psychiatrists, psychologists, nurse case managers and others. Psychiatrists were attentive to issues of diagnosis and enquired about symptoms that were the basis for existing diagnoses. Psychologists explained PBSPs, and DSPs provided critical examples from day-to-day living. Discussions were good, but it was simply too early in the process to tell whether the PBMCs have been transformed from medication management clinics to a place where meaningful integrated care was developed. <u>SFA Section on Differentiation of Behavior</u> One of the ways to understand the contribution of psychiatry and psychology was to examine what each discipline focuses on in its treatments. To the extent that behavioral psychology focuses on learned behavior and psychiatry focuses on psychopathology, one would expect somewhat different focuses for treatment. For that reason, one of the assessments made by the Monitoring Team had been whether the behaviors that were designated as "targets" of psychotropic medication were also described in the psychologist's functional analysis. When that was the case, there was concern that psychotropic medications could be used for behavior control, not to treat psychopathology. In past reports, the Monitoring Team had indicated for many individuals at the Facility, there was such overlap. To help further better integrated behavioral care, the Facility had now put in place a new format for the functional assessment that included a section called "Differentiation of Behavior." In that section the writer was prompted that "if a behavior is targeted for reduction in the PBSP and has been identified as a psychiatric indicator, tell the reader why this behavior is being addressed through behavior intervention and psychotropic medication. Indicate how the behavior is a demonstration of the psychiatric illness and identify why it may also be reinforced/maintained by environmental variables. " Two examples of the new format were provided by the Facility:	

		• Individual #576 was diagnosed with bipolar disorder with psychotic features that included hallucinations. The SFA identified that "hallucinations are being tracked as a psychiatric indicator; however, environmental factors (e.g. social positive reinforcement) cannot be ruled out as self-reports of hallucinations are likely to produce attention from direct care staff and professional staff." This example was a very helpful description of how psychiatric symptoms can become part of learned behaviors. • Individual #302 was diagnosed with Impulse Control Disorder NOS (a problematic diagnosis, per discussion for Provision J2 and J6). The Differentiation of Behavior section of the SFA stated "Both self injury and aggression are targeted for reduction in (the Individual's) current PBSP and with the use of psychotropic medications. Both target behaviors were identified as psychiatric indicators of impulse control disorder NOS. In addition, both injury and aggression appear to be reinforced by environmental variables." This example was problematic since the efforts to tease contributions of psychiatry and psychology were not particularly successful, as acknowledged by the Chief Psychologist when this example was discussed during the site visit. Elsewhere in the SFA however, there was a well-constructed graph that showed after a March 2012 increase in the individual's dose of Klonopin, there was a decrease in the aggression and self injury that persisted. Since Klonopin is an anxiolytic and it decreases arousal, it is possible that anxiety/arousal may have contributed to the individual's "impulse control." The individual was also diagnosed with autism, and the symptoms in question could be related to that diagnosis in many ways. <u>Monitoring Team's Compliance Rating</u> The new section on "Differentiation of Function" was an excellent addition to the SFA. It could not alone provide all the answers but it was evidence the Facility was moving in the right direction for quality integrated behavioral care.	
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	The Monitoring Team reviewed PBSPs and related record material, for evidence of each of the three components of the provision. <u>Psychiatrist Participation in Determinations of the Least Intrusive and Most Positive Interventions.</u> As outlined in the Facility self- assessment, there was increased emphasis on utilization of the PBMC clinic as a setting where integrative care took place. The intention was to use the PBMC to integrate pharmacological treatments with behavioral and other interventions. The Facility now encouraged "all clinical teams" to attend the PBMC and to verify that attendance with sign-in sheets. The Monitoring Team explored how this took place by attending two full mornings of PBMC clinic, one for each of the two Facility psychiatrists. The Monitoring Team observed the meetings, and later reviewed notes from previous clinic appointments for the same individuals. The following items were noted: • For Individual #17 there was a focus on his seemingly dependent personality characteristics, his interactions with the behavior analyst, and there was a discussion on the form of therapy that would be most appropriate for his needs.	Noncompliance

	psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	• For Individual #101 there was a focus on his sexuality, and his ability to tolerate change. • For Individual #137 there was a focus on his social challenges and his inability to maintain stable relationships. The role of the PBSP in addressing these issues was reviewed. • For Individual #239 there was focus on his confrontations with DSPs and the best way to provide support. • For Individual #322 there was a focus on daytime somnolence and (perhaps related) work refusals. • For Individual #487 there was a discussion about the irritation that may have been caused by a move to a new location, and resulting tensions with his roommate. • For Individual #493 there was a focus on his daytime structure and sleepiness. • For Individual #779 there was a focus on his weight loss and the exercise program – details were reviewed about the number of pushups and sit-ups performed, and the fact that at the time of the visit he tried to run every day. The Monitoring Team also learned from Chief Psychologist that the Facility introduced a new format for the SFA. The assessment contained a section on restrictive practices. The section required a listing of all attempts to use less restrictive interventions. When more restrictive practices were in place, a plan was required to alleviate the restrictions to the degree possible. <u>IDT determination About Whether Individuals are Best Served Through Behavioral, Pharmacology, or Other Interventions</u> In previous reports the Monitoring Team commented on the need to differentiate as much as possible between behaviors that reflected psychiatric diagnoses and behaviors that had a purely behavioral etiology. The Facility continued to have many individuals for whom aggression and self injury were the focus of both psychiatric and behavioral treatments. When that was the case it was often difficult to understand the roles of the different treatments, and it could become impossible to make the determinations required by this provision. During the visit, the Monitoring Team participated with the Facility in exploration of two possible ways to make better determinations about individual needs: 1. As described for Provision J8 above, the Monitoring Team met with the Chief Psychologist, and learned that the new SFA document will have an entry called "Differentiation of Behavior" in which the writer was prompted that "if a behavior is targeted for reduction in the PBSP and has been identified as a psychiatric indicator, tell the reader why this behavior is being addressed through behavior intervention and psychotropic medication. Indicate how the behavior is a demonstration of the psychiatric illness and identify why it may also be reinforced/maintained by environmental variables." Increased clarity about overlapping of behavioral targets and psychiatric symptoms would provide a tool to allow the IDT to best determine which treatments were most likely to be helpful. 2. The language of the provision directs the IDT and psychiatrist to individualize care, so that for any particular problem, individuals were referred to the appropriate modality of	

		treatment or treatments. During the visit the Monitoring Team asked the Facility how this would take place, and where the deliberations were documented. Although determinations were needed for ongoing as well as new treatments, the need was most evident when new interventions were proposed. The Monitoring Team was told that for new treatments the venue for discussion would be the PBMC and/or specially called IDT meetings. Eventual psychiatric documentation could be included in the annual CPE update. <u>ISP Specification of Non-Pharmacological Treatments to Minimize the Need for Medication</u> ISPs for individuals who took psychotropic medications stated that there was a PBSP in place with behavioral interventions. Most ISPs did not discuss how the interventions were chosen or why. For three of eighteen individuals (16%) in Sample J1 the Facility provided HRC reviews for new medication that addressed what had been done to minimize the need for medication. For example, the HRC review of added medication for Individual #19 stated "Less intrusive approaches previously attempted: (The individual) is on a positive behavior support plan which is targeting self injurious, verbal aggression, aggression to others, property destruction, non-compliance/refusal and psychosis." <u>Monitoring Team's Compliance Rating</u> The Facility was completing a transition of care from a consultant based model to one in which psychiatrists were full members of the IDT. The role of the psychiatrist was no longer limited to pharmacological care and included a role in determining behavioral healthcare support more broadly. That part of the integrated care process was still in its early stages. While progress was made, the Monitoring Team could not state that psychiatrists were properly involved in IDT deliberations about the overall behavioral treatment program.	
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	<u>Facility Policy</u> RSSLC Psychiatry Policy 1.00d, (revised 08/30/2011) provided guidance on discussions of risk and benefit for psychotropic medications: "*The psychiatrist must solicit input from and discuss with the IDT any proposed treatment with psychotropic medication."* The policy then repeated the language of the SA provision regarding risks, benefits, and alternative treatment strategies. The Monitoring Team reviewed with the Lead Psychiatrist how the 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, risks and benefits were considered. Specific requirements of the provision that were reviewed were: <u>Risk Benefit Analyses</u> Informed consent forms contained information about common and most serious side effects of the proposed medications, and the consent forms included the following statement:	Noncompliance

	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.	*<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 was 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 between the psychiatrist and PCP about the medication being proposed. This was needed. <u>Alternative Treatments</u> IDT discussion of whether reasonable alternative treatments (including no medication) were less likely to be effective or potentially more dangerous than the medications: Some consent forms had a section titled "Other possible choices of (type of medication)" that listed alternative medicines. For example: • Individual #555 (for Trazodone): "Other possible choices of sedative include but not limited to mood stabilizer or other new generation sedative if the above strategy fails to help patient (sic) achieve stability." • Individual #596 (melatonin) " Other possible choices of sedative include but not limited to mood stabilizer or other new generation sedative if the above strategy fails to help patient (sic) achieve stability." Other consent forms, for example for Individual #404 (for Trazodone), however, did not list alternative medications: Even when such a statement on alternative medications was included, the consent 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. <u>Monitoring Team's Compliance Rating</u> The Facility had not yet addressed adequately the requirements regarding risk benefit analyses and treatment alternatives and the provision remained in non compliance.	
J11	Commencing within six	<u>Facility Designation of Levels of Polypharmacy Review</u>	Substantial

	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 classified the polypharmacy reviews as four tiers of review. These were: Level 1: A clinical pharmacist attended all relevant IDT processes. Level2: QDDR consultation held on a quarterly basis. Level 3: The clinical pharmacists participated in all psychiatry and neurology clinics. Level 4: Three Polypharmacy/Medication Review panels held so far in 2012. <u>Pharmacy Activity in clinical meetings:</u> The pharmacy participated in each psychiatry and neurology clinic, as reported 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. <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 11/13/12 and 11/15/12. 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. <u>Tracking of Polypharmacy</u> The pharmacy provided a breakdown of polypharmacy information across the campus. The Facility reported that in November, 2012, 80 of 154 (52%) of the individuals treated with psychotropic medications had polypharmacy. This compared to a total of 90 of 155 individuals (58%) in April 2012. This continued a pattern of overall declines in rates of polypharmacy. The Facility tracking of polypharmacy included somatic medications, and individuals who took psychotropic medications were included in two groups – psychiatric polypharmacy (psychiatric medications only) and mixed index polypharmacy (psychiatric and somatic medications). The latter group included some individuals for whom the determination of polypharmacy might not have been made, had the somatic medications not been included. For November, 2012 there were 52 individuals in the psychiatric polypharmacy group and 28 in mixed index group. In April, 2012 there were 48 individuals in the psychiatric polypharmacy group and 42 individuals in the mixed index group. During the visit, the Monitoring Team had a very helpful meeting with the Facility during which pharmacy tracking for rates of psychiatric polypharmacy was reviewed. The meeting was required since manual tabulations about rates of polypharmacy by the Monitoring Team and data reported by the pharmacy differed. It emerged that a main reason for this was that pharmacy classifications of polypharmacy included distinctions of interclass and interclass polypharmacy. The SA, however, addressed categories of two or more medications from the class (intraclass) and a total of three or more medications (which were either intraclass or interclass).	Compliance

		The Monitoring Team noted that the document request submitted prior to the visit asked for an alphabetical listing of individuals and related information, including the psychotropic medications prescribed. Information on individuals' medications was not received. Instead, the Facility sent a listing of all medications given to all individuals in the Facility, organized by housing unit. Since the Department of Psychiatry had spreadsheets with key clinical information about each individual, it would be helpful for information on prescribed medications to be added to those spreadsheets. That way, data could be derived in varying formats, including groupings of information that were spelled out in the SA. <u>Facility Level Reviews of Polypharmacy</u> The SA required that there should be Facility- level reviews at least monthly for individuals who receive prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) or prescriptions of three or more psychotropic medications, regardless of class. The level 4 reviews described above are Facility level reviews, but not levels 1-3. On 09/14/12 the Facility conducted a review of seven individuals with intra-class polypharmacy, but such reviews were not done during other months. The need for monthly Facility levels reviews was discussed with the Facility. It was understandably not possible to conduct meaningful reviews, when psychiatry staffing was absent. During the compliance visit there were a number of discussions regarding how to best do the Facility level reviews. The decisions, of course remained with the Facility and there were many options. For example, during the P&TC committee meeting that took place during the visit the pharmacy presented information on changing views about rational polypharmacy. Whether polypharmacy was indeed rational depended of course on the diagnosis, the medication class and the clinical particulars. One option was to periodically review Facility polypharmacy practices by medication type (mood stabilizers, antipsychotics and so forth). Another possibility that was suggested by the Facility during the previous visit was to examine/report how polypharmacy and medication reduction practices were done for individuals newly admitted, since the circumstances for such individuals differed from individuals who had lived at the Facility for a long time. In previous visits the pharmacy had also suggested identifying individuals who had undergone successful reductions in medications deemed unnecessary or unhelpful. <u>Monitoring Team's Compliance Rating</u> The Facility had achieved a rating of substantial compliance and it will be continued. The Monitoring Team understands that monthly Facility level reviews of polypharmacy did not take place when psychiatric staffing was absent, but such reviews must be in place for the next visit, in order for the rating to be continued.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as	<u>Completion of MOSES and DISCUS</u> In response to a request from the Monitoring Team for a spreadsheet with results of DISCUS and MOSES evaluations done since the last review, the Facility provided information on the most recent administration of the side effect screens and the results of that screen. Information was limited to the individuals seen in the psychiatric clinic and did not include, for example, DISCUS screenings for individuals who took Reglan who were not seen in the psychiatric clinic. Since DISCUS screens were	Noncompliance

	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.	required at least quarterly and MOSES screens were due at least every six months the information that was provided allowed the Monitoring Team to verify that individuals in the psychiatric clinic had received at least one MOSES and two DISCUS examinations within the required time frame. Since the spreadsheet indicated that the information was updated on 10/11/12, the data were reviewed to confirm that all individuals had received at least one DISCUS examination in July 2012 or later and one MOSES examination in March 2012 or later. DISCUS examinations were done within that timeframe for 131 of 145 (91%) of the individuals. MOSES examinations were done within the required time frame for 98 of 145 individuals (67%). The Monitoring Team did not review DISCUS data for individuals taking Reglan during the current review and will do so at the next visit. The Monitoring Team also reviewed a total of 41 DISCUS and 40 MOSES screenings done over the past six months for the 18 individuals in Sample J1. Moses evaluations were required at least every six months, and DISCUS evaluations were required (for individuals who took medications that can cause dyskinesia) at least every three months. For the individuals in Sample J1 at least one MOSES screen was done in within the past six months for 16 of 18 (88%) of the individuals, and at least one DISCUS screen was done with the past three months for 17 of 18 (94%) of the individuals. Seventy-eightof 81 (96%) of the reviews were signed by the prescriber. However, for 18 of 40 (45%) of the MOSES screens the prescriber review section was not fully completed, and for 15 of 41(36%) of the DISCUS screens the evaluation section was not fully completed. QDRR reviews noted MOSES and DISCUS ratings, and that was a good practice. <u>Side Effect Ratings Following Changes in Medication Dose</u> The Facility informed the Monitoring Team that side effect screenings were often done after a change in medication dose, per orders written by the physician. The Monitoring Team observed that orders for side effect screening were given during the PBMC clinic on 11/13/12. DADS Policy and Procedures 007.3 Psychiatry Services (draft) stated that MOSES and DISCUS will be completed within 10-14 days of a psychoactive medication dose change, as determined by the psychiatrist. In the records reviewed by the Monitoring Team there were few side effect screens that followed changes in dose, perhaps reflecting the psychiatric staffing shortage during the review period. At the next visit the Monitoring Team will again request a spreadsheet for side effects and will need information on all administrations, not only the most recent administration and the psychiatry department is encouraged to retain data on older examinations, as new data is received. It is of course possible that this is already being done, but it is not possible to know that from the printout received. <u>Training for Side Effect Rating Scales</u> Nurse Training for MOSES and DISCUS administration were reviewed with the Nurse Educator. The Monitoring Team was informed that training for nurses on the MOSES and DISCUS examinations was provided during the orientation for new nurses. Initial training took place as part of a week-long nursing orientation. There were two sessions that totaled four and a half hours. In the first session the nurses received didactic information on the screen and that was part of their orientation	

		to the support nurses provided to psychiatrists in the PBMC clinic and in follow-up to that clinic. The second part of the training consisted of videotapes for the DISCUS examination that was prepared by the author of the screens. It included examples of the various forms of side effects and it included opportunities for the trainees to view and rate samples. After doing the latter, the trainees received feedback on how expert raters had assessed the same footage. The nurse educator also informed the Monitoring Team that prior to her departure, the previous Lead Psychiatrist had provided training sessions to the nurses, which the nurses found very useful, and they hoped that such collaborations between nursing and psychiatry would continue. <u>Facility Monitoring for Dyskinesia</u> In response to a document request for APLs for each individual with tardive dyskinesia, the Facility reported that there was only one individual at the Facility diagnosed with tardive dyskinesia. Care for that Individual (#574) was reviewed. Following the diagnosis, the individual was referred for additional evaluation by a national expert on movement disorders who works in the Houston area, and treatment with tetrabenazine had been considered. Her care was an example of high quality care by the Facility. Based on both dyskinesia screenings reviewed by the Monitoring Team during the current and previous visits, there may be other individuals at the Facility, who had dyskinesia. For example in 2011, the Monitoring Team was told that Individual #199 had dyskinesia, and Individual #119 had been rated with probable dyskinesia. Individuals #25, #101 #144, and #465 have had DISCUS ratings of 5 or higher in screenings that did not indicate that the movements noted could be accounted for by other conditions. In a Facility in which there were over 150 individuals treated with psychotropic medications, and where some of those individuals had been treated for many years, it was probable that more than one person would have dyskinesia. The Monitoring Team recommended for the incoming psychiatrists to conduct a Facility- wide review for dyskinesia, to explore continued collaboration with the Nursing Department to explore ways to support the screening program and ensure good quality examination, and to review the use of psychotropic medication among individuals known to have (or suspected of having) dyskinesia. Depending on the results, there may be a need for ongoing Facility level reviews of medication used for these individuals. <u>Monitoring Team's Compliance Rating</u> Some progress had been made in regard to this provision, as there was now monitoring for APL listings of dyskinesia, and psychiatrists reviewed and signed the MOSES and DISCUS ratings. However, from the materials provided to the Monitoring Team, it was not clear that all individuals received the required screens and efforts needed to be made to assure that screenings were of the best possible quality and that any findings resulted in appropriate clinical interventions.	
J13	Commencing within six months of the Effective Date hereof and with full	<u>Medication Plan Elements Included in Consent Forms for New Medications</u> 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	Noncompliance

	implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	08/30/2011.) Although psychotropic medication plans were not in place, the medication consent forms used by the Facility included several of the key elements required by Provision J13. These included: • The name of the medication • The psychiatric diagnosis • Target symptoms and behaviors • Reason for starting the medication All 24 (100%) of the medication consent forms (Sample J2) contained these elements. Medication Plan Elements Not Included in Medication Consent Forms The medication consent forms did not fully address several other requirements. These were: • The expected timeline for the therapeutic effects of the medication to take effect: The medication consent forms did contain a statement about the expected duration of therapy, but that did not address the matter of the onset of therapy's effects. • The objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy. The medication consent forms did provide some target symptoms and behaviors, but more details were needed to fully spell the details of monitoring (see the discussion under Provision J3). Monitoring Team's Compliance Rating The SA did not specify how medication plans will be developed and different facilities have accommodated the requirements of the provision in different ways. During the visit the Monitoring Team had a valuable discussion with the Chief Psychologist on the issue of the need for clarity on the issue of how the objective psychiatric symptoms or behavioral characteristics will be established. The next step will be for the Facility psychology and psychiatry faculties and others to discuss and establish a clinically meaningful process to do so. At this point the provision remains in non-compliance.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal	Facility Policy 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. Renewed consent needed to be obtained on an annual basis. Review of Consent for New Medications Since the last period 24 new medication treatments were approved (Sample J2). For each of these	Noncompliance

	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.	treatments the Monitoring Team received information from the clinical record (e.g., progress notes, psychiatric treatment reviews, PSPAs) selected by the Facility to help the Monitoring Team understand the reasons/clinical rationales for choice of the medication. The Monitoring Team also reviewed informed consent forms for use of the Psychotropic Medication, and Human Rights Committee reviews of the psychotropic medication. Results were as follows: All 24 (100%) of the medications newly approved over the past six months used the newer form for consent presented to the Monitoring Team during the October, 2011 visit and modified during the following six months. That form contained the following sections: Diagnosis Medication Name Target Symptoms and Behaviors Reason for Starting (the medication) Expected Duration of Therapy Expected Benefits of Treatment Dosing Monitoring (for safety) Side effect and risk vs. risk Treatment alternatives present for 16 of 24 (66%) of consents There were problems with the use of a number of the sections of the form. • In the "Expected Benefits of Treatment" section all plans described the expected benefits as "*remission of symptoms elimination or reduction 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."* As mentioned in previous reports, the description of the expected benefits needed to address the specifics of the medication and its use. For example, this language was used to describe the proposed benefits of melatonin for individuals (Eaton). It would have been better to describe the expected benefits from a sleeping pill as "improved sleep." • There were problems with the "Side Effects/Risk vs. Risk" section. All plans contained the standard language. 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 from not taking the medication, and (2) the benefits of taking the medication. Here too, the language needed to be tailored to the individual and to compare the risk of taking the medication with the risk of not taking the medication and the benefit expected. • All 16 of 24 plans (66%) that discussed treatment alternatives addressed only medication alternatives. As discussed by the Monitoring Team in previous visits, when appropriate,	

		non- medication alternatives should be considered too. Annual Renewal of Ongoing Medications The Monitoring Team reviewed the annual renewal of medication for the 18 individuals in Sample J1. Two individuals in the Sample had been admitted within the past year and annual renewals were not yet due. For the remainder, 11 of 16 (68%) used the previous forms for informed consent. The reasons those forms were not adequate were reviewed in prior reports of the Monitoring Team. Monitoring Team's Compliance Rating Gradual progress continued but as illustrated above, improvements were needed in various sections of the current informed consent form that was used for new medications. The Facility's current form for informed consent should be used for annual renewal of consent for medication use, but in many cases it was not. As a result of these difficulties, the provision remained in noncompliance.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Facility Policy 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 IDT process, when medications are prescribed to treat both seizures and a mental health disorder.*" Steps Already Taken to Promote Neurology and Psychiatry Integration Prior to the departure of the previous Lead Psychiatrist from the Facility in the spring of 2012, good progress had been made toward neurology and psychiatry integration. Steps taken included • Establishment by the pharmacy of a tracking of anticonvulsant medications based on their use: The pharmacy continued to track whether each such medication was used only for (1) neurological indications (seizure or otherwise), (2) for psychiatric indications (typically as a mood stabilizer) or (3) as a dual-purpose medication used for both. • Clinical pharmacists attended the neurology clinic. • The Lead Psychiatrist attended neurology clinics for individuals treated who were supported by both neurology and psychiatry. • PCPs attended the neurology clinic with individuals on their caseload. • The development of an Integrated Neurology Clinic Policy (4/17/12) that described the participation of psychiatry, pharmacy and medicine in the clinic, and that instructed the PCP to document integrated encounters in the IPN in the consultation form and medical follow-up database so that the IDT will have access to the assessment and plan of the evaluation from the integrated clinical services. Review of Individuals Supported by Psychiatry and Neurology The Facility provided neurology and psychiatry clinic notes for five individuals who were supported by both psychiatry and neurology: • For Individual #379, the neurologist commented on 7/24/12 on the discontinuation of	Noncompliance

		Depakote, an anticonvulsant that has mood stabilizing effects. The psychiatrist's PBMC note from 09/11/12 mentioned the Individual's participation in the neurology clinic and made no mention of difficulty related to the discontinuation of Depakote. • For Individual #426, the neurologist reported on the continuation of treatment with lamotrigine, an anticonvulsant that has antidepressant effects. A PBMC note from 08/02/12 acknowledged input from the neurology clinic. • For Individual #483 the neurologist reported on use of a vagal nerve stimulator, a device for the management of epilepsy that also has antidepressant effects. On 8/29/12 the neurologist suggested discontinuation of Tranxene, a benzodiazepine and anticonvulsant, "If it is ok with psych." This was an example of an effort toward coordinated care, due to the anxiolytic effects of the medication. • For Individual #574 the neurologist commented on the possibility of using tetrabenazine, to help manage the Individual's tardive dyskinesia. The PBMC note from 8/21/12 also discussed that issue. • For Individual #346 the neurologist commented on the use of Depakote for both behavioral and neurological indications. Overall, the Facility had made good efforts to continue to coordinate neurological and psychiatric care during a period where psychiatry staff was on an interim basis. Per the self-assessment, the Facility planned to resume participation by psychiatry in the neurology clinic. <u>Reviews of Neurological Issues during PBMC</u> The PBMCs attended by the Monitoring Team showed good attention to the co-management with neurology for dual purpose medications. For example, Individual # 101 was seen during the 11/13/12 PBMC. The IDT expressed concerns about possible plans for neurology to discontinue Depakote as unnecessary for seizure management, since the medication had been shown to be helpful for the Individual's mood. Subsequent review of the pharmacy list of anticonvulsant medications and their uses showed that the medication was on the list of dual purpose medications, used for both psychiatric and neurological indications. Nonetheless, there was a need for the Facility to review/correct the list of dual purpose anticonvulsants and to make sure that it was available to both psychiatrists and the consulting neurologist for reference. For example, the five individuals identified by the Medical Department as being treated with anticonvulsants for both neurological and psychiatric disorders were not included on the list of dual purpose medications provided by the pharmacy. Also, while the neurologist indicated that Individual #346 was treated with Depakote for both behavioral and psychiatric purposes, the psychiatrist listed the same medication in his PBMC note as an anticonvulsant. <u>Monitoring Team's Compliance Rating</u> The provision had been in non-compliance since psychiatry had not been able to participate in relevant neurology clinics. The rating of noncompliance must remain until this issue is addressed.	

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

1. The Facility needed to:
    a. Better utilize available auditing and monitoring tools
    b. Include all relevant activities in the Action Plan
    c. Provide more input from departments other than psychiatry for the section J self-assessment
    d. Better utilize the Facility QA process and the services of the QA Department
    e. Improve the use of the Facility Action Plan (Self-assessment)
2. Justifications for changes in diagnosis should be included in annual updates of the CPE. (Provisions J2 and J6)
3. Differences in diagnosis between various sections of the records should be resolved. (Provisions J2 and J6)
4. If chemical restraints are used, psychiatrists should complete the post chemical restraint review. (Provision J3)
5. The Department of Psychiatry spreadsheet that lists the diagnosis of each individual should also list the psychotropic medications prescribed for the individual. (Provisions J3 and J13)
6. The Department of Psychiatry should track whether anticonvulsant medications prescribed as psychotropics are also prescribed for neurological indications (dual purpose medications). (Provisions J3 and J15)
7. The behavioral characteristics that are the focus of medication treatment should be specified and there should be tracking of those characteristics to help determine medication efficacy. (Provisions J3 and J13)
8. The nursing department should review uses of the new Medical/Dental Restraint Checklist and determine if further training for nurses is needed. (Provision J4)
9. Plans to reduce the need for pre-treatment sedation need to be in place for individuals who receive such treatment. (Provision J4)
10. The Psychiatry Department should provide estimates of the number of psychiatric service hours that are needed to fulfill the requirements of the SA. (Provision J5)
11. CPEs should be completed for individuals who had Reiss Screens that exceeded clinical cutoff values. (Provision J7)
12. A Facility protocol that addresses the use of the Reiss Screen for possible change of status should be developed. (Provision J7)
13. Improved documentation is needed for psychiatrist participation in determinations about preferred modalities of behavioral care. (Provision J9)
14. Improved documentation is needed for psychiatrist participation in determinations about least intrusive and most positive clinical interventions. (Provision J9)
15. Improvements are needed in the way that psychiatrists are included in ISP specifications of non-pharmacological treatments to minimize the need for medication. (Provision J9)
16. Risk benefit analyses must be individualized. (Provision J10)
17. Discussion of treatment alternatives must be individualized. (Provision J10)
18. Monthly Facility level reviews of polypharmacy must be place. (Provision J11)
19. Psychiatrists should do a Facility level review for individuals with tardive dyskinesia and determine whether and how Facility level monitoring of dyskinesia should take place. (Provision J12)
20. The prescriber review section of MOSES screens and the evaluation section of the DISCUS screens should be fully completed. (Provision J12)
21. Psychiatrists and nurses should discuss possible psychiatrist participation in training of nurses for DISCUS screens. (Provision J12)
22. The Facility form for informed consent should be used both for new and annual renewal of consents for psychotropic medications. (Provision J14)
23. Psychiatrists should resume participation in selected neurology clinics. (Provision J15)

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

24. The Facility should consider the advantages of using the same format for medication tables, for both SFA/PBSP and PBMC presentations. (Provisions J3 and J13)

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 – 10/30/12 2. RSSLC Action Plans – 10/15/12 3. RSSLC Presentation Book for Section K 4. RSSLC Policy J.6: Psychological and Behavioral Services – 2/20/2012 5. Behavior Support Committee meeting minutes - 5/2/2012 – 8/13/2012 6. Behavior Service departmental meetings minutes – 6/8/2012 – 9/26/2012 7. 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, peer review documentation, and task analyses. All documents were reviewed in the context of the Self-Assessment and included the following Individuals: Peer Review: Individual #16, #17, #25, #27, #101, #151, #174, #179, #195, #210, #278, #287, #314, #320, #322, #328, #364, #404, #404, #470, #498, #502, #511, #526, #530, #552, #561, #600, #612, #626, #669, #758, #764, and #771 Data Monitoring: Individual #9, #25, #32, #51, #68, #165, #177, #287, #306, #314, #325, #346, #369, #391, #404, #448, #463, #530, #546, #558, #561, #584, #600, #613, #641, #718, #746, and #748 Psychologicals: Individual #19, #81, #82, #165, #239, #306, #600, #680, and #799 PBSPs and SFAs: Individual #302 and #576 Observations: Individual #25 and #344 **People Interviewed:** 1. Lloyd Robert Buckner, MS, BCBA – Behavior Services director 2. Cynthia Fannin – Director of Education and Training 3. Billie Dejean, MA, BCBA – Psychologist 4. Approximately 30 direct care staff in the following residences and day treatment areas: Angelina, Lavaca, Leon, Neches, Pecos, San Antonio, San Jacinto, Trinity, and all vocational settings **Meeting Attended/Observations:** 1. ISP annual planning meeting for Individual #465 – 11/14/2012 2. Behavior Support Committee – 11/12/2012 3. Behavior Service departmental meeting – 11/12/2012 4. Human Rights Committee meeting – 11/15/2012 5. Observations were conducted in the following residences and day treatment areas: Angelina, Lavaca, Leon, Neches, Pecos, San Antonio, San Jacinto, Trinity, and all vocational settings
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-

	assessment; and 3) a self-rating. For Section K, in conducting its self-assessment, the Facility: • Did not indicate whether monitoring/auditing tools had been used. In several Provisions, the Facility stated that an audit had occurred and provided targets of the audit. For example, the Facility reported that a review for Provision K.3 was conducted in part to determine if the Behavior Support Committee (BSC) had met at least weekly. Not all criteria for the audit were specific. For the same Provision, the Facility indicated that the review of the BSC was intended to determine if the "content of the review was sufficient". Without specifying an audit tool or procedure, or providing a more specific criteria, the value of information gained from the Self-Assessment was limited. • Did use other relevant data sources. For example, the Facility used the BSC minutes when auditing the BSC review process and used the PBSP Master List to determine if PBSPs were implemented in a timely manner. The Facility also used these other data sources in attempts to identify key indicators, such as the percentage of BSC meetings chaired by a BCBA or the percentage of adequate Structural/Functional Assessments (SFAs). In some cases, however, the other data sources were incomplete or unable to address the Self-Assessment process. In one circumstance, the Facility indicated that the BSC minutes were missing for some meetings. In addition, although it was reported that the PBSP Master List was used to determine if PBSPs were implemented in a timely manner, the PBSP Master List did not include initial referral or implementation dates. • The Facility consistently presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment: o Presented for some Provisions findings based on specific, measurable indicators. For example, the Facility reported the number of individuals for whom intellectual and adaptive skill testing had been completed, as well as the percentage of SFAs completed in the past year. In other circumstances, however, the Facility did not provide specific, measurable indicators. For example, it was reported that 100% of available graphs did not adhere to standard graphing conventions, but no criteria for graphing conventions were presented. o Did not consistently measure the quality as well as presence of items. • The Facility rated itself as being in compliance with the following provisions of Section K: Provision K.1, Provision K.2, and Provision K.13. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with Provision K.2. The Monitoring Team did not find the Facility in compliance with Provision K.1 as it could not be demonstrated that all PBSPs were of sufficient quality. The Monitoring Team did not find the Facility in substantial compliance with Provision K.13 as the Facility's interpretation of the requirements for the Provision were incorrect. The Facility indicated that one BCBA for every 30 individuals with a PBSP met compliance criteria. The criteria, however, actually require one BCBA for every individual living at the Facility. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.

	• Actions were reported as Completed, Complete and On-Going, In Process, and Not Started. For Provisions K.6 and K.7 there were no Action Plan steps; only a referral to "See K.5" was provided. Provision K.10 included a similar referral to Provision K.4. • The Facility data identified areas needing improvement. The Facility did not, however, provide an analysis of the information or indicate a rationale for the Action Plans. • The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. In several Provisions, the Action Steps did not specify qualitative criteria for the action to be taken. For example, Action Step two in Provision K.8 required that treatment plans were to be completed for all individuals receiving non-PBSP interventions. There were no criteria for what those treatment plans were to include.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 11/12/2012 through 11/16/2012. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that the Facility had maintained substantial compliance for Provision K.2. In some Provisions, the Facility had demonstrated areas of progress. In Provision K.1, the Facility had continued to hire BCBAs and enroll existing staff in BCBA training programs. The Facility had also developed a checklist to facilitate the peer review of PBSPs required in Provision K.3. In some areas, the Facility had initiated new procedures or document formats. These efforts suggested the potential for considerable progress toward substantial compliance. Due to the recent implementation of these efforts and the resulting small number of examples, it was not possible to fully assess the Facility's progress. One such area involved treatment data graphs and progress notes. The Facility had initiated a complete redesign of the data graphs and progress notes that allowed for a more clear and detailed presentation of an individual's response to treatment. These new procedures had only been implemented in one residence at the time of the site visit. A second example of new procedures and formats involved the Structural/Functional Assessments (SFAs) and PBSPs. The new SFA format included a much more structured organization for assessment presentation and encompassed the critical elements of behavior assessment. The new PBSP format was substantially simplified, including only those elements that were necessary for successful implementation of the program. At the time of the site visit, however, only two new SFAs and PBSPs had been completed. Despite the areas noted for improvement or the potential for improvement, there were several areas in which the Facility had demonstrated little progress. • Even though the number of BCBAs had increased and new peer review procedures had been implemented, SFAs and PBSPs were noted to have several areas of weakness. • The Facility required a coherent system for establishing the reliability of data and the integrity of PBSP implementation.

	• Only 13 of 344 individuals (4%) had been provided intellectual and adaptive skill assessment. • Of the 14 individuals receiving counseling or psychotherapy, none had been provided a formal treatment plan. • The Facility required a system for assessing staff competence regarding PBSPs and tracking staff participation in training. Based upon information obtained during the site visit, it was apparent that RSSLC had invested a variety of resources into improving services related to Section K of the Settlement Agreement. Although some areas had benefited from the efforts of the Facility, several more reflected the need for substantially greater improvement. If the RSSLC is to achieve compliance with the Settlement Agreement, the Facility must act to ensure that all services encompassed by Section K are improved.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>K1</td><td>Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td><u>Historical Perspective</u>
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 2011, 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. During the May 2012 site visit, the Facility had increased the number of BCBAs to six with 93% of the remaining eligible staff pursuing board certification.

<u>Current Site Visit</u>
At the time of the current site visit, RSSLC was actively promoting the development of BCBAs among the Behavior Services staff. The Facility employed seven psychologists/behavior analysts with the BCBA credential. This was one more than at the time of the previous site visit. Furthermore, all but one of the staff who lacked board certification was actively pursuing the BCBA credential through training and supervision. The individual who was not pursuing the BCBA credential was not required to be a BCBA due to assigned duties; this person was not counted by the Monitors in the calculations below.

<table>
<tr><th></th><th>5/2010</th><th>5/2012</th><th>11/2012</th></tr>
<tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>30%</td><td>42%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>0%</td><td>93%</td><td>100%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Percent of staff who were BCBAs or were pursuing board certification: 0% / 75% / 100% Facility policy (RSSLC Policy J.6 dated 2/20/2012) required that the PBSP author be demonstrably competent in applied behavior analysis but did not include that the PBSP author must be a BCBA. The Facility reported that all PBSPs included a BCBA as lead or co-author. Despite the requirement for demonstrable competence and the reported involvement of a BCBA in PBSP development, Facility documentation from the peer review process (Provision K.3) reflected several areas in which substantial improvement was necessary. Furthermore, Progress Notes did not reflect that a BCBA was involved in the monthly review of all PBSPs. Therefore, it was not demonstrated that the PBSPs at RSSLC promoted growth, development, and independence; and minimized regression and loss of skills; and ensured safety, security and freedom from undue restraints. The BCBA credential alone is not sufficient to ensure that PBSPs are adequate. In order to satisfy the requirements of the Settlement Agreement, RSSLC must address weaknesses in the PBSPs and ensure that all individuals requiring a PBSP are provided with an intervention plan likely to promote desired behavior and greater independence.	
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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Historical Perspective 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. In May 2012, notes were reviewed from 23 Behavior Support Committee meetings conducted during the past six months. The notes reflected a process that addressed many aspects of behavior assessment and intervention. 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 that a revised peer review process was to be implemented in the near future. Current Site Visit At the time of the current site visit, RSSLC reported that a new checklist had been developed for use during internal peer review. This checklist was completed by the supervising BCBA prior to submission of the PBSP and related assessments to the Positive Behavior Support Committee. The checklist targeted 10 areas of competence: 1) Personal attributes and support information, 2) Reason for Supports, 3) Definitions, 4) Current Data and Baseline, 5) Assessment, 6) Hypothesis, 7) Replacement and Adaptive Behaviors, 8) Environmental and Preventative Intervention, 9) Reactive Procedures, and 10) Data Collection and Monitoring. Items in each of these areas were rated zero (Incomplete or criteria not met) or one (Criteria met). A total of 33 PBSPs were provided internal peer review since the previous site visit. An aggregate comparison of those PBSPs is presented below; data for the current visit were provided by the Facility in response to a document request.	

Area of Competency	Percentage Achieved 5/2010	Percentage Achieved 5/2012	Percentage Achieved 11/2012
Personal attributes and support information	N/A	N/A	90.6
Reason for Supports	N/A	N/A	87.5
Definitions	N/A	N/A	25.0
Current Data and Baseline	N/A	N/A	53.1

#	Provision	Assessment of Status	Compliance

Assessment	N/A	N/A	59.4
Hypothesis	N/A	N/A	46.9
Replacement and Adaptive Behaviors	N/A	N/A	28.1
Environmental and Preventative Intervention	N/A	N/A	40.6
Reactive Procedures	N/A	N/A	6.3
Data Collection and Monitoring	N/A	N/A	34.4
Average of all Competencies	N/A	N/A	47.2

It was a positive step that RSSLC had initiated a more objective and quantitative approach to reviewing PBSPs. There were, however some noted limitations in the peer review process.

- For six of the 10 areas rated, fewer than half of the reviewed PBSPs achieved a satisfactory rating. In only two areas, Personal Attributes and Support Information and Reasons for Supports, did greater than 80% of PBSPs meet criteria. Overall, these were particularly low ratings for a facility that employed seven BCBAs.
- The rating system relied upon discrete measures; either the PBSP met criteria in a section or it did not. Such a system had limited ability to capture gradual or isolated progress, especially as each section to be rated was comprised of multiple items. For example, the section for rating Definitions was comprised of four separate elements. In order for a positive rating, all four of the items were required to meet criteria. Therefore, if a PBSP author increased from only one item meeting criteria on their first PBSP to three items meeting compliance on their second PBSP, the ratings for both PBSPs on that element would show no difference between the quality of the two PBSPs.

Despite the noted limitations, the checklist used by RSSLC reflected current accepted practice. It could be helpful, however, if the Facility revised the checklist to provide greater granularity and precision in the measurement of PBSPs.

In addition to the checklist, the Facility also utilized the Behavior Support Committee (BSC) to provide internal peer review. The minutes from the BSC meetings reflected that specific instructions were provided to PBSP authors regarding necessary revisions or additions. There was not any process, however, that required the documentation of when the revisions or additions were completed. Therefore, the Facility was not able to demonstrate that PBSPs were in fact improving due to the peer review process.

RSSLC also reported a process existed for external peer review. The Facility had continued to utilize the services of a licensed Psychologist, Dr. Deborah Grossett, who

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>was also a BCBA-D, to provide external peer review. Dr. Grossett certainly possessed the credentials necessary to provide peer review. The Facility did not, however, provide documentation regarding the external peer review process. Without documentation of the process, findings, or outcomes, it was not possible to offer an appraisal of the external peer review. Furthermore, the lack of documentation did not conform to the Facility's policy (RSSLC Policy J.6 dated 2/20/2012) for external peer review.

Overall, although the Facility had adequate policy regarding peer review and had demonstrated progress in regard to internal peer review, the requirements of the Settlement Agreement had not been met. Before substantial compliance can be offered, the Facility must demonstrate that both the internal and external peer review process provide regular and adequate review sufficient to improve the quality of PBSPs.</td><td></td></tr>
<tr><td>K4</td><td>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.</td><td><u>Historical Perspective</u>
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. 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. In May 2012, the records submitted by the Facility continued to reflect substantial weaknesses, including the organization of targets, no presentation of reliability data, and the lack of condition change lines.

<u>Current Site Visit</u>
In the Self-Assessment, RSSLC indicated that a sample of 10% of PBSP Progress Notes from all but one residence reflected minimal progress toward compliance with the Settlement Agreement. A sample of 10 progress notes selected by the Monitors provided few indications of substantive changes in the data tracking and treatment monitoring process, providing support for the Facility Self-Assessment. The table below illustrates the findings from the current review.

<table>
<tr><th></th><th>5/2010</th><th>5/2012</th><th>11/2012</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Data reliability is assessed.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Target behaviors analyzed individually.</td><td>0%</td><td>0%</td><td>30%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Targeted behaviors graphed sufficient for decision-making.	0%	0%	0%
Replacement behaviors graphed sufficient for decision-making.	0%	0%	0%

Based upon the sample, Progress Notes reflected weaknesses in 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. It 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 throughout the month, and does not provide a meaningful measure of behaviors that occur at high frequencies.
- 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 noted by the Monitoring Team that the person compiling the data and performing the review was not always a BCBA and therefore did not meet the requirement of Provision K1 of being demonstrably competent in applied behavior analysis.
- 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.

RSSLC did report that a new format for PBSP graphs and Progress Notes had been implemented in a single residence. In order to assess the quality of the new graphs and Progress Notes, the 21 Progress Notes completed at the time of the site visit were selected for review. The table below reflects the findings of this review.

#	Provision	Assessment of Status	Compliance

	5/2012 New Format
Targeted behavior data collection sufficient to assess progress.	100%
Replacement behavior data collection sufficient to assess progress.	100%
Data reliability is assessed.	0%
Target behaviors analyzed individually.	81%
Targeted behaviors graphed sufficient for decision-making.	100%
Replacement behaviors graphed sufficient for decision-making.	100%

Based upon the reviewed Progress Notes, it appeared that the new format was a substantial improvement over previous efforts. Although the Progress Notes contained several graphs and provided extensive information, the notes remained uncluttered and easy to use. Relationships between targets and other variables were readily apparent, and the use of percentage data was appropriate to the targets.

Despite the substantial improvement reflected in the new format, two weaknesses were notable.

- In four of the 21 Progress Notes (19%), it was not evident that progress was assessed individually for each target. For Individuals #32 and #287, this was due to a lack of narrative interpretation in the note. For Individuals #546 and #748, the Progress Note did include a narrative interpretation. For both individuals, however, the narrative did not specifically address all targets.
- None of the Progress Notes reflected reliability data. Record reviews and interviews with staff revealed that efforts to measure data reliability at RSSLC were sporadic and isolated to a few settings or individuals. Therefore, it was not likely that reliability data were available for inclusion on the Progress Notes.

Due to the problems with the data collection and presentation in the facility-wide sample, it was not possible to draw any conclusions about the ability of the Facility to implement an evidence-based approach to treatment monitoring. The Progress Notes completed using the new format were more appropriate to the formulation of treatment decisions. As the new format had just been implemented, however, there had not been the opportunity to utilize the Progress Notes for that purpose. If the Facility is able to address the noted issues in the new format and implement the format facility-wide, there is the potential for substantial progress toward an evidence-based approach to treatment and for compliance with the requirements of this provision.

K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months,	<u>Intellectual and Adaptive Behavior Assessment</u> Intellectual and adaptive testing results play an integral role in understanding an individual. While a functional assessment may provide vital information regarding a	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>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.

<u>Historical Perspective:</u> All site visits to RSSLC through May 2011 reflected no improvement in conducting intellectual and adaptive assessment or incorporating such assessments into the Psychological Evaluation. In October 2011 site visit, the Facility indicated a person had been hired to fulfill the role of completing intellectual and adaptive testing and write Psychological Assessment reports. In May 2012, however, the Facility indicated that the person hired to conduct the testing was no longer employed by the Facility. Despite the loss of staff, the Facility did demonstrate a substantial increase in the number of individuals who had been provided a Psychological Evaluation report. None of those reports, however, was shown to include current intellectual or adaptive behavior assessment results, but the provision of Psychological Evaluation reports reflected progress.

<u>Current Site Visit:</u> At the time of the current site visit, the Facility reported that a person responsible for intellectual and adaptive testing had very recently been hired. One individual had been provided intellectual and adaptive assessments since the previous site visit. There were also indications that RSSLC had maintain progress noted during the previous site visit. Documentation provided by the Facility revealed that 367 individuals (99%) had a Psychological Evaluation report in the record. Of those 367 individuals, 344 (95%) had a Psychological Evaluation report completed within the past year. Thirteen of these 344 evaluation reports (4%) were shown to include current intellectual or adaptive assessment results.

<table>
<tr><th></th><th>5/2010</th><th>5/2012</th><th>11/2012</th></tr>
<tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>99%</td><td>99%</td></tr>
<tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>89%</td><td>95%</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>4%</td></tr>
<tr><td>The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>0%</td><td>0%</td><td>4%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Assessment of Behavior 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. Historical Perspective: All site visits to RSSLC through May 2011 revealed substantial 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. In May 2012, it was evident in a sample of the 18 most recent SFAs that broad improvement had taken place. Current Site Visit: During the current site visit, RSSLC reported that the format for the Structural and Functional Assessment (SFA) was undergoing substantial revision. The Monitors agreed to focus the review of functional assessments on the SFAs that had been completed with the new format. SFAs for two individuals (Individual #302 and #576) had been completed using the new format. A review of these two SFAs revealed the following: • Both SFAs included substantial background information on the individual. Particular detail was provided regarding the developmental history, available intellectual and adaptive skill assessment, and medical conditions. • Both SFAs included a detailed presentation of the individual's historical need for behavior supports. Information was provided concerning behavior trends, previously attempted interventions, the utilization of restraints, and outcome measures. • The functional assessment procedures reflected in the two SFAs met current expectations for a thorough assessment. For each targeted behavior, the SFA included indirect assessments such as record reviews, interviews, and anecdotal	

#	Provision	Assessment of Status	Compliance
		assessments of function, as well as observation-based descriptive assessments. Substantial detail was provided for dates, times, settings, and informants. • Each target behavior in both SFAs was also provided a detailed interpretation and summary of assessment findings. This portion of the SFAs clearly identified pertinent variables and offered specific hypotheses that included, where appropriate, establishing operations, settings events, antecedents and consequences. • Both SFAs presented baseline data and offered specific recommendations for intervention, and treatment expectations defining success conditions as well as criteria for reviewing for lack of progress. Based upon the two available SFAs, the new SFA format appeared to be a substantial improvement over previous formats. Despite the degree of detail provided, neither SFA was particularly lengthy; the SFA for Individual #302 was 11 pages long, while the one for Individual #576 was eight pages in length. It must be noted, however, that the two SFAs represented a very small percentage of all SFAs required at RSSLC. The Facility will likely face a variety of challenges in maintaining the quality of assessment during full implementation. <u>Assessment of Mental Illness</u> 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. <u>Historical Perspective:</u> In the time since the baseline visit through October 2011, 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 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). In May 2012, a substantial drop was noted in the documentation of screening for psychopathology, emotional, and behavioral issues. This did not necessarily reflect a drop in the	

#	Provision	Assessment of Status	Compliance
		administration of the Reiss Screen. Rather, it could have reflected the failure to report or otherwise integrate an existing assessment into the SFA. Current Site Visit: As stated above, at the time of the current site visit the Facility was in the process of revising the SFA format. This revision included the integration of mental illness into the assessment process. The SFAs for Individuals #302 and #576 were reviewed in order to assess the mental illness assessment integration. The findings are presented below. • Both SFAs included a detailed presentation of psychiatric supports information. This information included the psychiatric diagnosis, historical and current psychotropic medications, and the rationale for those medications. • Each SFA included a description of the role that both the environment and the mental illness served in determining behavior displays. Behavioral correlates of mental illness were identified and contingencies relating to symptoms were presented. Based upon the two available SFAs, it appeared that the new SFA format provided for better integration of mental illness into the functional assessment process. As noted above, however, two SFAs is a very small sample. Additional review at future site visits will be necessary to determine if the new format can be implemented successfully. Observations and documentation reviewed as part of the current site visit revealed some areas of progress. A substantial amount of work remains, and the Facility will need to act diligently in order to achieve substantial compliance with the Settlement Agreement.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Based upon the information presented in Provision K5, the Facility had maintained previous progress in ensuring that individuals were provided with a current Psychological Evaluation report. Little progress had been achieved by the Facility in providing the necessary intellectual and adaptive skill assessments required for a complete Psychological Assessment. The new format for SFAs appeared to provide the foundation for a substantially improved functional assessment process. As only two SFAs had been completed, it was not possible to determine to what extent the format would facilitate compliance with the Settlement Agreement. As a result, there was little evidence to support that intellectual, adaptive behavior, or mental illness assessments were current, accurate, or complete.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later,	At the time of the current site visit, 344 out of 367 individuals (95%) had a Psychological Evaluation report that was completed within the previous 12 months. Only 13 of those reports, however, included findings from a current intellectual or adaptive skill assessment, addressed changes in mental illness and behavior, and offered specific	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>recommendations. Therefore, although reports were provided, the Facility did not meet the criteria for substantial compliance with the Settlement Agreement.

Since the previous site visit, four individuals had been admitted to RSSLC. One, Individual #352, was admitted less than 30 days prior to the end of the site visit and was not included in the sample of new admissions. Of the remaining three individuals (Individuals #391, #588, and #787) no Psychological Assessment report was completed within one month following admission.

<table><tr><th></th><th>5/2010</th><th>5/2012</th><th>11/2012</th></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>99%</td><td>95%</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>100%</td><td>0%</td></tr></table>
The Facility had not met criteria for substantial compliance with the Settlement Agreement because assessments had not been completed within one month following admission, and there was a lack of current intellectual and adaptive skill assessments..</td><td></td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td>At the time of the current site visit, the Facility reported that 14 individuals were provided group and/or individual counseling services. For all individuals, however, the counseling services did not involve individual treatment plans. Such interventions are required to have an initial assessment of the treatment target, as well as a formal treatment plan that includes the curriculum or approach to be used, the frequency or planned number of sessions, and a statement of the skill or intervention that is targeted. In addition there must be objective and measurable goals, specific success and failure criteria, and a regular review of progress. RSSLC reported that no treatment plans or documentation existed for non-PBSP interventions.

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.</td><td>Noncompliance</td></tr>
<tr><td>K9</td><td>By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary</td><td><u>Historical Perspective</u>
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</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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.	documentation did not consistently reflect that the review and consent process offered adequate protections for the individuals living at RSSLC. During the May 2012 site visit, documentation for several 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. The Facility indicted 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. <u>Current Site Visit</u> At the time of the current site visit, the Facility reported that there was still no system for tracking consents and approvals related to PBSPs. The only information that was currently being tracked by the Facility was the date of Behavior Support Committee (BSC) and Human Rights Committee (HRC) reviews. The average delay between BSC and HRC review was 67 days. Such a delay was indicative of the lack of a timely intervention process. During the current site visit, RSSLC reported that the format for the Positive Behavior Support Plan (PBSP) was undergoing substantial revision. The Monitors agreed to focus the review of functional assessments on the PBSPs that had been completed with the new format. PBSPs for two individuals (Individual #302 and #576) had been completed using the new format. A review of these two PBSPs revealed the following: • Both PBSPs included the reason for the intervention plan and stated how the PBSP would integrate with overall goals for the individual. • Behaviors targeted for increase and decrease, as well as tracked psychiatric indicators, were listed and defined on both PBSPs. • Specific, detailed intervention methodologies were provided in both PBSPs to address conditions prior to the display of the target behavior as well as following displays of the target. • Both PBSPs included specific steps for teaching replacement behaviors that involved multiple trials per day and formally identified reinforcers. • The PBSPs were organized to facilitate easy reading, with clear headers to sections and no extraneous text or jargon. • Data collection procedures were detailed and specific, including steps for documenting behaviors not targeted by the PBSP. The most notable aspect of the new PBSP format was the simple, straightforward style	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>and organization. All information not pertinent to program implementation had been moved to the SFA, including several items required by the Settlement Agreement. As a result, the PBSPs were shorter than in the previous format and much easier to read and follow.

Despite the advances noted in the new format, two PBSPs was a very small sample. Therefore, no conclusions could be reached about progress toward compliance with the Settlement Agreement. Additional review at future site visits will be required to assess the ability of the Facility to implement the new format successfully.</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><u>Historical Perspective</u>
Through May 2012, weaknesses in the presentation of treatment data were frequently noted. Although modest efforts at revising data graphs were reported by the Facility in the past, none had proven generally effective.

<u>Current Site Visit</u>
During the current site visit, RSSLC reported that a new format for PBSP graphs and Progress Notes had been implemented in a single residence. In order to assess the quality of the new graphs and Progress Notes, the 21 new Progress Notes completed at the time of the site visit were selected for review. The table below reflects the findings of this review.

<table>
<tr><th>Graph Element</th><th>5/2010</th><th>5/2012</th><th>10/2012</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>10%</td><td>100%</td></tr>
<tr><td>Horizontal axis and label</td><td>8%</td><td>50%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>8%</td><td>0%</td><td>100%</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>60%</td><td>100%</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>

The new format suggested substantial improvement in regard to type of data presented, axis labels, and data path. There were, however, some apparent weaknesses.
• The Facility lacked a system for consistently assessing the reliability of treatment data. As a result, graphs could not present any information pertaining to reliability.
• The graphs provided a clear illustration of the relationship between behavioral</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		correlates of mental illness and prescribed psychotropic drugs. None of the graphs, however, provided indications of other events that might have influenced behavior, such as illness, community-transition trips, or visits home. • Although the graphs allowed for comparison between behavioral correlates of mental illness and psychotropic drugs, the graphs did not compare other targeted behaviors and psychotropic medication. As drugs prescribed for a single symptom may influence a broad array of behaviors, it is important to be able to make more extensive comparisons than allowed by the new graph format. The new Psychology Progress Note format includes one graph that depicts the relationship between identified mental illness targets and prescribed psychotropic medication. The graphs depicting other target behaviors did not include condition change lines reflecting psychotropic medication changes. As the graphs related to mental illness targets and psychotropic medications were typically on different pages, it was difficult to determine if drug changes influenced these other behaviors. It would be appropriate for all graphs to include some indication of medication changes, as well as other significant events. Despite the noted limitations, the new graph format represented a substantial improvement in the quality and sophistication of behavior data graphing at RSSLC. If the necessary information can be incorporated into the new format, the potential exists for continued progress. At present, due to the implementation of the new graph format in only a single residence, it is not possible to offer an assessment of compliance with the Settlement Agreement.	
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.	In an attempt to ensure that all PBSPs were easily read and interpreted by staff, RSSLC required that the staff instructions section of each PBSP be written in simple English. To assess the readability of PBSPs, the Facility obtained a Flesch-Kincaid Readability Score for the staff instructions from each program using Microsoft Word. The Facility reported that the average grade level for staff instructions since the last site visit was 7.8. Requiring that PBSPs be written using accessible language was a good initial effort by RSSLC. In order to progress toward substantial compliance, however, the Facility must ensure that staff not only find the PBSPs easy to read but also can demonstrate the ability to both access and implement intervention plans. At the time of the current site visit, the Facility lacked a system for assessing staff ability to access and implement PBSPs. As no data were available regarding PBSP access and implementation, observations were conducted during the site visit to assess staff ability to effectively implement behavior interventions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In the Lavaca residence, Individual #25 was noted to be pacing, uncooperative, highly vocal and intrusive with peers. Although the individual had a PBSP that targeted physical aggression, the staff present did not access the PBSP or take the necessary steps to prevent or avoid potential aggression. After several minutes of agitation, the individual bit a peer with sufficient force to require medical attention. • In the San Antonio residence, Individual #344 was observed shouting loudly during his meal. When asked why staff did not attended to the individual, it was reported that the individual "was spoiled" and would become violent with little provocation. Staff did not attempt to implement the individual's PBSP. Based upon the lack of data regarding PBSP integrity, as well as observations of failures to implement intervention strategies, there was no indication that RSSLC had acted to ensure that PBSPs were routinely and accurately implemented by staff.	
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.	<u>Historical Perspective</u> 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. During the May 2012 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. <u>Current Site Visit</u> During the current site visit, the Facility continued to report that no system was in place to track staff training or ensure that staff were competent in regard to PBSPs. As noted in Provision K11, there were observed instances where staff failed to implement PBSPs appropriately. Based upon this information, the Facility was determined to not be in compliance with the Provision.	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	At the time of the site visit, RSSLC employed seven staff members who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 50 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	K.1 and maintain one psychology assistant for every two such professionals.	RSSLC currently employed eight Psychological Assistants, and had three vacant Psychological Assistant positions. This would be sufficient to meet the ratio of one assistant for every two BCBAs even if all qualifying positions were staffed by a BCBA.	

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

1. So that behavior assessments and interventions conform to accepted behavior analytic practices, ensure the Facility's plan to improve is fully implemented and that all assessments follow the new format; update current assessments to provide information that will lead to revisions in interventions as appropriate. (Provisions K3 and K4)
2. 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. (Provision K9)
3. 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. (Provisions K3 and K4)
4. Ensure that intellectual and adaptive testing is conducted, and information from such testing is used in annual psychological assessments. (Provisions K5 and K6)
5. 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. (Provision K5)
6. Establish a data collection and presentation system that is individualized, ensures valid and reliable data, and facilitates the monitoring of treatment effects. (Provisions K4 and K10)
7. 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. (Provision K8)
8. 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 individuals' PBSPs correctly. It is recommended that training be competency-based and that staff assessment and training be conducted on an ongoing basis. (Provision K12)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment 11/2/12 2. RSSLC Action Plans 10/15/12 3. Presentation Book for Section L 4. RSSLC Policy A.7 Administration, Actions Following Death of Individual Served, Policy, Revised: 10/10/12 5. RSSLC Chronic Clinical Indicator Policy, dated 10/12/11 (no policy number) 6. RSSLC Medical Follow Up Database Policy, dated 1/30/12 (no policy number) 7. RSSLC Developmental Disability Healthcare Screening Database Policy, dated 10/23/12 (no policy number) 8. Texas Department of Aging and Disability Services, Office of Management Support and Oversight of State Schools, Policy Directive 09-001, Clinical Death Review, Revised: March 2009 9. RSSLC Death Review Investigation Nursing Services (blank form), August 2009 10. RSSLC Clinical Death Review Committee Minutes for Individuals #146, #145, #30, and #7 11. RSSLC Administrative Death Committee Minutes Individuals #146, #145, and #30 12. RSSLC Unusual Incident Investigations for Individuals #146, #145, #30, and #7 13. RSSLC Clinical Records for Individuals #146, #145, #30, and #7 14. RSSLC Clinical and Administrative Death Review Committees' Recommendations for Individuals #146, #145, #30, and #7 15. RSSLC Recommendation Tracking Data and Follow-up for Individuals #146, #145, #30, and #7 16. Fort Bend County, Texas – Certificates of Death for Individuals #146, #145, #30, and #7 17. Nursing protocol placard for constipation 18. CPR training record for medical providers 19. List of all current medical providers, and support staff to the medical services office 20. List of all individuals with an active DNR order, and clinical rationale for DNR 21. List of all individuals over 50, and indication if they had screening colonoscopy 22. List of all females over 40, and indication if they had screening mammogram 23. List of all individuals who sustained a long bone or axial bone fracture during the reporting period 24. Active clinical record for Individuals #2, #77, #146, #686, #596, #792, #678, #751, #296, #353, #369, #148, and #649 25. List of all individuals with diagnosis of seizure disorder 26. Seizure record, medication list, most recent Quarterly Drug Regimen Review (QDRR), annual medical summary, and neurology consult reports for Individuals #500, #113, #689, #99, and #403 27. Report of the percentage of Individuals who are prescribed antiepileptic drugs (AEDs) that are prescribed two, three, four, and five different AEDs 28. List of percentage of those prescribed AEDs, who are provided older AEDs (Phenobarbital, Dilantin, and Mysoline) 29. List of all individuals with diagnosis of constipation 30. Bowel monitoring records, annual medical summary, most recent Individual Support Plan (ISP), QDRR, and medical providers IPNs, specific to management of constipation for individuals #596, #792, #678,

	#751, and #296 31. List of all hospitalizations that occurred during September 2012 32. Hospital liaison report, medical provider's post hospital discharge integrated progress notes (IPNs) for first five Individuals on the hospitalization list for September 2012 33. OT/PT, annual and quarterly medical summaries, imaging reports for evaluation of spine disease, consultation reports specific to spine disease, and the most recent annual ISP for individuals #760, #382, #773, #117, and #412 34. Annual and quarterly medical summaries, annual ISP, last two DEXA reports, consultation reports specific to osteoporosis, current medication list, and most recent QDRR for individuals #377, #207, #694, #679, and #614 35. Community living discharge plan (CLDP), and post move monitoring reports for Individuals #353 and #369 36. Internal and external medical audits for round six **People Interviewed:** 1. Valerie Kipfer, MS, RN, State Office Nursing Coordinator 2. Tran Quan, MD, Medical Director 3. Charlene McCurry, RN, Chief Nurse Executive (CNE) 4. Wilma Parker, RN, Quality Assurance Nurse (QA) 5. Robyn Partridge, BSN, RN, QA **6.** Wanda Hartensteiner, Medical Records Director **Meeting Attended/Observations:** 1. Observed individuals at Neches, Trinity, and San Antonio 2. Observed individuals at the Infirmary
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 10/30/12 and Action Plan dated 10/15/12. The Facility reported noncompliance with Provisions L.1 through L.4, and the Monitoring Team concurs with these findings. The Monitoring Team is concerned with the self assessment process, because the Facility generally assessed if the medical practitioner performed a specific activity, such as assessing the timeliness of medical intervention, ensuring that integrated progress notes were completed for preventative and emergency care, and assessing the annual medical summaries to ensure that routine, preventive, and emergency care were documented. While all of these activities are essential, and must be completed, there was no assessment to demonstrate if adequate clinical care was provided. For example, there was an individual who had known degenerative spine disease, and known risk factors that would result in this condition to worsen over time. The Individual was not regularly assessed, and was later discovered to have had multiple compression fractures of the spine, that once discovered, were not assertively triaged. The Monitoring Team concurs with the Facility's Action Plan for Provision L.1; however, it is strongly recommended that a plan be developed to assess the overall management of medical care, and that assertive assessments, follow-up, treatments, and all necessary supports and services have been provided,

	for each medical condition. The Monitoring Team fully concurs with the Facility's assessment of Provision L.2, as the Facility recognized that the current audit process did not address actual clinical performance issues. The Action plan should include an action step that would address the need to enhance the medical audit process so that clinical performance measure are identified, and assessed. The Monitoring Team fully concurs with the Facility's assessment of Provision L.3, because, as identified by the Facility, additional processes must be established with the development of medical databases. The Facility should better delineate its action plan for Provision L.3, to include the additional quality assurance processes that it will need to put in place, to achieve compliance. For example, the Facility should list all of the medical databases that it will need to assess all of the more common, and serious medical conditions that require medical management, and a process to develop on-going quality assurance indicators, as well as a process to track and trend outcome data. The Monitoring Team concurs with the Facility's self-rating of Provision L.4, as additional policies and procedures are needed to address clinical operations at the Facility. The Facility should enhance its action plan for Provision L.4, by developing action steps to assess that all policies, and procedures and fully implemented, and that they are efficacious.
	Summary of Monitor's Assessment: The Monitoring Team compliments the Facility for the outstanding work in further developing policies, procedures and system changes that positively affect the provision of medical services at the Facility. Under the leadership of the medical director, the Facility has developed several database systems which enable tracking and trending of important clinical conditions, has developed a comprehensive program to enhance the management of diabetes, and has partially implemented a process that will help ensure improved outcomes following hospitalizations. The medical providers are following up on acute medical conditions promptly, and documenting clinical activities more effectively. In addition, medical providers are following up on all medical consultations and diagnostic studies. Further improvement is necessary for compliance, especially in the area of diagnosing, treating, follow-up, and ensuring that all necessary supports and services are in place for known medical conditions. The Facility must also enhance its medical quality assurance process, and its clinical performance review process. Two major areas of concern are assessing individuals who manifest maladaptive behaviors for underlying medical conditions, and ensuring that all chronic care conditions are assertively assessed, and managed. **Provision L.1:** The Monitoring Team noted many improvements in the area of medical services. For example, the medical providers are more regularly documenting in SOAP format, and completion of medical summaries has significantly improved. It was noted that in most cases, for each identified diagnosis on the medical summary, a medical plan was formulated. In general, medical providers are addressing acute medical issues more timely, and are following up on acute care issues more closely. The Facility is doing an outstanding job by ensuring that individuals are offered screening colonoscopy and mammography. The Monitoring Team did note areas that continue to need marked improvement,

	especially in the area of ensure a comprehensive review of underlying medical conditions. For example, individuals were not assertively assessed as to the underlying causes of osteoporosis, and individuals with degenerative spine disease did not have assertive clinical plans developed to ensure that all appropriate supports and services could be provided, to better meet the needs of the Individual. Importantly, medical providers must assertively assess all acute conditions, and rule out medical conditions that may be manifesting in behavioral issues. The Monitoring Team had significant concerns over the development of the CLDP, and clinical follow-up of individuals who transferred to the community. It is essential that all appropriate supports and services be identified and provided to individuals who transfer to the community. Likewise, it is essential that individuals be clinically monitored through the post-discharge monitoring period. Medical providers should responsible to ensure that all clinically necessary supports and services are identified for individuals who reside at the Facility, and that nursing and direct care staff are provided clear, concise monitoring, and reporting parameters for all clinical conditions. **Provision L.2:** The Monitoring Team noted significant improvement in developing a meaningful process to assess clinical performance of medical providers. The current internal and external medical audit process is performed regularly, and provides good insight into the medical providers adherence to Facility policy, and to documentation standards. The Monitoring Team determined that the process did not adequately assess the clinical performance of the Facility's medical providers, as it did not review clinical outcomes, or assess the providers' adherence to standard of care guidelines. Compliance will require that the Facility develop and implement a process that assesses performance measures on clinical outcomes, and adherence to acceptable practice standards for medical management that are based on standard of care guidelines. The Facility had significantly improved on its mortality review process; however, compliance will require that the Facility develop and implement a process to track and trend mortality review outcome data, implement a process to ensure that a root cause analysis of the medical management of the underlying cause of death is assessed, and develop a standardized approach when conducting a mortality review. **Provision L.3:** Following discussion with the medical director, and review of the policies, current databases, and trends analysis, the Monitoring Team is most complimentary, and is supportive of the Facility's effort to develop, and implement additional databases to be used in the context of medical quality assurance. Most impressive was the Facility's development and implementation of the nursing diabetic education process, which helps to enable a multidisciplinary approach to the management of diabetes. At the time of this review, the Monitoring Team determined that the Facility is not yet compliant with Provision L.3, as compliance will require that the Facility fully implement its medical quality assurance process, and demonstrate efficacy by ensuring clinical practice meets standard of care practice. The Facility has clearly demonstrated its ability to effectively address and ensure quality practice and improved outcome in the area of diabetes. **Provision L.4:** The Monitoring Team was impressed by the level of commitment that the medical services department demonstrated by its development and implementation of many novel and comprehensive initiatives to improve medical services at the Facility. The Monitoring Team clearly concurs with the Facility's direction; however, at the time of this review, the Monitoring Team determined that the Facility

	remain noncompliant with Provision L.4. Compliance will require that all policies and procedures be fully developed and implemented, and that they demonstrate efficacy. For example, the Facility had developed and implemented a robust mechanism to ensure that a hospital discharge planning meeting take place, prior to discharge from the Hospital. The Monitoring Team reviewed this process, and determined it to be excellent; however, upon review of its implementation, the Monitoring Team noted that the policy was not being assertively adopted, as several hospital discharges occurred without the new process being followed.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	To assess the Facility's ability to provide medical services, the Monitoring Team reviewed several common conditions that occur frequently in individuals with developmental disabilities, such as constipation, seizure disorder, degenerative spine disease. The Monitoring Team also reviewed medical administration, follow-up to hospitalizations, preventive care management, and medical providers involvement in the community living discharge planning process. The following is a summary of the Monitoring Team findings for each category. <u>Medical Administration</u> The Facility maintains a medical staff of nine medical providers, of which seven are physicians, and two are nurse practitioners. The medical office is supported by a medical compliance coordinator, and an administrative assistant. All medical providers had current licenses in the State of Texas. CPR Training All medical providers were current with CPR training. Summary: The Monitoring Team determined that the Facility maintained adequate medical provider staffing, and that all practitioners were currently licensed, and had current CPR certification. The Monitoring Team recognized the benefit of including a medical compliance coordinator on staff. <u>Do Not Resuscitate Order</u> The Facility reported a total of 18 Individuals who were assigned a DNR order and provided a list of associated qualifying conditions for the DNR. The Monitoring Team is concerned over the reported qualifying conditions for nine of the 18 Individuals. For example, a qualifying condition must be a diagnosed medical condition, that will hasten death, and there are no known, or appropriate treatments, or documented evidence that resuscitative measure would result in more harm to the individual. The Facility reported "End-Stage Cerebral Palsy" as a qualifying condition for Individual #551; however, it is the complications of cerebral palsy, that if not assertively managed	Noncompliance

#	Provision	Assessment of Status	Compliance
		early on, that may hasten death, and not cerebral palsy itself. Another example is that the Facility documented urinary tract infection, and urosepsis as a qualifying condition for Individual #73, but such conditions are generally acute and reversible. The Individual may, however, have an underlying condition that predisposes the Individual to urosepsis, and if this condition cannot be appropriately treated, should be used as the rationale. Another common condition listed as a qualifying condition is "end stage brain degeneration", and the Monitoring Team expects a more definitive condition to be diagnosed, with supporting evidence. The Monitoring Team does, however, recognize that in some cases, a neurodegenerative condition cannot be adequately diagnosed, but suspected. In such cases, clear documentation should be delineated. Summary: On subsequent reviews, the Monitoring Team will more closely review the DNR practice at the Facility to ensure that appropriate qualifying conditions are delineated, along with supporting clinical evidence. Importantly, the Monitoring Team will look specifically at the levels of DNR provided to the Individuals who have been assigned a DNR. For example, the Monitoring Team will look closely to see if all options for less then a full DNR, have been considered, such as chemical resuscitation, or "no chest compressions." <u>Preventive Health</u> To assess the Facility's ability to provide preventive health care measures, the Monitoring Team reviewed the Facility's attempts to obtain screening colonoscopy and mammography. Screening Colonoscopy The Monitoring Team was provided a list of all Individuals who were age 50, and older, the date of their screening colonoscopy, and rationale if a screening colonoscopy was not completed. A total of 187 Individuals were age 50, or older, and 157 (84%) had undergone a colonoscopy, and only 20 Individuals (10%) did not have a documented rationale for not having a screening colonoscopy. The completion rate of screening colonoscopy is good, and an indication of the Facility's effort to provide preventive health screening, for Individuals who reside at the Facility. Mammogram The Monitoring Team reviewed a list of all females, over the age of 40, along with documentation of screening mammogram. The Monitoring Team noted that in all cases of not having obtained a screening mammogram, there was documentation indicating the rationale for the diagnostic not being completed, and when appropriate, rescheduling was noted. The Monitoring Team is complimentary of the Facility's efforts to attempt to provide standard of care preventative health measures, by offering screening mammography to Individuals who reside at the Facility.	

#	Provision	Assessment of Status	Compliance
		Fractures The Monitoring Team reviewed the active clinical record, and requested the most recent ISP, and addendums to the ISP, annual physician assessments, all physician IPNs specific to the management and follow-up of fracture, PT/OT assessments, and documentation by the physician indicating a search for the etiology for fracture, and the active problem list for individuals who sustained a long-bone or axial fracture within the reporting period. The Facility reported that the following individuals met such criteria: Individuals #2, #77, #146, and #686. The following is a summary of the Monitoring Team's review of four individuals who sustained fractures during the reporting period: • Individual #2 Sustained a fracture of the right ankle that required surgical fixation. The Monitoring Team noted that the Individual was promptly referred to orthopedics, and followed up with orthopedics through resolution. The Monitoring Team did not identify documentation through the IDT process that demonstrated a comprehensive review for the etiology of the fracture, or development of necessary service objectives. Importantly, the medical provider indicated that follow-up notes were dictated; however, such notes were not included in the document request, nor were they identified in the active clinical record. • Individual #146 Was reported to have sustained a supracondylar fracture of the left knee on 5/5/12 that was reported to be "severe and displaced". The Individual was hospitalized, and was later suspected of having two additional fractures, involving the pelvis. The Individual expired on 5/15/12, secondary to sepsis, while in the hospital. The Monitoring Team was most concerned with the Facility's assessment of the possible etiology of the fractures. As reported by the medical provider on an IPN dated 5/6/12, the Facility suspected that the individual hit her leg on a table that was positioned too low for the Individual, and an addendum to the ISP dated 5/7/12 indicated that the Facility believed that the individual's spastic movements and osteoporosis may have caused the knee fracture because such movements predisposed the Individual to fracture by hitting objects. The assessment did not take into consideration the two suspected fractures of the pelvis, and the explanation of the Individual hitting her leg on a table would not be an adequate explanation. Importantly, the Individual was placed on low risk for falls and fractures, despite having a known diagnosis of severe osteoporosis, spastic movements, cataracts, dementia, cerebral palsy, and the need for physical support for all transfers.	

#	Provision	Assessment of Status	Compliance
		Also of concern is that the Individual was reported to have had end-stage Alzheimer's dementia and cerebral palsy, as noted in the medical history; however, there was no specific plan documented on the most recent annual physician summary, delineating the necessary supports and services specific to the management of these two conditions, nor did the most recent annual ISP, or addendums to the ISP, comment on necessary supports and services for the management of cerebral palsy or end-stage dementia. Review of the IPNs indicated that the nurse who initially triaged the Individual for suspected fracture did not document an assessment until 5/11/12, which was six days following the fracture. • Individual #686 It was reported by the Facility, by means of a fracture report, that Individual #686 sustained a compression fracture of the knee; however, the active clinical record indicated that the fracture was a compression fracture of the spine. Review of the active clinical record, and documents provided, did not support on-going clinical follow-up by the medical provider, or physical therapy, having been provided through resolution of the fracture. Importantly, there was no evidence to support that the Individual was referred to a spine surgeon for evaluation, or that service objectives were enhanced to ensure that additional and necessary supports were provided to assist with mobility, transfers, and pain management. Given that the Individual was known to have experienced a previous fracture of the spine, has moderate kyphosis, and known degenerative disease of the spine, the individual is at risk for myelopathy, pain, and other manifestations from spine disease, and should have benefited by follow-up with a spine specialist. • Individual #77 The Individual was reported to have sustained an injury from bedrails, on 5/31/12, that resulted in a fracture of the tibia and fibula (leg). The Individual was immediately triaged to the local hospital, and received appropriate orthopedic follow-up. The medical provider documented on an IPN, dated 8/5/12, that the Individual had again experienced a bedrail mishap, and had fallen onto the floor. The Monitoring Team is concerned over the lack of available IPNs demonstrating on-going follow-up to resolution of the fracture by the medical provider, and that there was no evidence to support that the IDT effectively addressed bedrail safety, given a second bedrail incident. Summary: The Monitoring Team was not satisfied with the Facility's overall management and follow-up of fractures. Most important was the noted lack of meaningful review of fractures by the IDT. The Monitoring Team would expect to see that all fractures are	

#	Provision	Assessment of Status	Compliance
		closely followed-up through resolution by the medical provider, that the medical provider ensures that a comprehensive assessment as to the root cause of the fracture occurs, and that the IDT ensures that appropriate and necessary service objectives are included in the ISP or addendum to the ISP. <u>Seizure Disorder</u> To assess the Facility's ability to provide the necessary medical supports and services for the management of seizure disorder the Monitoring Team selected the first five individuals who experienced status epilepticus during the reporting period, and requested the following information: annual physician assessment, last quarterly physician assessment, active problem list, medical provider IPNs related to status epilepticus, most recent ISP and addendums to ISP specific to reference of status epilepticus, neurology consultation reports for past 12 months, hospitalization records for management of status epilepticus, last two quarterly drug regimen reviews (QDRRs), current medication list, and list of all prn medications administered for seizure disorder during the reporting period. • Individual #500 The annual medical summary did not define epilepsy as refractory, nor indicate the type of epilepsy. IPNs by the medical provider, dated 6/11/12, 6/13/12, 9/18/12, 9/30/12, and 9/18/12 provided an excellent assessment of recent seizure events. The Individual was regularly followed by a neurologist. The ISP dated 10/8/12 did not delineate the seriousness of the Individual's seizure disorder, nor did it list necessary supports and services required of staff to manage this condition. • Individual #113 The IPN, dated 11/7/12, and the hospital liaison nurse's IPNs for hospitalization secondary to valproic acid toxicity and aspiration pneumonia, was confusing. The medical providers IPN did not clearly delineate issues related to the hospitalization, as compared to the nurse liaison hospital follow-up documentation, and hospital records. A medical provider IPN, dated 8/17/12, indicated that valproic acid level was normal, at 78.2, and that Dilantin was being tapered off. There was no mention by the medical provider that more frequent monitoring of valproic acid was necessary when tapering off Dilantin, as Dilantin taper can cause significant elevation in valproic acid levels, and as above, the individual was hospitalized for severe valproic acid toxicity on 10/22/12. The annual medical summary, dated 10/15/12, provided an excellent summary of intractable seizures, and possible etiology of behavior issues; however, the active problem list did not delineate the classification of seizure disorder;	

#	Provision	Assessment of Status	Compliance
		furthermore, strategies for medication compliance, and need to closely monitor for medication refusal, were not addressed in the medical plan. Both issues were noted to be significant for the Individual. The annual ISP, dated 11/22/11, did not comment on necessary supports and services for managing seizure disorder, and there were no subsequent addendums to the ISP addressing this important issue. There were multiple addendums to the ISP documenting many restraint issues; however, the addendums did not comment on the Individual's known degenerative spine disease, and did not comment on the potential for additional risk when restraints where employed. Furthermore, the addendums commented on refusing seizure and behavior medications, but did not indicate what intervention must be done when a seizure medication is refused. Depending on the type of seizure disorder, refusal of a seizure medication may constitute a medical emergency, requiring prompt medical intervention. In addition, there was not an ISP addendum discussing the issue and potential etiology of valproic acid toxicity, which resulting in adverse reaction to the Individual and hospitalization. Neurology Consultations were determined to be adequate. • Individual #689 The admission medical summary, dated 4/17/12, accurately listed the appropriate classification of seizure disorder, but did not indicate refractory seizure disorder, and the active problem list, dated 5/15/12, indicated "intractable seizure disorder," but did not classify the seizure disorder. The medical plan did not clearly delineate necessary supports and services for the Individuals significant seizure disorder. For example, there was not a comment on the importance for staff to monitor for possible pre-seizure behaviors, on fall precautions, and vagal nerve stimulator (VNS) usage was not commented on, as it is important to correlate seizures with VNS usage by staff. The medical provider evaluated the Individual following reported seizure activity, and documented findings on the IPNs. The ISP, dated 5/21/12 indicated that the Individual was at high risk for seizures, and that the Individual had a diagnosis of generalized seizure disorder, but did not indicate issues related to the severity of the seizure disorder, did not provide a comprehensive assessment of necessary supports and services for the management of the Individual's seizure disorder, and did not comment on the use of the VNS.	

#	Provision	Assessment of Status	Compliance
		The Individual was regularly followed by a neurologist. • Individual #99 The annual medical summary, dated 5/24/12, indicated that the Individual experienced an elevated Dilantin level of 37.5, but did not document whether the Individual experienced toxicity or not, and the summary did not indicate the classification of seizure disorder, only listing epilepsy on the active problem list. The medical provider followed up on all reported seizures, and documented clinical findings on the IPNs. On 7/11/12, the Individual sustained a seizure, and the Dilantin level was noted to be subtherapeutic. The medical provider did not explore possible causes of a subtherapeutic level, but increased the baseline dose, with a drug level to be drawn seven days later. On 7/19/12, the Individual sustained an additional seizure, and the medical provider indicated that the Dilantin level was still pending. The medical provider did not document a lab review for Dilantin until 8/30/12; lab results were normal. The Monitoring Team was concerned that physician review of the Dilantin level was significantly prolonged. The Individual was routinely followed by neurology. The most recent ISP, dated 6/13/12, did not adequately delineate issues related to the Individual's seizure disorder, and did not document the necessary supports and services required to manage seizure disorder. For example, staff should be made aware of pre-seizure behaviors, fall risks, and possible medication refusal, and the impact on the Individual. • Individual #403 The annual medical summary, dated 1/20/12, indicated that the Individual had experienced a previously elevated Dilantin level, which required holding Dilantin therapy. The medical provider did not classify the type of seizure disorder, but only indicated "Epilepsy" as the diagnosis on the annual medical summary, and the medical plan did not provide information regarding necessary supports and services that living area staff must provide to better support the Individual. The annual medical summary did not review VNS usage, and comparison to incidences of seizure. It is extremely important to gauge whether staff are identifying pre-seizure behaviors, and initiating the VNS when a seizure occurs. Importantly, the clinical record included neurology clinic consultation reports, dated 4/10/12 and 2/1/11, that indicated that the Individual had a VNS replaced on 1/4/11, and that it was programmed with the old settings, and was	

#	Provision	Assessment of Status	Compliance
		seizure free while using the VNS. A neurology consultation report, dated 4/10/12, indicated a recommendation for VNS, and a medical provider IPN, dated 8/1/12, indicated that the Individual was seen for a neurological consultation on 8/1/12, and that a VNS, and follow-up with an epileptologist, was recommended, and that the medical provider concurred with the consulting neurologist. There was no comment on the issue of the consultant not being aware that the Individual actually had a VNS in place, or not. The record is unclear with regard to whether the Individual has, or does not have a VNS, and there is no documentation on its efficacy, if in fact the Individual does have a VNS. The medical provider followed up and documented findings on an IPN following all reported seizures. The medical provider's IPNs, dated 9/13/12, 9/18/12/, and 9/24/12, indicated a comprehensive physical assessment; however, there was no assessment of possible cause of the seizure; for example, documentation was not found of assessing if the Individual was possibly subtherapeutic with anticonvulsant therapy, and if the VNS was being used as prescribed. The only ISP provided was from 2011, and there were no addendums documenting issues related to the Individual's severe and refractory seizure disorder. The Individual was followed by a neurologist regularly; however, it is unclear whether the neurologist, and epileptologist was provided accurate information regarding VNS placement. <u>Antiepileptic Drug Utilization Review:</u> As part of the document request, the Monitoring Team requested that the Facility provide the percentages of those prescribed antiepileptic drugs (AEDs), who were prescribed two, three, four, and five different AEDs. The Facility reported that 29.2% were prescribed two AEDs; 17.1% were prescribed three AEDs; 8.1% were prescribed four AEDs; and 1.6% were prescribed five AEDs. The Monitoring Team recognizes the challenges associated with AED polypharmacy reduction, and encourages the Facility to continue to work towards reducing AED polypharmacy, when clinically appropriate, and with collaboration with a neurologist, and the legally appointed representative (LAR) for the Individual. As reported by the Facility, of those administered AEDs, 17.1% are prescribed Phenobarbital, 22.8% are prescribed Dilantin, and 2.4% are prescribed Mysoline. The Monitoring Team notes that a significant proportion of Individuals served remain on older, and more toxic AEDs. The Monitoring Team recognizes the challenges associated with cross tapering Individuals to newer, and less cognitively altering medications;	

#	Provision	Assessment of Status	Compliance
		however, the Monitoring Team strongly recommends continued attempts, when clinically appropriate, and in collaboration with a neurologist, and the legally appointed representative. Summary: The Monitoring Team noted that Individuals were followed regularly by consulting neurologists in five out of five (100%) cases; that the medical provider followed up and documented an assessment following reported seizures in five out of five (100%) cases; only one out of five examples (20%) indicated accurate classification of seizure disorder; zero out of five examples (0%) indicated a comprehensive review and identification in the ISP or addendums to the ISP of appropriate supports and services to manage seizure disorder,; and medical plans, as documented on the annual medical summary, documented clear and concise recommendations for living area staff to appropriately monitor and support the Individual in zero out of five (0%) examples. The Monitoring Team was concerned over misleading documentation regarding VNS placement for Individual #403, and the prolonged time before the medical provider followed up on Dilantin levels for Individual #99, and a general lack of comprehensive assessment of possible causes for recurrent seizures. Most important, the Monitoring Team noted lack of documentation, on the ISPs, indicating that there was a meaningful review of seizure disorder and that identification of necessary supports and services for Individuals with seizure disorder was done. <u>Constipation</u> The Monitoring Team reviewed the Facility's Nursing Protocol card for constipation. This card is provided to nursing staff as a reference on how to assess and report constipation. In addition, the Monitoring Team selected the first five Individuals from a list of all individuals who had a diagnosis of constipation, and requested the following documents, to assess the Facility's ability to manage constipation: Annual medical summary, all medical provider IPNs specific to the management of constipation, most recent QDRR, most recent annual ISP, current medication list, and the bowel tracking record for October 2012. Specific to the nursing protocol for constipation, the Monitoring Team is concerned that the reporting parameters of constipation to the physician were not adequate. For example, the protocol indicates that the nurse is to report to the physician if bowel movements do not occur within 2-3 days, if there is no stool in the rectum, and there is no associated PRN order. Constipation is a serious medical condition that must be assertively managed. An individual may have multiple bowel movements per day, and going one day without a bowel movement may be a potential significant indicator of impaction or obstruction; an individual may have a high obstruction, and therefore no stool will be in the rectal vault; and the protocol did not comment on frequent loose and	

#	Provision	Assessment of Status	Compliance
		watery stools as an indicator of complications of constipation, such as in the case of overflow fecal incontinence. • Individual #596 The Individual was noted on the annual medical summary, dated 6/27/12 to have had a past surgery for foreign body, and a diagnosis of pica, and chronic constipation. The medical plan indicated a need for early intervention, and the need to provide anti-constipation medications, and free water; however, there were no specific instructions provided to staff on the quantity of water, and what signs and symptoms to monitor for worsening constipation. The QDRRs, dated 6/29/12, and 9/10/12, did not address efficacy of anti-constipation medication. Review of the ISP, dated 6/18/12, indicated that the medical recommendation, as delineated above, was cut and then pasted into the ISP, and no further information regarding necessary supports and services, as well as potential risks, was provided. For example, staff must be well instructed on specifics for the management of chronic constipation, such as what signs and symptoms to monitor, and the amount of free water that should be provided. The Quarterly medical assessment did not include a review for constipation. The bowel movement record for October 2012 was not completed for 11 shifts during the month. • Individual #792 The annual medical summary, dated 7/13/12, indicated a diagnosis of constipation, but there was no discussion about the etiology of the constipation, and the medical plan did not include specific issues necessary to support the individual, such as increased fluids. The QDRR, dated 9/11/12, did not comment on the diagnosis of constipation, efficacy of anti-constipating medication, or potential medication related risk factors for constipation. The ISP, dated 5/7/12, indicated that the Individual was at low risk for constipation; however, the Individual has a known diagnosis of constipation, is on pro-constipating medications, and takes medication daily for constipation. The ISP did not clearly delineate supports and services necessary to manage constipation, such as ensure that direct care staff know signs and symptoms to monitor, and to ensure adequate hydration.	

#	Provision	Assessment of Status	Compliance
		The bowel monitoring record for October 2012 indicated that the Individual went for days without a bowel movement, and there was no documented corresponding follow-up by the medical provider. For example, the bowel record indicated no bowel movement from October 6th, through October 22. The Monitoring Team is concerned over the lack of appropriate monitoring of bowel movements. In the event the Individual self-toilets, staff should discuss bowel movements with the Individual at least daily, to determine if in fact the Individual had a bowel movement. • Individual #678 The annual medical summary, dated 4/2/12, indicated diagnosis of constipation, pica, and history of bowel obstruction. The medical plan did not outline necessary supports and service required to support an individual with known pica, history of bowel obstruction, and active diagnosis of constipation. The Individual is at high risk for bowel obstruction, and perforation, and specific information must be provided to direct care staff for monitoring of suspected bowel obstruction and constipation. This is especially important for this Individual because the anti-constipation medication, polyethylene glycol, is contraindicated in the event of bowel obstruction, and given a history of bowel obstruction and active diagnosis of pica, careful monitoring must be provided. The QDRR, dated 9/10/11 did not comment on the efficacy of anti-constipating medication, or risk factors of such medication in an Individual with known history of bowel obstruction and pica. Direct care staff completed the bowel record for October 2012. An IPN documented by the medical provider, dated 9/26/12, indicated that the Individual had ingested a foreign body (piece of paper), and an x-ray indicated a linear radiopacity in the upper abdomen. The medical provider's plan indicated that "Metamucil for bulking agent to help to remove the foreign body", and lactulose for constipation, would be added. The Monitoring Team has concerns over the medical provider's documented treatment regimen. The medical provider did not indicate specific monitoring parameters, other then to provide "medical monitor x 72 hours", and direct care staff were not provided specific signs and symptoms to monitor for, and how frequently to monitor such signs and symptoms. The medical provider prescribed the addition of Metamucil to help "remove the foreign body", which raised concern by the Monitoring Team because fiber supplements can have a paradoxical reaction by causing a bowel obstruction, in certain cases. Also, the medical provider indicated that the foreign body ingested was paper; however, according to the clinical record, the specific item was not observed by staff, other then on the previous day, the	

#	Provision	Assessment of Status	Compliance
		Individual had "vomited up paper". Given that the object was reported to be radiopaque, and the ingestion of the item was not directly witnessed, the Monitoring Team would expect that a gastroenterology consult be immediately obtained, or the individual triaged to an emergency department for further assessment. Importantly, the Monitoring Team was not provided evidence of the medical provider's follow-up through resolution of the issue, and follow-up x-ray reports were also not provided for this review. The annual ISP, dated 4/17/12, indicated that constipation and bowel obstruction were high-risk health issues; however, pica was not listed as a risk issue for the Individual. The ISP did not adequately represent all necessary supports and services required to support this person. For example, specific signs and symptoms for direct care monitoring of the Individual, and the frequency of monitoring, was not delineated in the ISP, or other component of the active clinical record. • Individual #751 The annual medical summary, dated 7/12/12, indicated that the Individual had diagnosis of constipation, and pica of cigarette butts, which resulted in exploratory laparotomy in the past. The medical plan indicated that constipation will need to be closely monitored and early intervention would be necessary to avoid impaction, and that the Individual will need adequate free water intake to prevent impaction. Instructions for specific monitoring of signs and symptoms for constipation and possible obstruction were not provided to the staff, and the amount of free water was not documented or tracked. The QDRR dated 7/21/12, did not comment on the diagnosis of constipation, efficacy of prescribed anti-constipation medication, and review of prescribed pro-constipating medication. Given the significant concern over constipation, and potential for impaction, the Monitoring Team would expect to see a comprehensive pharmacy review of constipation and related medications. The ISP, dated 8/22/12, did not adequately delineate necessary supports and services for the management of constipation. For example, the ISP documented a plan for constipation that was simply the medical recommendations documented on the annual medical summary, and the medical recommendation indicated to consider natural products such as prune juice to his daily regimen; however, there was no further documentation noted on the ISP indicating that this recommendation was considered, and there was no specific signs and symptoms listed for direct care staff to monitor. The bowel monitoring record for October 2012 indicated staff did not complete	

#	Provision	Assessment of Status	Compliance
		bowel tracking for eight shifts. • Individual #296 The annual medical summary, dated 6/19/12, indicated a diagnosis of constipation, and the medical recommendation was not comprehensive, as it did not delineate monitoring parameters for direct care staff, and other, non-medication treatments to consider. The QDRR, dated 7/27/12, indicated a review of the Individuals anti-constipation medications, and provided recommendations to enhance the treatment regimen. The ISP, dated 5/17/12, indicated that the Facility should "continue aggressive bowel regimen. Monitor for signs/symptoms of impaction, constipation, bowel obstruction"; however, it did not delineate specific on how, who, and what to specifically monitor, and there was no consideration of non-pharmacological approaches to the management of severe constipation. Direct care staff completed the bowel monitoring record for October 2012. Summary: The Monitoring Team noted a significant lack of continuity of care for the management of constipation. Of the five cases reviewed, five out of five (100%) listed constipation as a diagnosis; one out of five cases (20%) indicated a possible etiology of constipation; zero out of five cases (0%) included comprehensive recommendations for the management of constipation, that included not only pharmacological, but non-pharmacological treatment strategies, such as bowel training, and nutritional support; the bowel records for monitoring bowel movements by direct care staff was fully complete in only one out of the five cases (20%), while the remained had several days of omitted documentation; the QDRRs documented a review of the efficacy of anti-constipation medications in only one out of five cases (20%); and the ISP adequately documented the effects of constipation on the person's life, and the necessary supports and services to support the Individual in zero out of five cases (0%). <u>Hospitalizations</u> To assess the medical provider's follow-up on individuals hospitalized, the Monitoring Team requested a list of all individuals hospitalized during September 2012. There were a total of 17 hospitalizations, and the Monitoring Team reviewed the following information, for the first five individuals on the list: Hospital admission and discharge report; all nurse liaison reports; pre and post hospital admission documentation; medical provider IPNs documenting follow-up through resolution of the medical condition; and documentation of the medical provider's contact with the hospital.	

#	Provision	Assessment of Status	Compliance
		Of the 17 individuals hospitalized, the following admission criteria were diagnosed: Pneumonia: 5 Urinary tract infection: 8 Sepsis: 4 Seizures: 1 Gastrointestinal bleeding: 1 Dehydration: 1 Bronchitis: 2 Amputation (finger): 1 Of the five cases reviewed, five out of five (100%) indicated appropriate hospital monitoring by the nurse liaison; four out of five (80%) indicated post hospital follow-up, through resolution of the medical issue, by the medical provider; four out of five (80%) indicated a comprehensive post hospital note by the medical provider that outlined the hospital course, and indicated a post hospital physical assessment; there was a pre-hospital discharging planning meeting, as documented by the nurse liaison, in two of the five cases (40%); the medical provider made direct contact with the hospital, at the time of admission, in three out of five cases (60%); and in zero out of five cases (0%), was there documentation to support that the medical provider directly contacted the hospital physician, to discuss discharge criteria. Hospital admission and discharge summaries were not provided to the Monitoring Team. Summary: Following review of the active clinical records, and document request, the Monitoring Team noted that hospital admission and discharge summaries were not located within the active clinical records, and the documents provided per the document request were faxed to the Facility by the hospital on November 14, 2012, the day of the Monitoring Teams document request, and were not initialed by Facility's medical provider. Therefore, the Monitoring Team is concerned that hospital admission and discharge summaries were not incorporated into a care plan, following transfer back to the Facility. The Monitoring Team did note, however, that the Facility's medical providers documented a comprehensive review of the individuals hospitalizations. The Monitoring Team noted significant improvement with hospital follow-up, and continuity of care following hospitalizations. It is apparent that the Facility closely monitors Individuals when transferred to an acute hospital. The Monitoring Team recognizes that the Facility recently initiated its pre-discharge meeting process, which will continue to better enable continuity of care. <u>Degenerative Spine Disease</u>	

#	Provision	Assessment of Status	Compliance
		To assess the Facility's ability to manage degenerative spine disease, the Monitoring Team identified the first five individuals on a list of all individuals with known degenerative spine disease, and requested the following information: Most recent annual medical summary, OT/PT assessment, annual ISP, and addendum to the ISP, all diagnostics, and consultations specific to degenerative spine disease, and all medical provider IPNs specific to the management of degenerative spine disease. The following is a summary for each individual reviewed. • Individual #760 Has known severe cervical spine disease, as delineated in his medical history, and a history of spinal surgery on the lower spine for disc disease; however, the annual medical summary, dated 9/19/12, did not list the multiple spinal conditions as a diagnosis, or on the active problem list, and there was no medical plan to follow-up on these conditions. The Annual ISP, dated 10/4/12, did not provide insight into the significance of the Individual's spine disease, and did not adequately document supports and services necessary for this condition. Importantly, the Individual had been evaluated by physical therapy (PT) as early as 9/19/12, because of severe problems with weight bearing and abnormal gait; however, the ISP documented on the daily living skills sections that the Individual did not have a mobility issue, when in fact, the Individual had recently required the use of a wheelchair and gait belt. The ISP reported that the Individual sustained a total of three falls, when in fact the Individual sustained an additional fall, on 9/29/12, which was not discussed at the ISP meeting. A PT assessment, dated 9/18/12, documented that the Individual had a history of lower spine surgery, but did not comment on the severe cervical (upper) spine issues. The assessment reported that the Individual had sustained a total of two falls during the previous 12 months; however, the annual ISP indicated that the Individual actually had three falls during that time frame. An IPN by the physical therapist (PT), dated 9/19/12, indicated that PT services were requested because the Individual was unable to ambulate safely, and had difficulties bearing weight, and the need to provide "gait training". PT noted that the Individual required a gait belt, and identified the Individual has having a scissoring gait, and attributed the condition secondary to a recently diagnosed osteoarthritis of the knees. The Monitoring Team is concerned because at no time was concern documented over possible worsening degenerative spine disease, as a scissor gait is diagnostic of an upper motor neuron lesion, and not secondary to arthritis.	

#	Provision	Assessment of Status	Compliance
		The medical provider did not assertively follow up on the acute gait abnormality, nor was regular assessment performed to evaluate for subtle worsening of the Individual's spine disease. • Individual #382 Past medical history indicated a diagnosis of spina bifida, and the annual medical summary, dated 5/21/12, indicated a diagnosis of multilevel degenerative lumbar spine disease; however, the medical plan for this condition did not indicate necessary supports and services, such as periodic monitoring for worsening myelopathy, and scheduled pain assessments. There was no assertive assessment of other potential spine issues; for example, an x-ray dated 3/9/12, of the lumber spine diagnosed spina bifida, multilevel lumbar spine disease, but the Monitoring Team was not provided with evidence to support that that issue was addressed. The diagnosis of spina bifida, which is a congenital disorder of the spine that may result in additional acquired changes of the spine, was not listed as a diagnosis. The OT/PT assessments 4/28/11, and the most recent ISP, dated 6/14/12, did not indicate that the Individual had a medical condition of the spine. Also, the ISP indicated that OT/PT "recommendations are as follows"; however, there were no recommendations documented. • Individual #773 The Individual has a diagnosis of degenerative cervical spine disease, as indicated on the annual medical summary, dated 1/9/12; however there was no medical plan developed for this condition. The PT/OT assessment, and ISP, dated 1/10/12, did not address the diagnosis of degenerative cervical spine disease. • Individual #117 The annual medical summary, dated 3/17/12, indicated a diagnosis of "disc bulge" of the lower spine, and the medical plan indicated to "monitor for pain, gait difficulty, gait has not changed from last few years. If gait worsens then may need repeat MRI of lumbar spine". There was no specific plan for direct care staff to monitor the individual for this medical condition. Also, the PT/OT assessment, dated 3/27/12, indicated that the medical provider had requested the Individual to use a wheelchair for distances, indicated a change in ability to ambulate. There was no documented information provide to explain the rationale for the new need to use a wheel chair. • Individual #412 The annual medical summary, dated 4/24/12, indicated a diagnosis of progressive cervical spine myelopathy, and post cervical spine laminectomy;	

#	Provision	Assessment of Status	Compliance
		however, the medical plan only stated, "continue using medications for spasticity. Monitor for worsening of cervical myelopathy". The Monitoring Team was not provided any documentation to support that meaningful and regular assessments were specifically done for worsening of myelopathy. Importantly, there was no plan in place to regularly assess the Individual for pain, secondary to the cervical spine disease. A medical provider IPN, dated 5/18/12, indicated a review of a chest x-ray, which incidentally demonstrated compression fractures of the thoracic spine. X-rays of the cervical, thoracic and lumbar spine were then obtained on 5/23/12, which demonstrated multiple compression fractures of the thoracic and lumbar spine. The Individual was evaluated on 5/26/12 by the Facility's consultant neurologist, who documented a note stating that the Individual "returns with cervical myelopathy and is not ambulatory at this time. Again, he is not a surgical candidate. No new complaints", and indicated to re-evaluate the Individual in one year. There was no evidence to support that the consultant neurologist was provided copies of the x-ray reports demonstrating multiple compression fractures. There was no evidence to indicate a determination of the age of the compression fractures, and possible need for palliative treatment. The annual ISP did not indicate the necessary supports and services that were necessary to adequately support this Individual. For example, there was no evidence to indicate that direct care staff were made well aware of possible acute signs and symptoms of worsening myelopathy, pain management, and how to monitor the Individual for progressive worsening of myelopathy. The Monitoring Team is seriously concerned with the Facility not identifying the extent of the Individual's severe degenerative spine disease, and multiple compression fractures of the spine, sooner. Since at least 2003, when myelopathy was first diagnosed, the Individual should have had regular, comprehensive assessments for worsening spine disease, and was not afforded such level of care. Special services and supports, including close monitoring for pain and discomfort, use of a lift for all transfers, and specific treatment for compression fractures, such as calcitonin for acute pain, and perhaps limited invasive procedures, may have offered additional benefit to the Individual, and reduced the additional morbidity, and possible early mortality associated with multiple compression fractures. Summary The Monitoring Team is well aware, and appreciative, that the Facility had recently initiated a process to focus clinical attention on degenerative spine disease. Regardless,	

#	Provision	Assessment of Status	Compliance
		at the time of this review, the clinical practice specific to spine disease demonstrated a lack of a systemic, comprehensive approach to identifying, monitoring, and treating spine disease. <u>Osteoporosis</u> To assess the Facility's ability to clinically manage the diagnosis of osteoporosis, the Monitoring Team selected the first five individuals from a list of all individuals with a diagnosis of osteoporosis, and requested the following documentation: Most recent annual medical summary; most recent annual ISP, completed dental consent form indicating risks associated with bisphosphonate use; current medication list, medication administration record from October 2012; last 12 labs; DEXA reports for past three years; available consultation reports, specific to osteoporosis; evidence to support that the medical provider assessed possible etiology of low bone density. The following is a brief summary of the five individuals reviewed: • Individual #377 As indicated on the annual medical summary, dated 4/11/12, the Individual was diagnosed with osteoporosis by DEXA scan; however, because of gastrointestinal side effects, oral treatment with bisphosphonate was not provided. The medical provider indicated that treatment with calcium and vitamin D will be provided and that a referral to a rheumatologist for i.v therapy would be initiated. There was no evidence provided to support that a rheumatologist had evaluated the Individual during the reporting period. Also, there was no evidence provided that the medical provider initiated a search for the underlying cause of the Individual's severe osteoporosis. The Monitoring Team was unable to determine the total daily amount of calcium that the Individual was provided, as the medication administration record indicated that 400 mg of calcium citrate would be administered, along with a multivitamin (with no indication of the calcium content). The QDRR, dated 6/30/12, did not comment on the adequacy of calcium therapy for the treatment of osteoporosis. Furthermore, there was no information provided on the annual medical summary, or quarterly medical reviews, that estimated the Individual dietary intake of calcium. • Individual #207 There was no evidence provided to indicate that the Individual had seen or was referred to an endocrinologist, although the annual medical summary indicated that a referral would be made. • Individual #694 The Individual consults with a rheumatologist for i.v therapy to treat	

#	Provision	Assessment of Status	Compliance
		osteoporosis. A copy of the consultation report was not provided for review, as requested. There was no evidence to support that a search for the underlying cause of osteoporosis was completed. It is important that before treatment, or there after, that certain comorbid medical conditions be evaluated, such as reversible hormonal conditions, and parathyroid disease. • Individual #679 The Individual was provided a repeat DEXA scan less then two years after the previous DEXA scan. The DEXA scan completed in 2011 indicated a bone density of -2.6, of the lumbar spine, which is diagnostic of osteoporosis, and the DEXA scan completed on 8/6/2012, indicated a result of -2.4, which is osteoporosis. The Individual was appropriately continued on vitamin D and calcium treatment for osteoporosis. There was no evidence to support that the medical provider performed a search, as to the etiology of the Individuals low bone density. • Individual #614 The medical summary, dated 3/30/12, indicated an excellent plan for osteoporosis. The QDRR, dated 10/12/12, indicated a review of medications for osteoporosis. The last DEXA scan, dated 1/8/09, report was greater then three years old, which was appropriate in this case. There was no dental consent provided for review, to indicate a risk for osteonecrosis following dental procedures. Summary: Five out of five cases (100%) included appropriate diagnosis of osteopenia or osteoporosis; four out of five cases (80%) indicated that a bone density study was completed within three years from the previous study; zero out of five cases (0%), indicated that the medical provider had completed an assessment to determine that the etiology of low bone density was known, or that such an assessment was done in the past; of the three cases that indicated the need for consultation with endocrinology, zero out of three cases (0%) included documentation that such a consult had been completed; of the three cases that required specific dental consent for the use of medications for the treatment of low bone density, two of the three cases (33%) included an appropriate dental consent form. The Monitoring Team recognizes that the Facility has improved its assessment, follow-up and treatment of osteoporosis. The Monitoring Team stresses the important of searching for important underlying clinical causes of low bone density, so that such conditions can be clinical corrected. Importantly, certain conditions, such as parathyroid disease, and conditions involving calcium metabolism must be assessed prior to treating Individuals with certain medications. <u>Community Living Discharge Planning (CLDP)</u>	

#	Provision	Assessment of Status	Compliance
		As required by the provisions in Section T, the Facility has the responsibility of assessing individuals and providing information needed for successful movement to a more integrated setting, including identifying and monitoring to ensure provision of needed supports and services. As the following examples show, the Facility needs to improve on provision of such assessments and actions. • Individual #353 Due to death of Individual #353, the Monitoring Team reviewed the CLDP, dated 5/18/12, and post move monitoring reports, dated 5/14/12, and 6/21/12, for Individual #353. The following is a summary of that review: The CLDP did not include some important medical issues, and related follow-up information. For example, the Individual was known to have severe psoriasis, and was to follow-up with dermatology every three to six months. Follow-up with a dermatologist was not documented as an essential support; however, to follow-up as needed with a dermatologist was stated as a non-essential support. The Individual was noted to have a diagnosis of scoliosis, and a Harrington rod placement on the spine; however, this issue was never communicated in the CLDP. Imaging study of the lower spine dated 9/16/10 indicated that the Individual had degenerative spine disease, and this issue was not listed on the CLDP, nor was this condition followed up on at the Facility, or by a medical specialist. Not diagnosed by the Facility was a diagnosis of ischemic small vessel disease, and old lacunar infarcts within the left caudate nucleus, which was reported on a CT of the head report, dated 2/16/12. This serious issue indicated that the Individual had multiple small strokes in the brain, and may have been the cause of both behavior issues, gait imbalance, and falls; this Individual should have followed up with a neurologist for this condition. The Individual was also noted to have had old fractures, with deformities of the arm that were not reported on in the CLDP, nor was there orthopedic follow-up for that condition. The Individual was known to have severe issues related to prostate hyperplasia, and a recent history of both right and left ureter occlusion, which delayed his transition date, and was to follow-up with a urologist by July, 2012; however, the CLDP failed to identify that follow-up as a specific needed support, indicating it was to be scheduled as recommended by the ISP in one place and to continue follow-up with urologist in another. Importantly, there was no evidence the individual had been seen by a urologist prior to his death, as there was no documentation of any appointment or referral documented in the post move monitoring. Regarding post move monitoring, the Monitoring Team could not determine that all medical services and support were provided by the agency, based on review of the post-move monitoring checklists. For example, there was no comment on	

#	Provision	Assessment of Status	Compliance
		reviewing bowel monitoring data, or evaluating the individual's gait for potential worsening; there were no assessments to actually determine if the individual had developed a UTI, which was to be monitored for; there was no actual monitoring of a meal preparation to ensure that the prescribed diet was being adhered to, and there was no actual monitoring of the Individual eating a meal. The Individual was know to have severe arthritis, with reported contractures, and that the only treatment provided and recommendation to the accepting agency was to provide Tylenol for pain, and Tramadol for severe pain. The post move monitoring checklist did not indicate Tylenol for pain, just Tramadol. The Individual was not scheduled to follow-up with a medical specialist, such as an orthopedic specialist, or rheumatologist. Also, it was reported that the Individual was receiving regular physical therapy at the Facility, to assist the individual to maintain range of motion; however, the IDT determined that this support was to be discontinued following transfer from the Facility, and the accepting agency was simply informed to follow-up with a physical therapist in the community. Documentation indicated that the Facility physician provided a letter to the accepting physician, but that this letter was included in the CLDP packet, and not sent to the physician. Formal communication between the accepting primary care physician and Facility physician should (and, for serious issues, must) take place prior to transfer from the Facility, and necessary consultations should scheduled prior to transfer to ensure they will occur timely. • Individual #369 Individual #369 was scheduled to have a CLDP meeting during this monitoring visit. Following review of the Individual's active clinical record, CLDP assessments and the draft CLDP, the Monitoring Team noted the following concerns: o Abnormal EKG's suggestive of possible ischemic heart disease, and no documented follow-up with cardiologist was noted. This issue was not reported on the Medical Assessment provided for the CLDP meeting nor in the draft CLDP. o Had an echocardiogram, which demonstrated mild valve disease, but no follow-up plan in clinical record, CLDP assessment or draft CLDP. o The CLDP indicated to keep the systolic blood pressure below 130; however, the nephrologist consultation dated 7/11/12 recommended keeping the systolic blood pressure between 130 and 140, and the Facility reported to the transfer agency to keep the systolic blood pressure at "around 130's". The Monitoring Team could not find clarification of the monitoring parameter for the agency to follow.	

#	Provision	Assessment of Status	Compliance
		o There was a physician recommendation to follow-up with nephrology clinical at UTMB in six months, which would be 12/4/12. This was discussed at the CLDP meeting, there was agreement that the provider would keep an appointment, scheduled to follow-up with the nephrologist on 12/19/12. o An x-ray of the abdomen on 6/27/11, to evaluate for a bowel obstruction, was negative for bowel obstruction but indicated degenerative spine disease, and degenerative spine disease was not listed as a concern for the transfer agency address. o The Individual had a modified barium swallow on 6/1/11, which indicated the need for a ground diet, and regular liquids, while the CLDP indicated a regular diet. Also noted on this study was large anterior osteophyte at C3-C4, with disc space narrowing of the cervical spine, and there was no mention of cervical spine disease, and there was not follow-up for this condition, noted in the clinical records, and the issue was not discussed at the CLDP. Summary The Monitoring Team determined that the CLDP and post move monitoring process did not adequately ensure that all necessary supports and services were afforded the Individual. It is essential that medical staff ensure that all necessary medical conditions are identified, reported on the CLDP, and that comprehensive monitoring and reporting actions are provided for each identified medical condition, and that all clinical issues are closely monitored by Facility medical staff through the transition period. Also, all necessary medical consultation must be scheduled prior to transfer from the Facility. <u>Active Clinical Record Review / Continuity of Care</u> To assess continuity of care, the Monitoring Team reviewed the active clinical records of Individual #148, and #649. The following is a list of concerns, and brief summary for each review: • Individual #148 Review of the annual medical summary, dated 10/29/12, noted significant medical issues, that included severe osteoporosis; multiple fractures of the spine, ribs, and digits; bilateral cryptorchidism (undescended testicles); peripheral vascular disease; heart valve disease; dysplastic navus; arthritis; and enteral tube placement for dysphagia; and a ventricular shunt of the brain. The following concerns were noted, by the Monitoring Team: o The annual medical summary noted that the individual was to see the neurologist at least once per year to evaluate his ventricular shunt, and there was no neurology consult report documenting this issue. o The annual medical summary noted that the individual was to see the	

#	Provision	Assessment of Status	Compliance
		neurologist and rheumatologist once per year to follow-up on congenital block vertebrae, and the Monitoring Team did not see this issue being addressed by rheumatology and neurology. o The extent of degenerative spine disease and arthritis should have warranted a specific action plan to delineate all necessary supports and services for these severe, and serious medical conditions. In this case, the physician simply documented "Degenerative joint disease. The patient is to be monitored for any type of physical discomfort and follow-up with rheumatologist once per year". Review of consultants' notes indicated that osteoporosis was addressed and there was no indication that the rheumatologist assessed the Individual's arthritis and degenerative spine disease. o Severe osteoporosis, with multiple fractures, and known history of undescended testicles was noted by the physician, and the individual had followed up with rheumatology for osteoporosis; however, there was no indication that sex hormones were evaluated. Hypogonadism, which can be caused by undescended testicles can cause severe hypogonadism, which can manifest in serious osteoporosis. o The annual medical summary plan, dated 10/29/12 indicated that the Individual was to be followed by a urologist at least once a year, and was to have an ultrasound of his testes. Review of urology consult notes indicated that an ultrasound of the testicles completed on 10/29/10 demonstrated bilateral undescended testicles, and that a urology consult dated 1/23/12 recommended that no surgery was indicated because of the individual's age, and that there was a low chance for malignancy. This information was not included in the medical action plan. o There was no recommended follow-up to monitor for worsening heart valve disease. o The Individual was noted to have severe peripheral vascular disease that was diagnosed on 6/24/11 by CT of the abdominal arteries; and per an addendum to the ISP dated 9/2/11 that indicated that medical treatment was provided for peripheral vascular disease; however, there was no treatment plan for this condition documented on the annual medical summary. o The individual was noted to have recurrent aspiration, chronic obstructive pulmonary disease and reactive airway disease, with elevated carbon dioxide levels noted on labs. The physician documented that the condition was stable, and did not document a specific medical plan to assertively manage this issue, for example, careful monitoring of oxygen saturation levels, specific signs, and symptoms to monitor for respiratory distress and early signs of pulmonary infection. Also of concern, was that the etiology of	

#	Provision	Assessment of Status	Compliance
		chronic obstructive pulmonary disease, and reactive airway disease, was not documented. Review of the ISP dated 11/16/11 noted that the ISP and team poorly reflected many serious medical conditions, and did not delineate a meaningful and accurate understanding of the Individual health care issues, and did not indicate the necessary supports and services required to adequately manage this individual's medical issues. For example, the ISP did not comment of the severity of the Individual's respiratory condition, and importance of close monitoring for deterioration; did not comment on the severity of the Individual's degenerative spine disease and importance for staff to closely monitoring for pain, discomfort, worsening disability, and transfer requirements; did not comment on the severity of osteoporosis and how this condition is affecting the individuals life by causing multiple and serious fractures; and there was no discussion about important medical specialists' recommendations, such as the urologist's recommendation not to pursue surgery for undescended testicles because of his age, and low risk for cancer. The Monitoring Team noted that the physician was not involved at the annual ISP meeting, despite the serious nature of the Individual's health care issues. • Individual #649 The Individual was reviewed to assess management of acute care, and continuity of care. The Monitoring Team found a lack of appropriate clinical assessment of acute urosepsis, and subsequent follow-up by the medical provider. This may have contributed to the Individual's distress and to a behavioral exacerbation. The Monitoring Team strongly recommends review of this case and identification of appropriate care for this individual. Summary: Although the Monitoring Team observed improvements with follow-up on diagnostics, consultations, and laboratory data; as well as improvements with documentations, specific to SOAP format IPNs, the Monitoring Team continues to observe lack of meaningful follow-up on medical issues. The Monitoring Team strongly encourages the Facility's medical providers to carefully review all diagnostics, consultations, and other assessment, to ensure that all identified medical conditions are accurately diagnosed, and a comprehensive care plan is put in place. In addition, medical providers should provide regular follow-up through resolution of the medical conditions, and provide regular evaluations to assess chronic conditions. It is exceptionally important to fully evaluate all individuals who manifest signs and symptoms of behavioral conditions, for potential underlying medical explanations.	

#	Provision	Assessment of Status	Compliance
		Conclusion: The Monitoring Team noted many improvements in the area of medical services. For example, the medical providers are more regularly documenting in SOAP format, and completion of medical summaries had significantly improved. It was noted that in most cases, each diagnosis on the medical summary included a medical plan. In general, medical providers are addressing acute medical issues more timely, and are following up on acute care issues more closely. The Facility is doing an outstanding job by ensuring that individuals are offered screening colonoscopy, and mammography. The Monitoring Team did note areas that continue to need marked improvement, especially in the area of ensuring a comprehensive review of underlying medical conditions. For example, individuals were not assertively assessed as to the underlying causes of osteoporosis, and individuals with degenerative spine disease did not have assertive clinical plans developed to ensure that all appropriate supports and services could be provided. Medical providers must assertively assess all acute conditions, and rule out medical conditions that may be manifesting in behavioral issues. The Monitoring Team had significant concerns over the development of the CLDP, and clinical follow-up of individuals who transferred to the community. It is essential that all appropriate supports and services be identified and provided to individuals who transfer to the community. Likewise, it is essential that individuals be clinically monitored through the post-discharge monitoring period. Medical providers should responsible to ensure that all clinically necessary supports and services are identified for individuals who reside at the Facility, and that nursing and direct care staff are provided clear, concise monitoring and reporting parameters for all clinical conditions.	
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.	To assess the Facility's ability to maintain a medical review system that consists of non-Facility physician case review and facilitate quality of medical care and performance improvement, the Monitoring Team assessed the Facility's internal and external medical audit process, and mortality review process. <u>External Medical Audits</u> The Facility was provided round 6 of the external medical audit, on September 28, 2012. The Facility expects medical providers to achieve 100% compliance in essential items, and the medical management component of the audit process, and 80% in non-essential items. Six medical providers were included in the audit process. Four out of six medical providers were noted to have 100% compliance in essential items; one out of six medical providers achieved 88% in essential items; and the remaining medical provider achieved 97% compliance in essential items. Six out of six medical providers (100%), achieved	Noncompliance

#	Provision	Assessment of Status	Compliance
		greater then 80% compliance in non-essential items. Two out of six medical providers (33%) achieved 100% compliance in the medical management component of the audit. <u>External Medical Audit Report</u> The Facility contracted with an external physician who specializes in medical quality assurance, to conduct its external medical audits. The external physician issued a medical provider external review report, dated 10/5/12. The Monitoring Team concurred with the reviewer's report in determining the following strengths of the Facility: a. Provision of preventive services b. Appropriate and timely evaluation of individuals following readmission to the Facility (following a hospital admission) c. Prompt recognition of consultant recommendations. The report however, did not comment specifically on clinical performance issues, and did not comment if the provision of medical services met practice standards in the management of individuals with multiple and complex medical and behavioral conditions, within the context of a residential Facility. As noted above, in Provision L.1, the Monitoring Team noted significant issues with regard to the identification, treatment, and follow-up of medical conditions, such as degenerative spine disease, constipation, and evaluation of behavioral exacerbation. The Monitoring Team determined that the medical management component of the medical audit review process did not appropriately assess the medical provider's proficiency in providing medical care, as the audit tool does not assess clinical outcomes and determine if standard of care practice was employed in the provision of medical care. <u>Internal Medical Audits</u> The Facility conducts its own medical audit process, based on the same questions and format as the external medical audit, and requires the same compliance rating by its medical providers. Round six of the internal medical audit occurred on September 28, 2012. Two out of six medical providers (33%) achieved 100% on essential items, and four out of six achieved less then the required 100% compliance on essential items. Six out of six medical providers (100%) achieved greater then 80% on non-essential items. Only five medical providers participated in the medical management component of the internal medical audit process. Three out of five medical providers (60%) achieved the required 100% compliance, while the remaining two medical providers achieved less then 100%. <u>Corrective Action for Medical Audits</u> The Facility maintained a quality assurance process to ensure that medical providers	

#	Provision	Assessment of Status	Compliance
		follow up on all items noted to be deficient from the internal and external medical audit process. The Monitoring Team was unable to assess the Facility's quality assurance process at the time of this review. <u>Mortality Review</u> Since the last compliance review, four deaths had occurred at the Facility. One death had occurred while the Monitoring Team was onsite, on 5/15/12. This death was included in the compliance review. At the time of the Monitoring Team's compliance review, one of the recent deaths (10/4/12) had been reviewed by both the Clinical and Administrative Death Review Committees. For this death the Clinical Death Review Committee's recommendations had begun implementation. The Facility was in the process of completing the Administrative Death Review Committee's minutes and recommendations, if any. The Monitoring Team met with the State Office Nursing Coordinator, Medical Director, Chief Nurse Executive, Quality Assurance Nurses, and Medical Records Director and reviewed and discussed each of the four deaths. The Monitoring Team's review of the documents supplied for review on the four deaths demonstrated that the Facility conducted Clinical and Administrative Death Reviews according to their Administration, Actions Following Death of Individual Served, A.7, Policy, with the exception of including an external physician as part of the Clinical Death Review Committee as required by policy. According to the Administration, Actions Following Death of Individual Served, A.7, Policy, "A physician external to the Department of Aging and Disability Services could be physicians who are consultants or contractors, or physicians from other state centers, or one of their external consultants. The state medical coordinator could also act as the external physician." The Facility should ensure that external physicians participate at the Clinical Death Review Committee meetings. The Facility continued to maintain and improve their comprehensive tracking systems for recommendations resulting from the Clinical Death Review Committee and Administrative Death Review Committee. The Medical Records Director continued to notify staff members who were responsible for carrying out the recommendations and tracked completion of recommendation through to resolution. In addition, the Quality Assurance Program Auditor continued to conduct follow-up review of actions taken in response to the recommendations from each death review to verify they were carried out through to resolution. The Monitoring Team's review of the Facility's Death Review Recommendation Tracking data indicated that the recommendations were appropriate in relation to the findings in the documents supplied for review. The Monitoring Team noted however, that a comprehensive root cause analysis of each death did not occur.	

#	Provision	Assessment of Status	Compliance
		Each death reviewed included a comprehensive assessment of the circumstance that occurred immediately prior to death, and the management of the immediate cause of death but did not explore the clinical management of the underlying cause of death. For example, if an individual died secondary to a respiratory arrest, the Facility would assess management of the respiratory arrest, which would be the immediate cause of death; however, the overall management of the underlying pulmonary condition would not be assessed. It was positive to find that the recommendations were more systemic than were found in previous compliance reviews. All Clinical and Administrative Death Review Committees' recommendations for three of the four deaths had been implemented through to resolution, with one exception. This recommendation was for the Hospital Liaison Nurse to receive more training at another state center; the training was scheduled for 11/26/12. The recommendations for the most recent death were in process, but had not yet had time for completion. The status of the recommendations for this death will be reviewed at the next compliance review. General findings for the four deaths reviewed included: • Of the four deaths, the average age was 58.5 years (ages varied from 53 to 61 years of age). • All of the four decedents were residents in the Trinity Unit (three in Trinity D and one in Trinity B). This was in the unit where individuals reside who were identified as the most medically complex with multiple high-risk ratings. • Zero of the four (0%) deaths had an autopsy completed. • One of four (25%) deaths, according to the Unusual Incident Investigation-Incident Tracking Number: 12-173, was reported to the Department of Family Protective Services (DFPS), Office of the Inspector General (OIG), and Fort Bend County Sheriff's Department (FBCSD) for alleged neglect/abuse regarding the death of Individual #145. The reports of these investigations were not available for review. • Four of four (100%) deaths had appropriate Unusual Incident Reports (UIRs) completed related to circumstances surrounding the deaths. In three of four (75%) the manner of deaths were reported as occurring naturally and were expected. One death was reported occurring under unusual circumstances, pending investigation reports by DFPS, OIG, and FBCSD. • Four of four (100%) decedents had Do Not Resuscitate (DNR) orders signed prior to illness/injury and/or at the time of death. • Four of four (100%) of the deaths occurred in a local hospital. • The cause of individuals' deaths, as determined by the Fort Bend County, Texas, Death Certificates, are listed in the chart below: 1. Primary Cause of Death: Respiratory Failure Secondary Cause of Death: Pneumonia Tertiary Cause of Death: Septic Shock	

#	Provision	Assessment of Status	Compliance
		Significant conditions contributing to death: Multi-System Organ Failure and Down's Syndrome 2. Primary Cause of Death: Respiratory Failure Secondary Cause of Death: Acute Respiratory Distress Syndrome Tertiary Cause of Death: Septic Shock Significant conditions contributing to death: Dysphagia and Down's Syndrome 3. Primary Cause of Death: Septic Shock Secondary Cause of Death: Multi-system Organ Failure Significant conditions contributing to death: Severe Esophageal Reflux and Ileus 4. Primary Cause of Death: Respiratory Failure Secondary Cause of Death: Renal Failure Tertiary Cause of Death: Heart Failure Fourth Cause of Death: Sepsis As was recommended in past compliance reviews, 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. 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. According to the State Office Nursing Coordinator, the State was still 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. Summary: The Facility had made significant strides in improving on its mortality review process. Mortality reviews were completed more timely, and were more substantive. The executive director, along with the director of nursing and the medical director were more assertive in the review process. The immediate cause of death was carefully reviewed, and improvements in developing action plans for noted deficiencies occurred. The Facility had yet to develop a mechanism to track and trend outcomes from the death review process. Importantly, the Facility did not employ the use of a systematic approach when conducting a death review. The Monitoring Team also noted that the	

#	Provision	Assessment of Status	Compliance
		Facility did not conduct a root cause analysis of the clinical management of the underlying cause of death. Such an analysis would provide meaningful insight into the medical providers clinical practice, and performance. Conclusion The Monitoring Team noted significant improvement in developing a meaningful process to assess clinical performance of its medical providers. The current internal and external medical audit process is performed regularly, and provides good insight into the medical providers' adherence to Facility policy, and documentation standards. The Monitoring Team determined that the process did not adequately assess the clinical performance of the Facility's medical providers, as it did not review clinical outcomes, or assess the providers' adherence to standard of care guidelines. Compliance will require that the Facility develop and implement a process that assesses performance measures on clinical outcomes, and adherence to acceptable practice standards for medical management that are based on standard of care guidelines. The Facility had significantly improved on its mortality review process; however, compliance will require that the Facility develop, and implement a process to track and trend mortality review outcome data, implement a process to ensure that a root cause analysis of the medical management of the underlying cause of death is assessed, and to develop a standardized approach when conducting a mortality review.	
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 L.3, requires that the Facility develop and implement a meaningful process that enables a medical quality review process, that will lead to improvement with the provision of medical services. The Monitoring Team was most impressed by the many systems improvement measures that the Facility had been developing, and in part implemented. The following is a summary of the medical quality assurance processes that they have been further developing during the review period: <u>Chronic Clinical Indicator Policy</u> The Facility had developed and implemented a policy that requires the medical providers to research chronic disease topics and present findings to the medical staff. Chronic disease database is to be developed for each topic that was identified. The database would help ensure that standard of care practice in implemented, and outcome data is to be tracked and trended, and a plan of correction would be developed for areas identified as deficient. <u>Clinical Database</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
		At the time of this review, the Facility had developed and implemented the diabetes mellitus database, osteoporosis, and a medical follow-up database. The Facility was developing a developmental disability healthcare screening database, and a database for neuromotor, and musculoskeletal database. Review of the trends analysis, and policies for the diabetes mellitus, osteoporosis, and a medical follow-up databases, demonstrated the functionality, and benefit of tracking and trending clinical outcome data, and the Monitoring Team is supportive of such efforts. As an example, the diabetes trend analysis report of 8/31/12 recorded a discussion of what the database track;, which individuals were above goal for HgA1C and what has been done to respond; and similar information for some individuals with high blood pressure or elevated microalbuminuria to creatinine ratio. The Trend Report did not include data on the status across all individuals, which would provide a set of information that would be useful in determining the status of health care across the Facility. <u>Nursing Diabetic Education</u> Under the leadership of the medical director, the Facility established a comprehensive process to address the management of diabetes. In addition to the diabetes database, which monitors the medical providers management of diabetes, the Facility developed a comprehensive, multidisciplinary process that helps to ensure that nursing, dietary, and other discipline, are actively involved in the management of diabetes. Most impressively, the Facility also provides meaningful education to the individuals, as well as to their family members, prior to off campus experiences. Therefore, the individual, and family members are reminded of the importance of timely administration of medication, and dietary requirements. The Monitoring Team strongly encourages similar processes to be developed for other common, and serious medical conditions. Conclusion: Following discussion with the medical director, and review of the policies, current databases, and trends analysis, the Monitoring Team is most complimentary, and is supportive of the Facility's effort to develop, and implement additional databases to be used in the context of medical quality assurance. Most impressive was the Facility's development and implementation of the nursing diabetic education process, which helps to enable a multidisciplinary approach to the management of diabetes. At the time of this review, the Monitoring Team determined that the Facility is non-compliant with Provision L.3, as compliance will require that the Facility fully implement its medical quality assurance process, and demonstrate efficacy by ensuring clinical practice meets or exceeds standard of care practice. The Facility has clearly demonstrated its ability to effectively address, and ensure quality practice, and improved outcome in the area of diabetes.	

#	Provision	Assessment of Status	Compliance
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Monitoring Team reviewed the Facility's new policies, for medical quality improvement. Five new policies, and one policy revision were developed during the reporting period. The Facility had developed and implemented many new quality improvement measures, including a process to ensure that a pre-hospital discharge planning meeting occurs prior to individuals returning home from the hospital; a new process that helps to ensure that medical providers initiated an actual letter to consulting physicians provided needed information prior to a consultation visit, and a seizure management guideline. In addition, the Facility developed policies for its developmental disability healthcare screening, and medical follow up databases, and revised the policy for chronic clinical indicator policy. The Monitoring Team was impressed by the level of commitment that the medical services department demonstrated by its development and implementation of many novel and comprehensive initiatives to improve medical services at the Facility. The Monitoring Team clearly concurs with the Facility's direction; however, at the time of this review, the Monitoring Team determined that the Facility remain noncompliant with Provision L.4. Compliance will require that all policies and procedures be fully developed and implemented, and that they demonstrate efficacy. For example, the Facility had developed and implemented a robust mechanism to ensure that a hospital discharge planning meeting take place, prior to discharge from the Hospital. The Monitoring Team reviewed this process, and determined it to be excellent; however, upon review of its implementation, the Monitoring Team noted that the policy was not being assertively adopted, as several hospital discharges occurred without the new process being followed.	Noncompliance

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

1. Ensure that appropriate clinical rationale is designated for all active DNR orders. (Provision L.1).
2. The medical provider must assertively assess each fracture, as to the root cause. (Provision L.1).
3. The Facility must continue efforts to minimize the use of older AEDs, when clinically appropriate. (Provision L.1)
4. The medical provider must better classify the seizure disorder. (Provision L.1)
5. Medical providers must better assess possible causes of seizure exacerbation. For example, consider missed doses, drug-drug interactions, and co-morbid acute medical conditions. (Provision L.1).

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: 11/2/12 2. RSSLC Section M Action Plan, Updated: 10/15/12 3. RSSLC Section M Presentation Book 4. Texas Department of Aging and Disability Services (DADS) Policy: Emergency Response, Policy Number: 044.2, Effective 9/7/11 5. DADS Medication Variance, Policy Number: 053, Effective: 9/23/11 6. DADS Procedure: Medication Administration Guidelines, Revised: October 2012 7. DADS Nursing Services, Policy, Effective 9/20/12, Replaces: 010.1 8. RSSLC Pre-Hospital Discharge Planning Policy, Dated: 9/6/12 9. DADS Nursing Protocol: Seizure Management Guidelines, February 2011 10. DADS Nursing Protocol: Vagal Nerve Stimulator, February 2011 11. RSSLC Providing Health Care Services, Emergency Response, I.01, Revised: 5/2/12 12. RSSLC Nursing Services, Medication Administration Guidelines, A-1, Revised: 8/21/12 13. RSSLC Nursing Services, Vascular Access Ports (VAP), A-4, Revised: 11/7/12 14. RSSLC Nursing Services, Seizure Management Guidelines, A-12, Revised 6/6/12 15. RSSLC Vagal Nerve Stimulator (Seizure Management Attachment), A-13, Revised: 8/1/12 16. RSSLC Nursing Services, Nursing Procedure: Diastat AcuDial, A-14, Revised: 8/15/12 17. RSSLC Health Services, Nursing Protocol for "Real Time Data" Monitoring of Infections, Date: 7/23/12 18. RSSLC Health Care Services, Internal Nursing Monitoring Tools, Date: 3/1/12 19. RSSLC Providing Health Care Services, Medication Variances, I.34, Effective: 9/23/11 (2/27/12) 20. RSSLC Providing Health Care Services, Emergency Response, 5/2/12 21. RSSLC Nursing Services, Pain Management and Pain Medication Logarithm, E.25, Date: 10/24/12 22. RSSLC Nursing Organizational Chart 23. RSSLC Nursing Services Training Roster, 8/3/12 24. RSSLC Nursing Services Percentage of Trained by Course, 6/14/12 and 8/3/12 25. RSSLC Nursing Services Summary of Minimum staffing Patterns, for the past six months 26. RSSLC Nursing Positions Budgeted for Fiscal Year 2012 27. RSSLC Registered Nurse Case Managers' Caseload Roster 28. RSSLC Nursing Services Staffing Patterns 29. RSSLC Nursing Services – Nursing License Review, for the past six months 30. RSSLC Nursing Services Number of Overtime Hours used over past six months 31. RSSLC Nursing Services Meeting for the Week of 11/12/12 32. RSSLC Nursing Services Meetings, for the past six months 33. Longitudinal Trend Report for Monthly Nursing Monitoring Tool, April thru September 2012 34. RSSLC Nursing Services Monitoring Tools used, other than the Nursing Care Monitoring Tools 35. RSSLC Campus Nurse Report, 11/11/12 36. RSSLC 24-Hour Nursing Reports for all Units and Infirmary, 11/9/12, 11/10/12, and 11/11/12 37. RSSLC Nursing Plan of Improvement Meeting Minutes, for the past six months 38. RSSLC Lists of Pressure Ulcers and Non-pressure Ulcers, 11/7/12 to 11/14/12

	39. RSSLC Summary of Infections, 4/1/12 through 9/30/12 40. RSSLC Infection Control Hand Washing and Glove Use Data Report, 4/1/12 through 9/30/12 41. RSSLC Infection Control Quarterly Meeting Minutes, 4/10/12 and 7/10/12 42. RSSLC Infection Control Policy and Procedure Meeting Minutes, 5/8/12, 5/15/12, 6/26/12, 8/14/12, 8/21/12, 9/11/12, and 9/25/12 43. RSSLC Competency-based Infection Control Training Materials (Scabies, Conjunctivitis, Shingles, West Nile Virus, Tuberculosis Testing, Handling Biohazard Waste, Infection Control form for Real Time Data Reporting, Immunization Record Data Entry) and Training Rosters, for the past six months 44. Regional Clinical Laboratory Epidemiology Report, 4/1/12 through 9/1/12 45. Department of Health and Human Services, Centers for Disease Control and Prevention, Plan Now to be Ready for the Next Flu Pandemic, October 2008 46. RSSLC Infection Control Monitoring Tools and Summary of Audits April 2012 through September 2012 47. RSSLC Infection Control Active Employee Course Participation Report, 10/17/11 to 10/17/12 48. RSSLC Percentage of Individuals with Current Flu Vaccinations 49. RSSLC Percentage of Individuals Current with Tuberculosis (TB) Testing 50. RSSLC Percentage of Employees Current with TB Testing 51. RSSLC Percentage of Employees Current with Flu Vaccinations 52. RSSLC Percentage of Employees Current with Hepatitis B Vaccinations 53. RSSLC Skin Integrity Committee Meeting Minutes, for the past six months 54. RSSLC Infirmary Admission Log, September 2011 through September 2012 55. RSSLC Hospital Admission Log for 2012 56. RSSLC List of Individuals seen in the Emergency Center 2012 57. RSSLC Summary and Analysis of Nurse Managers' Emergency Equipment and Automated External Defibrillator (AED) Checklists, for past six months 58. RSSLC List for Location of Emergency Equipment and AED 59. RSSLC Cardiopulmonary Resuscitation (CPR) Basic Course Delinquency List, 10/17/12 60. RSSLC List of Staff Responsible for Conducting Mock Medical Emergency Drills 61. RSSLS Summary of Mock Medical Emergency Drill Reports, for the past six months 62. RSSLC Emergency Medical Response Committee, Core Membership Group 63. RSSLC Emergency Medical Response Committee Mission Statement 64. RSSLC Emergency Equipment Walkthrough Reports, for the past six months 65. State Supported Living Center's Emergency Drill Instructor Competency-based Training Material and Training Rosters 66. RSSLC Emergency Medical Response Committee Minutes, 6/14/12, 7/18/12, and 8/29/12 67. RSSLC Nursing Services Summaries and Analysis for Acute Care Plans, for the past six months 68. RSSLC Nursing Services Training Tracking Records, for the past six months 69. RSSLC Twelve Most Recently Completed Integrated Risk Rating Forms and Risk Action Plans 70. RSSLC Individuals' Risk Ratings by Risk Category Report, 10/11/12 71. RSSLC Medication Variances Committee Meeting Minutes, for the past six months 72. RSSLC Medication Variances Trend Reports for Rolling 12 Months 73. RSSLC Ten Most Recent Medication Variance Reports 74. RSSLC Pharmacy and Therapeutics Meeting Minutes, 5/16/12 and 7/11/12

	75. Sample of Seizure Records and associated documentation selected across Units for Individuals: #701, #202, #215, #227, #712, #471, #77, and #107 76. Sample of Blood Glucose Meter Quality Control Records for Individuals: #641, #530, #306, #723, #748, and #680 77. Sample of Active Acute Care Plans for Infections and associated documentation selected across Units for Individuals: #315, #712, #19, #389, #415, and #268 78. Sample of Active Acute Care Plans for Skin Integrity Issues and associated documentation selected across Units for Individuals: #596, #212, #413, #192, and #462 79. Sample of records from each unit for the Admission, Annual and/or Quarterly Comprehensive Nursing Assessments completed over the past six months for Individuals: #107, #689, #738, #77, #259, #275, #634, #284, #625, #109, #651, #480, #649, #212, #500, #25, #709, #152, #613, #24, #31, #576, #787, and #588 80. Sample of Community Nursing Discharge Summaries for Individuals: #615, #193, #166, #100, #43, #128, #550, #713, #375, #201, #290, #573, #261, and #119. 81. Sample of Aspiration Trigger Data Sheets and Integrated Progress Notes selected across Units for October 2012, on Individuals rated at high risk for aspiration: #284, #579, #377, #649, #259, #523, #603, and #701 82. Sample of Recently or Current Hospitalized Records for Individuals: #564, #783, #577, #161, and #148 83. Sample of Integrated Risk Rating Forms and Risk Action Plans for Individuals: #25, #709, #152, #613, #31, and #24 **People Interviewed:** 1. Valerie Kipfer, RN, MS, State Office Nursing Coordinator 2. Charlene McCurry, RN, Chief Nurse Executive (CNE) 3. Constance Bowie, RN, Nurse Operations Officer (NOO) 4. Genniffer Moore, RN, Program Compliance Nurse 5. Emma Purvey, RN, Infirmary/Campus Director 6. Franca Uzueqbu , RN Case Manager Supervisor 7. Adriano Soria, Jr., RN, Hospital Liaison Nurse 8. Ugo Nweke, RN, Nurse Educator 9. Wickliff Fawibe, RN, Skin Integrity Coordinator 10. Reneda Simmons, RN, Infection Control Nurse 11. Antonio Crescini, RN, Assistant Infection Control Nurse 12. Deloris Milligan, RN Nurse Manager, Trinity 13. Wilma Parker, RN, Quality Assurance Nurse 14. Robyn Partridge, RN, Quality Assurance Nurse 15. Staff RNs and LVNs **Meeting Attended/Observations:** 1. Nursing Report Meeting, 11/12/12 2. Nursing Plan of Improvement (POI) Committee Meeting, 11/12/12 3. Meetings with Nursing Administration and Specialty Nurses, 11/12/12 4. Medication Room Observations San Antonia, 11/13/12

	5. QA QI Council Meeting, 11/13/12 6. Infection Control Committee Meeting, 11/13/12 7. Integrated Clinical Meeting, 11/14/12 8. Skin Integrity Committee Meeting, 11/14/12 9. Pharmacy and Therapeutics Committee Meeting, 11/14/12 10. Interdisciplinary Team Meeting for Individual #465, 11/14/12 11. Medication Administration Observations, Trinity A, C, and D, 11/14/12 12. Pre-Discharge Meeting for Individual #161, 11/15/12 13. Pre-Integrated Support Plan Meeting for Individual #649, 11/15/12 14. Medication Variance Committee Meeting, 11/15/12 15. Meeting with the Emergency Response Team, 11/15/12
	Facility Self-Assessment: The Facility's Self-Assessment, updated 11/2/12, provided comments/status for Section M, Provisions M.1 through M.6 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions M.1 through M.6. This was consistent with the Monitoring Team's findings as all Provisions were found to be noncompliant. The new format used for the Facility Self-Assessment, was much improved over the format used in previous reviews. This provided useful information for the activities they had engaged in for each Provision. The Facility used data as part of their regular monitoring and reporting process, including trends reporting to the Quality Assurance/Quality Improvement Council. They used data in the Self-Assessment for each Provision to validate the activities performed and provided a rationale for their Self-Assessment of compliance toward each Provision. The information was valuable to compare each of the Provisions their assessment findings to those of the Monitoring Team. The Action Plan, updated 10/15/12, was equally as useful because it provided the Monitoring Team with a status of the action steps taken for each Provision, stated which steps were completed and/or were ongoing, and the projected date of completion for action steps that were in progress. The action steps began to include self-initiated activities as opposed to only including activities related to the Monitoring Teams recommendations. The completion of these actions steps should lead the Facility forward toward reaching compliance with this Section of the Settlement Agreement.
	Summary of Monitor's Assessment: Overall the Facility had made progress in all provisions except Provision M.5. The lack of progress in this Provision was due to the recently implemented new processes for the Integrated Risk Rating Form and the Integrated Health Care Plan, which had not yet had time to produce enough data to measure compliance. There was significant progress made in Provisions M.1, M.2, M.3, and M.4 relating to the assessment and documentation of acute changes in health status, annual and quarterly comprehensive nursing assessments and associated care plans. This was no doubt attributable to the increased efforts put forth in training and retraining the nursing staff and increased monitoring of Provision M.1, M.2, and M.3. These efforts

	significantly moved these Provisions toward compliance. 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 RN Case Manager Supervisor was hired, effective 6/1/12. There were four Registered Nurse and one Licensed Vocational Nurse vacant positions. The staffing ratios were reported as consistently being met. No agency nurses were used. Nursing internal audits and Quality Assurance Nurses' external audits had increased the inter-rater level of agreement between the two sets of auditors and Corrective Plans of Action were being developed, implemented, and tracked by the Quality Assurance Nurse for local and systemic issues. . 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 continuing improvement. The Infection Control Program continued to show improvement with the two Infection Control Preventionist Nurses. The Infection Control Program continued to refine and improve some processes in the areas of tracking, analyzing, and trending infection control data, as described in the report. The Wound Care Nurse continued to provide excellent wound care management in collaboration with other relevant disciplines. There was one hospital acquired Stage IV pressure ulcer reported and no facility acquired pressure ulcers acquired over the last six months. This was commendable considering the number of residents who were determined medically complex, which was a significant improvement. The Hospital Liaison Nurse continued to make routine visits and phone calls for individuals hospitalized and kept the IDTs informed of individuals' health status. Recently, the Hospital Liaison began arranging and participating in Pre-Hospital Discharge Planning meetings. The Pre-Hospital Discharge Planning meetings were a positive step forward in arranging for a smooth transition of individuals' return home. 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. 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 Committee was concerned with the storage and security of emergency equipment in areas outside the living units and was in the process of resolving the problem. The Mock Medical Emergency Drills should include a variety of scenarios that might require emergency response. 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 nursing assessments may be attributable to the recently hired RN Case Manager Supervisor and Nurse

	Educator who had worked aggressively with the RN Case Managers to improve the quality of nursing assessments. The training the Nurse Case Managers received on the State's required Physical Assessment and Documentation Class had made significant improvement in the quality of the physical assessments and documentation. However, the RN Case Managers need continuing improvement on 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. The recently hired RN Case Manager had worked aggressively with the RN Case Managers to identify deficiencies with the health care plans and had taken corrective action to improve the quality of the health care plans sufficient to meet individual health care needs. The Nurse Educators had also reinforced training and monitoring for compliance. The Facility had recently implemented the new processes for the Integrated Risk Rating Form and Integrated Health Care Plan. The Integrated Health Care Plan will replace nursing's Health Management Plans. The new processes were too recently implemented to determine compliance. Provision M.4: This provision was not found in compliance. The Nurse Educator continued to provide the required nursing annual competency–based refresher training and New Nurse Orientation. The Nurse Educator continued to maintain an excellent tracking system for training to ensure that nurses receive all required and other identified training as needed. The Nurse Educator had begun conducting audits on the nursing protocol to ensure the nurses understood and carried out the requirements of the protocols. 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, but also 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 and to meet compliance with this Provision. Provision M.5: This provision was not found in compliance. There was no significant improvement found in this Provision. For compliance, 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. The lack of progress in this Provision was due to the recently implemented new processes for the Integrated Risk Rating Form and the Integrated Health Care Plan, which had not yet had time to produce enough data to measure compliance. Provision M.6: This provision was not found in compliance. Although improvements were found, there remained the need for continuing improvement. 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. From the Monitoring Teams' medication administration observations it appeared that the nursing staff administering medications continued to need enhanced dysphagia training to better understand and carry

	out safe medication administration strategies. The State-developed Medication Administration for Individuals with Dysphagia and/or Swallowing Difficulty training was projected to be taught in December 2012 to all relevant administrative/management nurses and direct care nurses who administer medication.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	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. Continued improvements were 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 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. Information addressing assessment and documentation regarding restraint use is included in Section C and death review information is reported in Section L of the report. <u>Staffing</u> At the time of the compliance review there were 347 residents residing at the Facility. The Facility reported a total of 167 budgeted nursing positions (102 RNs and 65 Licensed Vocational Nurses [LVNs]) of which 162 positions were filled, with five vacancies (one LVN and four RNs). Ten of the RN positions were for Nursing Administration and three RN positions were dedicated to other departments (two to the Quality Assurance Department, and one to the Habilitation Department). The Nursing Department's Administrative and Management Nursing staff had continued to remain relatively stable. They continued to be highly motivated and dedicated to providing high quality nursing services. Since the last compliance review the Nursing Department had hired a RN Case Manager Supervisor. This was a much needed position. Having a RN Case Manager Supervisor providing more oversight and direction to the RN Case Managers will free up the Unit Nurse Managers to provide more oversight and direction to the direct care nursing staff. The Nursing Department was fortunate to continue to have experienced and competent specialty nurses, i.e., Program Compliance Nurse, Certified Wound Care Nurse, Nurse	Noncompliance

#	Provision	Assessment of Status	Compliance
		Educator, Hospital Liaison Nurse, Infection Control Preventionist Nurse, Infection Control Preventionist Nurse Assistant, and Clinic Coordinator. This was demonstrated through interviews and record reviews of their documented assessments and management of conditions related to their area of expertise, as well as evidence of collaboration with other relevant disciplines. Refer to information reported below in this section related to specialty areas of nursing practice. The Monitoring Team's review of the summary of nursing staffing reports for the last six months found that none of the Units/Infirmary shifts had fallen below the established minimum 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. The Nursing Department continued to not to use agency nurses to supplement staffing. <u>Quality Assurance Efforts</u> It was impressive to find that the Program Compliance Nurse had prepared an excellent and comprehensive summary of the activities performed for this provision since the last compliance review. She was knowledgeable of activities and was able to answer questions and provide supporting documentation when requested. Since the last compliance review the POI Committee 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, Infirmary Director, 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 identified and clarified technical problems and/or questions found on the monitoring tools. Since the last compliance review, the Nursing Care Monitoring Tool Guidelines had been revised for clarification. When the auditors had questions they were referred to the guidelines to clarify and to ensure consistency among the internal and external auditor. The POI made recommendations for corrective action as the monitoring tools were reviewed and discussed. The Monitoring Team validated recommendations made for corrective action through review of the weekly POI Committee Meeting Minutes and through attendance at the POI Committee Meeting on 11/12/12. Instead of auditing 12 monitoring tools monthly, the POI Committee will begin auditing four monitoring tools per month with an increase of 12 samples of each tool, in order to get a more accurate and systemic picture of each tool in a monthly review. The inter-rater agreement between the QA Nurses and internal Nursing had increased. A total of 15 audits were	

#	Provision	Assessment of Status	Compliance

completed on five different monitoring tools, April through September 2012, with a range of 98% to 100% agreement. The Monitoring Team found progressive improvement in all of Nursing Care Monitoring, which may be at least in part, attributable to the efforts put forth by the POI Committee. However, the POI Committee should not only look at satisfying the criteria on the Nursing Monitoring Tools, but also evaluate the quality of care documented in the records reviewed.

Nursing Care Monitoring Tools completed monthly included a sample of 12 tools selected by the Quality Assurance Department for April through September 2012. In October 2012 the nursing staff began auditing 12 samples of four of the 12 Nursing Monitoring Tools monthly. The nursing staff responsible for conducting the audits included the Nursing Administrative staff (Infection Control, Skin Integrity, Hospital Liaison Nurses, and RN Case Manager Supervisor), and Nurse Managers.

The Monitoring Team reviewed the Facility's Self-Assessment Longitudinal Trend Report for Monthly Monitor Tool Audits (Internal and External), April through September 2012, for the last six months in all 12 of the Nursing Monitoring Tools as demonstrated in the chart below:

Monitoring Tools	April	May	June	July	August	Sept.	Overall
Urgent Care/ER/Hospitalizations	55%	93%	83%	83%	76%	90%	80%
Management of Chronic Respiratory Disease	94%	94%	94%	100%	100%	58%	89%
Pain Management	67%	90%	90%	90%	60%	73%	80%
Skin Integrity	92%	77%	92%	100%*	100%*	100%*	95%
Medication Administration and Documentation	85%	80%	92%	90%	83%	72%	85%
Infection Control	100%	100%	80%	100%	100%	95%	96%
Prevention	100%	62%	100%	100%*	100%*	100%*	94%
Seizure Management	94%	83%	96%	97%*	99%*	100%*	95%
Documentation	33%	94%	89%	100%*	94%*	100%*	85%
Acute Illness and Injury	100%*	100%	100%*	100%	89%	84%	96%
Annual Nursing Assessment	91%	80%	99%	95%	84%	74%	87%
Annual Nursing Care Plans	95%	89%	44%	94%	96%	78%	83%

The Facility's Self-Assessment's Summary: Overall average compliance reported that three of 12 (25%) of the tools fell below 85% compliance from April 2012 through September 2012. *The inter-rater reliability for five of five (100%) tools (see asterisks on the above chart) was 85%. The overall average percentages for all monitoring tools were above 80% compliance

#	Provision	Assessment of Status	Compliance
		for the reporting periods for April through September 2012. Corrective Action Plans (CAPs) were implemented for trends identified in the Urgent Care/ER/Hospitalizations and Pain Management Monitoring Tools. Previously a CAP was implemented for the Annual Nursing Care Plans audits below 80% compliance. However, a CAP was not implemented for the Annual Nursing Care Plans during this reporting period because this CAP was ongoing and care plans were updated when annual nursing care plans come up or review. These CAPs were available for review. In addition to the CAP for Pain Management, the Nursing Department had developed and implemented Nursing Guidelines for Pain Management, 10/14/12, and a Random Pain Log review system to improve pain assessments and management. Since these guidelines and random monitoring for pain management were recently implemented, there was no analysis and trend data yet available for review. The Monitoring Team will review the pain management data at the next compliance review. The Nursing auditors and QA Nurse auditors completed the inter-rater reliability checks on the following Nursing Care Monitoring Tools and reported the following: • Acute Illness and Injury with 100% agreement April through June 2012 • Skin Integrity with 100% agreement July through September 2012 • Prevention with 100% agreement July through September 2012 • Seizure Management with 99% agreement July through September 2012 • Documentation with 98% agreement July through September 2012 This was a significant improvement from past compliance reviews. However, the two reports of percentage of agreement (this report and the self-assessment) differed in the percents reported, with the self-assessment reporting 85%. As more reliability checks are done, and if reports are consistent, 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. The Monitoring Team attended the QI/QA Council Meeting 11/13/12, where the Nursing Care Monitoring Tools for Acute Illness and Injury, Annual Nursing Care Plans, and Documentation data were presented for the reporting period 8/1/12 through 10/31/12. None of the areas covered by these monitoring tools required a CAP because the overall percentage of compliance was above 80%. The inter-rater agreement for all three tools between the Nursing staff and the QA Nurses was greater than 90%. Now that the Nursing Care Monitoring Tools are more consistently achieving an overall compliance of 80% or greater with the inter-rater agreement between the Nursing auditors and the QA Nursing auditors achieving 90% or greater agreement,, the Facility should consider either identifying an area for which improvement would benefit the individuals served, or else looking to see whether specific items within these are consistently not met and, in order to continue improvement, do CAPs even through the percentages are high for the tool as a whole. The monitoring process and	

#	Provision	Assessment of Status	Compliance
		development of outcome data continued to make progress since the last compliance review. However, the process was still evolving and should soon provide comprehensive measurement of outcomes toward compliance with all Section M provisions. In addition to completing the Nursing Monitoring Tools, the Nursing Department continued to conduct a variety of other monthly internal monitoring activities. These monitoring activities are reported in other sections of the report. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> The Nursing Department had put several systems in place to enhance communication and integration of services related to individuals' acute changes in health status. • The Unit Nursing 24 Hour Shift Log had been revised to improve communication and to assure issues that required nursing follow up were clearly documented. The information divided into separate categories with additional and wider space for writing the information, for example: A list of individuals hospitalized; Acute Illness/Injuries – new Acute Care Plans; Follow-up to Acute Illnesses/Injuries - Acute Care Plans not resolved; New Medical Monitoring/Neurological Assessment Plans (NAPs) Follow up on Medical Monitoring and NAPs; Pain Medications Administered and their Effectiveness; Miscellaneous Items and Notes; and X-ray and Labs. This revision should help prevent critical items from being overlooked. • The NOO attends the Thursday morning Medical meetings; the Wednesday morning meetings, where they discuss case studies, are attended by the Case Manager for that particular individual being discussed. • The Chief Nurse Executive and/or designee attended daily Incident Management Meetings. • The RN Case Managers attended the daily Unit Incident Risk Management Team Meetings. • The Nursing Administrative Nurses and Nurse Managers met daily and reviewed the Units' Nursing 24 Hour logs. The Monitoring Team reviewed records for Individuals #107, #689, #738, #77, #259, #275, #634, #284, #625, #109, #651, #480, #649, #212, #500, #25, #709, #152, #613, #24, #31, #576, #787, and #588. Records were reviewed for assessments and documentation associated with the individuals' who had acute changes in health status and found significant improvement in the quality and of the follow-up as required, with few exceptions. Improvements in assessment and documentation included the following: • Integrated Progress Notes more consistently contained documentation that Acute Care Plans were established; appropriate Nursing Protocols (Antibiotic Therapy, Vomiting, Head Injury, When Contacting the PCP, and PICA), and/or medical monitoring were initiated. • Documentation verifying that direct support professionals were trained on their	

#	Provision	Assessment of Status	Compliance
		responsibilities for individuals' Acute Care Plans. • Instructions regarding direct supports professionals' responsibilities for individuals' care were documented as provided in the ongoing Integrated Progress Notes, and included a statement that the direct support professionals verbalized understanding of the instructions provided. • Direct support professionals reported to nurses when individuals had an acute change in health status anytime during the shift and the nurses documented actions in response to their reports in the Integrated Progress Notes. • Primary Care Providers were notified timely of individuals' acute changes in health status and/or individuals were referred to Sick Call. • Notification of the RN Case Managers, Qualified Developmental Disability Professionals, Interdisciplinary Support Team and/or other relevant disciplines (PNMT, Dietitian, Behavior Analyst, Wound Care Nurse, and Infection Control Preventionist Nurse) when individuals' had acute changes in health status. • The SOAPE (subjective, objective, assessment, plan, and evaluation) format was used for documentation. The E was frequently used for ongoing assessments and management of care. • Allergies or no known allergies were documented in the ongoing SOAPE notes. • Written and verbal communication reports provided by off going shift nurses to on coming shift nurses were documented in the Integrated Progress Notes. • Focal and/or head to toe nursing assessments related to the identified acute changes in health status were completed and documented in the Integrated Progress Notes, per frequency identified in the Acute Care Plan and/or Nursing Protocols--for example, every shift, daily, or other specified frequency. The ongoing nursing assessments included, with few exceptions: o Mental status; activity tolerance in relation to individuals' acute changes in health status; lung sounds; quality of respirations; bowel sounds and palpation of the abdomen; vital signs and oxygen saturation levels (method temperatures were taken and whether oxygen saturation levels were measured on room air or oxygen); pain assessed using either the Wong-Baker or FLACC (face, legs, activity, cry, and consolability) pain scales; description of wounds and abrasions, by appearance, size and stage of healing, when applicable; whether there were adverse reactions or side effects detected to prescribed medications; therapeutic response to medications; response to nursing care interventions/treatments; progress of improvement or lack of progress toward identified acute changes of health status; and whether the identified acute changes in health status were resolved. Although the Monitoring Team found significant improvement overall, a few omissions/issues were found in the ongoing Integrated Progress Notes regarding the requirements for	

#	Provision	Assessment of Status	Compliance
		assessment, management, and documentation for acute changes in health status. The omissions/issues identified included: • Occasionally the Integrated Progress Notes were documented out of sequence, making it difficult to follow the continuity of care. In addition, several blank spaces without lines drawn through were found in the Integrated Progress Notes, which had the potential to contribute to entries documented out of sequence. • Acute Care Plans did not consistently incorporate the Nursing Protocols, medical monitoring and/or other specific treatment orders by the PCPs or other relevant disciplines that were initiated. • Occasionally the frequency for nursing assessments and documentation were not included on the Acute Care Plan making it difficult to determine in reviewing the Integrated Progress Notes if the ongoing assessments and documentation were completed consistently and sufficiently to meet the individuals' needs for assessing and managing individuals' acute changes in health status. • The frequency of nursing assessments and documentation occasionally differed between what was required by the Nursing Protocols and the frequency stated in the Acute Care Plan. The same was true on orders for medical monitoring, making it difficult to determine in reviewing the Integrated Progress Notes if the ongoing assessments and documentation were completed consistently and sufficiently to meet the individuals' needs for assessing and managing individuals' acute changes in health status. • Training of direct support professionals was not consistently or clearly documented on the ACPs to ensure that staff on all shifts were adequately trained. • Frequently the nursing assessments and documentation of individuals' wounds, abrasions, and scratches did not have their exact location, size, appearance, and status of healing consistently documented in the ongoing Integrated Progress Notes. • Occasionally for individuals' prescribed medication, particularly antibiotics, assessment for adverse drug reactions and side effects was not documented in the ongoing Integrated Progress Notes. The effectiveness of the medications was rarely documented in the ongoing Integrated Progress Notes. • Occasionally multiple problems were documented together into one progress note making it difficult to determine the status of each problem. • Occasionally Acute Care Plans were not revised when there was a change in interventions/treatments. • Frequently the Integrated Progress Notes did not follow through to resolution with a note that the problem was resolved. • Occasionally the time of the entries was not documented. • The legibility of some nurses' handwriting was still difficult to read. Although there was significant improvement in the assessment and documentation of individuals with acute changes in health status, the Nursing Department should maintain the	

#	Provision	Assessment of Status	Compliance
		positive practices identified in the report and continue to make improvements in the issues identified above, as has been recommended in past compliance reviews. The Monitoring Team reviewed eight individuals' Seizure Records and corresponding Integrated Progress Notes. Individuals rated at high risk for seizures were selected across the Units. Records were reviewed for Individuals #701, #202, #215, #227, #712, #471, #377, and #107. The Monitoring Team reviewed Seizure Records and associated Integrated Progress Notes for a total of 19 seizure episodes related to the above individuals. Findings included: • Twelve of the 19 (63%) seizure episodes also had a Seizure Record completed. According to the DADS Nursing Protocol: Seizure Management Guidelines, February 2011 and DADS Nursing Protocol: Vagal Nerve Stimulator, February 2011, all seizure episodes are required to be documented on the Seizure Records, as well as in the Integrated Progress Notes. It is essential that Seizure Records are completed to be able to use the data for tracking individuals' seizure activity longitudinally. • Twelve of 12 (100%) Seizure Records were filled out correctly as required. It was positive to find in reviewing the Integrated Progress Notes that the nursing assessments and documentation complied with the requirements of the Nursing Seizure Management Guidelines and Nursing Protocols for Seizure Management and/or Nursing Status Epilepticus Protocol and/or other Nursing protocols when applicable, such as Nursing Protocol When to Notify PCP, and Nursing Vomiting Protocol. In addition, if seizures were not witnessed by the nurse, there was documentation that the direct support staff reported and described the seizure to the nurses. Individuals were checked for fecal impaction; if an impaction was found rectal suppositories or Fleets enemas were administered as ordered and the results documented in the Integrated Progress Notes. The individuals' IDTs were notified of significant or unusual seizure activity. However, there were a few exceptions found in the ongoing monitoring and documentation in the Integrated Progress Notes. For example: • When medical monitoring was documented as initiated the following concerns were identified: The frequency and duration of the medical monitoring were not consistently documented. In instances where the frequency and duration was documented, a review of the documentation in the Integrated Progress Notes did not reflect that the medical monitoring was completed and documented as stated. For example: o Individual #107 had a 25 second seizure on 9/2/12 at 1500. The nurse documented in the Integrated Progress Notes that medical monitoring was initiated for every hour for 72 hours and documented every shift. The notes did not include documentation that the medical monitoring was completed every hour for 72 hours. Although there was documentation of medical monitoring on each shift, hourly assessments were not documented. o Individual #712 had a one minute seizure on 10/2/12 at 1520. The nurse documented that medical monitoring was initiated for every 30 minutes for 24	

#	Provision	Assessment of Status	Compliance
		hours. The notes did not include documentation for medical monitoring every 30 minutes for 24 hours. Medical monitoring was completed on 10/3/12 at 0030, 0130, 0830, and 1330 when the note stated, "problem resolved." o Individual #227 had a 70 second seizure on 9/25/12 at 0900. The physician was notified and ordered Diastat 10 mg rectally. The Diastat was administered at 0915. The nurse documented that medical monitoring was initiated but did not document the frequency and duration. Individual was seen in Sick Call at 11:00 a.m. Medical monitoring was documented completed as on 9/25/12 at 1130 and 2100 and on 9/26/12 at 0530 and 1345 when the note stated, "problem resolved." Due to the sedative effects of the Diastat, initially more frequent medical monitoring should have been completed as required by the Nursing Post-Sedation Protocol until Individual #227 was fully recovered from the sedative effects of the Diastat. o Individual #471 had a one minute and 30 second seizure on 10/1/12 at 0315. The physician was notified and ordered Diastat 10 mg rectally. The time the Diastat was administered was not documented in the notes. The nurse documented that medical monitoring was initiated for every 30 minutes for 72 hours. Individual was seen in Sick Call at 1145. Medical monitoring was documented completed on 10/1/12 at 0414, 1145, 1200, and 2200, on 10/2/12 at 0915 and 2200, on 10/3/12 at 0900, 2110, and on 10/4/12 at 1900 when the note stated, "problem resolved." Due to the sedative effects of the Diastat, initially more frequent medical monitoring should have been competed as required by the Nursing Post-Sedation Protocol until Individual #471 was fully recovered from the sedative effects of the Diastat. Although since the last compliance review, there had been improvements made in Seizure Management, in order to meet compliance with DADS Nursing Protocol: Seizure Management Guidelines, February 2011 and DADS Nursing Protocol: Vagal Nerve Stimulator, February 2011, the positive practices identified in the above report must be maintained and improvements made in other practices. The Nursing Department should ensure: • A Seizure Record is completed for each seizure episode, as well as a corresponding nursing assessment with documentation in the Integrated Progress Note, as specified in the Nursing Protocol: Seizure Management Guidelines and Nursing Protocol: Vagus Nerve Stimulator, February 2012. • When medical monitoring is initiated as follow-up to seizure activity, the frequency and duration should be documented and followed as stated through to resolution. • The Nursing Post-Sedation Protocol is followed when individuals are administered Diastat or any other sedating medication for prolonged or intractable seizure activity. <u>Diabetic Activities:</u>	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team's review of September and October 2012 Blood Glucose Meter Quality Control Records across Units for Individuals: #641, #530, #306, #723, #748, and #680 found: All Individuals' Blood Glucose Meter Quality Controls were checked daily with the exception of Individual #680, whose checks were not completed on 10/21/12 and 10/25/12. This was a significant improvement from past compliance reviews. <u>Hospital Nurse Liaison Nurse Activities</u> It was impressive to find that the Hospital Liaison Nurse had prepared an excellent and comprehensive summary of the activities performed for this Provision since the last compliance review. The Monitoring Team's interview with the Hospital Liaison Nurse demonstrated that he was readily knowledgeable of hospitalization activities and was able to answer questions and provided supporting documentation when requests were made. The Hospital Liaison Nurse continued to follow-up on individuals who were hospitalized in local and area hospitals, as well as Long Term Acute Care (LTAC) facilities, through daily onsite visits or by phone, and the Campus Nurse on duty follow hospitalized individuals on the weekend.. 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 visits to the hospital, all medical information was documented in each individual's Integrated Progress Notes and scanned into the shared drive to make it available to medical providers, nursing staff, and other relevant IDT members. The Hospital Liaison Nurse attended pre- and post-discharge planning meetings. He maintained communication with the Nurse Case Managers, Unit Directors, Qualified Developmental Disability Professionals (QDDPs), Wound Care Nurse, Occupational and/or Physical Therapist, and other IDT members as necessary. The Hospital Liaison Nurse had attended Individual Support Plan (ISP) and IDT Addendum meetings for individuals who were hospitalized or in LTAC facilities. The IDT members were notified as soon as pending discharges were known in order to discuss any necessary training or equipment needed on discharge. In addition to the activities above, the Hospital Liaison Nurse performed other activities, which included: • Completion of 18 Infirmary audit tools on individual's post hospitalization discharges. • Completion of 20 Nursing Care Monitoring Tools, from May 2012 through October 2012, for: Urgent Care/Emergency Room Visits and Hospitalizations, two for Pain Management, and one for Documentation. • Collaborated with the Data Analyst in the creation of an enhanced hospital database that will provide the clinical disciplines and IDT with more real time data regarding	

#	Provision	Assessment of Status	Compliance
		individuals' hospital course, as well as the capacity for the Hospital Liaison Nurse and other clinical disciplines to document observation and assessment notes. The Hospital Database that was being developed should be vastly improved over the excel spreadsheet that was currently used. One of the new features will provide the clinical disciplines with the current admission diagnoses, include the percentages for each diagnoses, of the hospitalized individuals. Over time the database will be able to generate longitudinal data regarding the number and percentages of diagnoses for which individuals were admitted and treated. This should provide the clinical disciplines with useful information upon which clinical decisions can be made to identify the frequent diagnoses. • In collaboration with the Nurse Educator, conducted classes for new nurse orientation on the Nursing Protocol for Hospitalization, Transfers, and Discharges from May 2012 through November 2012. • In November 2012 the Hospital Liaison Nurse will go to another SSLC for enhanced training as the result of a recommendation made in a recent death review. Since the last review, it was positive to find that the Facility had implemented the Pre-Hospital Discharge Planning Policy, 9/6/12. The policy also included a Pre-Discharge Meeting Algorithm to guide the IDT in decision-making. The Hospital Liaison Nurse was responsible for notifying the Medical Director at least 24 hours before discharge of individuals. The Pre-Hospital Discharge Planning Meeting occurs 24 hours before the hospital discharge. The required meeting members included: Medical Director who chairs the meetings, Primary Care Providers, Hospital Liaison Nurse, Infirmary Director, Wound Care Nurse, Infection Control Nurse, Habilitation Representative, the individuals' RN Case Manager, and QDDP. The Hospital Liaison Nurse's attendance at the pre and post discharge meetings provided the IDTs with valuable firsthand knowledge of the individuals' 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 Nurse and record reviews for Individuals: #564, #783, #577, #161, and #148 who were hospitalized at the time of the Monitoring Team's visit. The record reviews found that the activities described above were performed and documented in the Hospital Liaison Nurse's Integrated Progress Notes. Additionally, other documents reviewed in the records for the individuals hospitalized found that the nursing staff had assessed and identified acute changes in status and promptly notified the respective physician who assessed the individuals and sent them to the Emergency room/hospital for evaluation and treatment. All required documentation was consistently completed for the individuals according to the Nursing Protocol for Hospitalization, Transfers, and Discharges. There was documentation that all relevant disciplines and families were notified at the time of admission, throughout the hospital course, and upon discharge. The Unit nurses followed up by phone on individuals' health status over the weekends. Their typewritten Integrated Progress Notes contained their typewritten name and title but did not contain their handwritten signature. The Nursing Department should ensure that the Campus Nurses who contact the hospital	

#	Provision	Assessment of Status	Compliance
		regarding individual's health status over the weekend or when covering for the Hospital Liaison Nurse sign their typewritten notes. In an effort to further demonstrate the Hospital Liaison Nurse's activities related to Pre-Hospital Discharge Planning Meetings, copies were provided for review of the Hospital Liaison Nurse's Pre-Hospital Discharge Summaries and Pre-Hospital Discharge Planning Meeting Attendance Sign-in Sheets for Individuals #259 (10/9/12), #649 (10/3/12 and 10/22/12), and #99 (10/3/12). It was positive to find, according to the Attendance Sign-in Sheets, that the required members, as well as numerous IDT members, attended the Pre-Hospital Discharge Planning Meetings. The Pre-Hospital Discharge Planning Meetings were a positive step forward in identifying individuals' health status, change in needs for supports and services, and staff training needs prior to discharge, which should improve the quality of care when individuals return home. The Monitoring Team attended the Pre-Hospital Discharge Meeting, for Individual #161. The Medical Director Chaired the meeting. All required disciplines as well as other members of the IDT attended the meeting and was verified through review of the sign-in roster. The Medical Director conducted the meeting efficiently and effectively according to the Pre-Hospital Discharge Planning Policy. There was sustentative input provided by the members present. Issues reviewed and discussed in planning for Individual #161's discharge included: • A summary of Individual #161's hospital course was provided by the Hospital Liaison Nurse. • Anticipated date for discharge. • Discussed change in clinical status while in the hospital. • Discussed diagnoses resulting from the hospitalization. • Identified any new medications or changes in medications Individual #161 will require when discharge, as well as new treatments and equipment. • Discussed potential follow-up required after discharge. • Discussed physical and nutritional management supports and services, as well as habilitation therapy needed after discharge. • Identified any infectious precautions needed by Individual #161 and/or staff after discharge. • Identified and discussed management of Individual #161's surgical wound for open reduction and internal fixation of the left femoral neck. • Discussed any other needs to anticipate upon discharge. • Identified change in risk rating changes resulting from the fractured hip. Recommended changes in risk ratings will be sent to the IDT for review and final disposition along with the minutes of the meeting. <u>Wound Care Nurse Activities</u>	

#	Provision	Assessment of Status	Compliance
		It was impressive to find that the Wound Care Nurse had prepared an excellent and comprehensive summary of the activities performed for this Provision since the last compliance review. The Monitoring Team's interview with the Wound Care Nurse demonstrated that he was readily knowledgeable of wound care activities and was able to answer questions and provided supporting documentation when requested. The Wound Care Nurse continued to conduct weekly Skin Integrity Committee Meetings. The Monitoring Team attended the Skin Integrity Committee Meeting on 11/14/12, which demonstrated that the meeting was integrated with relevant disciplines. The Skin Integrity membership included: Medical Director, Physicians, Dietitian, Habilitation Therapist, Behavior Analyst, Clinical Pharmacist, Chief Nurse Executive, Nurse Educator, Quality Assurance Nurse, Nurse Managers, Infection Control Nurse, and RN Case Managers. One individual with hospital acquired Stage IV pressure ulcer on the left dorsum of the foot and five individuals with non-pressure wounds were reviewed and discussed, and further recommendations for care were made by the members. It was impressive to find that the Wound Care Nurse photographed in color individuals' wounds using a ruler to measure their actual size, which showed their various stages of healing over time. The photographs were shown to the Committee at each meeting, where the healing status of the wounds were reviewed and discussed. Other Wound Care Nurse activities provided were validated through interview, and review of supporting documentation included: • Between September 2011 and May 2012 the Facility had two pressure ulcers, of which one was hospital acquired and one was Facility acquired. • Between May 2012 and October 2012 the Facility had one hospital acquired pressure ulcer and no Facility acquired. • Barrier Cream Wipes Sage Product with 3% Dimethicone was introduced campus wide in June 2012 to susceptible individuals for pressure ulcers as preventative measures. As a result there had been no Facility acquired pressure ulcers in the past six months. • Developed a database to track skin impairment for improvement in skin integrity issues. • Continued to make consultation visits on hospitalized individuals who were referred by the Hospital Liaison Nurse and kept their respective IDT informed of wound status. This was validated by the Monitoring Team's review of records for Individuals #149, #99, and # 275. When significant skin integrity issues were identified on hospitalized individuals the Wound Care Nurse collaborated with the hospital's Wound care Nurse on the management and treatment of the skin integrity Issues. This was validated through a review of Individual #284's Integrated Progress Notes on 8/10/12. • Attended five Pre-Hospital Discharge Planning meetings between April 2012 and September 2012. • Collaborated with the nursing staff and reviewed/revised and kept updated at least seven	

#	Provision	Assessment of Status	Compliance

Acute Care Plans and Health Management Plans for various skin integrity issues. This was validated through review of plans for Individuals #535, #27, #743, #711, #149, #259, and #276.

- Completed Nursing Care Monitoring Tools: 18 Nursing Care Skin Integrity, one Documentation, one Pain Management, and two Acute Illness and Injury between April 2012 and October 2012.
- Provided Wound Care Management and Documentation to 18 new hired nurses.

It was positive to find that the Wound Care Nurse had developed a database to track improvement in skin integrity issues. In past compliance reviews the status of pressure ulcers and/or wounds was included in the minutes of the Skin Integrity Committee Meeting minutes. Thus, there was not a system in place for tracking longitudinal data. Although the raw data was provided in the Self-Assessment chart below, it lacked specificity in describing the data. Neither did the chart have an accompanying analysis of the data to interpret the findings for decision making purposes. The analysis should evaluate progress or lack of progress toward preventing or reducing the incidence of pressure ulcers or other wounds. The data should include whether the pressure ulcers or other wounds were hospital or facility acquired.

The Facility's Self-Assessment reported skin integrity longitudinal data for April through August 2012 (data for September and October 2012 was not included) in the chart below:

Month	Pressure Ulcers[Unduplicated]	Non-Pressure Ulcers [ACTIVE]	Number of wounds healed	Individuals with new cases of wounds for the month	Total number of individuals with wounds for the month
April	2	6	2	2	6
May	None	20	10	11	15
June	None	11	9	5	8
July	None	10	7	7	10
August	None	13	4	7	12

Although for a Facility of this size, with many individuals determined to be medically complex/fragile and at high risk for skin integrity issues, the incidence of skin breakdowns and decubiti was relatively low. In most cases, decubitus ulcers results from inadequate support by direct care, and can be exacerbated by poor nutrition, dehydration, and underlying medical conditions. The Wound Care Nurse should continue to review skin integrity/decubitus health care plans to ensure they are current and reflect the actual interventions carried out specific to the individuals. The Facility should enhance its direct

#	Provision	Assessment of Status	Compliance
		care support to prevent decubitus ulcers from developing, and ensure that all individuals who sustain a recurrent lesion, or any decubitus ulcer of stage II or greater, are evaluated by the Facility clinicians. Refer to Provision M.3 regarding Acute Care Plans and Health Management Plans for management of skin integrity issues and management of infections. <u>Infection Control Preventionist Nurses' Activities</u> It was impressive to find that the Infection Control Preventionist Nurses had prepared an excellent and comprehensive summary of the activities performed for this Provision since the last compliance review. The Monitoring Team's interview with the Infection Control Preventionist Nurses demonstrated that they were readily knowledgeable of infection control activities and were able to answer questions and provided supporting documentation when requested. Since the last compliance visit, Infection Control Committee Meetings were conducted quarterly. The Committee was integrated with other Facility disciplines participating. The standing membership included: Infection Control Preventionist Nurse, chair of the Committee, Medical Director, Quality Assurance Director, Maintenance Director, Maintenance Supervisors, Residential Services Director, Chief Nurse Executive, Support Services Representative, Housekeeping Director, Laundry Director, Unit Directors, Food Services Director, Risk Management Director, Program Compliance Nurse, Safety Officer, and Day Program Director. The Monitoring Team attended the Infection Control Committee Meeting on 11/13/12. The focus of the meeting an discussion centered around environmental issues, proposed protocol requirements for employee Influenza and Hepatitis B Vaccinations. There was no discussion regarding trends of infections or an analysis of the Infection by Type data. The Monitoring Team reviewed the Infection Control Committee meeting minutes for 4/10/12, 5/17/12, and 7/10/12, again the focus of the meetings centered primarily on environmental issues. Although these issues are vitally important to address; the minutes did not include a summarized trend analysis or rate of the Infections by Type, as was found at the last compliance review. In the 7/10/12 minutes, it was reported that the trend analysis of infections by type was discussed, e.g., MRSA, pneumonia, cellulitis and conjunctivitis. The incidences (rate of infections) of these infections and their location were not included in the minutes. There was a discussion about how to prevent individuals from putting their hands in their mouths, then their eyes, or somehow getting feces on their hands, and then touching their faces. No solution to these issues for prevention was included in the minutes. This did not adequately address the prevention of these infections. As was identified and recommended at the last compliance review, in order to accurately analyze infection data for trends/rates, there should be a standardized formula for calculating	

#	Provision	Assessment of Status	Compliance
		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 or 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. Infection by Type data were generated from the Infection Control Database and provided for the Monitoring Team's review. Although it was positive to have data provided to the Monitoring Team, it is essential that the data are used by the Facility to identify trends and for making clinical decisions for prevention of infectious diseases. This data should consistently be presented to the Infection Control Committee for review, discussion, and disposition. The Infection Control Database reported data by month, Unit, Infection Type, and organism, It and was 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 4/1/12 through 9/30/12 was reviewed. The results of the report are listed below from highest to lowest incidents of Infection by Type and percentage of occurrence by Unit: o Urinary Tract Infections (UTIs): ▪ UTIs Straight Catheters = 1 ▪ UTIs No Catheters = 29 ▪ UTIs = 21 (other not described) Total = 51 Percentage of UTIs Combined by Unit: ▪ Trinity = 31% ▪ San Antonio = 19% ▪ Four Rivers = 19% ▪ Three Rivers = 12% o Ophthalmic and Otic Infections: ▪ Bacterial Conjunctivitis = 3 ▪ Conjunctivitis = 22 ▪ Otitis Media = 6 ▪ Otitis Externa = 7 Total Infections = 38 o Soft Tissue Infections: ▪ Soft Tissue = 17 ▪ Cellulitis = 11 ▪ Herpes Zoster = 1	

#	Provision	Assessment of Status	Compliance
		Total = 29 Percentage of Soft Tissue Infections Combined by Unit: ▪ Leon = 35% ▪ Trinity = 24% ▪ San Antonio = 17% ▪ Three Rivers = 14% ▪ Four Rivers = 10% o Ophthalmic and Otic Infections ▪ Bacterial Conjunctivitis = 3 ▪ Conjunctivitis = 22 (not described by cause) ▪ Otitis Media = 6 ▪ Otitis Externa = 7 ▪ Total = 38 Percentage of Ophthalmic and Otic Infections Combined by Unit: ▪ Trinity = 29% ▪ San Antonio = 26% ▪ Three Rivers = 21% ▪ Leon = 16% ▪ Four Rivers = 8% o Lower Respiratory Infections were broken down by type of infection: ▪ Bronchitis = 7 ▪ Aspiration Pneumonia = 0 ▪ Bacterial Pneumonia = 0 ▪ Viral Pneumonia = 0 ▪ Pneumonia = 0 Total Infections = 7 Percentage of Lower Respiratory Infections Combined by Unit: ▪ San Antonia = 43% ▪ Trinity = 29% ▪ Four Rivers = 14% ▪ Three Rivers = 14% 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 Gastroenteritis Infections by Unit ▪ Leon = 1	

#	Provision	Assessment of Status	Compliance
		Percentage of Gastroenteritis by Unit ▪ Leon = 100% o Sepsis/Fever of Unknown Origin by Unit ▪ Sepsis = 1 Percentage of Sepsis/Fever of Unknown Origin by Unit ▪ Trinity = 100% o Prophylaxis by Unit ▪ Prophylaxis = 1 Percentage of Prophylaxis by Unit ▪ Trinity = 100% The Monitoring Team was concerned with the continued high incidence of UTIs in Trinity, San Antonio, and Four Rivers, as well as Soft Tissue Infections and Cellulitis in Leon, Trinity, and Three Rivers. Although there was evidence that the Infection Control Preventionist Nurses implemented corrective action by re-training the staff on handwashing and personal hygiene, there should have been more investigation of the underlying factors that contributed to the continued incidence of these infection and plans put into place to prevent or reduce their reoccurrence. The Infection Control Preventionist reported that if any home has 15 or more cases of any particular disease, she will consult with the primary care provider (PCP) to determine what measures to take to decrease the spread of the infection and how to prevent the reoccurrence. Not taking corrective action until there were 15 or more cases of a particular infection in a home was inadequate to prevent the spread or control of the infection. While collaboration with the PCP is important, it should be within the scope of the Infection Control Preventionist Nurses' scope of practice to investigate factors contributing to the increase of infections and to initiate plan of actions to prevent or reduce the incidence of infections in collaboration with Infection Control Committee. The Nursing Department should re-evaluate the practice of delaying infection control investigation of a particular infection until there are 15 or more cases are reported in any home. The Infection by Type data reported for various types of pneumonia was questionable. A review of Hospital Admissions Logs and death review reports for the past six months indicated numerous diagnoses of various types of pneumonia. Accurately tracking pneumonia data is essential and the reports for pneumonia should be re-evaluated and corrected in the database. There were no reported infectious/communicable diseases over the past six months.. The Infection Control Preventionist reported that she will work with the Data Analyst to convert the currently used spreadsheet for Infectious/Communicable Disease into the Infection Database. However, there was one case of Methicillin-resistant Staphylococcus aureus (MRSA) reported for Individual #462. She remained in the Infirmary on contact isolation for 17 days after the completion of antibiotics for 14 days. The IDT met regarding care after	

#	Provision	Assessment of Status	Compliance
		discharge to her home. Then she was discharged to her home with physician order's and recommendations from the infection Control Preventionist Nurse. It was positive to find, as recommended by the Monitoring Team in past review, that the Infection Control Preventionist had developed and implemented a Protocol for "Real Time Data Monitoring with an Individual Infection Control Report Form for the nursing staff to complete and send or fax to the Infection Control Preventionist Nurses' when individuals were diagnosed and treated for infections. In addition, an Infection Control After Hours Call-in Log was developed and implemented to capture after hour reports. This protocol was validated through reviewing copies of Infection Control Report Forms for : #369, #719, #342, #500, #84, and #27, as well as, review of other individuals' Acute Care Plans and accompanying Integrated Progress Notes. Refer to Provision M.3 for more information. The Facility's Self-Assessment data reported that monthly Handwashing/Glove Use monitoring was completed from 3/1/12 to 8/31/12, which found that 12 of 14 (86%) areas of the Facility achieved compliance of greater than 90%. This was verified through supporting documentation provided for review. Facility's Self-Assessment data reported that monthly Environmental Surveillance Audits were completed from 4/1/12 to 9/30/12, which found that one of nine (11%) of the areas inspected identified the for training on biohazard storage. This was verified through supporting competency-based training materials and training rosters provided for review. Other Infection Control activities performed by the Infection Control Preventionist Nurses included: • The new Infection Control Manual was distributed to all homes. The Infection Control Policy and Procedure Committee began the review and revision of infection control policies and procedures for 2012, which will be completed by November 2012. The revisions will be distributed to all homes by December 2012. The Facility did not have a nursing policy for the Emergency Preparedness Policy/Protocol for Influenza. The Center for Disease Control (CDC), Plan How to Be Ready for the Next Flu Pandemic document will be used until a local policy is developed. • In-service training was provided since the last compliance review on identified Infection Control issues including: o Shingles, Infirmary nursing staff, June, 5, 6, and 7, 2012. o Lateral Transfers, Real Time Data Reporting and Acute Care Plan Activity, Nurse Managers, 7/23/12. o Revised Infection Control Form for all Unit nursing staff, July and August, 2012. o Tuberculosis Skin Testing provided by the Fort Bend County Health Department, Nursing Administrative/Management and Clinic Nurses, 8/2/12. o Data Entry Immunization Record, Nurse Managers and RN Case Managers,	

#	Provision	Assessment of Status	Compliance
		8/16/12. o Handling Biohazard Waste and the Biohazard Box, San Antonio and Leon Units, Residential Coordinator, 8/31/12 and 9/4/12. o Infection Control Monitoring Tools, Administrative and QA Nurses, 9/13/12 • The Infection Control Preventionist Nurses reviewed the Regional Clinical Laboratory Epidemiology Report monthly 4/1/12 through 9/1/12, against antibiotics prescribed by the PCP to evaluate their susceptibility to the organisms treated, and then provided the information to the medical staff and to the Pharmacy and Therapeutics Committee. • The Infection Control Preventionist Nurses conducted the monthly assigned Nursing Care Monitoring Tools for Infection Control and other related tools. • The Facility began using the AVATAR system for reporting and tracking immunizations. No data was provided to review since the system was just recently implemented. The Monitoring Team will review the status of the Immunization Tracking database at the next compliance review. • Individuals' and employees' tuberculosis skin testing and influenza vaccination status: o 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. o Individuals' who received influenza vaccinations were reported as 100% complete. o Employees' tuberculosis skin testing and/or chest x-ray/screenings were reported at 99.25% completed. This was a significant improvement in the percentage of employees screened since the last compliance review, which was at 42% completion. This may have been the result of the Infection Control Preventionist Nurses' CAP for employees who were delinquent for annual tuberculosis skin testing and/or chest x-ray screenings for 2012. o Employees' who received influenza vaccinations were reported at 35% complete. Employees' who received Hepatitis B vaccination series were reported at 55%. • Both of the Infection Control Preventionists had attended the 2012 Summer Essentials of Infection Control and Prevention Seminar, presented by the Texas Society for Infection Control and Prevention, July 26 and 27, 2012 and the Steam Sterilization Monitoring Basic Seminar, provided by 3M Learning Connection, October 26, 2012. Both seminars provided continuing education credit. The Competency Training Department (CTD) Course Delinquency List indicated there were no delinquent employees for Infection Control refresher training. This was an improvement from previous compliance reviews, which consistently reported some employees were delinquent in Infection Control annual refresher training. Although significant improvements were found, the Infection Control Preventionist Nurses	

#	Provision	Assessment of Status	Compliance
		should maintain the positive practices identified and continue to make improvement in the items listed below. The Nursing Department should ensure that the Infection Control Preventionist Nurses continue to 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. • Re-evaluate the practice of delaying infection control investigation of a particular infection until there are 15 or more cases reported in any home. • Review the all new Acute Care Plans and Health Maintenance 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. <u>Mock Medical Emergency Drills and Emergency Response Activities</u> Since the last compliance review, the Facility continued to maintain the positive practices identified in previous reports. 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 Emergency Response Committee continued to be comprised of multiple Facility disciplines. The core membership included: Risk Management Director, Chair, Medical Director, Chief Nurse Executive, Nurse Educator, Competency Training and Development Director, Director for Residential Services, Security Director, and Quality Assurance Nurses. The Emergency Medical Response Committee met monthly, unless events prevented the meeting. The Monitoring Team reviewed Emergency Medical Response Meeting minutes for 6/14/12, 7/18/12, and 8/29/12. The Committee minutes for September and October 2012, were not provided for review. The minutes reviewed found they were substantive and issues identified in previous meeting that needed follow-up, were addressed in following meetings. The discussions of the meetings centered on decisions of regarding making emergency equipment available and securing some of the areas located outside the residential units. This was an ongoing issue that was not yet resolved. The Monitoring Team will following up regarding the emergency equipment issue at the next compliance review. The Monitoring Team met with the Risk Manager and representatives of the Emergency Response Committee and discussed changes and concerns since the last compliance review. Much of the discussion centered on making emergency equipment available and secure in the	

#	Provision	Assessment of Status	Compliance
		areas located outside the residential areas. They explained that they were still working on resolving this issue. The Medical Director was still working on developing a protocol for actual codes. The physician's participation in the Mock Medical Emergency Drills was also discussed. The group thought a solution might be to include conducting drills in the clinic area. In order to enhance communication during drills as well as for actual codes, they were in the process of setting up Nextel phones with AT&T. The Monitoring Team will follow up on these issues at the next compliance review. The Monitoring Team's review of the last two quarterly Mock Medical Emergency Drill Reports indicated data were analyzed and trended. It was reported that 100% of the scheduled drills were completed in the two quarters and all drills were passed. Data were represented in tabular and graphic form with narrative explanations of any identified deficiencies. Staff who failed the drills were retrained and repeated the drills. If they were not successful they were sent to CTD for retraining on Basic CPR. The Risk Manager notified the CTD Director of the staff who required retraining. The CTD Director followed-up with the staff's supervisor to ensure that the training was received. There was documentation that the Monthly Mock Medical Emergency Drill Reports were sent quarterly to the Quality Assurance Department, as required by policy. No CAPs were required because the monthly drills were completed correctly 100% of the time. It was reported that copies of the completed Mock Medical Emergency Drill Reports were sent to the Incident Management meeting. However, there were no copies of minutes provided for review to validate the reports were sent. The Monitoring Team's tour of Trinity and San Antonio's hallways and home showed that signs were posted and readily visible indicating the location of AEDs and emergency equipment. An observation of the AEDs and emergency equipment in these Units was found readily accessible and the equipment was in good working order. The nursing staff was able to demonstrate proper use of the equipment. The AED and Emergency Equipment Checklists and the Monthly Walkthrough Checklists were reviewed and completed as required by policy. The Competency Training and Development (CTD) Due/Delinquency Training Lists indicated no employees were delinquent in Basic Life Support (BLS) for Health Care Providers. The CTD Course Delinquency List identified six employees who were delinquent in Cardiopulmonary Resuscitation (CPR) Basic. This represented an increase in the number of delinquent employees Basic CPR Training since the last compliance review. All of the delinquent employees were from the Residential Services Department. The Facility should ensure that all required employees are current with Basic Life Support and/or Basic CPR training. As was found in past reviews, there was no documentation in the information reviewed that indicated the Mock Medical Emergency Drills included scenarios to address any illness or injury that might require emergency response. The Facility's Mock Medical Emergency Drills should include a variety of scenarios that might require emergency response, as described in	

#	Provision	Assessment of Status	Compliance
		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 in the following practices: The Facility should ensure that: • Mock Medical Emergency Drill Reports are sent to the Incident Risk 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.	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 that the RN Case Manager Supervisor had prepared an excellent and comprehensive summary of the activities performed for this provision since the last compliance review. The RN Case Manager Supervisor interviewed by the Monitoring Team was readily knowledgeable of these activities and was able to answer questions and provided supporting documentation when requested. Since August 2012, the RN Case Manager had self-identified numerous areas of nursing assessments and care planning requiring improvement and had implemented corrective measures. It was positive to find that the RN Case Manager Supervisor had also included corrective measures recommended by the Monitoring Team in past compliance reviews. Since the last compliance review, the recently hired RN Case Manager Supervisor in collaboration with the Nurse Educator continued to retrain all RN Case Managers: • To ensure that nursing problems/diagnosis were analyzed and summarized concisely. • To adequately and accurately represent individuals' health status. • To measure the effectiveness of their respective Health Management Plans. • To review/revise Comprehensive Nursing Assessments for significant changes in health status. • To ensure that nursing problems/diagnoses and accompanying Health Management Plans were developed and implemented for all individuals with medium and high risk rating. • To utilize a standardized format for completing the overall nursing summaries when	Noncompliance

#	Provision	Assessment of Status	Compliance
		completing Comprehensive Nursing Assessments. • To ensure that the Nursing Community Discharge Assessments contain special instructions that are written in clear, concise, and easy to read sentences. In addition, the RN Case Manager had developed and implemented a Quality Peer Review process and a standardized Monitoring Tool for Annual and Quarterly Nursing Assessments in addition to the Nursing Care Monitoring Tool for Annual Quarterly Nursing Assessments. This monitoring tool was more specific and included all of the requirements for accurately completing the Annual and Quarterly Comprehensive Nursing Assessment according to the Annual/Quarterly Comprehensive Nursing Assessment Policy. The RN Case Managers completed the monitoring tool audits monthly. The RN Case Managers audited the nursing assessments completed by their peers with the oversight by the RN Case Manager Supervisor. This process began in August 2012. A random sample of 18 nursing assessments was completed in August and September 2012 with an overall compliance of 87%. This was a promising positive step forward in achieving compliance with this provision. Since the last compliance review, the Nursing Department had implemented a tracking system to ensure that Annual Comprehensive Nursing Assessments were completed within 10 days of the annual ISP meeting. The Monitoring Team selected a sample of records to review from each unit for the Admission, Annual, and/or Quarterly Comprehensive Nursing Assessments completed over the past six months for Individuals #107, #689, #738, #77, #259, #275, #634, #284, #625, #109, #651, #480, #649, #212, #500, #25, #709, #152, #613, #24, #31, #576, #787, and #588. The Monitoring Team found progressive improvement over time in the quality and comprehensiveness of the nursing assessments reviewed. However, the most notable improvements were found in those nursing assessments completed since August 2012. Therefore, the overall improvements found in review of the nursing assessments over the past six months may not reflect the most recent improvements. Findings included: • Four of four (100%) Admission Comprehensive Nursing Assessment were completed within 30 days of admission as required. • Six of six (100%) Annual Comprehensive Nursing Assessments were completed within 10 days of the annual ISP meeting. • Nineteen of 22 (86%) Quarterly Comprehensive Nursing Assessments were completed according to the ISP schedule. • Thirty two of 32 (100%) Admission, Annual, and/or Quarterly Comprehensive Nursing Assessments had BRADEN skin assessments completed. • Thirty one of 32 (97%) Admission, Annual, and/or Quarterly Comprehensive Nursing Assessments contained the signature and date of the RN Case Manager completing the assessments.	

#	Provision	Assessment of Status	Compliance
		• Thirty one of 32 (97%) Admission, Annual and/or Quarterly Comprehensive Nursing Assessments contained documentation that the Qualified Developmental Disability Professionals were notified of the completed assessments. • Twenty six of 32 (81%) Admission, Annual, and/or Quarterly Comprehensive Nursing Assessments, Section I through IX showed improvement in completing assessment data and adequate summaries for each section assessed, with few exceptions. The exceptions included inconsistency on completing the following items: o Current Active Medical Diagnoses not updated when new diagnoses added or diagnoses eliminated. o Section III Medication Review: ▪ Listing food and allergies. ▪ Indicating current medications and corresponding diagnosis. o Section IV Nutrition and Weight Management: ▪ Date of last meal monitoring by the nurses was occasionally not updated for the current annual/quarter. Nursing observations of enteral feeding were rarely documented. o Section VII Infection and immunization: ▪ PPD skin test was not updated. Example: Individual #689 was dated as done on 2/6/11 but the result was not documented and should have been retested in 2012. ▪ Immunization status incomplete. Example: Individual #787. ▪ Weights at the last annual were copied from 2010 as opposed to 2011. o Section VIII Physical Assessment: ▪ SPO2 (oxygen saturation) did not indicate if measured on room air or on oxygen. ▪ Tympanic Color not assessed. ▪ Change in recent health status related to a specific body system not in respective summary. ▪ Date of last bowel movement not consistently documented or not updated for the current quarter. Bowel management plans not consistently documented. ▪ Missing EENT/Head and Neck assessment. Example: Individual #588. ▪ The quarterly Comprehensive Nursing Assessments were not consistently updated when there was a significant change in health status. o Section X Nursing Problems/Diagnoses ▪ Seven of 32 (22%) did not have nursing problems/diagnoses for all medium and/or high risk ratings that required nursing interventions and/or had Health Management Plans that did not include nursing problems/diagnoses. ▪ Four of 32 (13%) did not follow the standardized format for completing	

#	Provision	Assessment of Status	Compliance
		the overall nursing summaries. ▪ Twenty seven of 32 (84%) overall nursing summaries showed significant improvement in summarizing the raw clinical data that individuals' health status in relation to their identified nursing problems/diagnoses and whether they were progressing, maintaining or regressing and the effectiveness of their related Health Management Plans. An example of excellent summaries was for Individual #651. Conversely an example of a poorly written summary was for Individual #259. The summary did not follow the required format. Over two pages of single spaced typed summary was written that contained a voluminous amount of data, which was confusing and made it difficult for the reader to discern the actual health status of Individual #259 for each identified nursing problem/diagnosis. It was evident that the RN Case Manager was valiantly attempting to write a good summary. This RN Case Manager needs assistance in how to analyze and summarize raw clinical data into a meaningful summary that provides an accurate representation of individuals' health status. The most notable improvements may be attributable to the recent addition of a RN Case Manager Supervisor and to the State Physical Assessment and Documentation training RN Case Managers have received. Although there was general improvement in the Comprehensive Nursing Assessments, the RN Case Manager Supervisor and Nurse Educator should continue efforts toward improving all the RN Case Managers' competency in completing Comprehensive Nursing Assessments. The Monitoring Team reviewed Nursing Community Discharge Summaries and accompanying Health Care Plans on individuals that were discharged to the community within the past six months, for Individuals #615, #193, #166, #100, #128, #550, #713, #375, #201, #290, #573, #261, and #119, as well as one individual who was in process of development of a CLDP, Individual #43. Only minimal progress was found since the last compliance review. Findings included: • Fourteen of 14 (100%) Nursing Community Discharge Summaries were completed on the correct form. • Twelve of 14 (86%) individuals' preferences were documented in the overall nursing summaries. • Four of 14 (29%) individuals had special instructions that were inadequate or missing to describe "medication techniques (likes/dislikes/crushed medications or other preferences), triggers/signs/symptoms of illness (how individuals communicate when they do not feel well and/or what makes them angry), special techniques to elicit cooperation, as well as other pertinent information (special behaviors and what they	

#	Provision	Assessment of Status	Compliance
		mean and how they communicate pain or manifest seizure activity, if applicable." • Four of 14 (29%) individuals had a review of health status for the previous annual/quarter for identified nursing problems/diagnoses and/or high and medium risk ratings. It is essential that the receiving community agency have this information. • Twelve of 14 (86%) individuals had Health Management Plans for risk ratings identified and/or nursing problems/diagnoses that required nursing intervention. However, some Health Management Plans did not have nursing problems/diagnoses. Conversely, some nursing problems/diagnoses did not have accompanying Health Management Plans. Many, if not most, of the nursing problems/diagnoses were written as North American Nursing Diagnosis Association (NANDA) diagnoses that may not be easily understood by the receiving community agency staff. Nursing problems/diagnoses should be written in terms that can be clearly understood by the agency staff. • One of 14 (7%) individuals' Health Management Plans was reviewed/revised prior to discharge to the community. Many of the plans were develops months before discharge, one plan was developed in 2010, and several as early as January 2011. Many of the earlier plans were not individualized sufficiently to meet the individuals'' health care needs. It is essential that individuals' information provided to the community agencies regarding their nursing problems/diagnoses and/or risk ratings are current and accurate, as well as the accompanying Health Managements Plans. • Four of the 14 (29%) individuals' Health Management Plans' Instructions for the Direct Support Professionals were copied with the names of the Facility's direct support professional and their home leaders. Instructions for the Direct Support Professional should not contain Facility staff's names. • There were no training rosters included with the Community Nursing Discharge Summaries to validate that the agency staff were trained on individuals' nursing care plans. • There was no consistent format used for completing the overall nursing summaries. The Nursing Department should develop guidelines for completing the Community Nursing Discharge Summary's for the overall nursing summaries and plans of care to ensure that the information provided to the community agencies is complete, accurate, and current. 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.	

#	Provision	Assessment of Status	Compliance
		• 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. • Develop guidelines for completing the Community Nursing Discharge Summaries for the overall nursing summaries and plans of care to ensure that the information provided to the community agencies is complete, accurate, and current.	
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.	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 that the RN Case Manager Supervisor had prepared an excellent and comprehensive summary of the activities performed for this provision since the last compliance review. The RN Case Manager Supervisor interviewed by the Monitoring Team was readily knowledgeable of these activities and was able to answer questions and provided supporting documentation when requested. Since August 2012, the RN Case Manager Supervisor had self-identified numerous areas of care planning requiring improvement and had implemented corrective measures. It was positive to find that the RN Case Manager Supervisor had also included corrective measures recommended by the Monitoring Team in past compliance reviews. Since the last compliance review, the recently hired RN Case Manager Supervisor in collaboration with the Nurse Educator continued to retrain all RN Case Managers: • To ensure that the RN Case Managers include in the Health Management Plans the frequency of assessments and documentation, as well as where to document actions/intervention in the unified records. • To ensure that the Health Management Plans include preventative measures. • To ensure that Health Management Plans are developed in collaboration with other relevant disciplines, when appropriate. • To ensure that Health Management Plans are reviewed/revised on a quarterly basis and when there was a change in individuals' health status. • On 8/3/12 the RN Case Managers were retrained on the Comprehensive Nursing Assessments and Health Management Plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In August and September 2012, the RN Case Manager Supervisor reviewed the Peer Review of the Health Management Plans with the RN Case Managers for current format, signature of the author, baseline data, goals/objectives, reviews/revisions, preventative measures, and the Integrated Progress Notes for notification of the IDT when there were changes in individuals' health status. The overall compliance of these audits was reported above 95%. It was impressive to find the investment of effort the RN Case Manager Supervisor, Nurse Managers, and Nurse Educator had put forth to improve the quality of Acute Care Plans. They used the ACP/Documentation Review Tool to audit each Acute Care Plan and Health Management Plan and associated documentation for compliance. The Nursing Department had also enhanced its effort by placing a reminder sheet in front of each health care plan with the required health care components for the health care plans and the required corresponding documentation in the Integrated Progress Notes. The Monitoring Team's review of individuals' most recently completed and/or active Acute Care Plans and associated Integrated Progress Notes demonstrated the effectiveness of the efforts put forth for improvements in the quality and comprehensiveness of the Acute Care Plans and associated documentation related to the actual nursing interventions provided to individuals. The Monitoring Team selected a sample of records to review from each unit for the Admission, Annual, and Quarterly Comprehensive Nursing Assessments, and associated Health Management Plans (HMPs) completed over the past six months for Individuals #107, #689, #738, #77, #259, #275, #634, #284, #625, #109, #651, #480, #649, #212, #500, #25, #709, #152, #613, #24, #31, #576, #787, and #588. The Monitoring Team found progressive improvement over time in the quality and comprehensiveness of the nursing assessments reviewed. However, the most notable improvements were found in HMPs completed since August 2012. Therefore, the overall improvements found in review of the nursing assessments over the past six months may not reflect the most recent improvements. Findings included: • Eighteen of 24 (75%) individuals' had HMPs for all risk ratings and/or nursing problems/diagnoses requiring nursing interventions. • Sixty three of 78 (81%) HMPs contained adequate baseline data sufficient to identify the reason for the care plan. • Sixty six of 78 (86%) HMPs contained goals that were observable, measureable, and realistic. • Seventy two of 78 (92%) HMPs were individualized sufficient to meet individuals' need with respect to nursing intervention. • Seventy of 78 (90%) HMPs contained no information that was irrelevant or not applicable to individuals' care. • Seventy eight of 78 (100%) HMP's instructions for the direct care professionals were	

#	Provision	Assessment of Status	Compliance
		written in terms they could easily understand. • Seventy eight of 78 (100%) HMPs contained documentation verifying that the direct care professionals had been trained on the plans, although on some HMPs it was difficult to determine if all three shifts were trained • Sixty eight of 78 (87%) HMPs contained preventative measures. • Thirty five of 78 (45%) HMPs contained integration/collaboration with other disciplines. However, some HMPs may not have required integration of other disciplines. • Fifty six of 78 (72%) HMPs included the frequency for assessments and documentation and where to document actions/intervention in the unified record. However, frequently found on the plans was the requirement for the Nurse Case Managers to document on the plan quarterly. This was not adequate for periodic assessment of individuals' problems related to the identified health problems. • Forty of 54 (85%) HMPs that were due for annual or quarterly reviews/revisions were completed. According to the guidance for the new Integrated Health Care Plan (IHCP), the nursing HMPs will go away and their plans of care will be included in the IHCP. While it was positive for individuals' to have integrated plans of care, the HMPs should not be discontinued until individuals' annual ISP meetings were conducted, or in the case of change of status, when ISPAs meeting were conducted. Since the new processes for the Integrated Risk Rating Form and IHCP were so recently implemented, not enough time had elapsed to determine compliance with this provision. The Monitoring Team will review the IHCPs at the next compliance review. The Monitoring Team reviewed a sample of 11 most recently completed and/or active Acute Care Plans for Skin Integrity and Infections, as well as associated Integrated Progress Notes and other related documentation selected from Units across campus to determine the progress made toward management and documentation of acute changes in status for Individuals #596, #212, #413, #192, #462, #315, #712, #19, #389, #415, and #268. The findings included the following: • Ten of 11 (91%) Acute Care Plans had allergies listed. • Eleven of 11 (100%) Acute Care Plans contained adequate baseline data sufficient to identify the reason for the care plan. • Eleven of 11 (100%) Acute Care Plans contained goals that were observable, measureable, and realistic. • Eleven of 11 (100%) Acute Care Plans were individualized sufficient to meet individual's needs with respect to nursing interventions. • Zero of 11 (0%) Acute Care Plans contained information that was irrelevant or not applicable to individuals' care. • Eleven of 11 (100%) Acute Care Plans' interventions were appropriate and sufficient to	

#	Provision	Assessment of Status	Compliance
		address individuals' identified problems. • Nine of 9 (100%) Acute Care Plans and associated documentation were for infections with antibiotics prescribed. The ACPs and associated documentation included notification to the Infection Control Preventionist Nurses. There was documentation in the individuals' Integrated Progress Notes that the Antibiotic Therapy Protocols were initiated and followed. There were active infections at the time of the compliance review that had not yet had time to be resolved. The Integrated Progress Notes also included other Nursing Protocols for Vomiting, Head Injury, and PICA that were initiated and followed when indicated. • Eleven of 11 (100%) Acute Care Plans included prevention measures appropriate for the individuals' identified problems. • 10 of 11 (91%) Acute Care Plans included the frequency nurses were to monitor/assess individuals' problems and document in the Integrated Progress Notes or on other relevant documents. • Two of two (100%) Acute Care Plans for skin integrity issues required wound care interventions/treatments by the Wound Care Nurse. • Two of two (100%) Acute Care Plans for skin integrity issues required PNMP interventions, which were included on the plans. • Eleven of 11 (100%) Acute Care Plans' instructions for the direct care professionals were appropriate and sufficient to meet individuals' needs and were written in terms they could easily understand. • Eleven of 11 (100%) Acute Care Plans contained documentation verifying that the direct care professionals had been trained on the plans. Refer to M.1 regarding general trends found in the assessment and management of individuals with acute changes of health status. It was positive to find that the Nursing Department had developed and implemented an Aging Care Plan for all individuals 50 years and over. However, none were reviewed by the Monitoring Team Although significant 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: • Ensure the frequencies for nursing monitoring, assessments and documentation stated in Acute Care Plans are consistent with the requirements for Nursing Protocols and/or medical monitoring; and that the nursing staff consistently adheres to the stated frequencies. • Ensure that wounds, abrasions, scratches are consistently assessed, described and documented as to their exact location, size, appearance, and status of healing.	

#	Provision	Assessment of Status	Compliance
		• Ensure that Acute Care Plans are revised when there are changes in nursing interventions/treatments and/or other changes to the plans.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurred. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, and review of documents, there was evidence that the positive practices found in the last compliance review were continued and there had been 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. It was impressive to find that the Nurse Educator had prepared an excellent and comprehensive summary of the activities performed for this Provision since the last compliance review. The Monitoring Team's interview with the Nurse Educator demonstrated that she was readily knowledgeable of education activities and was able to answer questions and provided supporting documentation when requested regarding activities related to this Provision. The Nurse Educator also provided competency-based training materials used and training records for the training reported The Nurse Educator reported: • There were no new policies addressing the provision of nursing care since the last compliance review in May 2012. • New procedures and/or other documents addressing the provision of nursing care included: o Integrated Risk Rating Form (IRRF) process o Integrated Health Care Plan (IHCP) process Since the last compliance review the Nurse Educators had continued to train nursing staff on the State and Facility Nursing Policies, Procedures, Processes, and Protocols. The Nurse Educators in collaboration with the Nursing Department continued to randomly monitor the nursing staff on the trained, established, and implemented nursing policies, procedures, processes, and protocols to be sure that they were adequately put into actual clinical practices sufficient to address the health status needs of individuals served. They continued to track and report all required nursing training by each nurse through to completion using Nursing Training Tracking Database. The Nurse Educators continued to use the Nurse Education Handbook for new nurse orientation and annual refresher trainings. They continued to train the nursing staff on any new and revised policies, comprehensive health physical assessments, and teach the State mandated Observing and Reporting Clinical Indicators of Health Status Change of individuals served in the New	Noncompliance

#	Provision	Assessment of Status	Compliance
		Employee Orientation. Specific training reported included: • Since the last compliance visit the Nurse Educators implemented the state mandated, Mosby's Guide to Physical Examination. To date, a total of 23 RNs were trained on chapter 17, which was on the Abdomen. Twenty RN Case Managers (100%) and three Campus Nurses were trained. • 9/20/12: Started training on "Critical Thinking- Clinical Judgment" developed by the State Office Nursing Consultant. The class included Power Point presentations along with a DVD entitled "Critical Thinking-Clinical Judgment." To date, 89% of RNs were trained. • 10/08/12: The Nursing Department audited a total of 779 Integrated Progress Notes for one month, from one unit, as part of a death review recommendation. The results of the audits found the most common mistakes were: mistaken entries and late entries not properly documented. Consequently, the nurses identified making the mistakes were retrained. • 10/29/12: Started in-service training on Diabetic Education. The nurses were trained to educate family members or guardians of individuals who are diabetic. The purpose of the training was to educate them on what they should or should not give the individuals while they were out on a pass in order to properly manage their diabetes. To date, 94% of the nurses were trained and training was ongoing. • 10/31/12: Started training the RNs on Vascular Access Ports and Port-A-Catheters because some of individuals were discharged back from the hospital with Port-A-Catheter implants. To date, 90% of the RNs were trained and training was ongoing. • The Nurse Educators conducted pilot competency skill check monitoring, including the presence and use of nursing protocol cards during the actual assessment and documentation of care of individuals with acute change in health status. • Plans were in process to implement the new state mandated Medication Administration for Individuals with Dysphagia, which will be jointly taught by Habilitation Therapy, Physical Nutritional Management Team Nurse (PNMT), and the Nurse Educators. • Since the last compliance review, six New Nurse Orientation trainings were conducted using competency-based, formalized lesson plans from the Nurse Educator's Handbook. The Nurse Educators emphasized the importance of the use of Nursing Protocol Cards in the assessment and documentation of acute changes in health status of individual served. The week long nursing orientation trainings included, but was not limited to, actual daily documentation practices of different scenarios by the new nurses using the Protocol Cards and auditing their documentation to ensure that they understand the importance of adequately putting into actual clinical practice nursing policies, procedures, processes, and protocols. • The new nurses were trained on the following policies and procedures: o Nursing Services Policy	

#	Provision	Assessment of Status	Compliance
		o Nursing Documentation Guidelines o 24 Hour Clock o Nursing Standardized Abbreviations List o Medication Administration Guidelines o Self-Administration of Medications o Medication Administration Observation Guidelines o Medication Variances o Management of Acute Illness and Injury o Use of Protocol Cards o Emergency Response o Hospitalizations-Transfers-Discharge Nursing Protocol o Care Plan Development o Skin Management and Wound Prevention o Weight Management Procedure o Neurological Assessment o Seizure Management Nursing Protocol o Vagal Nerve Stimulator Nursing Protocol o Diastat Administration o Pre-Treatment and Post Sedation Monitoring Nursing Protocol o Post Anesthesia Care Nursing Protocol o Nursing Peer Review o PICA o Nursing Competency Based Training Curriculum Since the last compliance review, some Nursing policies and procedures were revised. These included both local and state policies. Also some forms were revised from at state level. Revised Policies and Procedures: • State Supported Living Center (SSLC) o Approved Abbreviation List o Nursing Services Policy o Medication Administration Observation Guidelines o Richmond State Supported Living Center (local policies) o Medication Administration Guidelines o Nursing Documentation Guidelines o Seizure Management Guidelines o Vagal Nerve Stimulator o Diastat Administration o Actions Following Death of Individual Served o Revised SSLC Forms	

#	Provision	Assessment of Status	Compliance
		o Medication Administration Observation • Listed below are the in-service trainings provided to the general nursing staff since the last compliance review: o 6/14/12, Trained all Case Managers on: ▪ Aspiration Pneumonia/Enteral Nutrition Evaluation (APEN) ▪ # of Nurses trained = 2 ▪ % trained = 100% o 8/03/12: The Nurse Educator in collaboration with the Case Manager Supervisor retrained the RN Case Managers on Comprehensive Nursing Assessment and Health Management Plan as part of the Plan of Improvement (POI) recommendations. Comprehensive Nursing Assessments and Health Management Plans: ▪ # of RN Case Managers = 21 ▪ % trained = 100% o 8/21/12, Campus wide mandatory training was conducted for all nursing staff on the Plan of Improvement Recommendations (POI): ▪ Assessment and Documentation of individuals when they have maladaptive behaviors. ▪ Revised Policies and Procedures: Seizure Management; Diastat; Vagal Nerve Stimulator; Nursing Documentation Guidelines; and Medication Administration Guidelines. ▪ # of Nurses trained = 144 ▪ % trained = 97% o 9/7/12, In-serviced nurses on the revised Medication Administration Guidelines: ▪ # of Nurses trained = 142 ▪ % trained = 93% o 10/19/12, Trained nurses on the revised Nursing Services Policy: ▪ # of Nurses trained = 146 ▪ % trained =96% o 10/25/12, The mandated Mosby's Guide to Physical Examination, (Chapter17 Abdomen): ▪ # of RN Case Managers trained =20 ▪ Trained 100% of Case Managers ▪ # of Registered Nurses trained = 23 This training was ongoing until all RNs were trained.	

#	Provision	Assessment of Status	Compliance
		o 08/06/12- 08/09/12: In addition, to the trainings listed above, the State Office Nurse Consultants returned to the Facility and continued the state mandated Physical Assessment trainings and check-offs. They conducted Physical Assessment classes and RN to RN check-offs on those nurses who completed the class. A total of 42 RNs took the class and a total of 37 adequately performed their RN to RN skills; five did not. The Consultants returned on 9/06/12 and 9/14/12 to complete the five RN to RN check offs. Four of the five RNs were checked off, one RN was absent. o March 2012, Trained nurses on the Nursing Protocol Cards: ▪ # of nurses trained = 159 ▪ % trained = 97% Approximately 5% of the nurses were on Family and Medical Leave Act (FMLA) leave; the expected completion date for missed trainings will be completed upon their return to duty. The projected completion date will be two weeks following their return to duty. The Nurse Educator continued to assist and coordinate the clinical rotations of new nursing students from the University of Houston Victoria. In September 2012, seven second-degree and 10 RNs to BSN nursing students returned to the Facility for their clinical and community clinical rotations. Since the last compliance review, it was promising to find the Nursing Department had conducted random monitoring/auditing other than the Nursing Care Monitoring Tools. The audits included: • Random monitoring for the use of Nursing Protocol Cards. • Documentation and assessment of individuals' health care status according to the identified Nursing Protocol in the Integrated Progress Notes until the problems were resolved. • Demonstration of nurses' skill competencies. The above audits were completed monthly and randomly by the Nurse Educator on the individuals' homes/Units to ensure the nurses were carrying the protocol cards on their person at all times and that they knew how to utilize the protocols when the need was identified in order to manage, assess, intervene, and document identified health problems of the individuals served. In addition, the audits evaluated the effectiveness of the training provided on the protocol cards to ensure the knowledge received from the training was utilized and adequately put into clinical practices sufficient to meet individuals' health care needs. The Facility's Self-Assessment reported the results of the daily random audits, June through	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>September 2012, of Integrated Progress Notes reviewed for documentation to validate compliance of the Nursing Protocol Cards were as follows:
<table>
<tr><th>Month</th><th># of Records</th><th># of Integrated Progress Notes</th><th>% of Compliance</th></tr>
<tr><td>June</td><td>7</td><td>4</td><td>57.14%</td></tr>
<tr><td>July</td><td>7</td><td>4</td><td>57.14%</td></tr>
<tr><td>August</td><td>29</td><td>25</td><td>86.21%</td></tr>
<tr><td>September</td><td>10</td><td>10</td><td>100%</td></tr>
</table>
The results were relatively consistent with the Monitoring Team's findings reported throughout the report. Over time, the Integrated Progress Notes showed progressive improvement with compliance in the use of the Nursing Protocol Cards.

According to the Nurse Educator, they were in the process of developing a procedure to audit all 18 of the Nursing Protocols. The audits and corrective action plans derived from the audits should further enhance compliance with the Nursing Protocols, was well as compliance with this Provision. At the next compliance review the Monitoring Team will review the progress made toward achieving clinical practices sufficient to meet individuals' health care needs and compliance with this Provision.

The Nursing Department and the Nurse Educator should continue to reinforce training and should monitor for the nursing practices contained in Nursing Policies, Procedures, Processes and Protocols, to ensure they are consistently demonstrated through actual clinical practices sufficient to address the health status of individuals served.

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, but also they must be demonstrated through actual clinical practice sufficient to address the health care needs of individuals served. Although significant progress was found throughout the other Provisions, regarding adherence to the Nursing Policies, Procedures, Processes, and Protocols they have not yet been adequately put into clinical practices sufficient to meet individuals' health care needs. Therefore, this provision was not yet found in compliance.</td><td></td></tr>
<tr><td>M5</td><td>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</td><td>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. Minimal 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</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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.	status of noncompliance. The Facility's Self-Assessment reported that Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) training was conducted at on 9/06/12 to 9/07/12 by trainers from State Office and the Statewide training on ISP and risk ratings was conducted in Austin on 9/18/12 to 9/19/12. Since the training on these processes was just beginning, the Facility stated there was not enough data at present to evaluate the process. After review of the documents supplied, the Monitoring Team concurs. Since the last compliance review, new processes were put in place for the Individual Support Plan (ISP), Integrated Risk Rating Form (IRRF), and Integrated Health Care Plan (IHCP) processes. The Facility's Self-Assessment, did not state the status of training the RN Case Manager Supervisor and RN Case Managers had received on the revised policy, ISP, IRRF, and IHCP, although two IDTs were beginning to implement the new processes. The Monitoring Team reviewed the revised At Risk Individual Policy and associated ISP, IRRF, and IHCP processes, along with the training material presented by the State Office staff. The review found the revised processes and related training material was significantly improved over the previous Integrated Risk Rating and Action Plan processes. The revised process for identifying risk ratings by grouping inter-related risk factors together and developing one integrated health care plan for all relevant disciplines to carry out individuals' plan of care for needed supports and services showed promise. After reviewing the IRRF and IHCP material several concerns were identified. The use of the nursing diagnoses for identifying the risk related health problem for each risk group was misleading, particularly if the North American Nursing Diagnosis Association (NANDA) were used. These diagnoses specifically relate to nursing practice. Other disciplines do not use these diagnoses and probably are not familiar with their interpretation. Some of the NANDA diagnoses are often vague and difficult to understand precisely what is being described. Even if nursing diagnoses per se were used they may not be as comprehensive in describing individuals' overarching health problems related to the group of risks for which it was intended. Further, calling the individuals' health problems nursing problems was again misleading. It was the individuals' problems and the diagnoses of the problems that should be clearly described in terms that were not specifically discipline driven. It was positive to find that the QDDPs were responsible for ensuring that the respective disciplines submit their clinical data that supported the risk rating 10 days prior to the ISP Meetings. This relieves the RN Case Managers of this responsibility, which had been identified as a problem in past reviews. According to the guidance for the IHCP, the nursing HMPs would go away and their plans of	

#	Provision	Assessment of Status	Compliance
		care would be included in the IHCP. Although it was positive for individuals to have integrated plans of care, the HMPs should not be discontinued until new ISP meetings are conducted, or in the case of change of status, when ISPAs meeting are conducted. The changes for risk rating assessments and health care planning also impact compliance with Provisions M.2 and M.3. Consequently, with the changes so recently implemented, the data was not yet available to determine the degree of compliance with this provision or Provisions M.2 and M.3. The Monitoring Team reviewed six of the most recently completed Integrated Risk Rating Forms and Risk Action Plans for Individuals #25, #709, #152, #613, #31, and #24. All of the Integrated Risk Rating Forms and Risk Actions Plans were completed on the previously used forms. The finding included: • Zero of six (0%) Integrated Risk Rating Forms adequately provided integrated clinical risk data to support each of the risk rating categories. There was no appreciable improvement from the last compliance review. They did not meet the requirements for compliance with Section I of the Settlement Agreement. • Zero of six (0%) Risk Action Plans adequately provided an integrated Risk Action Plan for each of the risk rating categories. There was no appreciable improvement from the last compliance review. Since individuals' Integrated Risk Rating Forms and Risk Action Plans were completed on the previous form, future risk ratings and plans of care using the new IRRF and IHCP processes along with additional training of the IDTs should show improvement. The Monitoring Team will follow up on the new processes at the next compliance review. The Monitoring Team reviewed eight Aspiration Trigger Data Sheets and Integrated Progress Notes when triggers were identified for October 2012, on Individuals rated at high risk for aspiration, Individuals #284, #579, #377, #649, #259, #523, #603, and #701, found: • Zero of eight (0%) sheets had individualized aspiration triggers identified. • One of 8 (13%) sheets was completely filled out daily, on each shift, by the direct support professional for all required trigger data. • Five of 8 (63%) sheets were reviewed and initialed daily by the nursing staff on the 6-2 shifts as required. • Five of 8 (63%) sheets were reviewed and initialed by the nursing staff daily on the 2-10 shifts as required. • Six of 8 (75%) sheets were reviewed and initialed by the nursing staff daily on the 10-6 shifts as required. • Seven of 8 (88%) sheets were reviewed and initialed, at least daily Monday through Friday, by the RN Case Managers as required. • One of 8 (13%) individuals had triggers marked on the 10-6 shift for the month. o Individual #649 had triggers reported on 10/9/12 on the 10-6 shift (which was	

#	Provision	Assessment of Status	Compliance
		in the early morning of 10/10/12) for cough with struggle, wet vocal quality/gurgling voice/wheezing, formula on mouth or in mouth/nose, and vomiting marked on the Aspiration Trigger Data Sheet. It was positive to find in the Integrated Progress Notes on 10/10/12 at 5:00 a.m., that the direct support professional reported the aspiration triggers to the nurse, who followed-up with a comprehensive nursing assessment documented in the Integrated Progress Notes according to the Nursing Vomiting Protocol. There was also documentation in the note that the physician was notified according to the When Contacting the Primary Care Provider (PCP) Protocol. Subsequently, the physician assessed Individual #649 on 10/10/12 at 8:45 a.m., and diagnosed her with hyperpyrexia with tachypnea and ordered her sent to the hospital to rule out sepsis and/or Healthcare-associated pneumonia (HCAP). Individual #649 was admitted on 10/10/12, diagnosed and treated for urosepsis. She was followed daily by the Hospital Liaison Nurse, who kept the IDT apprised of her condition. She was discharged on 10/22/12 with a discharge diagnosis of resolved urosepsis. A review of the associated documentation indicated that the Nursing Protocol for Hospital, Transfers, and Discharges, PMNT Nurse Post Hospitalization Assessment/Evaluation, ISPA post hospital/Infirmary discharge, and Acute Care Plan for Post Hospital Urosepsis were carried out as required until the urosepsis was resolved on 10/25/12. • Two of eight (25%) individuals who had aspiration triggers episodes documented in the Integrated Progress Notes did not have these marked on the Aspiration Triggers Data Sheets. In one case (Individual #523), adequate medical assessment and management was not provided for repeated episodes of vomiting. o Individual #523 had four episodes of vomiting on 10/8/12 at 1659, 10/9/12 at 2300, 10/10/12 at 1400, and 10/25/12 at 1035. There were vomiting trigger episodes marked on the Aspiration Triggers Data Sheets on 10/9/12 and 10/10/12. It was positive to find documented in the Integrated Progress Notes that the nurses had consistently followed the Nursing Vomiting Protocol and When Contacting the Primary Care Provider (PCP) Protocol. The physician assessed Individual #523 for each episode of vomiting. On 10/9/12, the physician's assessment and plan stated, "renal insufficiency based on lab results and instructed to continue to monitor vomiting." On 10/25/12, the physician's assessment and plan stated, the vomiting was "likely involuntary regurgitation of gastric content, suspicious for fish oil stimulation, resolved, clinically stable and to continue to monitor, continue precautions for aspiration." The Monitoring Team was concerned that physician ordered the nursing staff to continue to monitoring for vomiting without thoroughly exploring the underlying cause of the frequent vomiting episodes. o Individual #377 had a vomiting episode on 10/26/12 at 0745 documented in the Integrated Progress Notes that was not marked on the Aspiration Triggers Data	

#	Provision	Assessment of Status	Compliance
		Sheet. A review of the Integrated Progress Notes found that the nurses followed the Nursing Vomiting Protocol and Nursing When Contacting the Primary Care Provider (PCP) Protocol. The physician ordered, "Dilantin level, CBC, with Differential, CMP, urine analysis, chest x-ray and KUB to be done 10/26/12." On 10/26/12 at 1650, the nurse notified the physician that the Dilantin level was 5.8. The physician ordered one bottle of thickened Gatorade to give with his meal and to have him seen in sick call or to page if needed. On 10/27/12 at 0825, Individual #377 began having multiple tonic-clonic seizures back to back. The Nursing Seizure Protocol was implemented and the physician notified. The physician ordered Diastat 10 mg per rectum at 8:40 and was given, but seizures persisted. The physician ordered Individual #377 taken to the emergency room. He was transported via ambulance to the emergency room at 0919 a.m. where he was diagnosed and treated for active seizures and returned home stable at 1440. The records reviewed above were derived from a cross-section of records across the Units of individuals with high risk ratings for aspiration, who required daily monitoring, documented on the Aspiration Trigger Data Sheets. Review of the Aspiration Triggers Data Sheets showed a lack of compliance with the Aspiration Trigger Data Monitoring Guideline requirements by the direct support professionals and nursing staff, as well as lack of adequate oversight by Residential, Nursing, and Habilitation Management to ensure that individuals at risk for aspiration were monitored daily on every shift and followed-up appropriately. The Facility should ensure that all disciplines responsible for monitoring individuals at high risk for aspiration follow the required Aspiration Trigger Monitoring Guidelines/Instructions.	
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	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 that the Nursing Department had prepared an excellent and comprehensive summary of the activities performed for this provision since the last compliance review. The administrative and management nurses interviewed by the Monitoring Team were readily knowledgeable of these activities and were able to answer question and provided supporting documentation when requested regarding issues related to this Provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
	Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the last review, the Facility had continued to follow the Providing Health Care Services, Mediation Variances Policy, 1.34, Effective Date: 2/27/12 and Nursing Services Mediation Variances Guidelines, A-3, Date: 1/24/12, and to refine medication administration practices relating to medication variances. The Facility continued to have a comprehensive Medication Variance Database using a root cause analysis approach. The database aggregated, analyzed and trended data by: Person specific and facility aggregate, medication variances by Severity Index categories, types of medication variances, medication variances by nodes (dispensing, prescribing, administering, documenting, transcribing, and other), department responsible for the medication variances, medications by shift and day of the week, and month. The data were represented by bar graphs including the number of variances represented, and a color-coded legend explaining the graphs. The Quality Assurance Nurses performed the final review of Medication Variance Reports and entered the data into the Medication Variance Database. Monthly Medication Variance Trend Reports were provided to the Medication Variance Committee, Pharmacy and Therapeutics Committee, and the Quality Assurance Department. The medication variance data provided the Facility with detailed medication variance information from which to make decisions for corrective action to reduce the incidents of variances. Recently, the Facility began reporting medication variance data for the past rolling 12-month period. The Monitoring Team was provided with Medication Variance Trend Report for past 12 months that was aggregated, analyzed and trended. However, a narrative report interpreting the data was not included with the tabular and graphic information. The Monitoring Team reviewed the monthly Medication Variance Committee meeting minutes, June through October 2012. It was positive to find that the Committee showed progressive improvement in the review, discussion, and disposition of medication variances and other medication administration practices. Monthly, the Infirmary Director and Unit Nurse Managers continued to provide the committee with detailed medication variance reports describing the number, description, and corrective actions taken, as well as detailed reports on the number of Adverse Drug Reactions Reports, Medication Administration Observations, Medication Room Surveys, and Medication Administration Record Audits and corrective actions taken when indicated for deficiencies found on the audits. The Infirmary/Unit reports were summarized into the Medication Variance Committee minutes. Individuals who frequently refused medication were referred to their respective PCP, IDT and Behavioral Analyst for appropriate follow-up. There was a continuing concern that medication variances may be underreported. The Nurse Managers were instructed on improvements they need to make with their nursing staffs. Issues that were carried over from previous meetings were followed upon at the next meeting and/or until the issues were resolved.	

#	Provision	Assessment of Status	Compliance
		As was found at the last review, the focus on medication variances and corrective action plans was primarily directed toward the Nursing Department. It was of concern that there were very few issues or medication variances or corrective actions plans addressed in the Committee minutes for the Pharmacy Department and none for the Medical Department or Dental Department. The potential to commit medication variances is not limited to the Nursing Department. The Facility should ensure that all Departments responsible for medication administration practices should actively participate in Committee meetings and work collaborative to reduce the incidence of medication variances and to develop strategies to improve general medication administration practices that affect all departments. In addition, in reviewing the monthly attendance lists, it was noted that numerous members were consistently absent. In order to conduct viable meetings the required members should consistently attend the Committee meetings, unless there was a justifiable reason they could not attend. The Monitoring Team attended the Medication Variance Committee meeting on 11/15/12. As reported above, the Unit Nurse Manager provided written and verbal reports for October 2012 on Medication Variances, Medication Administration Observations, Medication Administration Records, and Medication Room Survey audits and any corrective actions taken both local and systemically. This information will be included in the Medication Variance Committee Meetings. The QA Nurses presented the Medication Variance Trend Report for the past rolling 12 months. The group reviewed the data findings and discussed how to use the data, what information was useful, and what data should be revised or eliminated. The trend data was presented in tabular and graphic form without a narrative to explain or interpret the data. The process for collecting and refining data was still evolving. The Monitoring Team will review the Medication Variance Trend Reports for any changes made to the data at the next compliance review. The Monitoring Team reviewed the Pharmacy and Therapeutics Committee minutes for 5/15/12 and 7/11/12, and found the Medication Variance Trend Reports were provided at the Committee meetings and reviewed with problem solving discussion to improve medication administration practices and to reduce the incidence of medication variances for relevant disciplines responsible for medication administration practices. Refer to Provision N.8 for information regarding the Pharmacy and Therapeutics Committee meetings. A review of the monthly Medication Variances reported, May through October 2012, found the following: April: Total – 9 (medication variances not identified by discipline) May: Total – 27 (medication variances not identified by discipline)	

#	Provision	Assessment of Status	Compliance
		June: • Nursing – 12 • Medical - 7 • Pharmacy – 11 Total – 30 July: • Nursing – 9 • Medical - 1 • Pharmacy – 3 Total – 13 August: • Nursing – 12 • Medical – 4 • Pharmacy - 13 Total – 29 September: • Nursing – 9 • Pharmacy – 6 Total – 15 The Medication Variance Committee reported in the September 28, 2012 minutes that they were working on collecting longitudinal data for a rolling 12 months, and trending data by severity, type of variance, node, responsible department, and shift and day of the week. It was cautioned that some of the data may not yet be complete. The following trend data for the past 12 months was reported: Medication Variance by Severity Index Categories: • 170 Category A (potential to cause variance) • 47 Category B (variance that occurred but did not reach the individual) • 45 Category C (variance reaches the individuals but did not cause harm) • 5 Category D (reaches the individual and required monitoring to ensure no harm and/or required intervention to preclude harm) Medication Variance by Node: • 119 dispensing (Pharmacy) • 48 prescribing (Physician) • 44 administration (Nursing) • 32 Documentation (all disciplines) • 10 transcribing (Nursing) • 14 other (discipline not identified) Medication Variance Shift and Day of Week:	

#	Provision	Assessment of Status	Compliance
		• 1 variance on the 10-6 shift • 61 variances on 2-10 shift • 129 variances on 6-2 shift • 90 variances on 8-5 shift (Pharmacy) This was a positive step forward in trending and analyzing medication variance data upon which decisions can be made regarding local and systemic medication variances, CAPs developed and implemented, followed through to resolution, and their efficacy evaluated to reduce the incidence of medication variances. The Monitoring Team will follow up for progress on this issue at the next compliance review. The Monitoring Team reviewed the 12 of the most recent Medication Variance Reports provided per the document request. There was steady improvement in correctly completing the Medication Variance Reports from previous reviews. Medication variances were reported that previously were not considered medication variances. Findings included: • Five of 12 (42%) Medication Variance Reports were filled out completely. Seven of the Medication Variance Reports did not document the notification of the respective physician. One did not have the date the medication variance was discovered; instead the time of day was listed. • Eight of 12 (67%) medication variances were discovered and reported within 24 hours. Four medication variances were not discovered for 44 days each. This was a transcription variance for a wound care medication that was ordered on 7/3/12 but was not discovered until 8/15/12. Consequently, the individual did not receive the wound care medication for 44 days. Once discovered, the Unit Nurse Manager notified the PCP and obtained new orders for the wound care medication, completed a Medication Variance Reports, and took corrective action with the nursing staff involved in the variances. • 11 of 12 (92%) medication variances were graded correctly on the Severity Index. One medication variance was reported for two pills found by the Unit Director. The pills could not be identified by the Pharmacy, nor could the individuals who spit them out on the floor. The nursing staff could not determine what category to rate this variance. The Unit Nurse Manager counseled the nurses involved. This demonstrates the need for the nurses to ensure that individuals' swallow their medications before they leave after medications are administered. • 12 of 12 (100%) medication variances had appropriate corrective action taken by the respective Unit Nurse Manager. • 12 of 12 (100%) medication variances had data describing why the variances occurred. • Six of 12 (50%) medication variances were committed by nurses floating to the home. • Unit trends where the medication variances occurred: Five of 12 (42%) occurred in Trinity B. Four of 12 (33%) occurred in San Antonio.	

#	Provision	Assessment of Status	Compliance
		The Nursing Department should ensure that all Medication Variance Reports are reviewed for accuracy and completeness before entering the data into the Medication Variance Database; otherwise the data will be inaccurate. The Facility's Self-Assessment reported the data analysis report for Nursing Care Monitoring Tool: Medication Administration and Documentation. The Monitoring Team reviewed supporting documentation that validated their report. The monthly percentage of compliance with the Nursing Care Monitoring Tool: Medication Administration and Documentation from April through September 2012, are reported in the chart below:	

Nursing Care Monitoring Tool	April	May	June	July	August	September	Overall %
Medication Administration and Documentation	85%	80%	92%	90%	83%	72%	86%

CAPs were not implemented because the overall percentage of compliance with the above tools was 80% or greater for the quarter.

It was positive to find, as mention 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 that consistently reached at least 98% to 100% between the Nursing auditors and QA Nurse auditors for the Nursing Care Medication Administration and Documentation Monitoring Tools.

In addition to the audits conducted by the Nursing auditors and QA Nurse auditors on the Nursing Care Monitoring Tools, they conduct monthly Medication Administration Observation, Medication Rooms Survey, and Medication Administration Records (MARs) audits. The Facility's Self-Assessment reported the data analysis report for monthly Medication Administration Observations (for 468 observations), Medication Rooms Survey (for 260 surveys), and Medication Administration Record (MAR) (for 86) audits. The Monitoring Team reviewed supporting documentation that validated their reports. The percentage of compliance on the monthly Medication Administration Observation, Medication Rooms Survey, and MARs audits from April through September 2012, are reported in the chart below:

Monitoring Tools	May	June	July	August	September	October	Overall %
Medication Administration Records	64%	77%	82%	93%	90%	94%	88%
Medication	99%	99%	97%	99%	93%	96%	97%

#	Provision	Assessment of Status	Compliance

Room Survey								
Medication Administration Observations	100%	90%	100%	100%	90%	100%	98%	

CAPs were not implemented because the overall percentage of compliance with the above tools was 80% or greater for the quarter. The longitudinal analyses of the above data were just recently implemented. There was no inter-rater reliability documentation provided for the above audits. If not conducted, the Nursing Department and QA Nurses should conduct inter-rater reliability checks on the Medication Administration Record, Medication Room Survey, and Medication Administration Observation audits.

The Monitoring Team conducted medication administration observations in Trinity C and D on 11/13/12 at the 4:00 pm medication pass. The Monitoring Team was accompanied by the CNE, Unit Nurse Manager, and QA Nurse. Three different nurses were observed. Medication Administration Observations were made on Individuals #284, #657, #724, #286, and #785, who received medications/feedings via enteral route. Although the nurses administering medication did not commit medication variances during the medication pass, several concerns were identified:

- Two of the three nurses (67%) failed to consistently follow standard medication administration practices for administering medications/bolus feedings via enteral route.
- Two of three nurses (67%) did not refer to individuals' Physical Nutritional Management Plans (PNMPs) for safe medication administration before they started to administer medications. They did not seem aware of the PNMPs or their purpose until prompted. Individual #284's PNMP was dated revised on 8/12/11. It should have been reviewed and updated at least annually. The instruction for medication administration was written on the last page of four pages and was not readily visible to the nurses.
- All three nurses failed to complete the third basic medication checks with the MAR. The opened medication bubble packages were immediately disposed of in the waste after the medications were opened and placed in the cup. The opened bubble packets were not reserved to perform the third check before administering the medications. This was an issue found at the past compliance reviews.
- The nurses did not consistently tell the individuals' what medications they were receiving and their purposes.
- When the nurse began administering medication to Individual #785 he was complaining of his throat hurting. His cheeks were flushed, the eyes were teary, and he was coughing. The nurse administered the medication via g-tube, immediately followed by an eight ounce bolus feeding. It appeared that the nurse administered the feeding too fast but before the feeding was slowed down Individual #785 coughed and spontaneously vomited a large amount. The CNE instructed the nurse to complete an assessment for aspiration and to notify the PCP. The PCP was notified and immediately assessed

#	Provision	Assessment of Status	Compliance
		Individual #785 in his home. A review of Individual #785's Integrated Progress Notes for acute change in health status indicated that he was followed-up promptly and appropriately diagnosed, and managed/treated. The CNE will follow-up with counseling for the two nurses who did not consistently follow standard medication administration practices. The Monitoring Team inspected the Medication Room in San Antonio on 11/12/12, accompanied by the NOO and QA Nurse. Issues of non-compliance identified included: • The Medication Room was not clean, particularly the floors. • Boxes of supplies were stored on the closet floor without pallets underneath. • The Narcotic Log Sheets for Cart D was missing nursing co-signatures at shift changes on October 26, 29, and 30, 2012 and November 7, 8, 10, and 13, 2012. • The Narcotic Log Sheets for Cart C was missing nursing co-signatures at shift changes on October 25 and 29, 2012. The Universal Signature Sheet in the MAR needs updating. • The Narcotic Log Sheets for Cart A was missing nursing co-signatures on October 27, 2012 and November 12, 2012. The Universal Signature Sheet in the MAR needs updating. It was positive to find that there were maroon spoons on the med carts in Trinity and San Antonio as opposed to the white plastic "picnic type" spoons found at the last compliance review. The Monitoring Team's Medication Administration Observations, Medication Room Surveys, and MAR audits were not consistent with the Facility's Self-Assessment report for Medication Administration Observation. The Nursing Department and QA Nurses should conduct inter-rater checks for the Medication Administration Observations, Medication Room Surveys, and MAR audits. The Nursing Department should collaborate with the Habilitation Department to ensure that individuals' PNMPs maintained in the Medication Administration Notebooks are current and that all nursing staff administering medications are trained on individuals' PNMP strategies for safe medication administration practices for oral and enteral administration. As was found at the last compliance review, a review showed the PNMPs contained in the Medication Administration Record Notebooks were not consistently reviewed/revised at the time of the annual ISP or when there was a change in status that required a revision. 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. Medication Administration instruction should be written on the front sheet on the upper left side of the page for easy visibility. Refer to Provision O.3 for additional information.	

#	Provision	Assessment of Status	Compliance
		According to the Nurse Educator the State Medication Administration for Individuals' Dysphagia or Other Swallowing Difficulty or risk for Aspiration training will be provided in December 2012 to relevant administrative/management nurses and to nurses who administer medications to help them better understand the rationale for the strategies contained in the PNMPs for safely administering medications orally and enterally. The Monitoring Team will follow up on the status of the training at the next compliance review. 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 ensure: • All Medication Variance Reports are reviewed for accuracy and completeness before entering the data into the Medication Variance Database; otherwise the data will be inaccurate. • The Nursing Department and QA Nurses should conduct inter-rater reliability checks on the Medication Administration Record, Medication Room Survey, and Medication Administration Observation audits. • Collaborate with the Habilitation Department to ensure that individuals' PNMPs maintained in the Medication Administration Notebooks are current and that all nursing staff administering medications are trained on individuals' PNMPs strategies for safe medication administration practices for oral and enteral administration. The Facility should ensure all Departments responsible for medication administration practices actively participate in Committee meetings and work collaboratively to reduce the incidence of medication variances and to develop strategies to improve general medication administration practices that affect all departments. In addition, in reviewing the monthly attendance lists, it was noted that numerous members were consistently absent. In order to conduct a viable meeting required members should consistently attend the Committee meetings, unless there was a justifiable reason they could not attend.	

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

1. The Nursing Department should ensure: (Provision M.1)
    - A Seizure Record is completed for each seizure episode, as well as a corresponding nursing assessment with documentation in the Integrated Progress Note, as specified in the Nursing Protocol: Seizure Management Guidelines and Nursing Protocol: Vagus Nerve Stimulator, February 2012.
    - When medical monitoring is initiated as follow-up to seizure activity, the frequency and duration should be documented and followed as stated through to resolution.
    - The Nursing Post-Sedation Protocol is followed when individuals are administered Diastat or any other sedating medication for prolonged

or intractable seizure activity.
- The Nursing Department should ensure that the Unit nurses who contact the hospital regarding individual's health status over the weekend or when covering for the Hospital Liaison Nurse sign their typed written notes. (Provision M.1)
- The Facility should enhance its direct care support to prevent decubitus ulcers from developing, and ensure that all individuals who sustain a recurrent lesion, or any decubitus ulcer of stage II or greater, are evaluated by the Facility clinicians. (Provision M.1)

2. The Nursing Department should ensure that the Infection Control Preventionist Nurses continue to 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.
   - Re-evaluate the practice of delaying infection control investigation of a particular infection until there are 15 or more cases reported in any home.
   - Review the all new Acute Care Plans and Health Maintenance 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.
3. The Facility should ensure that: (Provision M.1)
   - Mock Medical Emergency Drill Reports are sent to the Incident Risk 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.
4. The Nursing Department should continue to make the following improvements: (Provision 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 HMPs.
   - 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.
   - Develop guidelines for completing the Community Nursing Discharge Summary's for the overall nursing summaries and plans of care to ensure that the information provided to the community agencies is complete, accurate, and current.
5. The Nursing Department should continue to make the following improvements: (Provision M.3)
   - Ensure that entries in the Integrated Progress Notes are documented in sequence and that blank spaces have lines drawn through to prevent documentation from being out of sequence.
   - Ensure the frequencies for nursing monitoring, assessments and documentation stated in Acute Care Plans are consistent with the requirements for Nursing Protocols and/or medical monitoring; and that the nursing staff consistently adheres to the stated frequencies.
   - Ensure that wounds, abrasions, scratches are consistently assessed, described, and documented as to their exact location, size, appearance, and status of healing.
   - Ensure that Acute Care Plans are revised when there are changes in nursing interventions/treatments and/or other changes to the plans.
6. Ensure that guidelines are available that define the requirements for staff responsible for monitoring individuals at high risk for aspiration, and that staff carry out all requirements. (Provision M.5)
7. The Nursing Department should ensure: (Provision M.6)
   - All Medication Variance Reports are reviewed for accuracy and completeness before entering the data into the Medication Variance Database; otherwise the data will be inaccurate.

- The Nursing Department and QA Nurses should conduct inter-rater reliability checks on the Medication Administration Record, Medication Room Survey, and Medication Administration Observation audits.
- Collaborate with the Habilitation Department to ensure that individuals' PNMPs maintained in the Medication Administration Notebooks are current and that all nursing staff administering medications are trained on individuals' PNMP strategies for safe medication administration practices for oral and enteral administration. (Provision M.6)

8. The Facility should ensure all Departments responsible for medication administration practices actively participate in Committee meetings and work collaboratively to reduce the incidence of medication variances and to develop strategies to improve general medication administration practices that affect all departments. (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 10/30/12 2. RSSLC Action Plans 10/15/12 3. Presentation Book for Section L 4. RSSLC Pharmacy Policy #01.05.25 Adverse Drug Reaction, dated 7/15/11 5. RSSLC Pharmacy Policy #01.05.20 Medication Variances, dated 11/2/11. 6. RSSLC Pharmacy Policy, #03-15 Drug use evaluation – DUE process, dated 5/12/11 7. Pharmacy and Therapeutics Committee (P&TC) minutes for March 2012, and July 2012 8. First ten completed single patient drug intervention reports (SPDI) completed in August 2012 9. Medical providers response, and evidence to support that pharmacy recommendations were addressed by the medical provider for the first ten completed SPDI reports in August 2012 10. Last six months data elements and graphs for reporting of adverse drug reactions 11. Last ten completed Adverse Drug Reaction (ADR) report forms, and supporting documentation 12. Training materials for ADR process 13. Drug Utilization Review Schedule for 2012-2013 14. All completed DUE's completed during the reporting period 15. Active clinical records for individuals #600, #545, #649, #51, #239, #459, #584, #791, #212, #787, #239, #513, and #77 16. Last two QDRRs, annual medical summary, current medication list, most recent ISP and addendums to the ISP, last 12 months labs, last six months MOSES and DISCUS assessments, physician responses to recommendations made by the pharmacist for individuals #600, #545, #649, #51, #239, #459, #584, #791, #212, #787, #239, #513, #306, #728, #529, #680 and #77 17. Last ten completed medication variance report forms 18. P&TC minutes for 10/25/12 meeting 19. Graphs, and data charts for medication variances that occurred during the reporting period. **People Interviewed:** 1. Anto Parambil, Pharmacy Director **Meeting Attended/Observations:** 1. P&TC meeting
	Facility Self-Assessment: The Facility rated itself in substantial compliance with Provisions N.1, through N.7, and noncompliant for Provision N.8. The Monitoring Team concurred with the assessment for Provisions N.1, N.4, N.6, N.7, and N.8; however, the Monitoring Team determined noncompliance for Provisions N.2, N.3, and N.5. To better address the Monitoring Team's concerns, and to help improve the self-assessment process, the Monitoring Team offers the following review and recommendations for the self-assessment, and plan of improvement process: The Monitoring Team has concern with the self-assessment for Provision N.1, because the pharmacist's

	response and follow-up for pharmacists' recommendations were not assessed, and the action plan did not address this important issue. The Monitoring Team noted significant issues with pharmacists' responses, and follow-up for SPDIs. The self-assessment for Provision N.2 indicated that less then 50% of the QDRRs had a psychiatrist's signature, and then indicated substantial compliance by stating "because 90% completion of the QDDRs in 90 day period and there was a 90% approval rating from the PCPs". The Facility itself requires acceptance of the QDRR by a psychiatrist, when a psychotropic medication is prescribed. Furthermore, the assessment, or the plan of correction, did not address the need for the QDRR to specifically and comprehensively address stat chemical restraint, benzodiazepines, anticholinergics, metabolic syndrome, and polypharmacy. The Monitoring Team disagreed with the Facility's self-assessment of compliance. The self-assessment for Provision N.3 focused purely on whether or not an issue was documented on, but did not take into consideration the comprehensiveness or clinical appropriateness of the pharmacy review. The Monitoring Team recommends that the action plan, and self-assessment reflect concerns, and recommendations noted in this report. The Monitoring Team noted that for Provision N.4 the self-assessment focused purely on responses to QDRR recommendations; however, the Settlement Agreement clearly indicated "any recommendations". The self-assessment should ensure that all recommendations made by pharmacists are addressed. The clinical appropriateness of the medical providers response must also be assessed. The action plan did not address non-QDRR recommendations, and did not indicate a plan to address the appropriateness of the medical providers' responses to pharmacy recommendations. The Monitoring Team defers review of the self-assessment for Provision N.5 to Section J, of this report; however, the Monitoring Team noted a significant difference with regard to the self-assessment findings of 100% completion of the DISCUS and MOSES assessment. When reviewing MOSES and DISCUS assessments, the Facility should look closely atthe medical prescribers component of the assessment forms, and ensure they were appropriately completed by the medical provider. The Facility did not self-assess the comprehensiveness and clinical appropriateness of the action steps taken for ADRs, The number of ADRs being reported by the Facility remain very low, and a review of staff assertiveness in monitoring individuals for ADRs should be developed as an action step for the plan of improvement to ensure all ADRs are being reported. The self-assessment for Provision N.7 should include a review that ensures DUEs were developed for all relevant FDA advisories, and warnings. The plan of improvement did not indicate a process for the Facility to address FDA advisories. The self-assessment for Provision N.8 should include a more robust review for completion of the medication variance form, and assess the medical provider's clinical response to the medication variance, and the department supervisor's follow-up, and action. These issues were not assessed in the self-

	assessment, and there was no action plan to address these issues. The self-assessment focused mostly on a review of the P&TC minutes, and not the substance of the actual medication variances and reviews. The self-assessment and plan of improvement should ensure that there is a process that enables review to ensure that all relevant departments (medical, nursing, pharmacy), are actively involved with the medication review process. The Monitoring Team has significant concern over the low numbers of medication variances reported, and encourages the Facility to develop a process to assess whether all variances are being reported.
	Summary of Monitor's Assessment: The Monitoring Team noted the exceptional quality of the Facility's DUE process, and the more comprehensive approach the Facility had taken when completing QDRRs. In addition, the Monitoring Team noted some improvement with assessing metabolic syndrome. The Monitoring Team encourages pharmacists to provide meaningful recommendations when issuing a single patient drug intervention, and to the best of their ability, ensure that the medical providers' responses to pharmacy recommendations are clinically appropriate. **Provision N.1:** The Monitoring Team noted that the pharmacist provided an actual recommendation for SPDI reports in zero out of five cases (0%); and pharmacists appropriately reviewed and accepted the medical providers response in one out of five cases (20%). The SPDI report form clearly calls for the pharmacist to offer clinical recommendations, and in no case did the pharmacist actually make a recommendation. As a participant in the interdisciplinary process, the pharmacist has an obligation to question the response by the medical provider, and escalate concerns of unacceptable responses to the director of pharmacy. This level of review by the pharmacist was not evident. The Monitoring Team will continue a rating of substantial compliance, as the last report did not clearly address this issue; however, at the time of the next compliance visit, the Facility must, in order to maintain a finding of substantial compliance, provide evidence that the pharmacists make recommendations as needed and ensure there is response by the physician. **Provision N.2:** The Monitoring Team determined that the Facility is not in compliance with Provision N.2. QDRRs must be complete, and must appropriately address issues such as polypharmacy and metabolic syndrome; medical providers and psychiatrists must indicate their review, and agreement or disagreement with recommendations; the pharmacist must indicate that having a medical condition, such as diabetes, especially when being treated with pharmacotherapy for diabetes, is considered a risk factor for metabolic syndrome. **Provision N.3:** The Monitoring Team concluded that the Facility was not in compliance with Provision N.3, and did not adequately document appropriate review of metabolic syndrome, use of benzodiazepines, and stat chemical restraints. Pharmacy review of such issues must include a well documented clinical pharmacy review that includes the following information: Name of drug, indication, appropriateness, noted and potential side effects, noted and potential drug-drug interaction, and meaningful recommendations, that are addressed by the prescribing physician. Review of stat medication use must also include a review of the efficacy of the baseline psychotropic medications.

	Provision N.4: Although the medical provider responded to the pharmacists' concerns over new medication orders in six out of six cases (100%), the medical provider's response to the SPDI was determined by the Monitoring Team to be appropriate in three out of the six cases (50%). During review of the QDRR process, the Monitoring Team was concerned that the medical provider followed up on recommendations in only one out of five cases (20%), and that zero out of five psychiatrists (0%) followed up on recommendations. The Monitoring Team will continue to rate this provision substantial compliance; however, the pharmacy department must ensure meaningful and appropriate follow-up by medical providers for all pharmacy recommendations in order to maintain this rating. **Provision N.5**: Provision N.5 is assessed as a component of Provision J.12, of this report. The Monitoring Team determined non-compliance for Provision J.12, and refers the reader to Provision J.12. **Provision N.6:** The Facility maintained a comprehensive database of all ADRs. The Facility had a comprehensive mechanism to review, analyze, and report on ADRs. The number of ADRs reported and assessed had increased compared to the last reporting period but still remained lower than might be expected. The Monitoring Team continues to have concern over the reporting practices of ADRs by Facility staff. Completion of the ADR report form, follow-up on ADRs, the documentation and clinical appropriateness of treatments offered for ADRs, and the review process by the P&TC committee of ADRs were all of concern to the Monitoring Team. The Monitoring Team strongly encourages the Facility to develop a comprehensive strategy that is outlined by policy and procedure on training of all staff, including medical providers, nurses, pharmacists, and direct support staff on identify, reporting, and following up on ADRs. The Monitoring Team will continue a rating of compliance at this visit; however, the Facility must act to ensure that all ADRs are reported. **Provision N.7:** The Monitoring Team compliments the pharmacy department for developing and implementing a high quality DUE process, and determined that the Facility remains in substantial compliance. The Monitoring Team would like to remind the Facility to modify its policy for the DUE process, to include its practice of providing DUEs for all relevant FDA warnings and advisories. **Provision N.8:** The Monitoring Team determined that the Facility continues to be noncompliant with Provision N.8 because medication variance reports were not fully completed and lacked meaningful review by the department supervisors. In addition, the Monitoring Team continues to be concerned of the lack of meaningful summarization of medical provider variances.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18	Provision N.1, requires that the pharmacy maintain a process by which pharmacists review all new medication orders and provide recommendations to the prescribing medical provider as clinically indicated. To assess the comprehensiveness of pharmacist	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	review, the Monitoring Team reviewed a copy of the first ten single patient drug intervention reports generated in August 2012, along with the medical providers response, and evidence that recommendations were followed up on. The following is a summary of the Monitoring Team's review of each sample provided: Individual #613 On 8/24/12, the pharmacist issued a single patient intervention report (SPDI) that indicated a potential drug interaction which could cause a serious elevation with a potassium level, and sent an email report to the medical provider that stated "drug-interaction between Bactrim with Lisinopril, e-mail sent to NP, see the attachment. Potassium level is 4.6 on 8/14/12 (normal range is 3.5 to 5.2)". The medical provider responded by email on 8/14/12 stating "will order BMP for 8/14/12 to monitor K+ (potassium)". The Monitoring Team has the following concerns: • The date, which was computer generated, on the SPDI, was 8/24/12; however, the medical provider response, and the date of the laboratory result, was dated 8/14/12. • Drug monitoring, by serial potassium levels, until at least steady state of Bactrim, should have been considered. A one-time evaluation around the time of initiating the drug would not meet standard of care practice. • The pharmacist did not provide a recommendation but just reiterated what the drug interaction monogram stated. • The pharmacist did not question the medical providers response. Individual #719 On 8/29/12, the pharmacist issued a SPDI report stating that "drug-interaction between Bactrim with Lisinopril, email sent to MD, see the attachment and responses. Per MD D/C Lisinpril during Bactrim treatment". The medical provider responded by email on 8/28/12, and stated that "will D/C Lisinopril during Bactrim treatment. Thanks". A physician order to discontinue lisinopril was noted by the Monitoring Team. The Monitoring Team has the following concern: • The pharmacist did not provide a recommendation but just reiterated what the drug interaction monogram stated. • This drug interaction, was for the same drug interaction, as noted above for Individual #613; however, the response by the medical provider was different, which raises the question of how assertive pharmacy is following up on responses by the medical provider. Incidentally, the Monitoring Team concurs with this medical providers action. Individual #179 On 8/7/12, the pharmacist issued a SPDI report stating that "drug-interaction between	

#	Provision	Assessment of Status	Compliance
		Levaquin with citalopram email sent to MD, see the attachment. MD D/C levaquin and started doxycycline", "and order for to obtain EKG". The medical provider responded by email on 8/7/12, with instruction to obtain an EKG, and to change levaquin to doxycycline. A corresponding order was attached. The Monitoring Team has the following concern: • The pharmacist did not provide a recommendation but just reiterated what the drug interaction monogram stated. Individual #382 A SPDI was issued by the pharmacist on 8/6/12, that stated "drug-interaction between ibuprofen with Plavix, email sent to NP, see the attachment. Five day treatment was over on 8/4/12 and no report of signs of bleeding". The medical provider responded by email on 7/31/12, by stating "nurses are instructed to monitor for signs of bleeding and notify medical while on ibuprofen", and a corresponding order was noted by the Monitoring Team. The Monitoring Team has the following serious concerns: • The pharmacist did not provide a recommendation but just reiterated what the drug interaction monogram stated. • The SPDI was dated 8/6/12, while the medical provider responded on 7/31/12. • The SPDI was issued following completion of the drug regimen, as noted by the SPDI being issued on 8/6/12, with a response documented by the pharmacist stating that "five day treatment was over on 8/4/12, and no signs of bleeding". • The pharmacist did not raise concern with the medical provider's response of "monitor for signs of bleeding and notify medical while on ibuprofen". The Monitoring Team has significant concern with this response, and at a minimum, more assertive monitoring parameters should have been ordered. Individual #573 A SPDI report was generated by the pharmacist on 8/6/12, which stated "Sent drug interaction note for levaquin and hydrocortisone. "Dr. said they will monitor for adverse effects and that treatment is required". The medical provider responded by email on 8/6/12, and stated "Per Pulmonologist, the antibiotic is merited and patient will be followed clinically for adverse effects. Please see Dr (left blank for confidentiality) hospital summary/course". There was no accompanying order, or evidence of how the individual would be monitored. The Monitoring Team has the following concerns: • The pharmacist did not provide a recommendation but just reiterated what the drug interaction monogram stated. • The Monitoring Team concurs that the medication may have been necessary; however, in an intermediate care facility, that supports individuals who experience challenges with reporting signs and symptoms of underlying medical conditions, it is essential that specific parameters are well documented for	

#	Provision	Assessment of Status	Compliance
		nursing and direct care staff to follow. There was no evidence provided on how such monitoring would be carried through. Furthermore, the pharmacist did not question the basic response by the medical provider. Individual #525 SPDI issued on 8/13/12, stated "Sent drug interaction note for fluconazole and atorvastatin. Said they will monitor for myopathy. Course of fluconazole has ended with no reports of myopathy." E-mail sent by medical provider on 8/13/12, which stated that "We will monitor for S&S of myopathy". Myopathy is a potentially lethal condition. No other evidence to support that monitoring occurred, and specific monitoring parameters were not delineated. The Monitoring Team has the following concerns: • The pharmacist did not provide a recommendation but just reiterated what the drug interaction monogram stated. • The pharmacist did not question, or delineate monitoring parameters. • There was no evidence that the monitoring occurred. Review of the SPDI reports, and supporting evidence for individuals #452, #526, #792, and #783, revealed similar concern. Summary For the six SPDIs delineated above, the Monitoring Team noted that the pharmacist provided an actual recommendation for SPDI reports in zero out of six cases (0%); medical providers responded to the SPDI by email in six out of six cases (100%); and the Monitoring Team determined the medical provider's response to the SPDI was appropriate in two out of the six cases (33%). The SPDI report form clearly calls for the pharmacist to offer clinical recommendations, and in no cases did the pharmacist actually make a recommendation. As a participant in the interdisciplinary process, the pharmacist has an obligation to question the response by the medical provider, and escalate concerns of unacceptable responses to the director of pharmacy. This level of review by the pharmacist was not evident. It is important that the SPDI report actually reflects that date that the issue occurred, and that the physician's response is dated after the initial date on the SPDI. The SPDI, and physician response to the SPDI is part of the medical record, and is considered a legal document, therefore dates and time must be accurately reflected on the documentation. The Monitoring Team is very concerned with the Facility's ability to maintain substantial compliance with Provision N.1, and at this time will continue substantial compliance, if; however, the noted issues are not rectified, the Monitoring Team will revoke substantial	

#	Provision	Assessment of Status	Compliance
		compliance at the time of the next Monitoring Teams review.	
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 N.2 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 Services, Medication Regimen Review Guideline. To assess the Facility's QDRR process, the Monitoring Team selected the first five individuals from a list of all individuals with a diagnosis of diabetes, and who were on a neuroleptic drug, and requested the following information for review: Last two QDRRs, annual ISP and any addendums to the ISP for metabolic syndrome, last 12 months of labs, all physician notes documenting follow-up on pharmacists recommendations for the QDRR, current medication list, and last six months of MOSES and DISCUS assessments. In addition, the Monitoring Team also reviewed the QDRR schedule for quarters two and three. The following is a summary of the Monitoring Team review: <u>QDRR Schedule</u> Review of the QDRR schedule indicated that the Facility had not completed QDRRs timely. The Monitoring Team noted that 52 out of 480 QDRRs (11%) were completed greater then 14 calendar days late for quarter two, and 61 out of 480 QDRRs (13%) were greater then 14 calendar days late for quarter three. QDRR Completion Individual #239 QDRR for review period 9/30/12 was not dated by the pharmacist, and was not signed by the primary care physician and psychiatrist. Agreement or disagreement with the QDRR was not indicated by the physicians. The quality and comprehensiveness of the QDRR was excellent. A physician quarterly review, dated 9/11/12, indicated that the medical provider reviewed the QDRR, and addressed the pharmacist's recommendations. Although the individual was prescribed psychotropic medications, there was no evidence that the psychiatrist reviewed and followed up on recommendations. Although signed by the prescriber, the MOSES assessment that was completed on 11/8/12 was not completed by the prescriber, who did not indicate if side effects were present. Individual #728 The QDRR for review period 9/30/12 was signed, but not dated by the pharmacist. The	Noncompliance

#	Provision	Assessment of Status	Compliance
		psychiatrist, and medical prescriber did not sign, date or indicate agreement with the QDRR. For the most part, the QDRR was comprehensive; however anemia was not reported on by the pharmacists, and this could be secondary to medication, or an underlying medical condition. Although signed by the prescriber, the MOSES and DISCUS assessments, dated 10/30/12, and the MOSES, dated 9/10/12, and 3/26/12, were not completed by the prescriber. There was no evidence that the medical provider, and psychiatrist reviewed, and accepted or rejected, recommendations, and no evidence to support that recommendations were followed. Individual #529 The QDRR for review period 9/30/12, was signed but not dated by the pharmacist, and the psychiatrist and medical prescriber did not sign, date, or indicate agreement with the QDRR. The quality, and comprehensiveness of the QDRR was excellent. The Monitoring Team was pleased to see that the pharmacist followed up on the Individual's abnormal alk-phos. The DISCUS assessments dated 7/20/12, and 4/20/12 were not completed by the prescriber. There was no evidence that the medical provider and psychiatrist reviewed, and accepted or rejected, the pharmacist's recommendations. Individual #680 The QDRR for review period 8/30/12 was signed but not dated by the pharmacist. The medical provider signed and dated the QDRR on 10/31/12, and indicated agreement with the recommendations. There was a comment written on the QDRR, which was dated 10/23/12 but not signed, that stated, "see IPN dictation". There was no dictation, or other evidence to suggest that the medical provider followed up on the QDRR recommendations. There was no evidence to support that the psychiatrist reviewed, and accepted or rejected the pharmacist's recommendations. The MOSES assessments, dated 6/8/12, and 9/24/11, were not completed by the prescriber. DISCUS assessments, dated 9/11/12, and 9/23/12, were not completed by the prescriber. The Monitoring Team noted that the Individual had a critically elevated glucose level on 6/5/12, of 536. There were no laboratory data to indicate follow-up glucose levels were obtained. The QDRR noted this critical level on the QDRR; however, there was no recommendations made to more closely check serum glucose levels, or accuchecks. The only recommendation made for this issue was to address dietary issues, and to increase the insulin dose.	

#	Provision	Assessment of Status	Compliance
		In this case, the psychiatrist should have been made aware of the elevated glucose and A1C results, which indicated significant and uncontrolled diabetes, while being prescribed an antipsychotic medication. Importantly, the QDRR should have indicated how the critical glucose level was managed, ensured that follow-up fasting glucose levels were obtained, and recommended close monitoring of the glucose level, not just relying on quarterly A1C results. Antipsychotics can cause severe, and potentially life-threatening elevation in blood glucose levels, in individuals with diagnosed diabetes, and those without diabetes; hence, this must be closely monitored. The QDRR for review period 8/30/12, did not fully address the prescribing of polypharmacy to this individual, as there was no comment on appropriateness of use. Individual #306 The DISCUS assessments, dated 10/11/12, and 8/21/12, were signed, but not completed by the prescriber. The DISCUS, dated 10/11/12, was signed, and dated by the nurse, comments were documented, a total score of zero was documented but the assessment portion was not completed, just left blank. The MOSES assessments, dated 10/11/12, 8/21/12, and 6/4/12, were signed and dated by the physician; however, the prescriber portion of the assessment was not completed. The QDRRs for review periods 4/40/12, and 7/30/12, were signed but not dated by the pharmacist. The medical provider and psychiatrist did not sign, date, or indicate acceptance of the pharmacist's recommendations. There was no evidence to support that the psychiatrist and medical provider followed up on the pharmacist's recommendations. The QDRR for review period 7/30/12 was more comprehensive, but did not document if psychotropic polypharmacy was appropriate or not. Furthermore, the pharmacist indicated that the individual was "not exhibiting s/s of metabolic syndrome"; however, the Individual was diagnosed with diabetes, and prescribed drug treatment for diabetes. Importantly, the pharmacist documented that the Individual had "diagnosis of diabetes, which places the Individual at a higher risk for metabolic syndrome with Seroquel use". There were no formal recommendations to address the risk factor associated with the use of Seroquel. Summary Polypharmacy was assertively assessed by the pharmacist in two out of four cases which involved polypharmacy (50%); metabolic syndrome was documented in five out of five (100%) of the cases; QDRRs were determined to be comprehensive, and appropriate in two out of five cases (40%); the psychiatrist signed and dated the QDRR form in zero out of five cases (0%); the medical provider signed and dated the QDRR form in one out of	

#	Provision	Assessment of Status	Compliance
		five cases (20%); although the pharmacist signed all of the QDRRs in five, out of five cases (100%), the pharmacist dated the QDRR in zero out of five cases (0%); there was evidence to support that the medical provider reviewed, and followed up on the QDRR in one, out of five cases (20%); there was evidence to support that the psychiatrist reviewed, and followed up on recommendations in zero, out of five cases (0%). There were multiple examples of MOSES and DISCUS assessments that were not completed by the prescriber, and one DISCUS assessment was signed by the nurse who completed the assessment and medical provider; however, despite having documented a DISCUS score, there was no actual assessment completed. During preparation of the QDRR, the pharmacist must review all clinical assessments, including the MOSES and DISCUS, and part of that review should be to identify if an assessment was not complete. The Monitoring Team determined that the Facility is not compliance with Provision N.2, of the Settlement Agreement. QDRRs must be complete, and appropriately address issues such as polypharmacy, and metabolic syndrome; medical providers and psychiatrist must indicate their review, and agreement or disagreement with recommendations; the pharmacist must indicate that having a medical condition such as diabetes, especially when being treated with pharmacotherapy for diabetes, is considered a risk factor for metabolic syndrome.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	Provision N.3 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: <u>Stat Chemical Restraint</u> The Monitoring Team reviewed the active clinical record, and requested the following documents for all individuals who received a stat chemical restraint during the reporting period: Face-to-Face report for use of stat chemical restraint; the most recent QDRRs, annual ISP, annual medical summary, last 12 months of labs, documentation to support that the pharmacy recommendations had been followed up on, and the most recent two MOSES and DISCUS assessments. The following is a brief summary of concerns noted for each case reviewed: Individual #600 • Was reported to have been administered a stat chemical restraint on 7/24/12. • The pharmacist did not document review on a face-to-face form. • The QDRR for review period 7/30/12 did not document the use of a chemical restraint. • The psychiatrist signed the QDRR review form on the 7/30/12 QDRR on 11/16/12, and did not sign off on the 10/30/12 review form.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The psychiatrist, and pharmacists did not complete the signature date on the QDRR forms. • The Monitoring Team was provided a pharmacy comment, on what appeared to be an untitled database report. The entry was dated 7/24/12, which coincided with the stat chemical restraint. The comment indicated that the dose and indication were appropriate. The comment did not mention if potential side effects were noted, or if the scheduled psychotropic medications were reviewed and require a change. • The DISCUS and MOSES assessments, completed on 5/24/12, and 8/21/12, were not completed by the prescriber. Individual #545 • Reported administration of two stat chemical restraints on 10/5/12. • The pharmacist did not document review on a face-to-face form. • The QDRRs did not report use of stat chemical restraint because the administration was after the QDRR review period • The QDRR for review period 8/30/12 provided in response to the document request was signed by the primary care physician on 10/27/11, and not until 11/16/12 by the psychiatrist. The psychiatrist signed the document after this review period, and 23 days following completion on 10/23/12 of the QDRR. • The pharmacist did not include a date on the signature line. • The primary care provider and the psychiatrist agreed with recommendations. • The MOSES, and DISCUS assessments provided for review were not completed by the prescribing physician. • The Monitoring Team was provided a pharmacy comment, on what appeared to be an untitled database report. The entry was dated 10/5/12, which coincided with the stat chemical restraint. The comment indicated that the dose and indication were appropriate. The comment did not mention if potential side effects were noted, or if the scheduled psychotropic medications were reviewed and require a change. Individual #649 • Received stat chemical restraint on 11/7/12 • QDRRs were completed before administration of stat chemical restraint so there was no comment. • The Monitoring Team was provided a pharmacy comment, on what appeared to be an untitled database report. The entry was dated 11/7/12, which coincided with the stat chemical restraint. The comment indicated that the dose and indication were appropriate. The comment did not mention if potential side effects were noted, or if the scheduled psychotropic medications were reviewed	

#	Provision	Assessment of Status	Compliance
		and require a change. • The QDRR for reporting period 7/15/12, was dated by the pharmacist on 7/15/12, and reviewed and signed by the physician on 8/31/12. A psychiatrist was not required to review this QDDR. • MOSES and DISCUS assessments were appropriately completed by the prescriber. Summary The Facility has a low incidence of stat chemical restraint use, as only three individuals were provided stat chemical restraint during the reporting period. Review of the three individuals who received stat chemical restraint indicated the pharmacists documented a comprehensive review of the use of chemical restraint in zero out of three cases (0%); a psychiatrist documented a comprehensive review of each chemical restraint in 0 out of three cases (0%), and the QDRR documented the use of a stat chemical restraint in zero out of one case (0%). As discussed during meetings with the director of pharmacy during the last two compliance visits, and per the last Monitoring Team report, the pharmacist must document the following issues, specific to the administration of a stat chemical restraint: Name, and type of drug; indication for use; noted side effects; dose, and route; potential drug-drug reactions; appropriateness; and if the Individual's regularly scheduled psychotropic medication required adjustment. Furthermore, the Psychiatrist must also document a similar review, and also include if behavioral data was reviewed, if targeted behaviors were appropriate, and if the behavior plan was used and is appropriate. In addition, the Monitoring Team noted that MOSES and DISCUS assessments were not completed by the prescriber, and that QDRRs were not dated by the pharmacists and providers. Also, the psychiatrist review of the QDRRs was significantly delayed. <u>Metabolic Syndrome</u> The Monitoring Team selected the first five individuals, from a list of all individuals who had a diagnosis of dyslipidemia and were prescribed a neuroleptic. For those five individuals, the Monitoring Team reviewed the most recent QDRRs, annual ISP, annual medical summary, last 12 months of labs, documentation to support that the pharmacy recommendations had been followed up on, and the most recent two MOSES and DISCUS assessments. The following is a brief summary of concerns noted for each case reviewed: Individuals #51 • Annual medical summary, dated 8/1/12, indicated diagnosis of dyslipidemia, but not metabolic syndrome. There was no plan to address metabolic syndrome. • Most recent two QDRRs indicated excellent review for metabolic syndrome.	

#	Provision	Assessment of Status	Compliance
		• QDRRs were not signed or dated by pharmacists or physicians. • There was no indication if the physician agreed or disagreed with the QDRR recommendations. • MOSES and DISCUS assessments were not completed by the prescriber. • The most recent ISP was not included in the documents. Individual #77 • Annual medical summary, dated 12/27/11, indicated diagnosis of dyslipidemia. • QDRR, for the 5/31/12 review period, indicated risk for metabolic syndrome, and provided excellent review for metabolic syndrome. • The pharmacists and primary physician did not date the QDRR form for the 5/31/12 review; the primary physician agreed with the recommendations. • The psychiatrist signed, and dated the 5/31/12 QDRR on 11/16/12, and agreed with recommendations. • The MOSES assessment was not completed by the prescriber. • The ISP, dated 1/17/12, did not indicate a risk for metabolic syndrome, despite the Individual having a long history of being at risk for metabolic syndrome. Individual #239 • Annual medical summary, dated 6/5/12, indicated diagnosis of dyslipidemia, and diabetes. • QDRR, dated 6/30/12, indicated that the Individual was on quetiapine, and that because the Individual had normal labs, waist circumference, and blood pressure, the Individual was not at risk for metabolic syndrome. The Monitoring Team noted that the Individual had a diagnosis of both dyslipidemia and diabetes, and was being treated pharmacologically for these two conditions; therefore the individual was at risk for metabolic syndrome • The QDRRs were not signed or dated by the pharmacist or physicians. • The primary physician and psychiatrist did not indicate if they agreed or disagreed with pharmacy recommendations. • The MOSES and DISCUS assessments were completed by the prescriber. • The ISP, dated 6/5/12, indicated that the individual was at medium risk for diabetes; however, the Individual was diagnosed with diabetes, and was treated for diabetes. Importantly, the Individual had known risk factors for metabolic syndrome, was prescribed a medication that needs to be monitoring for metabolic syndrome, and the ISP did not comment on the potential risks for metabolic syndrome. Individual #459 • The annual medical summary, dated 3/19/12, indicated diagnoses of	

#	Provision	Assessment of Status	Compliance
		dyslipidemia and obesity. • The QDRR, dated 9/11/12, indicated that because of normal laboratory data, waist circumference, and blood pressure, the Individual does not have risk factors for metabolic syndrome; however, the Monitoring Team noted that the Individual had a diagnosis of dyslipidemia, for which treatment was provided, and a diagnosis of obesity. • The pharmacists signed and dated the QDRR on 9/11/12, and the primary physician signed and dated the QDRR on 9/13/12; however, the psychiatrist signed and dated the QDRR on 11/16/12. • Both the primary physician and psychiatrist agreed with the QDRR recommendations. • The DISCUS assessments completed on 5/21/12, and 2/13/12 were not completed by the prescriber. • The ISP, dated 4/3/12, did not indicate risk factors for metabolic syndrome. Individual #584 • Annual medical summary, dated 10/6/12, indicated diagnoss of obesity, and hyperlipidemia, for which treatment was provided. • The QDRR dated 7/30/12, indicated an excellent review for metabolic syndrome, and noted that the Individual was at risk for metabolic syndrome. • The pharmacists and primary care physician did not date the QDRR; the primary physician agreed with recommendations by the pharmacy. • The psychiatrist did not sign the QDRR until 11/16/12, and agreed with recommendations. • The DISCUS and MOSES assessments, dated 9/24/12, were not completed by the prescriber. • The annual ISP was not included for review. Summary The Monitoring Team noted that in three of the five examples (60%), the pharmacy department provided an excellent review of metabolic syndrome. The most recent ISP was provided for review in only three of the five cases (60%); of the three ISPs provided, zero out of three (0%) indicated metabolic risk factors. MOSES and DISCUS assessments were noted to be complete in three out of the five cases (60%). There was documentation to support that the prescribing physician followed up on the pharmacist's recommendations in zero out of five cases (0%). The primary care physician indicated agreement or disagreement with pharmacy recommendations in three out of five cases (60%), and the psychiatrist indicated agreement or disagreement with pharmacy recommendations in three,out of five cases (60%). Furthermore, there was significant delay in follow-up by the psychiatrist.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team noted that in two cases, the pharmacists did not consider positive risk factors for metabolic syndrome, in persons who had diagnoses of diabetes and dyslipidemia. Most important, there was no evidence to support that pharmacy recommendations were followed by the prescribing physician, and the ISP did not address metabolic syndrome risk factors in Individuals who were prescribed neuroleptics, which are medications that need to be closely monitored. <u>Benzodiazepine Use</u> From a list of all individuals who were prescribed benzodiazepines, the Monitoring Team reviewed the active clinical record, and requested the following documents for review: Annual medical summary, active problem list, most recent ISP, addendum to the ISPs, last two QDRRs, all physician notes specifically following up on QDRR and pharmacy recommendations, last 12 months of labs, current medication list, all physician orders following up on pharmacists' recommendations. The following is a brief summary of each case reviewed: Individual #791 • The QDRR dated 4/15/12 did not indicate a review for benzodiazepine use; however, the QDRR dated 7/15/12 did state that the use of benzodiazepine must be closely monitored because of possible respiratory depression, and recommended discontinuing its use because of possible lack of efficacy. • QDRRs were not signed or dated by the primary care physician, and did not require review by a psychiatrist. • The annual medical summary, dated 7/27/12, did not address pharmacy concern with the use of the benzodiazepine, and the benzodiazepine was continued. • The annual ISP, dated 8/13/12, did not address concerns over the use of benzodiazepine use. • There was no evidence provided for review that the prescribing physician agreed, disagreed, or followed up on the pharmacy recommendations. Individual #212 • The QDRR dated 4/6/12 did not indicate a review for the benzodiazepine; however, the 7/15/12 QDRR did comment about benzodiazepine use by indicating that the consulting psychiatrist recommended changing the dosing schedule of benzodiazepine. The pharmacists did not make an independent assessment of appropriateness, or efficacy, and did not provide a recommendation for the continued use of the benzodiazepine, other then reporting on the psychiatrist's recommendation to change the dose schedule.	

#	Provision	Assessment of Status	Compliance
		• The prescribing primary care physician reviewed, signed, and concurred with recommendation stated on the QDRR. • There was no evidence to support that the physician changed the dose of benzodiazepine, as recommended by the psychiatrist, and delineated on the QDRR. • The ISP did not address the use of benzodiazepine. Individual #787 • The QDRR, dated 11/5/12, did not address the Individuals use of benzodiazepine. • The ISP was not included for review. Individual #239 • The QDRR, dated 9/30/12, indicated that the Individual needed to be reevaluated for the continued use of benzodiazepine. • The Physician and psychiatrist did not sign, date, or indicate agreement with the pharmacy recommendations. • The ISP, dated 5/30/12, did not indicate a review for the use of benzodiazepine. • There was no evidence to support that the prescribing physician followed up on the pharmacist's recommendation. Individual #513 • The QDRR, dated 7/30/12, indicated that the individual be reevaluated for the continued use of benzodiazepine. The QDRR, dated 4/30/12, indicated that the pharmacist recommended consideration to discontinue the benzodiazepine. • The QDRRs were not signed, dated, or indicate that the primary physician and psychiatrist was in agreement, or disagreement with the recommendations. • The annual medical summary dated 10/15/12, did not address the pharmacist's recommendation, or document a review of the continued use of benzodiazepine. • The ISP, dated 1/2/12, did not comment on the use of benzodiazepine, and there was no addendum to address the pharmacist's concern. • There was no evidence provided to support that the physician followed up on the pharmacy recommendation. Summary The pharmacist documented a meaningful review of the use of benzodiazepine in three out of the five cases (60%) reviewed. There was evidence to support that the pharmacist followed up on QDRR recommendations in zero out of five cases (0%). The ISP reviewed the use of benzodiazepine in zero out of the four ISPs provided for review (0%).	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team determined that there had been improvement with pharmacy department's addressing of benzodiazepine use; however, the department must continue to enhance it's review process, and ensure that benzodiazepines are assertively reviewed by the pharmacist, and include a review for appropriate indication, appropriate dose, review for side-effects, drug-drug interaction, and efficacy. <u>Polypharmacy</u> The Monitoring Team reviewed the active clinical record, and the most recent QDRR, of the first five individuals from a list of all individuals who were prescribed polypharmacy. The Monitoring Team noted that the pharmacist reviewed each case for polypharmacy in five out of the five cases (100%), reviewed. <u>Summary</u> The Monitoring Team concluded that the Facility was not in compliance with Provision N.3, and did not adequately document appropriate review of metabolic syndrome, use of benzodiazepines, and stat chemical restraints. Pharmacy review of such issues, must include a well documented clinical pharmacy review that includes the following information: Name of drug, indication, appropriateness, noted and potential side effects, noted and potential drug-drug interaction, and meaningful recommendations, that are addressed by the prescribing physician. Review of stat medication use must also include a review of the efficacy of the baseline psychotropic medications.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Provision N.4 requires that the Facility develop a process for the pharmacy to ensure that medical practitioners consider the pharmacist's recommendations and for recommendations not followed document in the Individuals clinical record justification why the recommendation was not followed. The Monitoring Team utilized the SPDI reports generated for Provision N.1 of this report, and copies of the QDRRs, and associated physician IPNs, documenting review of the QDRR, which were reviewed for Provision N.2 of this report. Of the five examples reviewed, the psychiatrist signed and dated the QDRR form in zero out of five cases (0%); the medical provider signed and dated the QDRR form in one out of five cases (20%); there was evidence to support that the medical provider reviewed and followed up on the QDRR in one out of five cases (20%); there was evidence to support that the psychiatrist reviewed, and followed up on recommendations in zero out of five cases (0%). Of the six SPDIs delineated in Provision N.1, the medical providers responded to the SPDI by email in six out of six cases (100%); the medical providers response to the SPDI was	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		determined by the Monitoring Team to be appropriate in three out of the six cases (50%). Summary Although the medical provider responded to the pharmacists concerns over new medication orders in six, out of six cases (100%), the medical providers response to the SPDI was determined by the Monitoring Team to be appropriate in three out of the six cases (50%). During review of the QDRR process, the Monitoring Team was concerned that only medical provider followed up on recommendations in only one out of five cases (20%), and the psychiatrist followed up on recommendations in zero out of five cases (0%), The Monitoring Team will continue the rating of substantial compliance; however, future compliance will require that the pharmacy department ensures meaningful and appropriate follow-up by medical providers for all pharmacy recommendations.	
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 N.5 is assessed as a component of Provision J.12, of this report. The Monitoring Team determined non-compliance for Provision J.12, and refers the reader to section J.12. Furthermore, when reviewing MOSES and DISCUS assessments for Provisions N.2 and N.3, the Monitoring Team noted many examples of the MOSES and DISCUS assessment forms not being completed by the prescribing physicians, as they did not always indicate the presence or absence of tardive dyskinesia on the DISCUS form, or the presence or absence of side effects on the MOSES form. The reader is referred to Provisions N2 and N.3 of this report for a more detailed analysis of these findings.	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 N.6 requires that the Facility maintain a process to address adverse drug reactions (ADR). The Monitoring Team requested copies of the ten most recent ADR reports, assessments, summaries, database analysis, P&TC minutes, associated policy and procedures, including policy and procedure for staff training for the ADR process, and a summary of staff training for the ADR process. The Monitoring Team raised concern during the last review period that the Facility had a low rate of ADRs, and recommended that that the Facility review its process of reporting ADRs. During the last six month reporting period, there were a total of 22 ADRs reported, and assessed, compared to the last reporting period, which reported 14 ADRs. Given the number of medications prescribed at the Facility, the rate of ADRs reported, although somewhat increased, appears to be lower then expected by the Monitoring Team.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Although requested, there was no evidence that the Facility developed a policy and procedure that outlines the Facility's training process for ADRs. Review of the information provided regarding training, which included: • Materials used to train nurses on completing the MOSES and DISCUS assessments • Copy of an email sent to medical providers on the MOSES and DISCUS assessments • Training materials on the ADR process for case managers and pharmacists • Information indicating that direct care staff personal was trained on clinical status change, which include reporting ADRs. The Monitoring Team is concerned that there was no policy and procedure that clearly delineates the Facility's training and re-training process on identifying and reporting ADRs. Of the last ten completed ADR reports, seven out of ten had (70%) had fully completed adverse drug reaction forms; the documented treatment plan, as listed on the adverse drug reaction form, was complete and clinically appropriate in three out of ten cases (30%); the adverse drug reaction reporting form, which was completed by the staff reporting the ADR, was fully completed in six out of the ten cases (60%); and there was follow-up documentation noting resolution of the ADR in one out of ten cases (10%). The following is a brief summary of concerns regarding the treatment and follow-up on a sample of reported ADR reporting form: Individual #60 An ADR was reported because of hyponatremia (low sodium), secondary to the valproic acid. The medical provider indicated the dose of valproic acid would be lowered, but there was no documentation on how the Individual would be monitored for potential exacerbation of seizure disorder. Furthermore, there was no comment noted when the ADR resolved. Individual #728 The Individual was prescribed hydrocholorthiazide, which was discontinued because it was suspected of causing a low platelet count. There was no alternative treatment provided. There was no indication that the ADR resolved. Individual #598 The Individual experienced an elevation of prolactin level, which was induced by paroxitine. The medical provider initiated bromocriptine to treat the drug-induced hyperprolactinemia. There was no evidence reported that demonstrated an evaluation	

#	Provision	Assessment of Status	Compliance
		to exclude other causes of hyperprolactinemia, such as a tumor of the pituitary gland. Individual #152 A drug used to treat dyslipidemia was discontinued because of an abnormal CPK level. The medical provider only follow-up orders, and documentation were to obtain a repeat CPK level in six weeks, and to "monitor for muscle pain and weakness". The Monitoring Team is concerned that an evaluation for other causes of elevated CPK, such as a cardiac condition, was not conducted. Most important, an elevation of CPK can result in serious morbidity and mortality, if it is caused by muscle necrosis, and serial CPKs should have been orders, to ensure that levels were going down, and not up. Further more, monitoring parameters were not specific enough for direct care staff to monitor. Review of the May and July 2012 P&TC minutes noted that a report on ADRs was provided to the committee. The Monitoring Team attended the November 2012 P&TC meeting, and observed that data on ADRs was recited to the committee, but there was no discussion about the data, or the ADRs themselves. For example, the committee did not question why living area INF had no reported ADRs, while PEC had 7 ADRs; both were significant outliers, when compared to other living areas, which reported between two and three ADRs. Summary The Monitoring Team continues to have concern over the reporting practices of ADRs by Facility staff. Completion of the ADR report form, follow-up on ADRs, the documentation and clinical appropriateness of treatments offered for ADRs, and the review process by the P&TC committee of ADRs were all of concern to the Monitoring Team. The Monitoring Team strongly encourages the Facility to develop a comprehensive strategy, that is outlined by policy and procedure on training of all staff, including medical providers, nurses, pharmacists, and direct care staff on identify, reporting, and following up on ADRs. Also, it is strongly advised to develop a medical quality assurance process to review the clinical appropriateness of the medical provider's response to, and triage and remedial action in response to ADRs. The Monitoring Team will continue compliance; however, if the same issues are observed at subsequent reviews, the Monitoring Team will not issue substantial compliance.	
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	Provision N.7 calls for the Facility to develop and implement regular drug utilization evaluations (DUE). To evaluate compliance, the Monitoring Team requested a copy of all DURs provided during the reporting period, copy of the DUEs, the most current policy for the DUE process, and the DUE schedule. Review of the DUE process, did not indicate that the Facility would complete a DUE for all relevant FDA advisories. This issue was discussed with the pharmacy director at the last	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	compliance review, and was noted in the last compliance report. The Monitoring Team was pleased to learn that the Facility developed a new DUE schedule that enables tracking of all DUEs scheduled, provided, and followed up on. The Facility provided two scheduled DUEs, that were noted to be comprehensive. Furthermore, the Facility provided a total of five DUEs specific for FDA advisories for the drugs Pradaxa, methylprednisolone, Mirapexx, Biaxin, and Ampra. Review of the DUE policy, did not specifically indicated that the Facility must ensure that a DUE is provided for all relevant FDA advisories. Summary The Monitoring Team compliments the pharmacy department for developing and implementing a quality DUE process, and determined that the Facility remains in substantial compliance. The Monitoring Team would like to remind the Facility to modify its policy for the DUE process, as clearly indicated in the last Monitoring Team's compliance report, to include its practice of providing DUEs for all relevant FDA warnings and advisories.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	Provision N.8 calls for the Facility to maintain a process that provides review of all medication variances. To assess compliance, the Monitoring Team reviewed the last ten completed medication variance report forms (Individuals #164, #389, #68, #613, #82, #413, #346, #434, #501, and #555); P&TC minutes for 10/25/12, and all graphs; and data charts for medication variances that occurred during the reporting period. Review of the medication variance report forms demonstrated that one out of ten medication report forms (10%) was fully completed; the relevant department supervisor documented a review of the medication variance for two, out of ten cases (20%), and in the two cases that the supervisor documented a review, the Monitoring Team determined that one, out of the two (50%) was appropriately completed. Four out of ten cases (40%) involved the medical provider not documenting appropriately; one out of ten (10%) was reported as a medical provider prescribing variance; on out of ten (10%) was reported as a pharmacy dispensing variance; three, out of ten (30%) involved nurses not documenting appropriately; and one out of ten (10%) was reported as a nursing administration variance. Of the ten samples, six out of ten (60%) were rated as category A, four were rated as category B (40%), and one was rated category C (10%). The categorization of medication variances appeared to be appropriate in ten, out of ten cases (100%). The Monitoring Team observed similar findings with the medication variance report	Noncompliance

#	Provision	Assessment of Status	Compliance
		forms, when compared to the previous Monitoring Team report. For example, the medication variance report forms were not fully completed. Most important, the section for Follow-up By Department Supervisor was not completed, or not appropriately completed in many cases. In one particular case, the supervisor simply documented "Notified of error", while the other seven cases were just left blank. The Facility maintained a robust mechanism to track and trend medication variances. Review of the medication variance committee meeting minutes, dated 10/25/12, did not demonstrate a summary of the variances that occurred by medical providers, and as with the previous Monitoring Teams report, there was not a meaningful review of medical provider variances. The Monitoring Team did note that the medical director was not present for the 10/25/11 medication variance committee meeting. Summary: The Monitoring Team determined that the Facility continues to be noncompliant with Provision N.8, of the Settlement Agreement because medication variance reports were not fully completed, and lacked meaningful review by the department supervisors. In addition, the Monitoring Team continues to be concerned of the lack of meaningful summarization of medical provider variances.	

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

1. The pharmacist must provide the medical provider with meaningful recommendations when issuing a SPDI report. (Provision N.1).
2. The pharmacist must review and accept the medical providers follow-up plan for each recommendation provided, and when there is a disagreement, refer the issue to the director of pharmacy. (Provision N.1).
3. Ensure that all issues, such as polypharmacy, use of benzodiazepines, and stat medication drug use, are comprehensively reviewed and documented, along with the pharmacist's indication of appropriateness, and recommendations, on the QDRR. (Provisions N.2 and N.3)
4. QDRRs must comment on issues, such as efficacy, potential side effects, drug-drug interactions, and appropriate indication for use. (Provision N.2)
5. Ensure that all assessments utilized for review by pharmacy are appropriate completed. (Provisions N.1, and N.2).
6. Make sure to include medical conditions that are diagnosed and being provided treatment, such as diabetes, hypertension, and dyslipidemia, as a risk factor for metabolic syndrome, even if the monitoring parameter for such conditions were normal. (Provisions N.2, N.2, and N.3).
7. Ensure that medical providers, and psychiatrist (when prescribed psychotropic medications), sign, date, and indicate if they accept recommendations or not, on the QDRR form. (Provision N.2)
8. Ensure that medical providers indicate review, and appropriately address pharmacy recommendations. (Provisions N.1, N.2, and N.4)
9. Develop a comprehensive training, and refresher training process for identifying, reporting, and following up on ADRs. Ensure that a policy and procedure is developed to outline the process. (Provision N.6).
10. Ensure that the prescribing medical provider completes all MOSES and DISCUS assessments. (Provision N.5)
11. Ensure that all ADR reporting forms are fully and appropriately completed. (Provision N.6).
12. Documentation through full resolution of the ADR is required. (Provision N.6).

13. Develop a medical quality assurance process to review the clinical appropriateness of the medical provider's triage of ADRs. (Provision N.6, and L.3).
14. Update the policy for the DUE process to include its practice of providing DUEs for all relevant FDA warnings and advisories. (Provision N.7).
15. Ensure a more robust review for medical provider medication variances. (Provision N.8).
16. Ensure that the medication variance report forms are fully completed. (Provision N.8).
17. Ensure that there is a meaningful review and clinical plan developed for all medication variances. (Provision N.8).
18. Pharmacy review for the use of benzodiazepines, stat chemical restraints, anticholinergic medications, and polypharmacy must include a well documented clinical pharmacy review that includes the following information: Name of drug, indication, appropriateness, noted and potential side effects, noted and potential drug-drug interaction, and meaningful recommendations, that are addressed by the prescribing physician. Review of stat medication use must also include a review of the efficacy of the base-line psychotropic medications. (Provision N.2, and N.3).
19. Pharmacy review of stat chemical restraints requires an interdisciplinary approach, which ensures that the pharmacists and prescribing psychiatrist review the appropriateness of the drug, dose, route of administration, side effects, potential interactions, if the baseline psychotropic medications remain appropriate or need to be changed, and if the behavior plan is appropriate or needs to be changed. These issues must be well documented, such as on the face-to-face component of the stat restraint debriefing form, which is used at most other Facilities. (Provision N.3 and N.2).

The following are offered as additional suggestions to the Facility:
1. As per the last Monitoring Team review, it is strongly recommended that the Facility follow guidelines, such as that outlined in the 2006, Centers for Medicare Services, Medication Regimen Review Guideline, for the QDRR process. (Provision N.2)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self Assessment (10/30/12) 2. RSSLC Action Plan (10/15/12) 3. Section O Presentation Book 4. RSSLC Physical and Nutritional Management Policy K.01 (9/21/2012) 5. RSSLC Physical and Nutritional Management Team Process (rev 4/19/12) 6. Habilitation Therapies Policy K.04 Developing PNMPs (2/23/12) 7. Habilitation Therapies Policy K.07 Universal Monitoring (3/1/12) 8. Habilitation Therapies Policy K.05.1 Staffing Effectiveness-Occupational Therapy / Physical Therapy (8/22/2012) 9. Habilitation Therapies Policy K.05.2 Occupational Therapy / Physical Therapy Services (8/22/2012) 10. Record reviews: • Sample #1: Individuals #386, #404, #701, #711, #745, and #783 • Sample #2: Individuals #23, #500, #523 and #584 • Sample #3: Individual #787 • Sample #4: Individuals #120, #398, #404, #548, #577, #701, and #792 • Sample #5: Individuals #16, #99, #106, #185 and #259 • Sample #6: Individuals #125, #268, #429, #711, and #767 11. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 12. A list of continuing education sessions or activities participated in by PNMT members since last review (5/2012) 13. Minutes, including documentation of attendance, for the PNMT meetings for the past 6 months 14. Individual PNMT reports as available for individuals reviewed above 15. Tools used to screen and identify individuals' PNM health risk level 16. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 17. A list of PNM assessments and updates completed in the last two (2) quarters 18. ISPs for the sample individuals 19. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 20. Tools used to monitor implementation of PNM procedures and plans 21. A list of individuals for whom PNM monitoring tools were completed in the last quarter 22. Tools utilized for validation of PNM monitoring 23. 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 24. PNMP template and any instructions for use of template 25. Dining Plan template

	26. PNMT referral completion log 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, or other diagnostic swallowing evaluation since the last review and specific study results for individuals identified in Sample #6 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 3. Sally Martinez PNMT RN 4. Brandie Rabe PNMT SLP 5. Jean Cuevo PNMT PT 6. Dana Hatter QDDP/PNMT 7. Ten DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meetings Attended/Observations:** 1. PNMT 11/13/12 and 11/15/12 2. Observations at living units during meals, transition and leisure times--San Antonio, Trinity, Leon, Three Rivers, and Four Rivers
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 10/30/2012 and Action Plan dated

	10/15/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section O, in conducting its self-assessment, the Facility: ▪ Did use monitoring/auditing tools. However, the activities presented in the Self-Assessment did not consistently correlate with the Settlement Agreement Monitoring Tool. The activities reported appeared to relate to the content in Monitoring Team's reports, but it was unclear how some of this data was being collected. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section O. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. For example, the Settlement Agreement Monitoring Tool guidelines instructed the reviewer to review a PNMT assessment, staff training records, complete observation(s) of individual's PNMP being implemented, and conduct staff interviews to ask staff why the individual requires PNMP interventions. o The Self-Assessment identified the sample(s) sizes and the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The Self Assessment did not state the following staff/positions who were responsible for completing the audit tools, such Facility therapists (i.e., OTs, PTs, and SLPs); therefore there was no evidence of staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. ▪ The Facility consistently did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. The Facility rated itself as being in compliance with none of the subsections of Section O. This was consistent with the Monitoring Team's findings. The Facility data identified areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.

	The Action Plan updated 10/15/12 identified the action steps that RSSLC was involved in to potentially reach compliance. The steps were clear and provided information regarding the projected completion date as well as current status. Use of this format should assist RSSLC in better being able to identify their current status and the future areas that still require attention and improvement.
	Summary of Monitor's Assessment: Overall, significant improvement was noted throughout all provisions with the exception of the implementation of plans. The PNMT continued to improve their process as well as their assessments. The PNMPs while much improved regarding detail still lacked evidence of review by the entire IDT due to lack of consistent attendance by all relevant parties at the IDT. Staff knowledge as well as proper implementation continued to be a concern of the Monitoring Team. Staff was observed not implementing strategies that were designed to mitigate risk associated with aspiration and choking and therefore were placed at an unnecessary high risk of aspiration and choking as well as other PNM issues such as skin breakdown. Provision O.1: This provision was determined to be not in compliance. Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. The evaluations and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Provisions O.2 through O.7 of the Settlement Agreement. Regarding the PNMT, 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. Much improvement has been noted with regards to the comprehensiveness of the assessments, and the discussion during the meetings. Provision O.2: This provision was determined to be not in compliance. Areas of concern were the excessive delay in which it took many assessments to be completed and shared with the IDT. This was an area that had been noted as a problem by RSSLC and improvement has been noted over the past few reports. While review of the event by the IDT was much improved as well as discussion by the PNMT, there remains concern regarding how these two teams are interacting and sharing information. A new form was developed to help ensure successful transition but this had just been implemented. Another issue was the inconsistency in which the Aspiration Trigger data Sheets were completed. Provision O.3: This provision was determined to be not in compliance. The PNMPs, overall, continued to show significant improvement since the previous visit. PNMP content was listed in the ISP. However, there was no evidence that IDT members had discussed the efficacy of the interventions and integrated PNMP strategies into other plans and activities (e.g., action plans, skill acquisition programs, behavior support plans, nursing/health management care plans, and/or daily schedules). PNMPs were not clearly developed with input from the IDT with an emphasis on DSPs, medical/nursing staff, and behavioral staff (if appropriate).

	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. RSSLC had recently implemented a core competency class related to PNM but only 6% of the employees had received the training as of this review. Provision O.6: This provision was determined to be not in compliance. A monitoring process had been implemented since the past compliance review but the accuracy and validity of the monitors is questioned secondary to the significant discrepancy between what the Monitoring Team observed and that in which RSSLC reported. The Aspiration Trigger Sheet was implemented for all individuals who were identified as being high risk for aspiration. Issues were noted regarding the frequency in which professionals outside of nursing and the PCP were notified. Other issues with the Aspiration Trigger Sheet included: • The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. • Nursing review of the trigger sheet was inconsistent Provision O.7: There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized identified PNM related risks. 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 to determine if strategies (i.e., eating and positioning strategies) to address issues related to an increased risk for an individual were effective. There was no detailed comparative analysis of data or assessment findings. Outcomes were reviewed through the risk process but effectiveness of strategies was not. Provision O.8: This provision was determined to be not in compliance. Individuals were not consistently provided with assessments that identified the medical necessity of the tube and pathways to oral intake.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires	Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. The evaluations and	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 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	planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the Settlement Agreement. RSSLC had a Physical and Nutritional Management Team (PNMT). The PNMT focused on clinical issues and assessment and served as a resource to the IDT. Newly found this visit was evidence of systemic review and/or analysis of recommendations to determine if there was a resulting positive impact. This included the establishment of thresholds for return to the PNMT. Examples of thresholds included presence of identified triggers such as weight loss, coughing with struggle or other individualized signs or symptoms. The Physical and Nutritional Management Team (PNMT) consisted of: • David Taylor OTR • Jean Cuevo PT • Sally Martinez RN • Brandie Rabe SLP • Erin Linton RD • Dana Hatter QDDP/PNMT • Tran Quan MD Members added to the PNMT since the previous compliance visit included Tran Quan MD and Dana Hatter QDDP. Dr. Quan consulted with the PNMT regarding medical diagnoses and other issues, and Dana Hatter QDDP served as the primary liaison to the other QDDP and IDTs. The addition of these two members should assist in the development of a comprehensive review as well as improved communication between all relevant teams. The PNM Team met 22 times since the previous compliance visit. Minutes of PNMT meetings and Sign In Sheets from 5/31/12 to 11/8/12 documented consistent attendance by the five PNM Team standing members. PNM Team (PNMT) attendance records and meeting minutes from 05/31/12 to 11/8/12 documented the following attendance numbers. • SLP attended 19 of 22 meetings (86%) • OT attended 20 of 22 meetings (91%) • PT attended 19/22 meetings (86%) • RN attended 20 of 22 meetings (91%) • RD attended 20 of 22 meetings (91%) All standing PNM members averaged 85% or greater participation in the meetings with the exception of the QDDP who was present for 75% of the meetings. There were also backups for the registered dietitian as well as the PNMT RN. Participation by these two	

#	Provision	Assessment of Status	Compliance
	complex physical and nutritional management needs.	backups were noted as needed in the absence of the regular standing members. PNMT minutes reflected an overall impression of the meeting and provided clear action plans needed to ensure all responsibilities and discussions are documented. Review of documentation of PNM clinical instruction submitted revealed opportunities for PNMT members to participate in trainings relevant to increasing their knowledge of PNM. The courses attended focused on but were not limited to: • Beckman Oral Motor • Evidence-based practice for AAC evaluations • Medication Administration for Nurses • Issues in Evaluation and Treatment of individuals with developmental disabilities • Best Practices in Primary Care In addition to the state policy, the Facility had developed a localized PNMT policy K.01 (rev 9/21/12) that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the Interdisciplinary Team (IDT). Newly included in the policy was a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. Beginning in July 2012, data from the PNMP monitoring forms were sent to QA in the form of a monthly report. This information assisted QA as well as the PNMT in addressing issues that were occurring on a systems basis. Review of these systems should assist RSSLC in 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 and provided comprehensive strategies to mitigate risks associated with physical and nutritional issues. 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 five individuals (Sample #6) 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 IDT. While there was evidence of acceptance of the recommendation by the PCP, there was no evidence of review by the IDT to identify the extent of monitoring that may be needed to ensure tolerance outside of the fluoroscopy	

#	Provision	Assessment of Status	Compliance
		suite. Examples of changes in diet texture based on MBSS findings but not reviewed by the IDT included: • Individual #711 was upgraded from a ground texture to a regular cut bite size texture. • Individual #268 was upgraded to ground solid diet with regular liquids. A positive practice that continued to be noted was participation by PNMT in the medical morning meetings as well as participation during rounds at the infirmary thus allowing for the increased sharing of issues between multiple committees but this still did not reflect active collaboration at the unit level between the physicians and the PNMT and/or IDT 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 or choking event since the previous compliance review. The sample consisted of six individuals who accounted for 36% of the individuals who experienced an aspiration event and 100% of the individuals who had a choking event. Sample #2 consisted of four individuals chosen from a list provided by RSSLC of individuals who were provided with PNMT comprehensive evaluations. The sample consisted of 80% of those who received evaluations in the last two months. Sample #3 consisted of one individual or 33% of the individuals who were newly admitted since the previous compliance visit. Sample #4 consisted of seven individuals or 54% of the individuals who experienced a downgrade in diet texture since the previous compliance visit Sample #5 consisted of six individuals or 10% of the individuals at RSSLC who received enteral nutrition. Sample #6 consisted of five individuals or 25% of the individuals who had a Modified Barium Swallow Study (MBSS). Based on a review of 10 individuals' (Samples #1 and #2) records, seven of ten Individuals (70%) were provided with a comprehensive assessment by the PNM team or relevant Habilitation therapist that focused as indicated on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day and during nutritional intake. Two individuals had choking events and received focused assessments on the choking event in lieu of a comprehensive assessment leaving only one individual who was not provided with a	Noncompliance

#	Provision	Assessment of Status	Compliance
		comprehensive assessment. A problem noted with the PNMT assessment process was the excessive delay in which the reports were completed. For the individuals in Samples #1 and #2 who received a PNMT evaluation (seven individuals): • Four out of seven (57%) took over three months to complete following referral. • Two out of seven (29%) took over two months to complete following referral. • One out of seven (14%) took over one and a half months to complete following referral. Delay in getting the assessments completed results in an increased risk due to the team not receiving the needed feedback in a timely manner and therefore being unable to implement any needed strategies in an efficient manner. This was an area that had been recognized by RSSLC as needing improvement, and the PNMT has done a nice job in beginning to reduce the time in which it took to complete the assessments as evidenced by PNMT referral completion log provided by RSSLC.. Improved since the last compliance visit were the comparative analysis and oral motor portions of the assessments. These areas were found to be more comprehensive and provided more clarity regarding status changes over the past year. A primary role of the PNMT RN was to assess all individuals who returned from the hospital with a PNM related issues (i.e., aspiration, choking). The PNMT RN's responsibility was to alert the PNMT or Habilitation Therapists of individual cases of aspiration pneumonia and changes in health status that were pertinent to the PNMT and/or Habilitation Therapists. Currently, the PNMT RN was assessing all individuals upon return from the hospital. Members of the PNMT participated in the pre-hospital discharge meeting as indicated by hospital admission or discharge diagnosis and its relevance to PNM. RSSLC had also developed a "PNMT-IDT Discharge Meeting" form that was to be completed each time the individuals were discharged to the IDT. The purpose of this form was to improve the transition and information from the PNMT to the accepting IDT. This process was just implemented and therefore will need to be reviewed at the next compliance visit. Missing from the PNMT was additional guidance regarding the development of procedures to further define the PNMT discharge process to include, at a minimum: status of efficacy of implemented PNMT recommendations, justification for an individual to be discharged from the PNMT through the provision of objective clinical data to	

#	Provision	Assessment of Status	Compliance
		document stable or improved health, integration of the PNMT recommendations into the ISP, and individual-specific objective clinical data for referral back to the PNMT. The PNMT nurse assessed four of four (100%) individuals from Sample #1 who returned from the hospital, and six of six (100%) from Sample #1 were discussed at the PNMT meeting. Another form of review noted by the Monitoring Team was discussion by the IDT in response to a hospitalization. Four of four individuals (100%) diagnosed with pneumonia from Sample #1 were reviewed by the IDT. This was noted to be an improvement since the last compliance visit, which showed only 33% of individuals receiving the needed review and/or assessment. The problem noted was that while the IDT did meet in response to an individual's anticipated return from the hospital, the meetings offered inconsistent evidence of investigation into the root cause of the issue. The primary topic of the IDT meeting was stating that the person would be returning and that a referral would be made to the PNMT but as stated above, there was a significant delay in getting the assessment completed; therefore, there were many times in which the individual was home for more than 2 months with little intervention provided post hospitalization. While review of the event by the IDT was much improved as well as discussion by the PNMT, there remains concern regarding how these two teams are interacting and sharing information. As stated previously, a new form was developed to help ensure successful transition but this had just been implemented. Another issue was regarding the inconsistency in which the Aspiration Trigger data Sheets were completed. Please refer to Provision O.6 for details.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing	All persons identified as being at risk (requiring PNM supports) were provided with a comprehensive Physical and Nutritional Management Plan (PNMP). The PNMPs for the 11 individuals in Samples #1, #2, and #3 were reviewed. All of these individuals had a PNMP. Seventeen of the 17 individuals (100%) had a PNMP. • Eleven of the 11 individuals' PNMPs (100%) were current within the last 12 months • Eleven of 11 individuals' PNMPs (100%) noted individual-specific risks and related triggers. • In 11 of 11 individuals' records (100%), the PNMPs included adequate positioning instructions for wheelchair and alternate positioning, including strategies for safe elevation ranges. • In 11 of 11 individuals' records (100%), the PNMPs included adequate transfer instructions.	Noncompliance

#	Provision	Assessment of Status	Compliance
	difficulties.	• In 11 of 11 individuals' records (100%), the PNMPs included adequate mealtime/dining plans that included written and/or pictorial instructions for positioning, food texture, fluid consistency, and/or staff presentation techniques. • In 10 of 11 individuals' records (91%), the PNMP included the time an individual needed to remain upright after eating and/or receiving enteral nutrition. • In 9 of 11 individuals' records (81%), the PNMP included adequate strategies for medication administration. • In 11 of 11 individuals' records (100%), the PNMPs included adequate strategies for oral hygiene. • In 11 of 11 individuals' records (100%), the PNMPs included a listing of individual adaptive equipment. • In 11 of 11 individuals' records (100%), the PNMPs included adequate bathing/showering positioning and related instructions. • In 11 of 11 individuals' records (10%), the PNMP included adequate personal care instructions, with elevation strategies during checking and changing. • In 11 of 11 individuals' records (100%), the PNMPs included communication strategies. PNMPs were located in the active record, individual/group notebook, MAR, Infirmary (as applicable) and at the workshop. Per observations, notebooks were readily available to staff but were not being referenced during any of the observations. Regarding the MAR, as was found at the last compliance review, a review showed the PNMPs contained in the Medication Administration Record Notebooks were not consistently reviewed/revised at the time of the annual ISP or when there was a change in status that required a revision. 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. RSSLC continued to provide Head of Bed (HOB) assessments but these were not consistently provided as indicated by a need of the individual. Since the last review, 13 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 continued to represent a reactive approach to the assessment issue. As of this review, 42 individuals had received Head of Bed assessments. RSSLC was unable to provide the total number of individuals who had the need to have their beds elevated; therefore, the Monitoring Team was unable to	

#	Provision	Assessment of Status	Compliance
		determine the percentage completed or the percentage of individuals in need of assessments. PNMPs were reviewed annually at the ISP meetings, and updated as needed. A review of the 10 individuals' ISPs in Samples #1 and #2 found PNMP content was listed in the ISP. However, there was no evidence that IDT members had discussed the efficacy of the interventions and integrated PNMP strategies into other plans and activities (e.g., action plans, skill acquisition programs, behavior support plans, nursing/health management care plans, and/or daily schedules). In one of 11 records reviewed for samples #1, #2, and #3 (9%), PNMPs were clearly developed with input from the IDT with an emphasis on DSPs, 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. Review of the 11 individuals' ISP attendance sheets in Samples #1, #2 and #3 found: • Medical attendance was 45% (5 of 11 meetings); • Nursing attendance was 100% (11 of 11 meetings); • Dental staff attendance was 0% (0 of 11 meetings) • Occupational Therapist attendance was 72% (8 of 11 meetings); • Physical Therapist attendance was 72% (8 of 11 meetings): • Speech Language Pathologist attendance was 45% (5 of 11 meetings); • Registered Dietician attendance was 18% (2 of 11 meetings); and • Direct support professional attendance was 100% (11 of 11 meetings). The absence of these professionals impacted the discussion related to the integration of PNMP and dining plans into the ISP, risk assessment, and multiple support plans. In addition, the absence of dental staff as well as the other professionals impacted the ability of the IDT to adequately review and integrate an individual's PNMP into the ISP. Their significant contribution to the content of a PNMP and/or dining plan should not be underestimated. All professionals should have the opportunity to discuss PNMP and dining plan strategies that might not be effective and/or request clarification on how to implement a strategy. This should lead to a dynamic discussion resulting in acceptance and/or revision of the proposed PNMP and dining plan strategies. Furthermore, dental staff play an important role in providing information regarding the current oral hygiene status of the individual. As a result, changes to an individual's oral care services and/or supports might need to be made.	

#	Provision	Assessment of Status	Compliance
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 and Dining Plans were generally developed by the therapy clinicians with limited evidence of input by other IDT members as described above. Generally, the PNMP was located in the individual notebook or was otherwise readily available nearby. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. Staff were observed not implementing interventions and recommendations outlined in the PNMP and/or Dining Plan, which continued to be a concern of the Monitoring Team. Observations on San Antonio, Leon, and Trinity demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to prevent swallowing difficulties, increased risk of aspiration, or contractures and skin breakdown in the following areas: • In two of 11 (18%) observations, staff were following mealtime plans. • In two of 5 (40%) observations staff were following positioning instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: o Individuals #598 and #776 were not provided with cues to alternate liquids and solids. o Individual #230 was observed taking large bites when the plans called for small bites, thus increasing risk of choking and/or aspiration. o Individual #471 was observed with staff initially attempting to assist. When it appeared the individual was not being cooperative, the staff moved to another table to help someone else. At this point, the individual began taking large bites, eating at an unsafe rate and not taking liquids as recommended on the dining plan. o Individual #212 was observed with no pillow under her right lower leg or between knees, resulting in increased scissoring of legs and pressure on the right leg. o Individual #623 was observed in bed with no folded sheets between her knees resulting in poor positioning. Although PNMPs had improved, they were not implemented any better at this visit than at past visits. Physical and Nutritional Management Plan Coordinators (PNMPCs) were noted to be in the dining rooms at the time and in many instances were looking right at the individual who was not having his/her plan implemented; however, no intervention was provided. This is of special concern as these same staff was responsible for monitoring to ensure	Noncompliance

#	Provision	Assessment of Status	Compliance
		PNMPs were being implemented. This lack of identification concerns the Monitoring Team and questions the accuracy of the monitoring data provided by RSSLC. An example of this is as follows: o Individual #719 was receiving assistance by staff. Staff was observed feeding the individual unsafely. The individual was yelling and staff was still proceeding to place food in the individual's mouth. The rate of feeding was also unsafe and liquids were provided while the individual's neck was hyper-extended. In addition, the headrest was improperly attached facilitating the poor head positioning. The PNMPC was in the dining room and did not observe or recognize these issues as risks to the individual's safety. RSSLC must take immediate steps to improve the implementation of plans at the homes as well as ensure accuracy of data acquired through the monitoring process. Staff did not consistently understand the 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 questions asked during interviews with 10 DSPs, percentage of correct responses regarding PNMPs were: • Where is the PNMP/Dining Plan located? (100%) • What kind of transfer do they require? (100%) • What do you look for to ensure the individual is in the correct position? (40%) • Why does the individual need thickened liquids? (70%) • Why does individual eat modified texture foods? (70%) • Why does the individual require a specific utensil? (70%) • Why does the individual require a specific assistance technique? (60%) • 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%) • Have you been trained to implement this plan? (70%) • 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. Failure to recognize triggers places the individuals at an unnecessary risk as these triggers have been identified through assessments and observations to be clinical warning signs of increased risk.	

#	Provision	Assessment of Status	Compliance
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. Since the last compliance visit, RSSLC developed Physical and Nutritional Management Core Competency Training. The training included the following areas: • Mealtime practice and adaptive equipment • Diet texture and liquid consistency • Positioning (bed, wheelchair, and trolley) • Lifting and transferring • Bathing and dressing • Oral hygiene • Augmentative/Alternative Communication (AAC) systems Once staff completed the classroom based training, they were then required to complete competency/skill verification checklists. Skill Verification Checklists were as follows: • Triggers Recognition • Core Meal Time • Diet Texture/Liquid Consistency • Adaptive Dining Equipment • Wheelchair Positioning • Bed Positioning • Bed safety • Arjo Bathing • Use of Draw Sheet and Changing • Mechanical Lift • Two-Person Manual Lift • Gait Belt Use • Augmentative/Alternative Communication (AAC) Roll out of the new training and skill verification proces was divided into three phases: • Phase 1: Therapist and Physical and Nutritional Management Plan Coordinators (PNMPC). This phase was completed in September 2012. • Phase 2: Residential Coordinators and Home Supervisors. This training was completed in October 2012. • Phase 3: Direct Support Professionals (DSPs) was scheduled for November 26, 2012.	Noncompliance

#	Provision	Assessment of Status	Compliance
		All of the above trainings were focused on the homes located in Trinity. Nurses were scheduled to receive PNM related Medication Administration training but that had not occurred as of this review. New staff were provided with both the new classroom training plus the on the job training that focused on skills verification whereas existing staff, who had already received the old training, were provided with just the skills verification portion. As of this review, According to training records supplied by RSSLC, 6.3% of staff (Residential Coordinators, Home Supervisors, and DSPs) were provided with the new training or skills verification checklists. There was no formal 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. As of this review, 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 task based training. Training was regulated primarily to inservices, and there was no safeguard in the E.6 Policy (Training Reassigned Staff) that prevented those who had not received this higher level of training from working with those who were at the highest level of risk. 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. Additionally, these staff should not assist those for whom they have not been trained.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	The Universal Monitoring Policy (K.07) included the frequency of the monitors for individuals at risk as well as the areas in which the monitors are expected to be completed (i.e., bath, meal, oral care). The monitoring policy included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, and • Evidence that results of monitoring activities in which deficiencies are noted are	Noncompliance

#	Provision	Assessment of Status	Compliance
		formally shared for appropriate follow-up by the relevant supervisor or clinician. There were a tremendous amount of monitoring forms completed, and since the last compliance review, a system had been developed to facilitate the review, and analysis, of findings to direct system change, staff training and other supports. As of July 2012, the data acquired from the completion of the monitoring forms were provided to Quality Assurance and shared with the Unit Directors to help assist with the identification of the need for additional training as well as staff performance issues. A review of Facility monitoring reports from June 2012 to September 2012 documented that staff and individuals were being monitored in all aspects in which the individual was determined to be at increased risk. Per report provided by RSSLC, 2225 monitors had been completed since June 2012. o 33% of the monitoring forms focused on oral intake (meals and snacks) o 12 % of the monitoring forms focused on bathing o 12 % of the monitoring forms focused on medication administration o 8 % of the monitoring forms focused on Oral Care. o 20 % of the monitoring forms focused on positioning o 7 % of the monitoring forms focused on lifting/transfers The risk process did include a monitoring component where the IDT determined through an action plan if increased monitoring was needed, but the process was informal and as stated previously did not contain clear directives on what areas would be monitored. Due to this informality, it was unclear as to who was responsible for what monitoring area (i.e., meal, bathing, snack, oral care). Based on review of IDT meeting minutes for individuals with a change in status (Sample #1) there was no evidence that these monitors were ever increased and therefore it was not evident that this process was consistently implemented. 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. For example, staff not implementing the PNMP was one single item, so if it wasn't implemented at all, the person could still score 90% and be found in compliance. PNMPCs were primarily in charge of completing the monitoring forms. During observations it was noted that PNMPCs were in the dining rooms and in many instances	

#	Provision	Assessment of Status	Compliance
		were looking right at the individual who was not having their plan implemented; however, no intervention was provided. This is of special concern as these same staff were responsible for monitoring to ensure PNMPs were being implemented. This lack of identification concerns the Monitoring Team and questions the accuracy and validity of the monitoring data provided by RSSLC. An Aspiration Trigger Sheet was implemented for all individuals who were identified as being high risk for aspiration. Issues were noted regarding the frequency in which professionals outside of nursing and the PCP were notified. Other issues with the Aspiration Trigger Sheet included: • The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. • Nursing review of the trigger sheet was inconsistent and even when present.	
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 10 individual records (Sample #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 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). Measurable outcomes were 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. To achieve compliance within this provision, members of the IDT and/or PNMT should conduct effectiveness monitoring. Effectiveness monitoring should not be confused with compliance monitoring. A compliance monitoring system, as required in Section O.6, provides information on the status of staff compliance with PNMPs. The purpose of effectiveness monitoring is to report on the efficacy of the interventions developed to minimize and/or reduce high and/or medium PNM risk indicators. Effectiveness monitoring should answer the question of whether the individual is better or worse. Issues with the current trigger process were described in Provision O.6. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		or evaluate the actual efficacy of the plan. For example, there was no review to determine if strategies (i.e., eating and positioning strategies) to address issues related to an increased risk for an individual were effective. There was no detailed comparative analysis of data or assessment findings. Outcomes were reviewed through the risk process but effectiveness of strategies was not. There was no system in place that allowed for the overall tracking and trending of the monitoring data. A system did accumulate the data but did not provide information regarding the difference between effectiveness of the plans and staff implementation of the plans.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	There were 58 individuals listed as receiving enteral nutrition. The Monitoring Team requested enteral evaluations for individuals in the sample. The following section was based on a sample gathered from individuals who received enteral nutrition (Sample #5). Five of these individuals had been included in the sample reviewed by the Monitoring Team. All individuals who were enterally fed were to receive at a minimum annually an Aspiration Pneumonia/Enteral Nutrition Evaluation (APEN). 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. Per review of the APENs for individuals in Sample #5, two of five (40%) had APENS and zero of five (0%) were developed by a full interdisciplinary team. The two APENs completed were created by the Dietitian, Certified Occupational Therapist (COTA), RN, and QDDP Missing from the process was direct support professionals, and Speech Pathology. 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 APENS that were completed were vague and did not address the provision or reflect an interdisciplinary approach. As stated, based on the sample of five individuals (sample #5), two of five individuals (40%) had received the APEN. While some APENS included why the tube was medically necessary, none of the APENs for those individuals who were NPO identified a clear pathway to oral intake. Missing was identification of ways to improve oral musculature in an effort to not only move the person towards potential oral intake but to improve oral musculature. Based	Noncompliance

#	Provision	Assessment of Status	Compliance
		upon review, individual trials of intake or a MBSS were the only method attempted by RSSLC to increase oral 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.	

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

1. RSSLC must take immediate steps to improve the implementation of plans at the homes as well as ensure accuracy of data acquired through the monitoring process. RSSLC would benefit from increased reliability checks between the clinicians and the PNMPCs. The frequency of these checks should be at an increased level until a high degree of reliability can be established. (Provision O.6)
2. 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)
3. 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).
4. The turnaround time for the PNMT evaluation should be improved so that individuals are provided the care and interventions that they need in a timely manner. RSSLC should consider implementing a hard deadline of 30 days post referral date for the completion as well as the information sharing of the completed assessment. (Provision O.1)
5. Any tests and or interventions that are identified through the PNMT evaluation process that are related to health and safety should be completed at the time of the identification and not wait until the comprehensive PNMT assessments has been completed. (Provision O.2)
6. While the IDT has done a better job in meeting in the event of hospitalization, there was limited evidence of investigation regarding the etiology of the hospitalization as it relates to PNM; therefore, the IDT would benefit from guidelines to help ensure appropriate and comprehensive investigation. This additional information would also assist the PNMT in better being able to determine the need for additional comprehensive assessment and consultation to the IDT. (Provision O.2)
7. The Facility should implement an effectiveness monitoring system to evaluate and report on the progress resulting from supports and services in individuals' risk action plans, and revise interventions as appropriate. (Provision O.7)
8. The Facility should provide additional training and/or support to relief/pulled staff to ensure PNMPs are implemented as prescribed. (Section O.5)
9. The Facility should provide additional guidance through the development of procedures to further define the PNMT discharge process to include, at a minimum: status of efficacy of implemented PNMT recommendations, justification for an individual to be discharged from the PNMT through the provision of objective clinical data to document stable or improved health, integration of the PNMT recommendations into the ISP, and objective clinical data for referral back to the PNMT. (Section O.2)

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 (10/30/12) 2. RSSLC Action Plan (10/15/12) 3. Section R Presentation Book 4. RSSLC Policy K.05.1 Habilitation Services "Staffing Effectiveness-Occupation Therapy/Physical Therapy (rev 8/22/12) 5. RSSLC Policy K.05.2 Habilitation Services "Occupational Therapy and Physical Therapy Services (rev 8/22/12) 6. RSSLC Physical and Nutritional Management Policy K.01 (9/21/2012) 7. Record or Partial Record Reviews: • Sample #1: Individuals #386, #404, #701, #711, #745, and #783 • Sample #2: Individuals #23, #500, #523 and #584 • Sample #3: Individual #787 • Sample #4: Individuals #17, #109, #140, #161, and #799 • Sample #5: Individuals #57, #296, #309, #483, #686, #743, and #700 • Sample #6: Individuals #24, #60, #148, #161, #164, #181, #184, #264, #302, #340, #346, #351, #358, #369, #386, #405, #463, #470, #500, #518, #523, #529, #613, #621, #661, #693, #694, #709, #726, #745, and #787 8. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 9. RSSLC PNM Policy K.01 (9/21/2012) 10. RSSLC PNMT Process (rev 4/19/12) 11. Habilitation Therapies Policy K.04 Developing PNMPs (2.23.12) 12. Habilitation Therapies Policy K.07 Universal Monitoring (3.1.12) 13. Habilitation Therapies Policy K.05.1 Staffing Effectiveness-Occupational Therapy / Physical Therapy (8/22/2012) 14. Habilitation Therapies Policy K.05.2 Occupational Therapy / Physical Therapy Services (8/22/2012) 15. 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 16. OT/PT assessments template 17. Wheelchair seating, PNM clinic assessment templates and related documentation OT/PT-related

	spreadsheets 18. 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 19. List of individuals receiving direct OT and/or PT services and focus of intervention 20. Last five assessments completed by OT/PT **People Interviewed**: 1. Ping Law PT Habilitation Therapies Director 2. David Taylor OTR 3. Jean Cuevo PNMT PT **Meetings Attended/Observations:** 1. PNMT 5/15/12 and 5/17/12 2. Observations (San Antonio, Trinity, Leon, Three Rivers, Four Rivers)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 10/30/12 and Action Plan dated 10/15/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section P, in conducting its self-assessment, the Facility: • Did use monitoring/auditing tools. The activities presented in the self-assessment did not consistently correlate with the Settlement Agreement Monitoring Tool. The activities reported appeared to relate to the content in Monitoring Team's reports, but it was unclear how some of this data was being collected. Based on a review of the Facility Self- Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included a comprehensive assessment audit tool. o This monitoring/audit tools did not consistently include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. For example, the monitoring tool guidelines instructed the reviewer to review individual-specific assessments, conduct observations to determine if staff were following PNMP instructions, and interview staff to explain why the individual needs OT/PT interventions. o The Self-Assessment did identify the sample(s) sizes and identified the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The Self Assessment did not include staff responsible for conducting the

	audits/monitoring nor evidence that they had been deemed competent in the use of the tools. o Did use other relevant data sources and/or key indicators/outcome measures. For example, the Facility had reviewed staff training rosters. • The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. The Facility rated itself as being in compliance with none of the sub-sections of Provision P. This was inconsistent with the Monitoring Team's findings of compliance with Provision P.1. The Facility data did identify areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not consistently provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. The Action Plan updated 10/15/12 identified the action steps that RSSLC was involved in to potentially reach compliance. The steps were clear and provided information regarding the projected completion date as well as current status. Use of this format should assist RSSLC in better being able to identify their current status and the future areas that still require attention and improvement.
	Summary of Monitor's Assessment: Overall, there was noted improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at RSSLC. Assessments were much improved and did a respectable job in providing a comprehensive review of the individual. This was especially noted with the most recent assessments that had begun with a new format and with additional staff assistance. While Provision P.1 was considered to be in substantial compliance on this visit, there was some concern by the Monitoring Team regarding the lack of skill acquisition as part of the assessment. RSSLC was aware of this needed area of improvement through discussion with the Monitoring Team as well as through their self assessment and audit process. It is expected that this area will continue to improve and become a standard component of the assessment so that compliance may be retained for future visits. Provision P.1: This provision was determined to be in substantial compliance. Assessments were completed in accordance to the schedule set forth by the Facility and contained the components necessary to identify issues with functional mobility as well as other therapy needs. Although skill acquisition was not a consistent piece of the assessment RSSLC was aware of this need and had established a plan to address the deficiency moving forward. 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. Justification for continued therapy was not well documented nor was discharge well justified as a result. Notes focused on the activities at hand but did not provide clear detail regarding benefits of the treatment and the expected outcome of the direct treatment. 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 PNMT. Following the compliance visit, the Facility provided information about newer versions of Policies K.04 and K.07 not reviewed by the Monitoring Team and stated these issues were addressed in the revised policies. 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. As stated above and in Provision O.6, the accuracy of the monitors and monitoring process was questioned secondary to the significant discrepancy between what the Monitoring Team observed and that in which RSSLC reported as well as the lack of intervention of the staff conducting these monitors during the Monitoring Team's observations.. Percentage of compliance with monitors conducted by RSSLC and presented as part of the presentation book demonstrated over 98% compliance. The Monitoring Team's observations as noted in Provisions O.4 contradicted the high percentage of compliance identified by RSSLC.

#	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	Sample #1 was chosen from the list of individuals who were diagnosed with an aspiration or choking event since the previous compliance review. The sample consisted of six individuals who accounted for 36% of the individuals who experienced an aspiration event and 100% of the individuals who had a choking event. Sample #2 consisted of four individuals chosen from a list provided by RSSLC of individuals who were provided with PNMT comprehensive evaluations. The sample consisted of approximately 80% of those who received evaluations in the last two months. Sample #3 consisted of one individual or 33% of the individuals who were newly	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	admitted since the previous compliance visit. Sample #4 consisted of five individuals or 50% of the individuals who have had the most Falls since the previous compliance visit. Sample #5 consisted of seven individuals or 18% of the individuals receiving direct OT or PT services. Sample #6 consisted of the last 5 OT/PT assessments completed by each of the Occupational and Physical therapists. This sample consisted of 31 assessments or 100% of the OT/PT assessments completed between 9/4/12 and 10/31/12. All requirements of this provision were identified as being in substantial compliance. All recent assessments (completed since September 2012) were noted to be comprehensive and addressed the generalized standards of a comprehensive assessment. Missing from the assessment was clear of identification of methods to improve skills related to Activities of Daily Living (ADLs) outside of the use of adaptive equipment; however, current status with ADLs was clearly stated throughout the assessment. The individuals who did not have a comprehensive assessment in the new format had received at a minimum an assessment that exceeded the requirements of this provision for a screening although it was not determined to be a comprehensive assessment as per the standards identified below in Provision P.1. Individuals in Samples #1, #2, #3, and #4 were provided annual assessments as well as interim assessments as indicated by a change in status in accordance with general standards of care and per state and RSSLC policy. An audit process had begun in September 2012 and was completed by both the therapists in the format of a self assessment as well as review by the HT director. The lack of skill acquisition development was noted by the HT Director and was an area that was currently being worked on as part of an improvement project. RSSLC should remain aware of this lacking area and ensure over the next six months that improvements continue to be made in this area. The Facility provided an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There were six Occupational Therapists (OTs), Three Certified Occupational Therapist Assistants (COTAs), six Physical Therapists (PTs), and two Physical Therapy Assistants (PTAs). This is an improvement in staffing since the previous assessment.	

#	Provision	Assessment of Status	Compliance
		There were no openings for any of the positions listed above. With the current staffing, the ratios for Occupational Therapists and Physical Therapists were 1:58. This ratio was within the 1:60 ratio identified by RSSLC as appropriate. At the time of this review, the census at RSSLC was 347 individuals. The reported number of individuals with PNM needs was 315 or 90% of the total census. Some of those individuals 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. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with additional supports available from the therapy assistants. The assistants were not licensed to complete assessments but their roles were critical, however, in that they were to provide training, supervision of technicians and Physical and Nutritional Management Plan Coordinators (PNMPCs), assist with data gathering, provide monitoring, and provide direct/indirect supports. OT and PT completed annual assessments/updates collaboratively This level of supports and services could be adequately met with the current staffing levels for OT and PT. At the time of this onsite review, Ping Law OTR continued to serve as the Habilitation Therapies Department Director as well as a member of the PNMT. As stated earlier, OT/PT staffing had shown improvement since the previous review. PTs and PTAs included Ping Law OTR (who also served as Habilitation Therapies director), Jean Cuevo PT (PNMT and PT lead), Melissa Amores PT, Estrele Posadas PT, Dawn Williams PT, Alton "DeMario" Howard PT, Nadhimu Niyamathullah PT, Emmanuel Valdez PTA, and Kathryn Ball PTA (PNMPC supervisor). OTs and COTAs included David Taylor OTR (lead), Rena Banks OTR, Sara Korreth-Danlas OTR, Miriam Ammerman OTR, Raquel Garcia OTR, Chetna Shah OTR, Randi Farrell OTR, Hyacinth Omeludike COTA, and Sylvia Zepeda COTA. All clinicians with the exception of the Habilitation Therapies (HT) Director carried full caseloads in addition to any administrative duties that were required. The Facility did document appropriate qualifications for licensed OTs, COTAs, PTs and PTAs; 17 of 17 staff (100%) were licensed to practice in the state of Texas.	

#	Provision	Assessment of Status	Compliance
		All OT and PT staff (100%) had completed continuing education related to their areas of practice as evidenced by all staff retaining the appropriate licensure to practice in the state of Texas. Documentation of continuing education courses completed by the OTs and PTs were submitted. The continuing education attended by the clinicians included but was not limited to the following topics: • Issues in Evaluation and Treatment of Individuals with DD • Individual Support Plan and Integrated Risk Assessment Process • Beckman Oral Motor Assessment and Intervention A new comprehensive assessment format was in use at the Facility and included assessment by OT and PT. The outline submitted included medical history, medications, behavioral concerns, and other current health issues that would impact the delivery of OT and PT services. The assessment included physical assessment of sensory/motor/neuromuscular systems and functional motor and daily living skills performance. Physical Nutritional Management issues related to positioning supports, mealtime, medication administration, and oral care were also addressed. The outline also included sections to address the clinicians' analysis of findings (summary, strengths and needs), recommendations, measurable outcomes, interval for reassessment, and factors for community placement. Therapists were instructed to analyze the clinical information as each section was completed so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated. Recommendations for supports and activities, other than direct therapy requiring a licensed professional, should be incorporated into the ISP so they may be integrated throughout the individual's daily routine. This was of significant concern to the Monitoring Team because all aspects of supports and services should be included in the ISP. The comprehensive assessment was to be completed within 30 days of admission and an update was to be completed at least annually to address services provided to the individual during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was to be included in the written report. The content areas of each of these were extensive and comprehensive in nature. Generally accepted standards of a comprehensive assessment include the following: • Signed and dated by the clinician upon completion of the written report	

#	Provision	Assessment of Status	Compliance
		• Dated as completed 10 days prior to the annual ISP • Diagnoses and relevance to functional status • Individual preferences, strengths, interests, likes, and dislikes • Medical history and relevance to functional status • Health status over the last year • Medications and potential side effects relevant to functional status • Documentation of how the individual's risk levels impact their performance of functional skills • Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. • Evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work) • Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings • Discussion of the expansion of the individual's current abilities • Discussion of the individual's potential to develop new functional skills • Comparative analysis of health and impact on functional status over the last year • Comparative analysis of current functional motor and activities of daily living skills with previous assessments • Identify need for direct or indirect OT and/or PT services • Reassessment schedule • Monitoring schedule • Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs • Factors for community placement and a determination of the most appropriate living environment • Recommendations for services and supports in the community • Manner in which strategies, interventions, and programs should be utilized throughout the day. The total number of assessments reviewed was 54 (Samples #1, #2, #3, #4, #5, and #6). Comments are below: • 88% (48/54) were identified as comprehensive assessments. The evaluations varied in format and content, though those since January 2012 were generally of the current assessment template. The assessment for Individual #783, dated 12/9/11, did not include a discussion of his risk levels or clear comparative analysis. Individuals #783 and #701 did not have community integration included as part of the assessment. • 90% (49/54) were signed copies of the original, although none had dated	

#	Provision	Assessment of Status	Compliance
		signatures. The date of the assessment was consistently identified in the heading, but it was not possible to determine when the report was finalized and signed and, thereby, available to the IDT for review and integration into the ISP. • 77% (42/54) of the assessments were dated as completed prior to the annual ISP meeting. • 100% (54/54) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. • 94% (51/54) included an analysis section which provided a sufficient rationale for the interventions and supports recommended. • 87% (47/54) included a monitoring schedule. In some cases the frequency of PNMP monitoring was not identified. The level of health risk was generally used to drive the frequency of monitoring for individual status, effectiveness of supports and interventions, or implementation of the PNMP. • 100% (54/54) included a re-assessment schedule. • 81% (44/54) included supports required for placement in a community setting. • 100% (54/54) included evidence that communication and or collaboration was present in the OT/PT assessments. • For the ISPs: o 100% (54/54) of the ISPs submitted were current within the last 12 months. o 94% (51/54) of the current ISPs with signature pages submitted were attended by either the OT, PT or both Although some assessments were found not to have all components, it is felt that this did not accurately reflect the Facility's improvement and competence in this area. The majority of assessments that were not found to be comprehensive were assessments that were completed prior to the format revision of September 2012. With this taken into consideration, compliance percentages exceed 90% for the new assessments. For individuals newly admitted to the Facility (Sample #3) since the last onsite review, one of one individual (100%) received the required OT/PT assessments within 30 days of admission.	
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	Individuals were not consistently provided with timely interventions to minimize regression and/or enhance current abilities and skills. Please refer to Provision O.2 regarding completion of assessments in response to a change in status. An area of improvement noted was regarding response by the team in response to	NonCompliance

#	Provision	Assessment of Status	Compliance
	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 who have had an increase in falls. For individuals who had experienced an increase in falls (Sample #4), five of five were seen in a timely manner by the IDT and received assessment and/or review by the PT. Intervention plans related to positioning were based on findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. See above in Provision P.1 for examples. Based on reviews of PNMPs and other positioning plans for 54 individuals (Sample #1, #2, #3, #4, #5, and #6) equipment was specified for 54 of 54 (100%) plans reviewed. Plans were generally limited to the PNMP that was reviewed at the time of the annual ISP and were updated as needed due to a change in status. The main issue was that there was little to 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.1 for examples. 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, ambulation, and transfers and range of motion. OT intervention was designed to promote range of motion or to provide splints. The interventions contained as part of the PNMP were in place, were well documented, and had established measurable and functional goals that were included as part of the OT/PT assessment. Findings were often not integrated into the ISP. Recommendations other than the PNMP were often not included and there was limited to no evidence of therapist-designed skill acquisition plans (SAPs) in general or related to direct therapy services. Justification for continued therapy was not well documented nor was discharge well justified as a result. Notes focused on the activities at hand but did not provide clear detail regarding benefits of the treatment and the expected outcome of the direct treatment. 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. Overall, PNMPs were comprehensive and contained the needed specificity to ensure safe oral care, medication administration, and/or personal care. Please refer to Section O for additional information. • Based on reviews of PNMPs and other positioning plans for 54 individuals	

#	Provision	Assessment of Status	Compliance
		(Sample #1, #2, #3, #4, #5, #6) the rationale for the plans were clearly stated in the OT/PT assessment or update for 94% (51/54) individuals. • Assessments clearly stated that the PNMPs should be followed as well as stating the function of the device. Staff did not consistently implement interventions and recommendations outlined in the PNMP. See Provision O.4 for information.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs was addressed in detail in Provision O.4. Equipment generally was available but implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standards of care. For examples, please refer to Provision O.4. Staff were also not knowledgeable of the plans that were intended to implement. Examples of this are included in Provision O.4. Since the last compliance visit, RSSLC developed Physical and Nutritional Management Core Competency Training. The training included the following areas: • Mealtime practice and adaptive equipment • Diet texture and liquid consistency • Positioning (bed, wheelchair, and trolley) • Lifting and transferring • Bathing and dressing • Oral hygiene • Augmentative/Alternative Communication (AAC) systems Once staff completed the classroom based training, they were then required to complete competency/skill verification checklists. Skill Verification Checklists were as follows: • Triggers Recognition • Core Meal Time • Diet Texture/Liquid Consistency • Adaptive Dining Equipment • Wheelchair Positioning • Bed Positioning • Bed safety • Arjo Bathing • Use of Draw Sheet and Changing	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Mechanical Lift • Two-Person Manual Lift • Gait Belt Use • Augmentative/Alternative Communication (AAC) Roll out of the new training and skill verification process was divided into three phases: • Phase 1: Therapist and Physical and Nutritional Management Plan Coordinators (PNMPCs). This phase was completed in September 2012. • Phase 2: Residential Coordinators and Home Supervisors. This training was completed in October 2012. • Phase 3: Direct Support Professionals (DSPs) was scheduled for November 26, 2012. All of the above trainings were focused on the homes located in Trinity. Nurses were scheduled to receive PNM related Medication Administration training but this had not occurred as of this review. New staff were provided with both the new classroom training plus the on the job training that focused on skills verification whereas existing staff who had already received the old training were provided with just the skills verification portion. As of this compliance review, 6.3% of staff (Residential Coordinators, Home Supervisors, and DSPs) had participated in "Core Competency" training. Although DSPs had received training during new employee orientation, the training lacked the needed competency testing portion and therefore the Core Competency Training class was recently implemented in an effort to improve competency of staff and their return demonstration of skills. There was no formal 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. As of this review, 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 task based training. Training was regulated primarily to in services and there was no safeguard in the E.6 Policy (Training Reassigned Staff) that prevented those who had not received this higher level of training from working with those who were at the highest level of risk. Following the compliance visit, the Facility provided information about a newer version of Policy K.04 not reviewed by the Monitoring Team and reported this policy states the training required prior to working with high risk individuals. The Monitoring Team will	

#	Provision	Assessment of Status	Compliance
		determine at the next compliance visit whether this results in improvement in implementation of PNMPs. 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.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was inconsistently implemented at RSSLC and addressed in Provision O.6 above. Recommended frequency of monitoring was overall included in the OT/PT assessments. As stated on Provision O.7, the effectiveness of the supports and/or adaptive equipment were not consistently included as part of the PNMP monitoring process. Frequency or interval of monitoring conducted by the PNMPCs was not identified in the assessments and findings of the monitoring conducted were not reported in the OT/PT assessments in an effort to determine efficacy of the interventions previously recommended and implemented. Following the compliance visit, the Facility provided information about a newer version of Policy K.07 not reviewed by the Monitoring Team and reported this policy states the frequency of monitoring under PNMPC responsibilities. RSSLC had a wheelchair repair log that identified the date the wheelchair was repaired, the name of the individual, who completed the order, and the part repaired. The log contained information regarding when the repair request was initiated; therefore, it was possible to determine if repairs were being provided in a timely manner. Per OT/PT and PNMP monitors, a system still existed that was designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT were included in the routine monitoring of the PNMPs as described above in Section O. There were no routine maintenance checks documented to assess the working condition of the wheelchairs, gait trainers, and adapted chairs, other than the PNMP monitoring conducted by PNMPCs or through the annual reviews. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		with the individuals. This includes pulled and relief staff (please refer to Provision O.5). Following the compliance visit, the Facility provided information about a newer version of Policy K.04 not reviewed by the Monitoring Team and reported this policy states the training required prior to working with high risk individuals. The Monitoring Team will determine at the next compliance visit whether this results in improvement in implementation of PNMPs. A policy/protocol addressing the monitoring process did exist and provided information regarding frequency of monitors and staff responsible. Based on review of the PNMP policy, a system was in place to monitor staff implementation of PNMPs and other OT/PT interventions which included: o Definition of monitoring process o Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities o Formal schedule for monitoring to occur o Re-evaluation of monitors on an annual basis by therapists and/or assistants o Results of monitoring activities in which deficiencies noted are formally shared for appropriate follow-up by the relevant supervisor The data collected was aggregated in a way that allowed productive trending and analysis. See Provision O.7 for more information. On a regular basis, DSPs were monitored for their continued competence in implementing the OT/PT programs. This was accomplished through the monitoring process and the use of annual refresher trainings that focused on lifting and transfers as well as the monitoring of the PNMPs. As mentioned in Provisions O.4 and P.2, the increased training and monitoring did not translate into increased implementation and knowledge of interviewed staff. Individuals receiving direct OT/PT treatment did not have comprehensive data regarding benefits of and status with direct interventions provided by the OT or PT. Zero of seven (0%) individuals from Sample #5 were provided with detailed documentation regarding progress, benefits and effectiveness of interventions and treatment. As stated in Provision O.6, a monitoring process had been implemented since the past compliance review but the reliability of the monitors was questioned secondary to the significant discrepancy between what the Monitoring Team observed and that in which RSSLC reported as well as the lack of intervention of the staff conducting these monitors during the Monitoring Team's observations. Percentage of compliance with monitors conducted by RSSLC and presented as part of the presentation book demonstrated over	

#	Provision	Assessment of Status	Compliance
		98% compliance. The Monitoring Team's observations as noted in Provisions O.4 contradicted the high percentage of compliance identified by RSSLC.	

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

1. 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 in collaboration with the SLPs and/or psychology. (Provision P2).
2. Current therapy services being provided to individuals should be integrated into ISP skill acquisition programs to provide multiple opportunities for incidental teaching, formally and informally (Provision P.2).
3. 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)
4. There should be established thresholds for staff re-training; identification, training, and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies (Provision P.3 and P.4).
5. The Facility should ensure comprehensive progress notes related to OT/PT direct interventions and indirect programs include:
   - Information regarding whether the individual showed progress with the stated goal;
   - A description of the benefit of the goal to the individual;
   - A report on the consistency of implementation; and
   - Recommendations/revisions to the direct intervention or OT/PT program as indicated related to the individual's progress or lack of progress. (Provisions P.2 and P.4)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment 10/30/12 2. RSSLC Action Plans 10/15/12 3. Presentation Book for Section Q 4. RSSLC policy for suction toothbrushing, undated, and no policy number. 5. RSSLC policy for dental emergency procedure, undated and no policy number. 6. List of all individuals provided suction toothbrushing. 7. Facility generated random list of ten individuals who were provided an oral hygiene care plan (OHCP), and provide a copy of the OHCP, associated ISP demonstrating that the OHCP had been adopted by the IDT, and documentation that all applicable staff were care were trained. 8. Dental records, and integrated progress notes for dental emergencies that occurred during the reporting period for Individuals #797, #779, #56, #16, and #483. 9. List of all individuals who require TIVA (Provision Q.1) 10. Annual dental summary, dental progress notes IPNs, annual ISP, and anesthesiology report for Individuals #796, #273, #791, #10, #207, #584, #626, #316, #166, and #324. 11. Hands on use of the DADS, dental database **People Interviewed:** 1. Carol Heath, DDS, Dental Director **Meetings Attended/Observations:** None
	Facility Self-Assessment: The Monitoring Team concurs with the Facility's self-assessment of noncompliance with Provisions Q.1 and Q.2 of the Settlement Agreement. For Section Q, the Monitoring Team agrees with many of the issues assessed by the Facility's self-assessment. For example, the Monitoring Team noted that annual dental examinations were current, and that that dental treatment forms were completed, and that oral hygiene reports indicated ratings of oral hygiene. The Monitoring Team did not identify in the Self-Assessment, where the Facility evaluated to see if actual dental treatments were completed timely, or if appropriate, and ample dental care was being provided. For example, the Monitoring Team noted significant delay in actual treatment for individuals who required TIVA, and general anesthesia. Although the self-assessment indicated that all appropriate staff had been trained on dental issues, the Monitoring Team noted that all direct care staff had not been trained on the individual's oral health care plans, in fact, the dental office could not provide the Monitoring Team with any insight as to how many direct care staff were actually trained on oral health care plans. The self-assessment indicated that 101 out of 103 dental summaries were completed and submitted for the IDT review, ten days prior to the ISP, but did not take into consideration the effectiveness of the summaries in communicating oral health care issues. Although it is essential that the Facility first determine whether dental summaries are provided timely (as was done in this Self-Assessment), it would also be important to

	assess whether the summaries provide information on all necessary issues that the IDT must take into consideration. The self-assessment reported that it assessed policies to ensure that they were accurate and current. The Monitoring Team reviewed the dental emergency policy and determined that it did not address dental emergencies, but medical emergencies that occur at the dental office. The Monitoring Team noted that the Facility had engaged in an extensive oral health care plan project, and despite this project being partially implemented, there was no policy or procedure, or even a draft version of a policy and procedure. In the self-assessment, the suction toothbrushing protocol was assessed and determined effective; however, the Monitoring Team noted that the policy was a procedure for performing suction toothbrushing, and there was no policy and/or procedure that outlined the suction toothbrushing program. The Monitoring Team has significant concern with the dental action plan, as it was mostly a list of items that the dental office had completed, and not an actual plan that indicated what forward processes the dental office had planed, to achieve compliance.
	Summary of Monitor's Assessment: The Monitoring Team has significant concerns with the overall provision of dental services by the dental office, which are necessary to support individuals with complex intellectual and physical disabilities. The Facility had made very little progress in moving forward towards compliance in the area of dental services. The Facility had not addressed many recommendations made in the last Monitoring Team's report. The Facility did not provide timely oral health care treatment to individuals who required intravenous or general anesthesia. Documentation practices by the dental office did not adequately communicate oral health care issues to other members of the IDT. The Monitoring Team noted that the dental office did not have an effective means to manage important oral health care database elements. The following is a summary of some concerns noted for Provisions Q.1, and Q.2: **Provision Q.1:** The Monitoring Team determined that the Facility is not in compliance with Provision Q.1. The Monitoring Team has significant concern with the provision of dental services at the Facility. Although the Facility had developed a new process to better improve oral hygiene effort at the living areas, called the oral health care plan (OHCP), the process was not fully implemented, and there was no documentation to demonstrate that direct support professionals (DSPs) were trained on the individual OHCPs. The Facility did not have a meaningful process in place to track and trend dental database elements. For example, the Facility could not readily provide the Monitoring Team with a list of individuals who were assessed, and were pending sucttion toothbrushing. There was significant delay in treatment for individuals requiring emergency dental care, because TIVA was not readily available. Based on the TIVA scheduled provided, and noted delays in providing emergency dental services, the Monitoring Team determined that the Facility did not offer adequate TIVA support services for individuals who required that level of support. Documentation of dental treatments in the IPNs was not adequate because they did not provide necessary information for non-dental office staff to rely upon. For example, information was not provided in language that could be easily understood by other team members; also, specific treatment plans, oral healthcare issues, and concerns, prognosis, monitoring parameters, follow-up plans, and necessary supports and services were not identified in the ISPs reviewed by the Monitoring Team. Post TIVA follow-up orders were determined

	to be not meaningful for nursing staff, as they were not individualized by taking into account the Individual's medical and behavioral health care needs. The Monitoring Team informed the Facility at the time of the last compliance visit that it needed to develop a mechanism to provide services for individuals who required general anesthesia for dental care, and at the time of this review, the same individuals were awaiting treatment. **Provision Q.2:** The Monitoring Team determined that the Facility is noncompliant with and has made very little progress on compliance with Provision Q.2. The Facility had made no progress with improving on its ability to track and trend dental appointments and other dental data elements, did not develop a meaningful dental quality assurance process, did not improve its ability to participate in the IDT process, and did not work in collaboration with the psychology department to develop meaningful processes to help mitigate the need for sedation. The Monitoring Team is very concerned with the little progress demonstrated by the dental office.

#	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 Q.1 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 oral health hygiene, provision of dental and oral health care, dental administration, the Facility's use of suction tooth brushing, and the use of intravenous sedation (TIVA), pre-treatment oral sedation, and general anesthesia. In addition, the Monitoring Team also assessed the ability to provide emergency dental treatment. The Following are the results of the Monitoring Teams findings in these areas: <u>Dental Administration</u> The Facility maintained one dental director, who provides approximately 30% of the time to direct dental care; one full time dentist, who provides 100% time to direct dental care; and had two positions available for dental hygienists; and two positions for dental technicians. At the time of this review, one hygienist and one technician were on long-term disability. The Monitoring Team recommends that the Facility's administration review staffing issues of its dental office. Following its review, the Monitoring Team determined that the Facility had made very little progress in moving forward with compliance, and given the staffing ratios and responsibilities, administration may need to address staffing issues. <u>Suction Toothbrushing</u> The Policy for suction toothbrushing outlined the procedure for performing suction toothbrushing, but did not delineate a process for assessing individuals for the need for suction toothbrushing, and the dental director reported that there was no dental policy or standardized practice for re-assessing of individual for the potential need for suction	Noncompliance

#	Provision	Assessment of Status	Compliance
		toothbrushing, other then if staff note a change in the Individual's status, they are to report that suction toothbrushing should be initiated. Oral hygiene that leads to oral health is an essential component of dental care. The Facility must ensure policies and procedures are in place to establish and maintain good oral hygiene; suction toothbrushing is an important component of such procedures. Although the dental director informed the Monitoring Team that the physical and nutritional management team is responsible for assessing individuals, the dental office is responsible for the program, as it falls under Provision Q1. The Monitoring Team strongly recommends that a formal process, which includes a policy, and procedure be developed to clearly delineate how, when, and by whom, individuals will be assessed, and reassessed for the use of suction toothbrushing. The Monitoring Team requested a list of all people assessed for suction toothbrushing, and a list of all individuals who were pending suction toothbrushing. The document request form was returned stating such lists were not available; however, the Facility then provided a list of names that stated "suction brush candidates"; this list, without explanation, included numbers to the side of some names. Following discussion with the dental director, and review of documents provided, the Monitoring Team determined that the Facility did not have an effective process to maintain data elements with regard to individuals have been assessed for suction toothbrushing. The dental office must better track individuals who have been assessed, and re-assessed, for suction toothbrushing, and of those who have been identified as needing suction toothbrushing and those pending administration of suction toothbrushing. <u>Oral Hygiene</u> The dental director explained that the Facility had initiated an oral hygiene care plan (OHCP) process, whereby individuals were assessed and an initial plan developed by the dental office; the IDT would then review the plan and either adopt the plan into the individual's care plan, or revise the plan in collaboration with the dental office. The dental office did not maintain a list of individuals who had an OHCP, and was unable to inform the Monitoring Team what individuals already had an OHCP adopted into the individual's care plan and fully implemented, and who was awaiting development of a OHCP plan. The Facility documented a process for staff training for the OHCP on 11/2/12, which was described as a "multiphase training program targeted to reach as many staff as possible". The process was reported to be a "multitier approach", with the top tier targeting daytime residential coordinators, and phase two of the training would be to "provide residential coordinators the tools and knowledge to adequately train supervisors and staff of their home". Although the Facility provided a list of residential coordinators who were trained on individual OHCPs, there was no evidence to support that direct care	

#	Provision	Assessment of Status	Compliance
		staff, who provide the oral health care to individuals, were trained. The Monitoring Team requested that the Facility generate a random list of ten Individuals, and provide a copy of their OHCP, documentation that the IDT had reviewed the OHCP, and documentation that direct care staff were trained on the OHCP. For the ten randomly selected individual, an initial OHCP and been developed for ten out of ten cases (100%), and the IDT had reviewed ten out of ten OHCPs (100%). The Facility provided evidence that direct care staff were trained for zero out of ten cases (0%). At the time of this review, there was no policy, procedure, or guideline that outlined the process for the OHCP process. The Monitoring Team was pleased to learn that the Facility had moved forward in developing, and implementing a OHCP process, that may help to improve the provision of oral hygiene at the living area. The Monitoring Team strongly suggests that the Facility develop a mechanism to track individuals who have been assessed for OHCPs, who are pending an OHCP, and develop a process that ensure the OHCP is amended whenever there is a status change with the individual that would require a change of the OHCP. It is essential that the Facility formalize a policy and procedure for the OHCP process, and ensure that all applicable staff have been trained on the OHCP process, and that applicable staff have been trained on the individuals' specific OHCPs. <u>Dental Emergencies</u> The dental office policy and procedure titled, "Emergency Procedure", was undated, and there was no policy number assigned. The procedure did not delineate the Facility's procedure for managing dental emergencies; rather, it was a process for providing medical care to individuals who sustained an cardiopulmonary, or other event at the dental office, and not a dental emergency. The dental director informed the Monitoring Team that there were a total of two dental emergencies, with one being triaged after hours, that occurred during the reporting period. The dental director noted that the dental office did not maintain a mechanism to track dental emergencies. As part of the document request, the Monitoring Team was provided with a list of 17 dental emergencies, which occurred during the same reporting period. The dental director, dental office, and the Facility must be able to readily, and accurately identify dental emergencies at the Facility. This is especially important for dental quality assurance. The Monitoring Team determined that the Facility did not have a meaningful mechanism to management database elements, as related to dental emergencies. The following is a review of the IPNs, nurses notes, and dental records of the first five	

#	Provision	Assessment of Status	Compliance
		individuals on the list of individuals who sustained a dental emergency during the reporting period: Individual #797 The only documentation provided for review, for two separate reported dental emergencies that occurred on 6/8/12, and 9/17/12, was a dental progress record that stated, "verbally refused tx. Asked in Spanish if he had mouth pain – dental pain. No external swelling noted. No Tx at this time". There was no follow-up, or any recommendations for nursing or direct care staff to monitor the individual, and no meaningful documentation of the issue. Individual #779 Sustained a dental emergency on 7/17/12. Dental progress note reported "FU to report of TA". Dental exam was completed, and individual was scheduled to have dental filling on 7/31/12. No specific instructions were provided for nursing or direct care staff. An IPN, dated 7/17/12 by the dental office, was one line stating that "1 xray, exam, Rx (Motrin)". There was no explanation of findings, concerns, or necessary treatment. Individual #56 Required emergency dental appointment on 5/31/12. On 5/30/12, the Individual complained of tooth pain, and the nurse triaged the issue, and referred the Individual to the on-call medical provider. The medical provider prescribed analgesic for pain, and referred the issue to the dental office. On 5/31/12, the IPN indicated an entry stated "See Dental [can't read word]". There was no further documentation by the dental office in the IPN regarding this issue. The dental progress treatment record dated 5/31/12 indicated the Individual was seen for evaluation of dental pain. The dental record stated "very poor oral hygiene – heavy plaque and food debris". The record also indicated that attempts at obtaining x-rays was "limited" and that the Individual would need to be assessed when provided i.v. sedation. The Individual was evaluated under i.v. sedation on 8/30/12, and decay was noted on tooth #17. The Monitoring Team is very concerned over the time frame in providing dental care for an individual who reported dental pain, who was not provided treatment for three months. Also, the dental office did not adequately document dental issues in the IPN, nor adequately report monitoring parameters for nursing and direct care staff. Individual #16 Was reported to be seen urgently by the dental office on 6/27/12. There were no nursing notes or dental IPNs provided for this issue. A dental progress record, dated 6/27/12, indicated that the dental office evaluated the individual and stated, "a small nick of tissue was noted reddened and elevated under tongue in area of salivary ducts.	

#	Provision	Assessment of Status	Compliance
		Impression: patient had pinched underside of tongue during one of her constant chewing episodes. No treatment was rendered and condition has resolved". Although the condition had resolved, there should have been some instructions to staff who are responsible for monitoring the individual. Individual #483 Seen for an urgent dental visit on 8/8/12 for dental pain. Nursing staff evaluated, and triaged the individual appropriately to the dental office. The dental IPN, documented on 8/8/12, indicated that the Individual was evaluated for toothache and that there was "periodontal involvement of #30", the area was "cleaned and irrigated", and that follow-up appointed with oral sedation would occur on 8/22/12. IPNs were not provided for the 8/22/12 follow-up; however, the dental progress noted indicated continuing dental issues with area #30, and the need for extraction. The Individual was scheduled for extraction under i.v sedation. The extraction occurred on 8/30/12, and the only IPN provided for review was an IPN dental form that indicated that the Individual was provided extraction of tooth #30, and that a history of a dental abscess was noted. The IPN was not documented in a way that non-dental professionals would understand, it did not delineate necessary supports and services for nursing and direct care staff to provide, and there were no specific follow-up recommendations noted on the IPN. No other dental records or dental progress notes were provided for review. The Monitoring Team has significant concern with the dental office's documentation practice, lack of providing nursing staff and direct care staff with meaningful information of what and how to monitor the individual's condition, and what supports and services may be necessary to provide the individual. There was no mention of prognosis, or follow-up instruction. Most concerning was that the Individual self-reported dental pain on 8/8/12, which was immediately triaged by nursing staff to the dental office, and definitive treatment, for a dental abscess and extraction, did not take place until 8/30/12. This delay in treatment of more than three weeks is unacceptable. Summary. The Monitoring Team has serious concerns over the quality of dental services provided by the dental office. In an intermediate care setting, that supports individual with intellectual and other disabilities, it is expected that dental services be provided timely, and without unnecessary delay. The Facility's dental office must be proactive in assisting other staff to better understand the oral health care needs of individuals serviced, and to ensure that all necessary supports and services are clearly delineated for the individuals oral health needs. It is alarming to the Monitoring Team that the dental director reported that only two individual were seen urgently, when the Facility reported a total	

#	Provision	Assessment of Status	Compliance
		of 17 distinct appointments that were scheduled for emergency evaluation. Intravenous Anesthesia (TIVA) The Facility provided a list of all appointments that were provided under TIVA. A total of 55 TIVA appointments were provided during the six-month reporting period, which is an average of 9 appointments per month. The dental director reported that only a maximum of 12 TIVA appointments are provided in any given month. Therefore, if someone needs emergency treatment under TIVA, the individual would be scheduled for the next TIVA treatment day, which occurs on Fridays, and someone who was scheduled for TIVA would be bumped to a later appointment. The dental director indicated that the Facility did not have a mechanism to readily identify individuals who require treatment under TIVA, and would have to review the individual dental record, or the dental schedule; therefore, the Monitoring Team was unable to determine if the Facility provided adequate TIVA services. Based on two out of five dental emergencies, as delineated above, there were two cases in which delayed treatment was noted, because the Individuals required TIVA for treatment (Individuals #56, and #483). Given that the Facility continues to not have a mechanism to track individuals who require oral health care evaluations and treatments under TIVA, and because two individuals received delayed treatment for their dental needs, the Monitoring Team determined that the Facility did not provide adequate TIVA support. The Monitoring Team again raises concern over the Facility's ability to maintain an active list of all individuals who require TIVA support. The Monitoring Team assessed dental services under TIVA for the first five individuals from a list of all individuals who were provided TIVA support during the reporting period. The Monitoring Team compliments nursing services for their consistent documentation of follow-up following the use of TIVA. In five out of five cases (100%), nursing documented post TIVA monitoring. Anesthesiology records were completed for five out of five cases (100%); consent forms were completed in five out of five cases (100%); the dentist provided comprehensive and concise post TIVA follow-up instructions in zero out of five cases (0%); the dentist documented in the IPN an explanation of services provided under TIVA, prognosis, and follow-up instruction, in zero out of five cases (0%). Summary The Monitoring Team determined that the Facility did not provide ample TIVA services for individuals who require the support of TIVA for their oral health care services. The Monitoring Team noted significant issues with regard to post TIVA follow-up instruction, and dental documentation in the IPN. Nursing services significantly improved their	

#	Provision	Assessment of Status	Compliance
		follow-up and documentation of care during the post TIVA monitoring period. The dental office must improve on their documentation practice, and ensure that clear, concise post TIVA follow-up instructions are provided for each individual following all dental treatments, including those who were provided TIVA support. The dentist must individualize care plans for each individual, and inform nursing and direct care staff of all necessary precautions, monitoring parameters, and follow-up instructions. In addition, the IPN should clearly delineate the services provided, and prognosis. The Monitoring Team determined that the post TIVA orders were nothing more then a form, that was not individualized specific to the individual's medical and behavioral needs. For example, the post TIVA discharge order form stated "do not operate heavy equipment" – such a statement is unacceptable for an individual with complex disability and profound intellectual disability. <u>General Anesthesia</u> As per the last Monitoring Team review, the dental director reported that a total of six individuals require dental services under general anesthesia; however, as with the previous Monitoring Team review, the Facility had yet to implement a mechanism that would ensure those individuals are provided with general anesthesia. The dental director informed the Monitoring Team that a contract with an oral surgeon is still pending. Summary The significant delay in providing much needed dental services under general anesthesia means that individuals have not received dental services. <u>Pre-Treatment Oral Sedation</u> Please refer to Provision J.14 for review of pre-treatment oral sedation. <u>Conclusion</u> The Monitoring Team determined that the Facility is not in compliance with Provision Q.1, of the Settlement Agreement. The Monitoring Team has significant concern with the provision of dental services at the Facility. Although the Facility had developed a new process to better improve oral hygiene effort at the living areas, called the OHCP, the process was not fully implemented, and there was no documentation to demonstrate that direct care staff were trained on the individual OHCPs. The Facility did not have a meaningful process in place to track and trend dental database elements. For example, the Facility could not readily provided a list of individuals who were assessed, for and pending oral toothbrushing. There was significant delay in treatment for individuals requiring emergency dental care, because TIVA was not readily available. Based on the TIVA scheduled provided, and noted delays in providing emergency dental services, the Monitoring Team determined that the Facility did not offer adequate TIVA support	

#	Provision	Assessment of Status	Compliance
		services for individuals who required that level of support. Documentation of dental treatments in the IPNs was not adequate because they did not provide necessary information for non-dental office staff to rely upon. For example, information was not provided in language that could be easily understood by other team members; and specific treatment plans, oral healthcare issues, and concerns, prognosis, monitoring parameters, follow-up plans, and necessary supports and services were not identified in the ISPs reviewed by the Monitoring Team. Post TIVA follow-up orders were determined to be not meaningful for nursing staff, as they were not individualized by taking into account the Individual's medical and behavioral health care needs. The Monitoring Team informed the Facility at the time of the last Monitoring Team review that it needed to develop a mechanism to provide services for individuals who required general anesthesia for dental care, and at the time of this review, the same individuals were awaiting treatment.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	Provision Q.2 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 interdisciplinary team process (IDT), and ensure a robust scheduling system that efficaciously tracks all dental services to ensure timely provision of assessments and services to each individual. In order to ensure that appropriate dental services are provided by safe and clinically appropriate means, the Facility must ensure that there is a comprehensive quality assurance process for dental services. Following is the Monitoring Team's assessment of each of these areas: <u>Integration Of Dental Services in the ISP, And IDT Process</u> The Monitoring reviewed the most recent annual ISP, dental progress notes, IPNs by the dental office, and annual dental summary for Individuals #796, #273, #791, #10, #207, #584, #626, #318, #166, and #324. The IDT reviewed and incorporated the preliminary OHCP into the individual's ISP, per an addendum to the ISP in ten out of ten (100%) cases; the ISP adequately represented the individual's overall oral health care needs in zero out of ten (0%) cases; dental issues, including the reason for dental treatment, findings, diagnosis, prognosis, monitoring parameters for nursing and direct care staff, follow-up plan, and list of necessary supports and services were identified in zero out of ten (0%) IPNs documented by the dental office. Summary The dental office must significantly improve on its communication of oral health care issues to the IDT, and in the IPNs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Programs to Minimize Sedation Following discussion with the dental director about the dental office's effort to develop and assist in the implementation of programs to minimize sedation, the dental director reported that such efforts are "not working well", and reported that it was the psychology department's responsibility to develop and initiate such efforts. The Dental office did report that the dental hygienist provided a desensitization process whereby individuals who have behavioral challenges are brought to the dental office, and are provided opportunities to sit in the dental chair while gradual efforts by the hygienist are made to provide dental hygiene. There was no reported collaborative effort between the psychology department and the dental office in developing a comprehensive program to minimize the need for sedation. Summary As per the previous Monitoring Teams report, it is strongly recommended that the dental office and psychology department develop a collaborative effort in developing a comprehensive and systemic approach to developing a mechanism to help mitigate the need for sedation. Quality Assurance for Dental Services With the exception of conducting oral hygiene spot checks, and periodic monitoring of suction toothbrushing, the dental department had not develop a process to track and trend quality assurance outcomes for dental services. Summary As recommended in the previous Monitoring Team report, it is strongly recommended that the Facility develop a process to track and trend outcome measure for dental services, especially for the development of pneumonia and injury following the provision of dental services. A comprehensive QA process must be developed for dental services. Scheduling And Missed Appointments As per the previous Monitoring Team review, the Facility had not improved its process to track and trend dental appointments. Furthermore, the dental director informed the Monitoring Team that the Facility was using the newly adopted DADS dental database system; however, upon attempting to demonstrate the system, the dental director was not able to effectively utilize the database, and concurred with the Monitoring Team that the database was non-functional. The Monitoring Team also learned that the dentists were not utilizing the database, but were having support staff enter data from the dentists' handwritten reports. The Facility notifies the living area of missed appointment on the day that the appointment is missed; however, there is no database to efficaciously review missed appointments for trends analysis.	

#	Provision	Assessment of Status	Compliance
		Summary The Facility did not have a mechanism in place to track and trend dental appointments, and other important dental database elements.. <u>Conclusion</u> The Monitoring Team determined that the Facility is noncompliant with Provision Q.2, of the Settlement Agreement. The Facility has made very little progress in compliance with Provision Q.2. As per recommendations in the last Monitoring Team report, the Facility had made no progress with improving on its ability to track and trend dental appointments and other dental data elements, did not develop a meaningful dental quality assurance process, did not improve its participate in the IDT process, and did not assertively work in collaboration with the psychology department to develop meaningful processes to help mitigate the need for sedation.	

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

1. The Facility administration should review staffing issues at the dental office, to ensure that appropriate staffing is in place. (Provision Q.1, and Provision Q.2).
2. The dental office must track and trend the use of suction toothbrushing, and maintain an active list of those who were assessed and determined to require, and not require suction toothbrushing. (Provision Q.1, and Provision Q.2).
3. Ensure that an appropriate OHCP is in place for each individual. (Provision Q.1).
4. Ensure that all applicable staff have been trained on the OHCP. (Provision Q.1).
5. The Facility must ensure that there are policies and procedures for all dental office operations, including policies that accurately address the Facility's practice the OHCP, and dental emergencies (Provision Q.1, and Provision Q.2).
6. Ensure that all dental treatments, including emergency dental treatments, are provided timely, and without undue delay. (Provision Q.1).
7. The Facility must develop a meaningful mechanism to track all clinical data elements, including dental emergencies, dental scheduling, and all data elements necessary for tracking and trending of dental services and dental quality assurance. (Provision Q.1, and Q.2).
8. Ensure that there is ample availability of TIVA and general anesthesia support services. (Provision Q.1).
9. The dental office must enhance its documentation practices, and its communication of oral health care issues by ensuring that the IDT is made aware of, and the IPNs developed by the dental office include, the following information: Oral health issues, including diagnosis; reason for dental office visits; prognosis of oral health care issues; necessary treatments required and provided; monitoring parameters for nursing and direct support staff; risks and benefits of treatments; and that all necessary supports and services for the management of the individual's oral health care needs are clearly delineated, in language that non-dental office staff can easily understand. (Provisions Q.1, and Q.2).
10. The dental office, in collaboration with the psychology department, must develop meaningful processes to help mitigate the need for sedation. (Provision Q.2).
11. The dental department must develop a comprehensive dental quality assurance program, that enables tracking and trending the quality of oral health care provided to individuals, and other important clinical outcomes, such as the incidence of pneumonia and injury following oral health care treatments. (Provisions Q.1 and Q.2).

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 (10/30/12) 2. RSSLC Action Plan (10/15/12) 3. Section R Presentation Book 4. RSSLC Policy K.06.1 Habilitation Services "Staffing Effectiveness-Speech Therapy (2/1/12) 5. RSSLC Policy K.06.2 Habilitation Services "Speech Language Pathology Services (8/1/12) 6. Record reviews: • Sample #1: Individuals #386, #404, #701, #711, #745, and #783 • Sample #2: Individuals #23, #500, #523 and #584 • Sample #3: Individual #787 • Sample #4: Individuals #130, #340, #551, #621, #661, and #694 • Sample #5: Individuals #100, #232, #321, #399, #540, and #666 • Sample #6: Individuals #56, #160, #192, #260, #302, and #379 • Sample #7: Individuals #31, #70, #161, #463, #470, #529, #676, #754, #760, and #779 • Sample #8: Individuals #24, #48, #112, #157, and #794 7. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management Team (PNMT) members, including credentials 8. A list of people with Alternative and Augmentative Communication (AAC) devices 9. Augmentative and Alternative Communication (AAC) evaluation and Speech Language assessment template 10. Monitoring tools template for AAC and SLP programs 11. List of individuals receiving direct speech services, and focus of intervention 12. PBSPs for sample individuals 13. Communication assessments for sample individuals 14. Communication programs for sample individuals 15. Habilitation Therapies Policy K.06.1 Staffing Effectiveness-Speech Therapy (rev 2/1/2012) 16. Habilitation Therapies Policy K.06.2 Speech-Language Pathology Services (rev 8/1/2012) 17. Last five assessments completed by each Speech Language Pathologist (SLP) **People Interviewed:** 1. Ping Law OTR Habilitation Therapies Director 2. Brandi Rabe CCC-SLP 3. Ten DSP staff (Trinity, San Antonio, Three Rivers, Four Rivers and Leon) **Meetings Attended/Observations:** 1. Observations on Leon, San Antonio, Three Rivers, Four Rivers, and Leon
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 10/30/12 and Action Plan dated 10/15/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self assessment; 2) the results of the self-assessment; and 3) a self-rating.

	For Section R, in conducting its self-assessment, the Facility: • Did use monitoring/auditing tools. The activities reported appeared to relate to the content in Monitoring Team's reports, but it was unclear how some of this data was being collected. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included a comprehensive assessment audit tool. o This monitoring/audit tools did not consistently include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. For example, the monitoring tool guidelines instructed the reviewer to review individual-specific assessments. o The Self-Assessment did identify the sample(s) sizes and identified the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The self assessment did not include staff responsible for conducting the audits/monitoring nor evidence that they had been deemed competent in the use of the tools. • The Facility consistently did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did present findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. The Facility rated itself as being in compliance with none of the provisions of Section R. This was consistent with the Monitoring Team's findings of noncompliance with all provisions of Section R. The Facility data did identify areas of need/improvement. However, for these areas of need, the Facility Self-Assessment did not consistently provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. The Action Plan updated 10/15/12 identified the action steps that RSSLC was involved in to potentially reach compliance. The steps were clear and provided information regarding the projected completion date as well as current status. Use of this format should assist RSSLC in better being able to identify their current status and the future areas that still require attention and improvement.

	Summary of Monitor's Assessment: RSSLC showed overall improvement with Section R. Recent assessments were noted to be much more comprehensive and provided a much clearer picture of the individuals' level of functioning. An area of the assessment process that still required improvement was the transfer of the information acquired through the assessment process into functional and meaningful goals that can be applied to a variety of situations. General area communication devices were in the process of being reviewed and implemented in a more functional manner and the Monitoring Team looks forward to seeing how review of these systems impact the lives of the individuals at RSSLC. Direct and Indirect programs continued to need to be expanded to those Individuals who are most in need. Monitoring of these programs once in place was also an area that was in need of review to ensure appropriateness. Provision R.1: This provision was determined to be not in compliance. This provision of the Settlement Agreement includes a number of requirements that are addressed in subsequent provisions within Section R and which have the ability to affect compliance of this provision with the Settlement Agreement. This provision addresses compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. Compliance in Provision R1 related to the adequacy of clinicians must be determined by compliance in Provisions R2 through R4. RSSLC increased their number of SLPs to six on campus for which one was dedicated to dysphagia. This resulted in a ratio of 1:59, which was within the RSSLC identified optimal staffing of 1:60. Presence of SLPs at meetings in which their expertise would be required was inconsistent but should improve as a result of RSSLC obtaining full staffing. 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. DSPs interviewed were not knowledgeable of the communication programs. Additionally, AAC devices (individualized as well as common area) were not consistently utilized. Provision R.4: This provision was determined to be not in compliance. RSSLC had a list of shared devices and monitoring process that tracked the presence and working condition, but review of effectiveness of the AAC equipment was missing. Missing from the Monitoring Policy and/or process was monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work).

#	Provision	Assessment of Status	Compliance

#	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.	Sample #1 was chosen from the list of individuals who were diagnosed with an aspiration or choking event since the previous compliance review. The sample consisted of six individuals who accounted for 36% of the individuals who experienced an aspiration event and 100% of the individuals who had a choking event. Sample #2 consisted of four individuals chosen from a list provided by RSSLC of individuals who were provided with PNMT comprehensive evaluations. The sample consisted of approximately 80% of those who received evaluations in the last two months. Sample #3 consisted of one individual or 33% of the individuals who were newly admitted since the previous compliance visit. Sample# 4 consisted of six individuals or 18% of the individuals identified by the Facility with severe expressive or receptive language disorders. Sample #5 consisted of six individuals or 33% of the individuals receiving direct speech services. Sample #6 consisted of six individuals or 33% of the individuals with a PBSP and communication deficits. Sample #7 consisted of 10 individuals or 40% of the Communication assessments completed since August 30, 2012. Sample #8 consisted of five individuals or 8% of the individuals with personal AAC devices. This provision of the Settlement Agreement includes a number of requirements that are addressed in subsequent provisions within Section R and which have the ability to affect compliance of this provision with the Settlement Agreement. This provision will address compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed in Provision R.2. Staff training will be addressed in Provision R.3 and the Facility's monitoring system will be presented in Provision R.4. Compliance in Provision R1 related to the adequacy of clinicians must be determined by compliance in Provisions R2 through R4. <u>Staffing:</u> At the time of the review, RSSLC had five full time Speech Language Pathologists plus one SLP who was assigned to the PNMT.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The current ratio of therapist to client was 1:59. This ratio should allow for the appropriate follow up or involvement of the SLP in all facets of the individuals care. Per policy K.06.1, the recommended staffing ratio was 1:60. Presence of SLPs at meetings in which their expertise would be required was inconsistent but should improve as a result of RSSLC obtaining full staffing. <u>Qualifications:</u> The Facility did document appropriate qualifications for licensed SLPs. • Six of six staff (100%) were licensed to practice in the state of Texas. • Six of six staff (100%) had evidence of ASHA certification. <u>Continuing Education:</u> Documentation of continuing education courses was not provided by RSSLC; however continuing education was completed by staff as evidenced by all therapists being in good standing with the national and state level boards. <u>Facility Policy:</u> RSSLC had a localized Communication Services Policy (K.06.1 Staffing Effectiveness and K.06.2 rev2-1-2012 and Speech-Language Pathology Services rev 8-1-2012). The policy contained the following components: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Timelines for completion of new admission assessments, Community Living Discharge Planning, and annual ISPs) • Criteria for providing an update • Outlines assessment schedule. • Frequency of assessments/updates. • Documentation standards related to intervention plans. • Addressed a process for effectiveness monitoring by the SLP. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. Although the Facility had achieved a staffing level that allowed an acceptable ratio of qualified clinicians to individuals served, and had a localized policy that covered the responsibilities of professionals, issues raised in the remainder of the provisions make clear that these have not yet resulted in meeting the requirements of this provision for conducting assessments, developing and implementing programs, training staff, and monitoring program implementation.	
R2	Commencing within six months of	<u>Assessment Plan:</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Policy K.06.2 Speech Language Pathology Services that outlined the assessment process was provided to the Monitoring Team. Per the policy, beginning July 2012, regardless of the last time of assessment, all individuals will be assessed with the Comprehensive Communication Evaluation prior to the annual meeting. This would ensure all individuals had received a new comprehensive assessment by July 2013. Thereafter, an annual communication update would be prepared for each individual receiving direct therapy services or those using individualized augmentative communication devices. Per review of new admissions (sample #3): • One of one individual (100%) received a communication screening or assessment within 30 days of admission or readmission. <u>Communication Assessment:</u> Per generally accepted clinical standards, a comprehensive assessment should contain the following elements, at a minimum: • Signed and dated by the clinician upon completion of the written report • Dated as completed 10 days prior to the annual ISP • Diagnoses and relevance of impact on communication • Individual preferences, strengths, interests, likes, and dislikes • Documentation of how the individual's communication abilities impact their risk levels • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. • Evidence of observations by SLPs in the individual's natural environments (day program, home, work) • Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were non-verbal • Discussion of the expansion of the individual's current abilities • Discussion of the individual's potential to develop new communication skills • Effectiveness of current supports, including monitoring findings • Comparative analysis of health and functional status from the previous year • Comparative analysis of current communication function with previous assessments • Identify need for direct or indirect speech language services • Reassessment schedule • Monitoring schedule • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits	

#	Provision	Assessment of Status	Compliance
		• Factors for community placement and a determination of the most appropriate living environment • Recommendations for services and supports in the community • Manner in which strategies, interventions, and programs should be utilized throughout the day. Based on review of 39 assessments (Samples #1, #2, #3, #4, #5, #6 and #7), 24 of 39 (61%) individuals had comprehensive assessments that contained each of the elements listed above. Those assessments that were not considered to be comprehensive did not include the following elements: • Manner in which strategies, interventions, and programs should be utilized throughout the day • Factors for Community Placement • Provided in a timely manner prior to the ISP Another concern noted by the Monitoring Team continued to be the 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 individual expresses themselves and work around those strengths to build a communication system. <u>SLP and Psychology Collaboration:</u> Based on review of six records for individuals in Sample #6 the following was noted: • Three of six (50%), communication assessments and PBSPs reviewed addressed the connection between the PBSP and the recommendations contained in the communication assessment. Individuals #302 and #379 had communication goals that focus on the use of manual signs to improve expressive and receptive language but there was no integration of this method of communication into the PBSP. • Three of six (50%) communication assessments reviewed contained evidence of review of the PBSP by the SLP. A concern that continued to be noted by the Monitoring Team was the lack of	

#	Provision	Assessment of Status	Compliance
		identification of those individuals who experienced both a target behavior and communication deficit. The list provided by RSSLC listed 33 individuals as needing behavioral and communication supports were inaccurate as the Monitoring Team found many more individuals who were identified as having both behavior/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 and adaptable to a variety of settings.	<u>Integration of Communication in the ISP:</u> Based on review of the ISPs for 27 individuals in Samples #1, #2, #3, #4, and #7 the following was noted: • In 21 of 27 ISPs reviewed (77%) for individuals with communication needs, an SLP attended the annual meeting. • In 16 of 27 ISPs reviewed (59%), the type of AAC and/or communication supports was identified. • In 16 of 27 ISPs reviewed (59%) a description of how the individual communicated, including the AAC system if they had one, was included. • Four of 27 ISPs reviewed (14%) included how communication interventions were to be integrated into the individual's daily routine. • Fourteen of 27 ISPs reviewed (51%) contained skill acquisition programs to promote functional communication. • Five of 27 ISPs reviewed (18%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. Upon review of attendance at individuals' ISPs, SLPs were not consistent in their attendance and therefore participation. Per 11 ISPs for Samples #1, #2 and #3, the SLP only attended five of 11 meetings or 45% of the meetings. This may be a factor contributing to the lack of ISP integration. <u>Individual-Specific AAC Systems:</u> Per review of the AAC list provided by RSSLC, RSSLC had 58 individuals with either AAC or Environmental Control (EC) devices. Recommendations were limited to how individuals who did not have individualized AAC devices could utilize the common area devices; when recommendations were provided they were vague and did not provide clear direction as to how and when individuals would utilize such devices. Personal AAC devices ranged from high tech (dynavox) to low tech (communication books). Observations were conducted in various locations for individuals with AAC systems in Sample #8. Findings included the following:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• AAC systems for three of eight individuals (37%) were present. • AAC systems for two of eight individuals (25%) were noted to be in use. • AAC systems for eight of eight individuals (0%) were portable but not utilized. • AAC systems for eight of eight individuals (100%) were functional but again not utilized. • For five of eight individuals with AAC systems (63%), staff instructions/skill acquisition plans related to the AAC system were available. <u>General Use AAC Devices:</u> RSSLC had shared devices scattered throughout all homes and work environments. Since the previous visit, RSSLC restructured their attempt at providing general AAC to individuals. Per the HT director, RSSLC was focusing on a per unit approach in which the AAC needs of the individuals residing at that home would be taken into consideration when installing general AAC. As of this review, the focus was as follows: • Trinity and Leon focused more on the use of general AAC devices to promote receptive language. • San Antonio focused more on the use of general AAC devices to promote expressive language. This was a relatively new process and will be reviewed during subsequent visits. It should be noted that many new switches and environmental control devices were observed in day programming but as stated above, these devices were just recently implemented and will be reviewed further at the next compliance visit. Observations were completed in Trinity, San Antonio and Leon to determine the presence and use of general AAC devices. Findings included the following: • Three of the three homes (100%) had general use AAC devices present in the common areas. • Four of the 10 general use AAC devices (40%) noted contained clear directives on how staff should use these devices. • Four one of four general use AAC devices (100%) noted had a clear function within that setting/situation. • Zero of four general use AAC devices observed (0%) were used by individuals during situations in which use of devices were appropriate (i.e., mealtime, bathing, going outside). <u>Direct Communication Interventions:</u> Overall, 11 individuals were receiving direct services by the SLPs at the time of the review. Direct communication-related intervention plans for individuals included in	

#	Provision	Assessment of Status	Compliance
		Sample #5 were reviewed. Generally accepted practice standards for comprehensive progress notes related to communication interventions include: • Contained information regarding whether the individual showed progress with the stated goal. • Described the benefit of device and/or goal to the individual. • Reported the consistency of implementation. • Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. Documentation of SLP review for one of six individuals (16%) was comprehensive as per the indicators outlined above. The progress reviewed that were not comprehensive were missing the following: • Described the benefit of device and/or goal to the individual. • Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. • Contained information regarding whether the individual showed progress with the stated goal. <u>Indirect Communication Supports:</u> Programs for individuals who received indirect communication supports included in Sample #4 were reviewed. • Quarterly documentation for six of six individuals (100%) contained information regarding whether the individual showed progress with the stated goal(s). • Quarterly documentation for zero of six of individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for one of six individuals (12%) identified consistency of implementation. • Quarterly documentation for one of six individuals (12%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. <u>Staff Interviews:</u> Findings from the ten staff interviews and observations conducted on Trinity, Three Rivers, Four Rivers and Leon included the following: • In three of ten interviews conducted (30%), direct support professionals stated whether the individual had an AAC system. • In two of ten interviews conducted (20%), direct support professionals stated whether there was a communication program.	

#	Provision	Assessment of Status	Compliance
		• In one of ten interviews conducted (10%), direct support professionals described the communication program goal. • In one of ten observations (10%), direct support professionals implemented the communication program as written. • In two of ten interviews conducted (20%), direct support professionals showed where, when, and how data was recorded for the program. • In one of ten interviews conducted (10%), direct support professionals described the schedule for implementation of the communication program. • In one of ten interviews conducted (10%), direct support professionals identified how communication skills in the program were addressed throughout the day. • In four of ten interviews conducted (40%), direct support professionals stated that they had received individual-specific training for the program and/or AAC. • In zero of ten interviews conducted (0%), direct support professionals described individual-specific communication strategies as identified in the individual's PNMP, ISP, PBSP, and/or Communication Dictionary. <u>Competency-Based Training and Performance Check-offs:</u> Staff was provided with Core Competency training during new employee orientation in which AAC was a component. Staff also received another class titles "Use of AAC and Maintenance" which addressed AAC components. All staff was required to participate in the class through group exercises (i.e., activation of devices). In-service training was provided by the SLPs upon the introduction of a new communication system and return demonstration of implementation was required. There was no annual refresher provided related to communication. While the interactions of staff with the individuals were generally positive, much of the interaction observed by the Monitoring Team was specific to a task, with little other interactions that were meaningful, such as during a meal. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology), should be made a priority. Based on review of the NEO training curriculum and observations, direct support professionals, PNMPCs and therapy aides were provided with some level of AAC and Communication training but as of this review only 6% of staff had received the core Competency Training as this process was newly implemented. New Employee Orientation (Core Competency Training) and individual training included: • Methods to enhance communication	

#	Provision	Assessment of Status	Compliance
		• 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. • Adequacy of skill performance check-offs While the NEO training appeared to meet basic standards, missing from the process was the ability of Speech Staff to have the needed presence at the homes to model and guide staff through real life activities and situations. This is an area; however, that appears to be showing improvement since full staffing has been achieved. RSSLC had recently developed "Core Competency" Training that was intended to improve hands on training with many aspects of care including communication. As of this compliance review, only 6.3 % had received this new training class.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	<u>Monitoring System:</u> The monitoring system consisted of monthly PNMP monitoring that included communication. These were generally conducted by the PNMPCs to check for availability, condition, and working order. RSSLC Universal Monitoring Policy (K.07 rev 3.1.2012) defined the following: • Monitoring for the presence of communication adaptive equipment or other AAC supports/materials. • Monitoring for the working condition of communication adaptive equipment. • The frequency of monitoring. • The process for identification, training, and validation for monitors. • The process of inter-rater reliability. Missing from the policy was: • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work). The policy appeared to be sufficient in providing guidance regarding the monitoring process. Based upon review of monitoring data, communication monitors were completed at the level identified as part of the monitoring policy. The Facility did not provide monitoring reports analyzing and trending results from the Compliance Monitoring forms	Noncompliance

#	Provision	Assessment of Status	Compliance
		One of seven Individuals in Sample #5 was provided with consistent efficacy monitoring or review of progress. Missing from the notes were: • Benefits of the device or program • Progress with the device or program • Information regarding generalization of device and/or program Based upon observations, the amount of monitoring conducted by RSSLC did not appear to have an impact at the level of the home. Individuals were not observed consistently utilizing their personal AAC devices or general area devices.	

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

1. Individual communication programs should be integrated into ISPs through skill acquisition programs, as well as PBSPs (when appropriate), to ensure the communication strategy and AAC device is meaningful to the individual and the individual can communicate and be an active participant in multiple environments (Provision R.3).
2. Staff would benefit from increased hands on modeling of the use and integration of devices with normal daily contexts by the PNMPCs and the SLPs. (Provision R.3)
3. Communication Goals should be followed by the SLP at a level that allows for consistent review of progress with goals and objectives. (i.e., at least on a monthly basis if service is direct and quarterly if indirect). (Provision R.2)
4. Communication Assessments must do a better job at identifying methods to enhance communication in the contexts of a 24 hr day. (Provision R.1)
5. A monitoring system needs to be developed that not only outlines the frequency in which the presence and working condition of devices will be tracked but outlines the frequency for effectiveness monitoring by a licensed speech therapist. (Provision R.4)
6. Speech Therapists should review individuals who have indirect supports a minimum of quarterly to ensure communications programs and devices remain appropriate and meaningful. (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 10/30/12 2. RSSLC Action Plans 10/15/12 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 #23, #73, #173, #180, #216, #382, #484, #552, #574, #579, #600, and #758. **People Interviewed:** 1. Cynthia Fannin – Director of Education and Training 2. Bobby Buckner, MS, BCBA – Director of Behavior Services 3. Approximately 30 direct care staff in the following residences and day treatment areas: Angelina, Lavaca, Leon, Neches, Pecos, San Antonio, San Jacinto, Trinity, and all vocational settings **Meeting Attended/Observations:** 1. ISP annual planning meeting for Individual #465 – 11/14/2012 2. The following residences and day treatment areas: Angelina, Lavaca, Leon, Neches, Pecos, 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. In relation to the Self-Assessment, the following circumstances were noted: • Provision S1 o The review process used by the Monitoring Team for Provision S1 focuses upon the content and quality of the skill acquisition programs (SAPs), as well as whether the SAPs are supported by assessments and the ISP. The Facility, however, placed considerable emphasis upon the training provided to staff. While there is no question that training is critical to the quality of SAPs, the Facility's emphasis upon training in Provision S1 provided minimal information for the Facility in regard to complying with specific elements of the Provision. o Where the Facility did conduct a record review in relation to SAPs and assessments, it was

	not stated what tool was used to conduct the record review. Furthermore, part of the record review focused only upon the work of a single QDDP, substantially limiting the scope of the Self-Assessment. o The findings reported by the Facility for Provision S1 were substantially more positive than those obtained by the Monitoring Team. In one area, the Facility reported that half of SAPs were personalized. Elsewhere in Provision S1, the Facility reported that, "0 of 10 records reviewed reflected a lack of personalized assessments, programs and skill acquisition programs." The Facility provided data regarding the Self-Assessment activities, but those data were inconsistent with record reviews conducted by the Monitoring Team. The Facility is encouraged to conduct the Self-Assessment process with objectivity and to maintain adherence to strict criteria. Without objectivity and strict criteria, ratings often reflect unrealistically optimistic appraisals. • Provision S2 o The review process used by the Monitoring Team for Provision S2 focuses upon whether annual assessments are conducted. Much of the review conducted by the Facility for this Provision, however, focused upon whether assessments and the ISP supported the SAPs, whether SAPs were individualized, and if supports were identified. The organization and wording in the Self-Assessment for this Provision, however, made it very difficult to determine what specific actions the Facility and completed. For example, one element of the Self-Assessment stated, "Reviewed the data from Section S monitoring tool 06/01/2012 – 08/31/2012 to include Psychological and Behavior Assessment." Although this statement referenced the monitoring tool, it was not clear exactly how the tool had been used or for what purpose. • Provision S3a o The review process used by the Monitoring Team for Provision S3a focuses upon the efficacy and practicality of SAPs at the Facility. In regard to Provision S3a, the Facility reported that record reviews had been conducted to determine if "supports developed support the individual's needs", although it was not indicated how this review was completed, how the sample was selected, or what criteria were used to determine SAPs were supported by assessments. • Provision S3b o The review process used by the Monitoring Team for Provision S3b focuses upon the opportunity for learning and other activities in the community. In this Provision, the Facility reported the use of specific tools (the Trip Tracking Tool), as well as specific numbers of individuals who had participated in training and activities in the community. While the Facility reported that 946 individuals had participated in SAP training in the community between 6/1/2012 and 9/30/2012, there was no mention of the type of skills taught or how well the SAPs were 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 of tasks the Facility would complete, such as purchase materials or track data. There was no indication, however, of

	how these tasks were to be conducted, what the intended outcome was, or how the results of these tasks would be measured. As a result, it was unclear how these tasks would produce greater success in complying with the Settlement Agreement. Based Upon the Self-Assessment and Action Plan, it was evident that the Facility had not yet fully implemented a functional self-assessment process that matched the requirements of the provisions. It is recommended that RSSLC review the current report to identify the provision requirements assessed by the Monitoring Team, identify gaps between current status and what would meet those requirements, and use that information to produce a self-assessment process that is useful and produces a more cohesive approach to complying with the Settlement Agreement.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 11/12/2012 through 11/16/2012. 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. Despite the lack of substantial progress in the specific Provisions, there was an area in which the Facility had achieved progress. In comparison with the previous site visit, the Facility had increased the degree to which individuals were provided the opportunity for functional engagement. In Leon and Pecos residences, the level of functional engagement often rose to 75% or greater. In campus vocational settings, the level of engagement was often above 85%. Furthermore, the vocational settings often demonstrated sophistication in accommodating changes in routine without disrupting engagement. Although this increase in engagement was a positive step, it reflected progress only in comparison with the immediately previous site visit. The levels of engagement noted in October 2011 were roughly the same as those observed during the current site visit. Although there had been an increase in engagement, the provision of formal teaching had not substantially increased. Observations did not reveal staff implementing SAPs. Although staff were observed at times providing prompts or praise, these actions were not performed in a systematic manner and did not target specific skills or behaviors. Substantial weaknesses were also revealed in the SAP development process. A variety of assessment reports were often submitted as part of the annual ISP process. In many cases, however, neither the ISP nor the SAPs reflected that the needs identified in assessment reports had been targeted for training. SAPs, likewise, did not reflect the use of a task analysis. Several SAPs did include steps. The steps in many of those SAPs, however, were not taken from the task analysis assessments found in the record. Overall, there was little indication that the SAP development process consisted of a cohesive and systematic approach to identifying individual needs and developing teaching methodologies to address those needs. There were also indications of weaknesses in the data collection and outcome monitoring procedures. Discrepancies were noted between data collection sheets, data summaries, and progress notes. For some

	individuals, historical data changed from one progress note to the next. There were also examples where individuals had continued on the same step of an SAP for well beyond the required number of months despite having demonstrated mastery of the skill. Based upon information obtained from observations, interviews, and record reviews, it was apparent that skill acquisition training at RSSLC did not approach the requirements of the Settlement Agreement. Without adequate assessments, the integration of individualized assessment into the SAP development process, and a valid and reliable means of collecting teaching data and monitoring progress, it remains unlikely that individuals living at RSSLC will develop the skill necessary for greater independence.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Use of Assessment Information in Planning Skill Acquisition 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. Historical Perspective 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. In May 2012, a sample of 26 ISPs and corresponding SAPs reflected no indication that assessment information was used in the development of skill acquisition programs. It was also noted that none of the ISPs included in the sample involved formal assessment of preferences or reinforcers. 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. Current Site Visit At the time of the current site visit, a sample of two Skill Acquisition Programs (SAPs) was selected from each Unit at RSSLC. The Facility was asked to provide for each SAP the most recent ISP, Functional Skills Assessment (FSA), preference assessments, and assessment reports from each discipline, as well as the data sheets and progress notes for the SAP. The	Noncompliance

#	Provision	Assessment of Status	Compliance

table below reflects the degree to which assessments were utilized as part of the ISP process in the development of the sampled SAPs.

	5/2010	5/2012	11/2012
Skill acquisition plans are implemented to address needs identified in:	0%	0%	0%
ISP	0%	0%	0%
Adaptive skill or habilitative assessment	0%	0%	0%
Psychological assessment	0%	0%	0%
Skill acquisition plans are chosen in an individualized manner.	0%	0%	0%
Skill acquisition plans are related to the individual's preferences.	0%	0%	0%

Based upon the sampled SAPs and related materials, there was no indication that assessment information was used in the development of skill acquisition programs. There were indications that assessment data had been reviewed during the ISP process for several individuals. None of the reviews documented in ISPs in the sample, however, included information specific to the SAPs, such as assessment findings or documentation that IDT discussions had encompassed skills targeted by the SAPs.

- For Individual #73, the ISP indicated that an SAP would be continued relating to the self-administration of medication (SAM). The SAP in question involved allowing staff to guide the individual through applying a facial cream. The FSA did not address skills in this area. No task analysis was conducted for the skill. Both the SAM and Nursing assessments indicated the individual required physical guidance to complete the application of facial cream. The ISP did not reflect any discussion of the fact that the SAP in question had been ongoing for at least a year with no substantive changes in performance. Furthermore, the ISP did not address why an SAP was implemented for passive cooperation with a task without the inclusion of an adequate task analysis.

Only one individual in the sample of SAPs, Individual #600, had been provided a formal assessment of adaptive skills within the year prior to the ISP. There was no indication in the ISP document that this assessment had been considered in the development of the SAPs. For the nine remaining individuals in the sample, 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. Many of the individuals in the sample (six of 10

#	Provision	Assessment of Status	Compliance
		individuals, 60%) 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 (0%) 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) 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. 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. Based upon information obtained in the review process, it was clear that the Facility had not integrated 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. <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 10 SAPs was selected. The table below	

#	Provision	Assessment of Status	Compliance
		reflects the degree to which SAPs included the necessary components.	

Area	5/2010	5/2012	11/2012
Plan reflects development based upon a task analysis	0%	0%	30%
Behavioral objective(s)	0%	0%	40%
Operational definitions of target behavior	0%	0%	0%
Description of teaching conditions	0%	0%	0%
Schedule of implementation comprised of sufficient trials for learning to occur.	0%	0%	0%
Relevant discriminative stimuli	0%	100%	80%
Specific instructions	0%	0%	10%
Opportunity for the target behavior to occur	0%	100%	60%
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%	0%	0%

*However, as noted below, the consequences were not individualized, and were not based on a preference or reinforcer assessment.

During the previous site visit in May 2012, two elements relating to SAPs were consistently satisfactory--the presentation of discriminative stimuli and the opportunity for the targeted skill or behavior to be displayed by the individual. SAPs reviewed during the current site visit, however, did not reflect that the Facility had continued the previous level of performance. Relevant discriminative stimuli, such as prompts to begin, were included in eight of 10 (80%) of sampled ISPs. Only six of the 10 sampled SAPs (60%) included the opportunity for the target behavior or skill to be displayed by the individual involved in the SAP. The lack of evidence of satisfactory performance may have reflected an actual performance decline or may have been due to the samples selected during the previous and current visit. In either case, the findings from the sample do not reflect adequate development of SAPs.

RSSLC did demonstrate modest improvement in regard to behavioral objectives. Four of the 10 SAPs included in the sample (40%) included an Objective statement that reflected behavioral language. This was an improvement, as none of the SAPs during the previous site visit included a behavioral objective. A valid Objective statement, however, 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 elsewhere, SAPs reviewed during the current site visit lacked individualized task

#	Provision	Assessment of Status	Compliance
		analyses and other assessments. 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 for the majority of SAPs. • Individual #484 was provided an SAP to enhance choice-making. The Objective for the SAP stated, "By 11/7/12, when instructor provides hand over hand guidance with [Individuals] left hand, [Individual] will feel a choice of four items to engage in for 20 minutes 4 out of 5 trials for 3 reporting periods." Although this statement provided the semblance of a behavioral objective, it was unclear if the individual was required to feel the items, feel and select an item, or use an item for 20 minutes. Other than the issues noted above, RSSLC achieved minimal to no progress in the majority of elements relating to teaching new skills. These areas are discussed below. <u>Task Analyses</u>: 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 similarity across task analyses at RSSLC suggested that there was no individualized assessment. Therefore, it could not be said that SAPs were based upon individualized task analyses. In addition to the similarity of task analyses, the record review revealed that not all records included at least a task analysis protocol. In May 2012, although not of adequate quality, each record had included some form of a task analysis. During the current site visit, documentation for only six of 10 individuals (60%) in the sample provided by the Facility included some form of a task analysis protocol. This was substantially less than that obtained during the previous site visit, suggesting that it was no longer routine practice to complete a task analysis. It was also noted, in those individuals for whom a task analysis was provided, that the steps in the task analysis protocol often did not match the steps for training included in the SAP. As stated above, the intent of the task analysis is to break down a complex task into steps that will then be used to teach the skill. In several circumstances, it was obvious that the steps included in the assessment were not used in the development of the teaching methodology.	

#	Provision	Assessment of Status	Compliance
		Based upon information obtained during the site visit, it was evident that the Facility did not effectively conduct or use task analyses. As a task analysis is essential to the development of effective training programs, the current circumstances reflected an inability to provide adequate SAPs to the individuals living at RSSLC. Operational Definitions: An operational definition of a behavior is a description of the behavior in observable and measurable terms. Such a definition should include a description of the movements used to perform the behavior, as well as parameters of the behavior such as frequency, duration and intensity. In addition, an operational definition should be objective (based only upon observable actions), clear (sufficiently precise to allow anyone to consistently measure the behavior with accuracy), and complete (explicitly indicating the boundaries between what is and is not the behavior). Furthermore, 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 includes in the SAPs reflected operational definitions. 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 set up 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 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	

#	Provision	Assessment of Status	Compliance
		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. • Individual #484 was blind. The instructions for implementing the Individual's SAP provided no accommodations for the lack of vision, and in fact required the individual to "look at" and "study" objects that were presented. <u>Consequences for correct and incorrect responses</u>: The SAPs included in the sample contained the provision for a specific response to follow a successful display of the target behavior. All 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 would 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 or offer prompting. As each individual presents different strengths and needs for support, the instructions for incorrect responses should be specifically tailored for the needs of each individual. Furthermore, there were no instructions provided on how to address situations in which the complete prompting hierarchy was attempted without gaining a correct response or when the individual actively resisted prompting. <u>Generalization and Maintenance</u>. 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. | | 5/2010 | 5/2012 | 11/2012 | | Overall, the set of skill acquisition programs promote growth, development, and independence | 0% | 0% | 0% | Based upon the information obtained from the sample of 10 SAPs and related documents, it was apparent that staff at RSSLC did not demonstrate the skills and sophistication necessary for the development of skill acquisition training programs. The weaknesses noted during the review illustrated the following more global issues at the Facility in	

#	Provision	Assessment of Status	Compliance
		relation to SAPs. • Staff did not integrate assessments from multiple sources and identify the most salient needs of the individual. As a result, the legitimate training needs of individuals were often overlooked while less functional behaviors were included in SAPs. • Staff did not identify the training methodology best suited to the behavior or skill being taught. All skill acquisition programs that were reviewed at RSSLC were described as using either forward chaining or backward chaining teaching methodologies. Although chaining procedures can be very effective, they are not appropriate for all skills and all circumstances. In many instances, it is more appropriate to use total-task training, discrete trial training, match-to sample approaches, informal teaching or other procedures. Furthermore, despite the description of the methodology, it was not clear that program authors understood the concepts of forward and backward chaining, or when each should be used. o For Individual #579, the SAP targeted toileting from walking to the bathroom to post-voiding hygiene. The skill was being taught using forward chaining and the individual was currently on step one, walking to the bathroom. In this situation, forward chaining would be less desirable than backward chaining because, if the person fails step one, there is no opportunity for correction, a second trial, or an attempt at errorless learning. o For Individual #600, the SAP addressed asking for assistance when working. Although this was described as a forward chaining program, there were no steps in the SAP. A task analysis was included, but the task analysis consisted of a series of discrete tasks that did not form a larger, more complex skill. It would have been more appropriate to teach the identified skill through discrete-trial training or total task training. • Staff did not accurately compile training data, organize those data into graphs, and determine when progress had occurred. For several individuals there were errors such as graphs not matching data sheets, historical data changing from month-to-month, statements of progress when no progress had been made, and SAPs continuing at the same step for several months despite documented mastery. As a result, it was difficult to determine whether an SAP was facilitating learning for any individual. o For Individual #484, the SAP indicated there were to be two trials per session. The data collection sheet only allowed for one trial. o For Individual #574, the SAP continued at the same step for over six months at 100% mastery. o For Individual #23, the individual met success criteria for two consecutive months. On the third month, success was graphed as zero although the	

#	Provision	Assessment of Status	Compliance

individual had been provided no training opportunities. On the fourth month, training resumed at the same step. At the end of the fourth month, the individual was rated as making progress rather than completing the step although the criteria of mastery for three months was met.

- For Individual #73, June 2012 data sheets showed 12 successful trials while the summary stated eight of eight trials were correct and the graph reflected 60% success. September 2012 data sheets documented nine correct trials, but the summary stated zero of eight trials were correct. October 2012 data sheets documented three correct trials, but the summary stated zero of eight trials were correct.

Based upon the materials provided by the Facility at the time of the current site visit, skill acquisition plans did not include elements that met generally accepted standards of quality needed to make the acquisition or strengthening of skills effective and efficient.

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
Lavaca	1	2	1	50%
Lavaca	3	6	2	33%
Lavaca	3	5	2	40%
Leon	8	8	3	38%
Leon	9	9	7	78%
Pecos	2	4	3	75%
Pecos	2	10	9	90%
San Antonio A	2	3	1	33%
San Antonio A	8	13	5	38%
San Antonio B	1	4	1	25%
San Antonio B	1	8	3	38%
San Antonio C	2	5	2	40%
San Antonio D	1	5	1	20%
San Jacinto	1	5	2	40%

#	Provision	Assessment of Status	Compliance

Trinity A	4	8	1	13%
Trinity B	2	4	0	0%
Trinity D	4	10	4	40%
Work Activity	3	9	8	89%
Work Activity	6	24	3	13%
Work Activity	4	7	6	86%
Work Activity	6	14	13	93%
	73	163	77	
Total percentage of individuals functionally engaged				47%
Percentage of locations with greater than 50% functional engagement				29%

During the current site visit, observations reflected that 29% of locations involved functional engagement by more than 50% of the individuals present in that location. Furthermore, approximately 47% of the individuals observed were engaged in some type of formal or informal functional activity. While this did reflect an improvement in comparison with the previous site visit, it remained slightly below that noted during the October 2011 site visit.

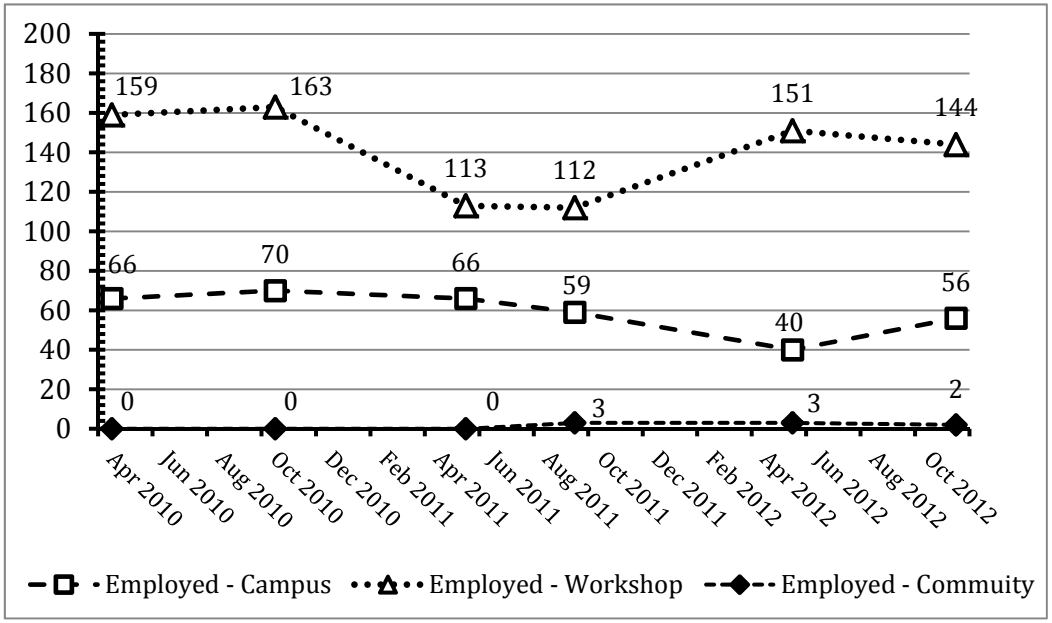
	5/2010	5/2012	11/2012
Total percentage of individuals functionally engaged	50%	23%	47%
Percentage of locations with greater than 50% functional engagement	29%	9%	29%

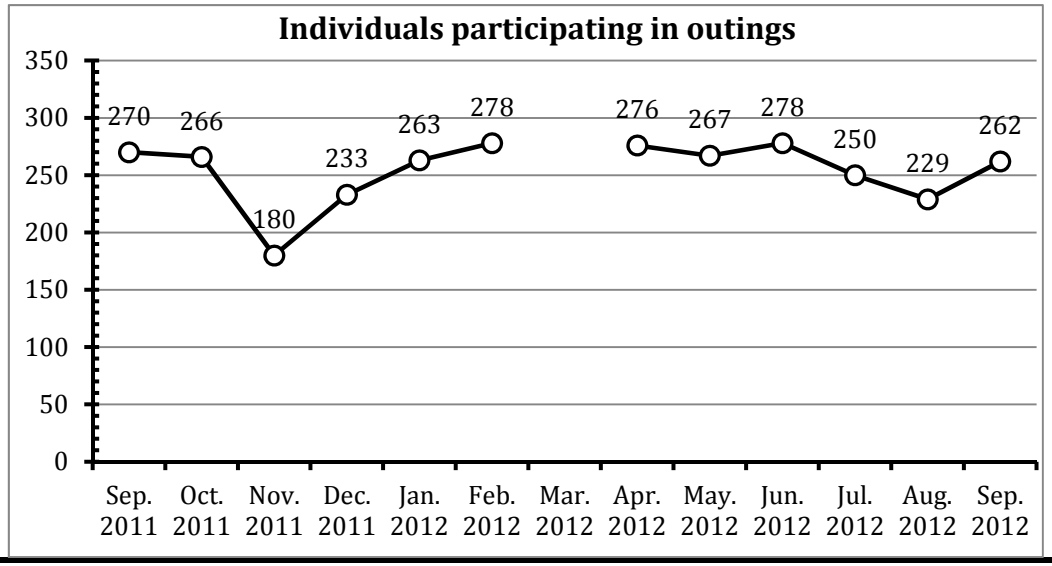
Despite the short-term improvement in functional engagement, there were multiple examples in which individuals were not provided opportunities for choice or learning.

- In the San Antonio dining room, one individual was attempting to eat rapidly. A staff member stood behind the individual, forcefully holding the individual's hands away from the plate. After several seconds, the staff member released the individual's hands and walked away, following which the individual consumed his food very rapidly without further intervention.
- In Trinity A, a group was being guided in singing, "If You're Happy and You Know It". Only one individual was engaged in the singing. One additional individual was sitting in a slouched position with fingers inserted in ears; no alternatives were provided for this second individual.
- In the Lavaca dining room, individuals were required to sit at the same table. One individual moved to a different table, so other individuals were required to move. Also in this dining room, individuals were told to stop using condiments without an opportunity to explain preferences or training to encourage appropriate use of condiments.

#	Provision	Assessment of Status	Compliance
		• In several residences, engagement consisted of providing puzzles, items to manipulate, television, and music. Individuals frequently ignored these activities and were not provided either encouragement or options of other activities. Vocational training activities was the one area in which abundant examples of functional engagement that included training were observed. In this area, staff were observed to use frequent reinforcement and were diligent in ensuring opportunities for meaningful activity. • In one work area, eight of nine individuals (89%) were engaged in work. Staff interacted with the remaining individual, offering prompts and encouragement; the individual soon began working. • In a second work area, staff were informed that materials had run out for an on-going contract. Staff quickly reoriented the room to a different contract, and activities continued without substantial disruption. Although exceptions were noted, in most settings there were not ample opportunities for choice, expression, or learning. Without the inclusion of formal and informal training in routine activities, enduring acquisition and strengthening of skills is not likely to occur. The Facility should act to ensure that teaching and generalization of skills is provided in all environments.	
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 ISP 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. • Many of the individuals in the sample (six of 10 individuals, 60%) 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

#	Provision	Assessment of Status	Compliance
		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 seldom implemented. In many instances, staff failed to demonstrate accurate and skillful implementation of SAPs. 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.	<u>Historical Perspective</u> 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

#	Provision	Assessment of Status	Compliance
		had been provided employment in the community. During the May 2012 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. <u>Current Site Visit</u> During the current site visit, campus employment had increased by almost half to a total of 56 individuals. At the same time, workshop employment dropped to 144 individuals and community employment dropped from three to two individuals.  The Facility continued during the current site visit to provide summarized information regarding community outings made available to individuals living at RSSLC. Although fluctuations were noted, the data reflected relative stability across the previous six months. During previous site visits, RSSLC had reported that skill acquisition training during outings involved implementing Facility SAPs in the community settings. At the time of the current site visit, the Facility indicated that only money management SAPs were being implemented in the community. No money management programs were included in those made available	

#	Provision	Assessment of Status	Compliance
		by the Facility for the Section S review. As money management programs were developed by the same staff who developed the SAPs that were reviewed, it was unlikely that there were substantial differences in quality or content. 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.  	

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

1. The Facility should act to ensure that skill acquisition programs reflect the findings of comprehensive assessments utilizing adequate assessment instruments and procedures. (Provisions S1, S2, and S3)
2. It is essential that skill acquisition programs be individualized, and reflect the needs and preferences of the individuals for whom they are intended. (Provisions S1 and 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 should develop a process to ensure that staff performs to these expectations. (Provision 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. (Provisions S1 and S3)
5. The Facility must ensure that a range of skills is taught in the community rather than only money management skills. (Provision S3)
6. 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. (Provision S3)

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Richmond State Supported Living Center (RSSLC) Self-Assessment, updated 10/30/2012 2. Richmond State Supported Living Center Action Plans, updated 10/15/2012 3. Richmond State Supported Living Center Settlement Agreement Presentation, dated 11/9/2012 4. Section T Presentation Book materials 5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10 6. Draft of updated DADS Policy 018: Most Integrated Setting, undated 7. Draft of DADS Policy 004: Individual Support Plan Process undated 8. RSSLC Policy G.6 Admitting/Moving Individuals: Community Movement, Revised 08/11/11 9. RSSLC Policy G.5 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement, Revised 08/11/11 10. RSSLC Policy G.05.1 Admitting/Moving Individuals: Community Exposure, Revised 09/11/11 11. RSSLC Policy G.6.1 Admitting/Moving Individuals: Post Move Monitoring, Revised 08/11/11 12. RSSLC Policy G.12 Admitting/Moving Individuals: Alternate Discharge, Revised 10/24/11 13. RSSLC Policy G.8 Withdrawal of Referral for Community Movement 8/11/11 14. Community Integrated Discussion Record, revised 03-2010 15. Job Description: Transition Specialist 16. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 17. Since last on-site review, a list of all individuals who have been referred for placement 18. 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” 19. Since last on-site review, a list of all individuals who have died after moving to community living 20. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 21. For the last twelve months, a list of individuals who were reported to have been assessed for placement 22. Community Placement Report, dated Monday, October 08, 2012 23. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 24. Community Transition Process from a SSLC 25. Annual Report: Obstacles to Community Transition, Fiscal Year 2011, Data as of 8/31/2011 26. Obstacles in Moving to a Community Setting, dated Wednesday, October 24, 2012 27. Inclusion of the Designated Local Authority during Living Options Meetings (adopted 5/03/2012) 28. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 29. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #60, #76, #119, #130, #152, #156,#180, #195, #253, #267, #273, #358, #420, #500,

	#529, #551, #568, #584, #604, #651, #709, #754, #760, #779,#785, and #796 30. List of Individuals with ISPs held in November 2012 31. Individual Support Plans (ISPs) and Preferences and Strengths Inventory (PSI) for Individuals #31, #156, #661, #746, and #760 32. ISP and documentation of activities to encourage and assist individuals to move to the most integrated setting for Individuals #51, #363, and #773 33. Completed CLDPs for Individuals #100, #166, #550, #573, and #784 34. Partial CLDPs for Individuals #164, #405, #480, and #508 35. CLDP Assessment Checklist, undated 36. Pre Move Site Reviews for Individuals #100, #119, #128, #166, #193, #210, #261, #290, #550, #573, #615, #673, #713, and #784 37. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #100, #119, #128, #166, #193, #210, #261, #290, #550, #573, #615, #673, #713, and #784 38. Completed Post Move Monitoring (PMM) checklists for Individuals #119, #128, #166, #193, #210, #261, #290, #353, #550, #573, #615, #673, #713, and #784 **People Interviewed:** 1. Cynthia Newton, Transition Coordinator 2. Terri Carter, Post Move Monitor 3. Latonya Akorede, Transition Specialist 4. Stacey Burdue, Acting QA Director 5. David Savage, QA Auditor **Meetings Attended/Observations:** 1. PMM visit for Individual #100 2. ISP annual planning meetings for Individuals #165 and #465 3. Pre-ISP meeting for Individual #251 4. CLDP for Individual #369 5. Self-advocate meeting
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. 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. For Section T, in conducting its self-assessment, the Facility had not consistently used monitoring/auditing tools up to this point except in a few instances. Much of the process was focused on whether the Facility had completed certain tasks and not on whether they had produced the desired outcomes. It was noted that there was a very thoughtful approach to the Facility's assessment of why compliance had not been achieved which was often, although not always, consistent with the Monitoring Team's assessment. The Facility should use this portion of the self-assessment to further develop a set of outcome indicators that it

	believes would be likely to lead to substantial compliance based on its own experience and the findings and recommendations in the Monitoring Team's report. The Facility also provided as part of its self-assessment an Action Plan that reported a large number of actions being taken or planned to achieve compliance. Once it develops its outcome indicators, the Facility should review these actions to ensure they are focusing on those most likely to support the identified outcomes. **For Provision T1**, the Facility indicated it was not in full compliance with his provision, but it did report it had achieved some level of compliance for Provision T1c2 which requires the Facility to specify the SSLC staff responsible for CLDP actions, and the timeframes in which such actions are to be completed. The Monitoring Team concurred with Facility findings of both substantial compliance and noncompliance for subprovisions. **For Provision T2**, the Facility self-rated substantial compliance in Provision T2a due to timely completion of all PMM visits and reports, high compliance scores on the Section T monitoring tools and IDT review of all PMM reports. The Monitoring Team could not substantiate compliance, largely due to serious concerns related to the one death that occurred in the community. The Monitoring Team continues to urge the Facility to 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. The Facility did not complete a self-rating in Provision 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 compliance rating is required. **For Provision T4,** the Facility provided no rating as no alternate discharges had occurred at the time the self-assessment was completed. An alternate discharge did occur in the interim that was not completed in compliance with CMS discharge requirements.
	Summary of Monitor's Assessment: The Monitoring Team continued to find noncompliance for the Section. The Facility had maintained a relatively high level of referral for community living and transition, but more work remained to ensure those transitions were effectively planned and successfully implemented. Positive developments noted included increased integrated discussion by IDTs and the augmentation of transition staffing to enhance education and awareness of community living options as well as increase the pace of transitions once a referral is made. Other specific findings are detailed below: **For Provision T1,** fifteen individuals had transitioned to community living and there were 20 active referrals. The Monitoring Team found substantial compliance in Provision T1c2 which addressed the identification of Facility staff responsible for required CLDP actions and the timeframes in which such actions are to be completed. RSSLC still needed to improve its processes to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an

	individualized education/awareness strategy for each individual that takes in to account their specific learning needs. Continuing deficits in assessments also translated to many instances in which the IDT 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, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits were apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living. The Monitoring Team was encouraged to observe significant progress in the quality of the CLDP integrated discussion by the IDT during this visit, in which discussion was more focused on ensuring the provider staff understood how to implement services and supports rather than on a mere recitation of assessment findings. The Monitoring Team was particularly impressed with the level of specific detail about the individual's characteristics, needs and day-to-day functioning provided in the Positive Behavior Support Plan and encourages IDT members to use this example to help improve the content of their assessments as well. **For Provision T2**, the Facility reported it was in compliance with Provision T2a, but the Monitoring Team did not concur. The Monitoring Team found that the PMM Checklists were completed in a timely manner, but RSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDP. Adverse outcomes during this six month period were reported for eight individuals who had transitioned during the past year, including one death. The Monitoring Team urges the Facility to use the adverse events to examine how it may improve its own CLDP and PMM processes. Given the number, and in at least one case severity, of the adverse outcomes, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months. **For Provision T3**, no rating is required. **For Provision T4**, the Facility was not in compliance. The Facility reported one Alternate Discharge during the past six months, which was not completed in compliance with CMS discharge planning requirements and DADS policy due to some extenuating circumstances. There is potential for such circumstances to recur, so the Facility should review its policy to ensure an appropriate response.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a	Transition Outcomes During Last Six Months: • Community Transitions: There were 15 transitions to community living between the last monitoring visit and early November 2012. • Referrals for Community Transitions: RSSLC had 20 active referrals in process,	Noncompliance

#	Provision	Assessment of Status	Compliance
	criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	according to the Community Placement Report. • Adverse Outcomes Related to Transitions: There had been some significant adverse outcomes in the past six months for individuals who had moved to the community. o Returns from Community Placement: There were no returns from a community placement during this six month period. o Deaths Following Community Placement: There was one death of an individual following a community placement that occurred during this six month period, shortly before the 90th day post-move. See Provisions L1 and T2a. o Unauthorized Departure/Police Contact/Transferred to a Different Setting: There was police contact on two separate occasions for an individual who has transitioned to the parents' home and became aggressive to the mother and father. As a result, the individual moved to a group home setting. Another individual was required to move to a new residence when the provider consolidated operations. A third individual moved to the home of a new provider within three months of transition from RSSLC because the individual's mother felt staff were not sufficiently attentive. o Emergency or unexpected medical hospitalizations: There was one unexpected Emergency Room (ER) visits for an individual who had transitioned during the past six months, whose enteral feeding tube became dislodged. It was reported this was satisfactorily resolved. Two other individuals who had transitioned earlier in the year also required ER care, including one who had two falls requiring stitches. It is notable that eight individuals who had transitioned in the past year had experienced some adverse or unexpected outcome. The Facility should use these data to continually evaluate and improve its CLDP and PMM processes as a part of its formal QA methodologies. Each of these adverse or unexpected outcomes should be examined by the Facility to ascertain whether additional planning, monitoring or technical assistance from the Facility IDTs may have resulted in a more predictable and/or positive outcome. Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting: During this past six months, RSSLC had taken some steps that were intended to assist IDTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs, as evidenced by the relatively high pace of referral and transition. In addition to continuing training of the IDT by the Transition Coordinator, the Facility had hired two Transition Specialists funded by the State's Money Follows the Person grant. Much of the work of	

#	Provision	Assessment of Status	Compliance
		these positions will be to encourage and assist individuals to move to the most integrated setting, as discussed in Provisions T1b2 and T1c below. Conclusion: This provision was found to be not in compliance. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 and F2ab); education for community awareness (see Provision T1b2); and transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not yet be said to be effectively assisting and encouraging individuals to move to the most integrated setting.	
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: At parties' meetings in July 2012, the parties agreed that the Monitors would rate T1b as just the development of an adequate policy. The sections T1b1 through T1b3 would be considered stand-alone provisions that require implementation independent of T1b or any of the other cells under T1b. The Facility reported that it had made no changes to transition and discharge policies. There was a pending revision of DADS Policy 018, which is expected to also require modifications to local policies Due to the fact that the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such	Status of Process and Training on ISP Development: The Facility had begun to implement the most recent statewide modification to the ISP process. The Monitoring Team was asked to focus primary attention on two ISPs held during the site visit as an indication of the direction the Facility was pursuing. As discussed further in Provision F1e, throughout Provision F2, and below, these early examples did not reflect any significant progress. Consultants continued to provide training on this new process, but additional training was still 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. Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting: As noted above with regard to Section F of the Settlement Agreement, although RSSLC had continued to make efforts to improve ISPs, the Facility remained out of substantial	Noncompliance

#	Provision	Assessment of Status	Compliance
	obstacles.	compliance with Provisions F.1.d, F.2.a.1, and F.2.a.3. There was little overall progress demonstrated in the ability of the IDTs to identify the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. There must be an independent determination of the most integrated setting appropriate to an individual's needs, and the IDT must also identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported. The identification of needed services and supports is also pre-requisite to assisting the team to identify and address potential obstacles. The Facility typically did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2 below, a very 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 PSI, which was originally intended to assist teams in developing a vision for a future life, had become more of a preference assessment that was no longer completed as a part of a team meeting. The PSIs reviewed during this compliance visit provided little in the way of a visioning of an individual's ideal living arrangement. 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 possibilities could be. 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 typically 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 by itself still did not provide an adequate forum or comfortable discussion of community living opportunities, as described in Provision F1e. IDTs needed to do more to engage LARs and family members in these discussions on an ongoing and informal basis, rather than as an annual occurrence. <u>Identification of and Plans to Overcome Obstacles to Transition:</u> RSSLC gathered obstacle information through the ISP process, and categorized these using a list of DADS-approved obstacles. These included: • Individual's reluctance for alternate placement • LAR's reluctance for alternate placement	

#	Provision	Assessment of Status	Compliance
		• 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 The lack of presence of a Local Authority (LA) representative at the ISP meeting was no longer to be considered an obstacle to a referral being made. The revised process called for the IDT to proceed with the referral, ensuring that the LA was notified within three business days. If there were any questions or concerns on the part of the LA, a meeting with the IDT was to be held within two weeks of the referral. The Facility presented a document entitled Obstacles in Moving to a Community Setting, dated Wednesday, October 24, 2012 with a date range of 11/1/2011-10/24/2012. For 343 individuals, it listed the count and percentage of each of the obstacles in the categories above. The most frequently cited obstacles included LAR and Individual's reluctance for alternate placement. Overall, the Monitoring Team found that obstacles to transition were not yet consistently addressed by the IDTs. In a review of five recent ISPs, and the two new ISPs, two resulted in a referral. None (0%) of the ISPs reviewed in which a referral was not made evidenced proficiency in identification and addressing of obstacles. The obstacles cited were typically LAR and/or Individual choice, but in no case was an individualized plan developed to address the concerns. In a number of the ISPs, the teams indicated in the narrative they would develop a plan, but the Action Plans found were generic. They often called simply for the individual to "continue" group home tours on an as-needed basis, even when there was no discussion of any previous tours. The narratives also stated the Social Worker and LA would "continue" to provide information to the LAR, but there was no information regarding ongoing efforts in this regard other than the annual CLOIP process. The Action Plans would then simply call for the LA to provide CLOIP information annually or as needed. <u>Conclusion:</u> This provision was found to be not in compliance.	
	2. The Facility shall ensure the	<u>Provision of Adequate Education About Available Community Placements to Individuals</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	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: The Facility did not yet succeed in developing individualized plans for community education and awareness. There was little progress observed in the sample of five recent ISPs reviewed, and two new-format ISP process meetings attended. In the ISP process itself, the Monitoring Team found there continued to be little attention devoted to careful assessment of the individual's specific need for education in this area, even when lack of awareness was identified as an obstacle to movement. For zero of the five (0%) recently completed ISPs was there an individualized plan for increasing awareness of community living options that took into account the learning needs of the individual. The Monitoring Team did find that in one of the two new format ISPs, for Individual #165, the IDT did have an extensive discussion about the individual's needs for community exploration and developed what appeared to be appropriate strategies. The Monitoring Team looks forward to reviewing how these were to be incorporated in the final ISP document and implemented across the next six months. The Monitoring Team also reviewed the ISPs and documentation of activities to promote education for community living options for several other individuals who would benefit from a carefully constructed and implemented plan. Documentation provided did not evidence such plans. Examples included: • For Individual #51, the Monitoring Team requested written documentation of any tours of group home and community living options for the past six months, including notes regarding her reactions and IDT review, and evidence of any efforts to reduce anxiety regarding community living. The Facility provided only the ISP for review. While there were Action Plans to encourage participation in tours in the ISP, there was no documentation provided that any of these activities had occurred or been evaluated by the IDT. • For Individual #773, the ISP documented the IDT would be exploring community living options, including day programs, that would provide a PICA safe environment and would discuss quarterly. There was no specific evidence provided of any of such contacts made with providers over the past ten months. The only reference in the documentation provided was the first quarterly review that indicated team members were exploring community providers to determine their level of awareness of PICA precautions. An Annual Provider Fair: The Facility had held its semiannual provider fair on May 20. 2012, held in conjunction with a meeting of the Parent Association on Sunday. The Facility documented only 30 individuals and four parents/LARs attending. Another fair	

#	Provision	Assessment of Status	Compliance
		is scheduled for November 30, 2012. It will be held in the gym, as have most of the others, but will also include a secondary area near the homes of individuals who may not be able to access the gym as freely. The Facility continued to complete a survey of the participants in the fairs and use these data to vary its approaches to this activity. Regular SSLC Meeting With Local LAs: The office of the Transition Coordinator continued to meet on an occasional basis with local LAs and transition staff from Brenham State Supported Living Center. Education About Community Options: RSSLC did not have a 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: RSSLC reported it was not yet collecting data regarding the development and 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. The Transition Coordinator reported that a plan was being developed to track such Action Plans once initiated by the IDT. This process would require the QDDP to send a service request to the Admissions and Placement office, where it would be entered into a spreadsheet. The Transition Specialists would then take responsibility for setting up the required tours and ensuring their completion. • 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 26 CLOIP Worksheets for recent ISPs. For these individuals, only 12 of 26 (46%) were allowed by the LAR to participate in the CLOIP. For two of the 14(20%) in which the LA was permitted to engage the individual, the LA Service Coordinator was able to document the individual had any interest in or meaningful response to the materials or information being offered. In each of the remaining twelve reviewed, the LA Service Coordinator documented the individual did not seem to comprehend or attend to the material presented. 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/did not have a formal process for documenting the community tour process. The Facility's own Self-Assessment indicated data regarding CLOIP tours and other community exposure involving trips to the community was not complete or reliable. Tours Of Community Providers: There did not yet appear to be a consistent, formalized	

#	Provision	Assessment of Status	Compliance
		process in place at the Facility to fashion these provider tours as a part of an individualized community living awareness and education plan. 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 was not yet a consistent, formalized process in place at the Facility for ensuring opportunities for community tours were available to all. In the past six months, the documentation provided by the Facility listed a total of 66 names of those who had participated in CLOIP community tours. This did not reflect that 66 individuals had the opportunity to make such visits, as several individuals had multiple visits. As this was the only vehicle for acquainting individuals with community programs prior to a referral being made, this did not appear to provide sufficient opportunities for the 347 individuals residing at the Facility to obtain enough experience about community living to form an opinion, much less participate in informed decision-making. The Facility acknowledged that this was an area that needed improvement and had examined how it might expand on the CLOIP tour process to make more such opportunities available to individuals and had a new process in the planning stages. This process called for the two Transition Specialists to act as liaisons with designated sections of the campus to arrange tours. Tour assignments will be based on upcoming planning meetings and/or ISP Action Plans that call for community exploration. • 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 not a consistent or formalized process described for choosing tour sites based on individual preferences and needs. It was reported the Transition Specialists would be assigning individuals to specific tours based on the preferences and needs described in their ISPs and Action Plans. • 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. Overall, the size of tours at the Facility appeared to be conducive to both individual learning and assessment of responses. • Individual's response to tours assessed: RSSLC did have a procedure managed by the Recreation Department, for making an assessment of an individual's response to the tour experience. Staff accompanying individuals on tours were expected to complete a brief form entitled Community Tour Documentation that asked how the individual reacted to the tour and for any staff comments about the program, However, the Transition Coordinator reported this process was	

#	Provision	Assessment of Status	Compliance
		not yet being effectively or consistently implemented unless an individual had been referred for transition planning, in which case information was typically well documented. 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. Opportunities Are Provided To Visit Friends Who Live In The Community: Data provided by the Facility indicated three individuals had been afforded the opportunity to visit with friends who had moved to the community. Education Provided In Various Venues: The Facility did hold bimonthly self-advocacy meetings for adults and youth. There was some emphasis on community living options including, for example, a presentation by the two Transition Specialists at a meeting held during the monitoring visit. A Plan For Staff To Learn More About Community Options: Some educational opportunities about community options had been provided through staff participation in community tours, community exploration activities for individuals, and transition related visits. During the six months since the last monitoring site visit, the Facility documented approximately 41 staff participating in such activities, including tours and visits. As a part of its overall plan for increasing education and awareness, the Admissions and Placement Department was hoping to propose requirements for various disciplines to participate some minimum number of times each year. Staff also had the opportunity to attend the semi-annual Provider Fairs and the Facility documented 42 staff who took advantage of this. Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories: There was no evidence presented as to individuals and families having been provided with opportunities to learn about success stories related to transition from RSSLC. 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,	

#	Provision	Assessment of Status	Compliance
		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. The Facility should also consider how it can address each of the criteria in this provision to create a comprehensive coordinated plan for community living education and awareness.	
	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.	<u>*Assessment Practices Pursuant to Transition and Discharge Policies and Procedures:*</u> *In describing it process for assessing individuals for community living, the Facility provided a document entitled "Community Transition Process from a SSLC." The Facility provided a list that indicated 379 individuals had been assessed for placement, pursuant to the procedures prescribed in this section. For most individuals on the list, however, unless a referral for transition took place, the assessment process was limited to the annual ISP meeting.* <u>*Percentage of Individuals Assessed as Required:*</u> *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. Issues that affected the adequacy of the assessment included:* • *As described in Provision T1b1, there had been minimal progress demonstrated in the ability of the IDTs to identify the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs;* • *The Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provisions T1b2 and F1c; plans to educate individuals as to community living options were not well-thought out, individualized or sufficient in scope in most instances.* • *As described in Provision F1e, each discipline's ISP assessment needed to include an opinion/recommendation regarding community living. For the two new ISPs held during the monitoring visit, not all assessments included this recommendation. In most cases, a template statement in the assessment shell simply indicated that the professional opinion was based on the current services and support being provided at the Facility and did not take into account that any different services might be needed in the community.* <u>*Conclusion:*</u> *This provision was found to be not in compliance. The Monitoring Team found there was*	Noncompliance

#	Provision	Assessment of Status	Compliance
		not an adequate formal assessment process that included a substantive interdisciplinary evaluation and discussion. This was consistent with the Facility's own evaluation of their assessment process.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	<u>CLDP Policy and Process</u>: The Transition Coordinator was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. There were no changes reported to policies related to the CLDP, but a new format for the Community Living Discharge Plan (Exhibit F to DADS Policy 018) had been promulgated. The Facility had begun using this new format with new referrals received after 7/1/2012. <u>Timeliness of Development and Implementation of CLDP:</u> The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. Documentation indicated CLDPs were typically initiated upon referral. The Monitoring Team also reviewed an updated Community Placement Report, updated on November 12, 2012. Five of the 22 (23%) current referrals had exceeded the 180 days allowed in the current policy and pending revision. Nine of the 16 (56%) transitions that had occurred also exceeded 180 days. 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. DADS policy also acknowledges this and provides an avenue to apply for and receive a waiver when needed. For the in-process CLDPs, however, it appeared that there was sometimes a delay in initiating community exploration following the initial referral meeting. For example, for Individual #405, the referral date was 7/12/12 and the initial referral meeting was held on the same day, but the IDT did not select providers for pre-selection visits until 10/15/12. The Transition Specialists were reported to be focusing concerted attention working with the IDTs of individuals who had reached or were approaching the 180 day mark. The primary activities included assisting IDTs to identify potential providers who could provide the array of services and supports needed by the individuals in question, assisting with trial visits, and participating in all IDT meetings and deliberations. The Facility was also considering formally assigning a Transition Specialist to each individual referred to assist the individuals and teams in this manner. The Facility should ensure that timeliness of actions related to referrals and community placements is included as a measure in its development of the quality assurance procedures required under Provision T1f. The office of the Transition Coordinator should develop and monitor a tracking list of action steps that need to be implemented once a referral is made and make follow-up with IDTs to ensure timely actions when	Noncompliance

#	Provision	Assessment of Status	Compliance
		necessary. This should be accomplished in conjunction with the provision of the revised Policy 018 that requires the IDT to meet every 30 days once the initial 180 days has expired. Development of CLDP in coordination with the LA: A review of completed CLDPs indicated that four of four (100%) evidenced that the plan was developed in coordination with the responsible LA. In addition to 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 Provision T1e below. The Monitoring Team was concerned, however, that all agreed-upon pre-move and post-move supports may not be being provided as memorialized in the CLDP. During the PMM visits for Individual #100 during this monitoring visit, the Post-Move Monitor inquired about a bathroom doorway that was supposed to be widened according to the CLDP no later than 12/05/12. The response given by the provider was that the LA had indicated this support would not be considered for approval until an LA Service Coordinator had been assigned and an individual service plan developed. The date for that meeting was not yet scheduled. The Facility should clarify the expectations that all supports mutually agreed upon in the CLDP will be provided as indicated and not subject to additional review and approval post-move. Conclusion: Provision T1c was found to be not in compliance. Overall, the Facility continued to make progress in terms of balancing timeliness of completing a transition with a cautious approach toward selection of the best provider for an individual. There were a number of instances in which placements did not occur within the 180-day requirement, which was sometimes related to a lack of timely action and follow-up by the IDT after a referral was made. The Admissions and Placement Office was making use of the two new Transition Specialist positions in a manner that should contribute to a timelier outcome for most individuals. It would also be helpful for the Transition Coordinator to institute and monitor a tracking list to ensure follow-up with IDTs to ensure timely actions when necessary. Coordination with the LA in the development of the CLDP did not appear to be of significant concern at this time, but there was at least one instance in which agreed upon supports were subject to additional review and approval post-move due to a funding mechanism, which may have an impact on implementation and timeliness. There also remained concerns related to the adequacy of the CLDPs that were developed, primarily in the failure by the IDTs to adequately identify the appropriate essential and nonessential 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,	Identification of Essential and Non-Essential Supports: The CLDP process is a continuation of the Facility's responsibility to assess the needs of	Noncompliance

#	Provision	Assessment of Status	Compliance
	including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	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 or pre-move supports (that must be in place at the time of the move) and non-essential or post-move required supports (that may be put into place following the move) must begin by considering those things identified in the ISP. The IDT did continue to rely heavily on the ISP and the assessments associated with it to guide the identification of the essential and non-essential supports. This remained an area of concern as IDTs did not yet 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. 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. The Monitoring Team found this overall deficiency reflected in the CLDP meeting for Individual #369 held during the monitoring visit. As described in Provision T1d below, there was not an adequate speech assessment, the speech therapist did not participate in the meeting and the team physician left before the meeting concluded, all of which limited the opportunities of the IDT to thoroughly examine the support needs of the individual. The Nursing Assessment did not provide any special instructions for the individual related to how likes and dislikes might impact cooperativeness during nursing care or how the individual communicated signs of pain or illness, even though the assessment template prompts for these to be included On a positive note, however, the Monitoring Team observed significant progress in the quality of the integrated discussion by the IDT during this meeting. More of the discussion was focused on ensuring the provider staff understood how to implement services and supports rather than on a mere recitation of assessment findings. The Monitoring Team was also particularly impressed with the level of specific detail about the individual's characteristics, needs, and day-to-day functioning provided in the Positive Behavior Support Plan and encourages IDT members to use this example to help improve the content of their assessments as well. The Monitoring Team looks forward to seeing this integrated approach represented in the final CLDP during the next visit. There was some progress noted in the description of the evidence that was required to demonstrate a support was adequately in place. The teams more often identified evidence beyond written documentation than in the past, including observation and staff interview, but they still seldom specified what the observation or staff interview should reveal. Sometimes this appeared to be self-evident, but in many cases it was not. The IDT should clearly state what evidence is to be elicited through these processes. This is	

#	Provision	Assessment of Status	Compliance
		important because the Post-Move Monitor cannot be expected to have expertise in every area; she must rely on the expertise of the team to explicitly define what should be observed and what staff should be able to explain about the supports to be provided. The potential for negative outcomes related to this are further described in Provision T2a, as it related to the PMM for Individual #353. The Facility should also consider identifying appropriate disciplines or clinicians to participate in PMM visits with the Post-Move Monitor when there are complex health and/or safety support needs. Coordination of CLDP with provider staff: A review of four completed CLDPs indicated provider staff were typically very involved throughout the CLDP process. There was documentation of training of provider staff and the visits by the individual to the provider sites and the individual's responses. Provider staff attended each CLDP meeting. However, as documented in Provisions T1e and T2b below, and in previous monitoring reports, this participation was not routinely translated into provider staff being knowledgeable of an individual's support needs. The Facility should continue to examine its CLDP processes as a whole to ensure that knowledgeable staff are providing the supports and services once transition has taken place. Conclusion: This provision was found to be not in compliance.	
	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 four of four (100%) of CLDPs the Facility consistently identified Facility staff responsible for each of the essential and non-essential supports by name. As noted in Provision T1c, however, there was one support that had as responsible staff assigned the Post-Move Monitor and a provider representative, but the provider had reported it still required approval by the LA before it could be considered for implementation, so the provider had no specific plan in place. The individual service plan meeting in which the support would be considered had not yet been scheduled. The Facility should ensure there is clarity as to the responsible staff; in this case an LA representative should also have been designated if the implementation required action by its staff. Completion timeframes for needed actions identified: For four of four (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. The support discussed in Provision T1c also had a prescribed timeframe for completion, but it was reported by the provider staff it was subject to review and approval by some unspecified date. It was not therefore clear that approval would be granted, or when. Conclusion: This provision was found to be in substantial compliance. The Facility should take care	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		to ensure its assignments of responsible parties and timeframes take into account all necessary factors. The Monitoring Team will consider this in future reviews.	
	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 four completed CLDPs and four CLDPs in process, for a total of eight, to assess compliance with this provision. For eight of eight (100%), there was ample documentation of the level of involvement by the individual and/or the LAR in the decision-making process prior to the move. As the Facility correctly self-assessed, however, documentation did not provide evidence that RSSLC continued to involve the LAR and/or family past the transition date. There was no evidence that PMM results were routinely shared with the LAR or family. For example, in the case of Individual #353, the PMM Checklist indicated it had been reported the individual's father/LAR wished to have the individual move to a different home, but there was no documentation of Facility or IDT follow-up to ascertain the concerns or provide assistance regarding the supports and services being provided in the new setting. Conclusion: This provision was found to be in substantial compliance, based on the review process for the development of the CLDP. Failure to also involve the LAR post-move may have significant negative implications for the individual and/or success of the transition, however, and may impact future compliance ratings for this Provision as well as Provisions T1f and T2.	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 continued to need 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 four completed CLDPs, the Monitoring Team found that the assessments did not consistently address the services and supports needed for each an individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. In addition, few 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. In addition, the Monitoring Team reviewed the assessments prepared for the Individual #369, whose CLDP was held during the monitoring visit. As reported in Provision L1, there were health conditions that were not adequately addressed in the CLDP assessments nor discussed at the CLDP meeting until raised by the Monitoring Team. For example, an x-ray of the abdomen on 6/27/11, to evaluate for a bowel obstruction, was negative for bowel obstruction but indicated degenerative spine disease, and degenerative spine disease was not listed as a concern for the transfer agency address. The individual also had a modified barium swallow on 6/1/11, which noted a large anterior osteophyte at C3-C4, with disc space narrowing of the cervical spine, and there was no mention of cervical spine disease, and there was not follow-up for this condition noted in the clinical records nor in the CLDP assessments. There was also not an adequate or current speech and language assessment provided. An update dated November 5, 2012, indicated the last assessment was completed in 2008 and was deemed to be current and valid, but this 2008 assessment was not included. The update indicated it had no instructions for the provider and no recommendations when in a community setting. Speech Therapy was not represented at the CLDP. There was useful communication information actually provided in the Positive Behavior Support Plan, which made clear that an understanding of the individual's communication skills and styles was essential to a successful adjustment. The Monitoring Team recommended that an adequate speech assessment be conducted prior to the individual's transition date and in-service training for provider staff completed. <u>Conclusion:</u> This provision was found to be not in compliance. Facility action must 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	<u>LA Continuity of Care Process:</u> The Monitoring Team reviewed documentation for 15 individuals who had transitioned to the community in the last six months and found each of the LA Continuity of Care Pre-	Noncompliance

#	Provision	Assessment of Status	Compliance
	comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	Move Site Review Instruments 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 Transition Coordinator or the Post-Move Monitor were 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 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 15 individuals who had transitioned in the past six months. Each (100%) appeared to have been completed in a timely manner and included a visit to each service provision site. The Monitoring Team reviewed five of the Pre-Move Site Reviews more extensively to assess thoroughness in addition to timeliness. The Facility did not routinely document a due date for implementation of non-essential (post-move) supports that were not yet in place. As a result, it was often not possible to verify some non-essential (post-move) supports were being implemented until well after their due date. The rationale for obtaining a plan from the provider rather than just indicating that a support is not yet due is to avoid such gaps. The Facility should ensure it obtains detailed information from the provider as to the plan for implementation. The Facility often verified that the stated essential supports were present but this process was clearly not sufficient to ensure this was the case. For example, for Individual #100, there were a number of concerns found during the 7-Day PMM visit that reflected inadequate implementation of the requirements of the CLDP. Examples included: • The Pre-Move Site Review required the Facility to ensure that home and day program staff were trained as to the individual's needs. The Pre-Move Site Review indicated only that in-services had been provided on a certain date. During the PMM visit completed during the monitoring visit, it was apparent staff at both the day program and the home were unaware of most of the pre-move and post-move supports as prescribed in the CLDP. • The CLDP called for a number of other supports based on the individual's preferences and personal goals that were not reviewed during the Pre-Move Site Review, nor had they been consequently implemented as agreed. Examples included: o There were to be both a television and mini fridge in her room. The television did not have cable and therefore the individual had to go the living room to watch shows. The mini fridge was in the closet in an inaccessible spot and was empty. o The individual had a job as an office assistant on campus before her move and wanted a similar job in the community. The CLDP discussed a	

#	Provision	Assessment of Status	Compliance
		referral for a DARS evaluation would be made, but that in the interim the individual would have the opportunity to work in the provider's office. The provider had thus far provided only an opportunity to attend a traditional day program where the individual could engage in shredding. This was reported by the provider to be a 30-day evaluation. This was not consistent with the individual's expectations as described in the CLDP. The individual had already refused to remain at the day program on two occasions and was very vocal about being dissatisfied with the arrangement. o The CLDP indicated the individual would have frequent opportunities to participate in preferred leisure pursuits, such as shopping, on at least a bi-weekly basis. During the PMM visit, the individual indicated both disappointment and dissatisfaction that she had not been allowed to go on any outing the previous weekend. The provider indicated they had decided outings would take place once a week rather than the two prescribed as the minimum in the CLDP. The Monitoring Team was very concerned that the individual, who was able to clearly express her preferences for leisure and recreation, was limited to some artificial number of community outings, when one of the benefits of community living should be to enhance opportunities for community participation and integration. The community living option should be structured to meet the individual's preferences and needs. <u>Conclusion:</u> This provision was found to be not in compliance. The Pre-Move Site Review process did not adequately assess the presence of supports that would be due before the 7-Day visit or obtain plans for them. This provision relies heavily on supports and evidence having been adequately identified in the CLDP comprehensive assessments and the Monitoring team did not find this to be the case, as described under Provisions T1c1 and T1d, further resulting in a finding of noncompliance. Given the number, and in at least one case severity, of the adverse or unexpected outcomes that have occurred over the past six months, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months.	
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	<u>Quality Assurance Processes to Ensure Development of CLDPs:</u> QA procedures related to ensuring the development of CLDPs remained essentially unchanged since the last monitoring visit. They focused primarily on the tracking of the provision of the 45-Day assessments from the various disciplines by the Transition Coordinator using the Assessment Checklist. The Transition Coordinator also reviewed the assessments on an ongoing basis to attempt to identify any issues that needed	Noncompliance

#	Provision	Assessment of Status	Compliance
	plans for which the Facility is responsible, consistent with the provisions of this Section T.	clarification prior to the meeting. Given the concerns related to the adequacy of the CLDP and some negative outcomes, as detailed in Provision T1c1 and T1d, the Monitoring Team strongly encourages the Facility to undertake a focused initiative within the Quality Assurance Department and in conjunction with the Department of Admissions and Discharges, to improve the quality of all of the processes involved in the CLDP consistent with the findings and recommendations in this report, including the development of outcome indicators and monitoring of CLDP assessments, the CLDP meeting, pre-move in-service training implementation, Pre-Move Site Review and PMM visits, . <u>Quality Assurance Processes to Ensure Implementation of CLDPs:</u> The Pre-Move Site Review conducted by the Post-Move Monitor or Transition Coordinator continued to provide 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 practice, as the existing LA pre-move site visit did not focus heavily on ensuring specific supports were in place; however, the process needed to be improved to be fully functional as a mechanism for ensuring quality. As noted above in Provision T1e, there was evidence that supports designated in the CLDP were not being implemented as required. <u>Conclusion:</u> This provision was found to be not in compliance. 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.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take	<u>Obstacle Information Gathered:</u> The Facility gathered data on the identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences as described in Provision T1b1. <u>Annual Obstacle Analysis by Facility:</u> An Obstacles Report had not been issued since FY 2011, with data as of 8/31/2011. The Monitoring Team has reported on this analysis in both of the last two reports and had no new findings in this area. <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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained. The Monitoring Team looks forward to reviewing the upcoming Annual Report in order to assess progress in this area.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing	<u>Issuance of the Community Placement Report:</u> The Facility issued an updated Community Placement Report on Monday, November 12, 2012 covering the period of 5/1/2012-11/12/2012 <u>Required Reporting Categories:</u> The report was in the standardized format as prescribed by DADS State Office. It listed: • Sixteen community placements (It was noted the report covered a small portion of time previously reviewed by the Monitoring Team during its last visit, such that placement numbers included one individual who was also included in the previous sample. The actual number of individuals who had transitioned since the last visit was 15.) • Twenty current referrals • Two rescinded referrals • Four individuals who preferred community, not referred-LAR choice • No individual who preferred community, not referred-other reason • No individuals for whom the LAR prefers community, not referred. <u>Reporting on Individuals not referred due to LAR choice:</u> The Monitoring Panel had asked that a final category be added to the Community Placement Report that includes a list of names of individuals who would be referred by the team 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. As noted above with regard to provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The data provided in the category of individuals who preferred community, not referred-LAR choice did not	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	appear to be 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, the Facility provided an additional document, the Obstacles Database, which indicated many individuals were not referred due to LAR Choice. Conclusion: This provision was found to be in substantial compliance. The report was made in a timely fashion. As a stand-alone document, it still did not fairly represent the relatively large number of individuals who were not referred due to LAR choice, but the Facility did collect this information in the Obstacles Database and provided it to the Monitoring Team for review.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory	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 the pace of transitions (15) over the past six months had created a significant workload. With current referrals standing at 22, the Monitoring Team expressed concern as to whether quality of the process had been or would be affected by the workload. The Facility should continue to monitor the workload for any negative impact it may have on quality and thoroughness. The Post-Move Monitor also stated that DADS State Office was considering re-instituting the practice of cross-facility PMM, which could weigh disproportionately on RSSLC due to its proximity to the Houston metropolitan area. The Post-Move Monitor reported she had told State Office staff there that she would not be able to handle additional workload alone as long as the current pace of transitions at RSSLC continued. Review of PMM Checklists: The Monitoring Team reviewed PMM Checklists for 14 individuals who had moved to the community for 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	agency.	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. The Post-Move Monitor also gathered documentation of the completion of supports in many, although not all, instances, and maintained these materials in a file. Assessment of Presence of Supports Called for in CLDP: 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. The most significant of these were related to Individual #353, who died shortly before the 90th-day post-move visit. The Monitoring Team's physician reviewed the CLDP and PMM Checklists. As reported in Provision L1, the Monitoring Team could not determine that all medical services and supports listed on the CLDP were provided by the agency, based on review of the post-move monitoring checklists. For example: • There was no comment on reviewing bowel monitoring data, or evaluating the individual's gait for potential worsening; there were no assessments to actually determine if the individual had developed a UTI, which was to be monitored as called for in the CLDP • Documentation did not include any actual monitoring of a meal preparation to ensure that the prescribed diet was being adhered to, or actual monitoring of the individual eating a meal. The PMM process is supposed to include observation of key supports. • The individual was known to have severe arthritis, with reported contractures, and that the only treatment provided and the recommendation to the accepting agency was to provide Tylenol for pain, and Tramadol for severe pain. The post move monitoring checklist did not indicate Tylenol for pain, just Tramadol. • Documentation indicated that the Facility physician provided a letter to the accepting physician, but that this letter was included in the CLDP packet, and not sent to the physician. Formal communication between the accepting primary care physician and Facility physician should (and, for serious issues, must) take place prior to transfer from the Facility, and necessary consultations should scheduled prior to transfer to ensure they will occur timely. Other examples of continuing deficiencies in the process included: • As reported in the prior monitoring report, DADS and RSSLC policies clearly state that the PMM process should identify the plan to achieve post-move	

#	Provision	Assessment of Status	Compliance
		supports. In many instances, for post-move 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. • There continued to be some items in the PMM Checklists left blank. For example, for Individual #353, the item in the 7-Day Checklist addressing the knowledge of staff as to certain health conditions and needs was not filled in, even though this was a matter of great concern that had been brought to the Post-Move Monitor's attention by the Monitoring Team. • In addition, the Monitoring Team again 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 Post Move Monitor maintained a file with materials to verify the implementation of supports as well as to document follow-up. The Monitoring Team appreciated the work of the Post Move Monitor in maintaining supporting documentation in some instances, but it was not yet consistently implemented nor was the process sufficient to ensure supports were implemented. The Monitoring Team had expressed concern about the adequacy of the PMM process for Individual #353 at the 7-Day review held during the previous monitoring visit. A review of the completed PMM Checklist for the individual for that visit indicated not all of the original deficiencies in the process that had been communicated to the Post-Move Monitor by the Monitoring Team had been adequately captured in the final document, and there was insufficient evidence the issues had been resolved. Examples included: • The 7-Day PMM Checklist indicated the staff did not have knowledge of a diagnosis. It stated a re-in-service would be completed. The 45-Day Checklist simply indicated that the condition would be monitored by "Tina." This did not sufficiently address the support needs associated with the condition, which had significant implications for the individual's health and requirements for all staff to engage in ongoing monitoring and intervention. There was no notation that staff providing daily support had any knowledge of this situation. • The IDT review of the 7-day PMM visit indicated the residence social worker would have weekly contact with the community home during the first 30 days to monitor adjustment. The Facility could provide no evidence these contacts had occurred. • The Post-Move Monitor recommended in the 7-Day PMM Checklist that the IDT should make a visit to the day habilitation program. There was no evidence of	

#	Provision	Assessment of Status	Compliance
		any follow-up provided. • The Facility requested the provider submit a written order of events leading up the individual's death. This was not received nor additional follow-up completed to obtain this information. The Facility remained unaware of the cause of death. There was also not a consistent approach to IDT review of the PMM Checklists. IDT review did not always take place in a timely fashion or address all necessary concerns. Examples included: • For Individual #353, the IDT did not fully document its review of the significant findings of the 7-Day until 15 days after that visit. In addition, the 45-Day IDT review indicated that the individual's father wanted to have the individual move to another home. There was no documentation of any contact with the father to discuss his concerns or needed action by the IDT or Facility. • For Individual #550, there were no IDT reviews provided to the Monitoring Team for any PMM visits, even though the Facility did include an email from the Post-Move Monitor to the QDDP requesting this action for the 45-Day review. <u>Conclusion:</u> This provision was found to be not in compliance. Overall, the post move monitoring process did not adequately ensure that all necessary supports and services were afforded the Individual. The PMM process was not always implemented in a thorough manner and follow-up was not adequately ensured or documented on a consistent basis. Given the number, and in at least one case severity, of the adverse outcomes, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before	<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 that it had achieved compliance in this provision, the Monitoring Team accompanied the Post-Move Monitor on the 7-day PMM visit for Individual #100. The CLDP and accompanying assessments were also reviewed. One of the Transition Specialists, who had previously been a QDDP for the individual, also attended. The Monitoring Team commends the Facility for having familiar staff participate in the PMM process. Overall it was difficult to make an accurate assessment of the thoroughness of the PMM review during this visit. As described in Provision T1e, staff at both the day program and the home were very unfamiliar with the supports the CLDP prescribed for the individual, exhibiting a broad lack of knowledge ranging from the individual's diagnoses to	Noncompliance

#	Provision	Assessment of Status	Compliance
	the 90th day following the move date.	medications, diet and adaptive equipment. At a certain point, it became clear that continuing to question the staff was unproductive, such that not every support was specifically assessed. The Post Move Monitor did appropriately indicate that she would immediately notify the Facility that additional in-service training would be required. While the Monitoring Team cannot comment with certainty whether the Post-Move Monitor would have observed all supports as required under normal circumstances, it did observe some issues of concern that should have been identified or addressed by the Post-Move Monitor, but were not. These included: • The individual made comments on several occasions throughout the visit regarding dissatisfaction with the placement overall and asked to return to the Facility. While Facility staff were on hand who knew her well and indicated this was not an unexpected phenomenon in the best of circumstances, there should have been a private conversation held with the individual to determine if there were specific concerns or fears. This did not occur. • The provider staff indicated in the interview process that she had been terminated from another long term care facility for some unspecified action related to someone in her care. The Post Move Monitor did not immediately recognize this as a matter of concern to be followed up on to ensure that appropriate background clearances had been obtained. This was discussed with the Post Move Monitor for follow-up. • The Post Move Monitor observed for the individual's television and mini-fridge in her room, but did not independently assess that these supports were functional. In fact, the television did not have adequate reception and the mini-fridge was in a closet inaccessible to the individual and was empty. • The Post-Move Monitor did not independently recognize the significance of the provider's statement that outings were only going to be scheduled for every other week, which was not in accordance with the individual's CLDP. This was also brought to her attention by the Monitoring Team for follow-up. <u>Conclusion:</u> 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		Not Rated

#	Provision	Assessment of Status	Compliance
	criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment	<u>Number and Categories of Alternate Discharges:</u> In response to the document request, RSSLC reported one alternate discharge during the past six months. Individual #58 was discharged to the LAR. <u>Compliance with CMS-required Discharge Planning Procedures:</u> The discharge did not reflect compliance with CMS planning procedures. There were extenuating circumstances. The LAR had expressed some displeasure with the services being provided at RSSLC and indicated to the Facility that she did not want anything in the way of a discharge packet to be sent to her. She was planning to find other services in Louisiana. In deference to the LAR's request, no discharge materials were prepared. The Monitoring Team recommends that if such a situation recurs, the LAR should be informed that the Facility is required to mail the information but that it would, of course, be up to the LAR to decide whether to make use of it. This would allow the Facility to document compliance; more importantly, it would ensure the LAR had access to the most recent information available in the event it was needed. <u>Conclusion:</u> This provision was found to be not in compliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	order.		

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

1. The Facility should use its self-assessment of the reasons for areas of noncompliance to further develop a set of outcome indicators that it believes would be likely to lead to substantial compliance based on its own experience and the findings and recommendations in the Monitoring Team's report. Once it develops its outcome indicators, the Facility should review these actions to ensure they are focusing on those most likely to support the identified outcomes. (Self-Assessment)
2. The Facility should use data related to adverse or unexpected outcomes following community transition to continually evaluate and improve its CLDP and PMM processes as a part of its formal QA methodologies. Each of these adverse or unexpected outcomes should be examined by the Facility to ascertain whether additional planning, monitoring or technical assistance from the Facility IDTs may have resulted in a more predictable and/or positive outcome. (Provision T1a)
3. DADS should to assess how the CLOIP process, materials and/or information might be modified to more effectively meet the needs of the individuals living at RSSLC. (Provision T1b2)
4. IDTs should continue to receive additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. (Provision T1b2)
5. The Facility should also consider how it can address each of the criteria in Provision T1b2 to create a formal and comprehensive coordinated plan for community living education and awareness. (Provision T1b2)
6. The office of the Transition Coordinator should develop and monitor a tracking list of action steps that need to be implemented once a referral is made and make follow-up with IDTs to ensure timely actions when necessary. (Provision T1c)
7. 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. (Provision T1c)
8. The Facility should clarify the expectations that all supports mutually agreed upon in the CLDP will be provided on a timely basis as indicated. (Provision T1c)
9. The Facility should continue to examine its CLDP processes as a whole to ensure that knowledgeable staff are providing the supports and services once transition has taken place. (Provision T1c1)
10. The Facility should consider identifying appropriate disciplines or clinicians to participate in PMM visits with the Post-Move Monitor when there are complex health and/or safety support needs. (Provision T1c1)
11. The Facility should take care to ensure its assignments of responsible parties and timeframes in the CLDP take into account all necessary factors. (Provision T1c2)
12. Adequate assessments and resulting in-service training for providers should be conducted prior to transition—for example, a speech assessment for Individual #369. (Provision T1d)
13. Given the number, and in at least one case severity, of the adverse post-transition outcomes that have occurred over the past six months, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months. (Provision T1e and Provision T2a)
14. The Facility should undertake a focused initiative within the Quality Assurance Department and in conjunction with the Department of Admissions and Discharges, to improve the quality of all of the processes involved in the CLDP consistent with the findings and recommendations in this report, including the development of outcome indicators and monitoring of CLDP assessments, the CLDP meeting, pre-move in-service training implementation, Pre-Move Site Review and PMM visits, . (Provision T1f)

15. With current referrals standing at 22, the Facility should continue to monitor the workload for any negative impact it may have on quality and thoroughness of the PMM process. (T2a)
16. If an alternate discharge occurs in which the LAR declines to receive a discharge packet, the LAR should be informed that the Facility is required to mail the information but that it would be up to the LAR to decide whether to make use of it. (Provision T4)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Richmond State Supported Living Center (RSSLC) Self-Assessment, updated 10/30/2012 2. Richmond State Supported Living Center Action Plans, updated 10/15/2012 3. Section U Presentation Book materials 4. Richmond State Supported Living Center Settlement Agreement presentation, dated 11/9/2012 5. DADS Policy 019: Guardianship, effective 3/7/2012 6. DADS Policy 057: Self-Advocacy, effective 5/30/2012 7. Draft DADS Policy: Advocate, undated 8. Draft DADS Policy 059: Consent and Authorization for Treatment and Services, undated 9. RSSLC Policy C.3: Guardianship, dated 3/7/2012 10. RSSLC Policy C.18: Self-Advocacy, effective 7/20/2012 11. 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 10/15/12 12. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 13. Over the six (6) months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates 14. Rights Assessment, Form 6614, dated September 2011 15. Completed Rights Assessments for Individuals #113, #148, #165, #354, #465, #551, #568, #677, and #787 16. Self-Advocacy Minutes for the past six months **People Interviewed:** 1. Jim North, Human Rights Officer (HRO) 2. Stacey Burdue, Acting QA Director 3. David Savage, QA Auditor **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #165 and #465 2. Pre-ISP meeting for Individual #251
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section U, in conducting its self-assessment, the Facility had not used monitoring/auditing tools up to this point. The Facility did not consistently measure the quality of items, but rather merely their presence. Similarly, the Facility's process for determining compliance focused largely on inputs; that is, on activities it undertook rather than on the outcomes those activities produced. The Facility should develop a set of outcome indicators that it believes would be likely to lead to substantial compliance based on its own experience and the findings and recommendations in the Monitoring Team's report. For example, the Facility indicated it was requiring QDDPs to demonstrate competency in the completion of the Rights

	Assessment, but there were no specific indicators of how that competency was measured; if there were such indicators, they would constitute one appropriate means for assessing progress in a quantitative manner. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. In many instances the projected steps had not yet been started. For example, for Provision U2, nine of 14 steps were reported to be not started. The actions also did not provide a set of steps likely to lead to compliance with the requirements of this Section. For example, the action steps for Provision U1 did not clearly and specifically address what the Facility planned to undertake to ensure IDTs have appropriate tools and methodology to assess decisional capacity. The only step that addressed this was to "coordinate with State Office to develop a tool to address functional capacity." This step was not yet started. Overall, the Facility rated itself as being not in compliance with either of the two provisions of Section U. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: This Section was not yet in compliance. While new policies on guardianship had been in effect since the last monitoring visit, progress toward implementation since then had been limited. A summary of noted progress included: The Facility had begun to deploy the expanded Rights Assessment and had offered some training in its use. The Facility continued to provide substantial supports for self-advocacy, including a pilot project that trained staff on homes serving individuals with more extensive health care needs to act as self-advocacy mentors. 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. An expanded Rights Assessment was in use and represented an improvement over the previously used process in that it did prompt the team with specific probes in each of seven categories of informed consent. It was not predicated on any objective criteria or a currently accepted standardized tool for assessing decisional capacity. Lack of such a tool or methodology and its effective implementation by the IDT remained the most significant barrier to achievement of substantial compliance for this Section. The Facility had provided some training on the expanded Rights Assessment, but there was no discernible difference in the process or outcomes from the previous monitoring visits in which the earlier version had been used. The IDTs continued to rely almost solely on their own subjective assessment of capacity, with no

	objective standardized criteria. As part of undertaking an effective and appropriate large-scale effort to solicit guardians, RSSLC must ensure it has an appropriate methodology in place to determine the actual need for guardianship. DADS should provide guidance through the formal promulgation of policy as soon as possible. **Provision U2:** This Provision was found to be not in compliance. Many of the requirements of DADS Policy 019, including the Guardianship Committee, were not yet implemented. As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, it still needs to ensure it has an appropriate methodology in place to determine the actual need for guardianship. This remained the biggest barrier toward achieving compliance for this provision as well. A new DADS policy on Self-Advocacy had recently been issued, and RSSLC did continue to provide commendable support for self-advocacy as noted above.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking 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.	<u>Policies and Procedures related to functional capacity to give consent and/nor need for LAR:</u> DADS State Office had issued policy DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits, as discussed in detail in the previous monitoring report. No changes to this policy had occurred. 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. The 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 unnecessarily result in an individual losing rights to make and/or participate in his or her own decisions. <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 prioritization criteria contained in DADS Policy 019 were identical to the requirements in the SA, including those determined to be least able	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 reviewed the Priority List, dated 10/15/2012, which contained 347 names. The list had prioritized rankings from Priority 0 through Priority III. Individuals with current guardians (221) were ranked as Priority 0. Priority I included those individuals with the highest need for decision making and without a family member or correspondent to advocate for them (21); Priority II included those who had a relatively high need for decision making without a family member or correspondent who regularly visited or attended meetings (48); and, Priority III included those who had a relatively high need for decision making but had an involved family member or correspondent (58). The HRO indicated he had requested the list be reviewed by the IDT at least every six months and any changes reported to his office. <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 decisional capacity, so the decision to place someone on the prioritized list was still without a sound basis for the most part. The new Rights Assessment was an improvement over the previously used process in that it did prompt the team with specific probes in each of the seven categories of informed consent but it was still not predicated on any objective criteria. The Facility provided a copy of a Rights Assessment Form 6614, dated September 2012, which included an expanded section for assessing an individual's ability to provide informed consent. It was now in use campus-wide. Staff from DADS State Office had provided the HRO with training, and he, in turn, had provided training to the Facility's QDDP staff in June 2012. No written instructions were provided for staff as to how to implement the expanded Rights Assessment; however, a brief written test was administered to test their understanding of the process. While it was termed a competency-based test, it did not truly test competency in administering the Rights Assessment, nor competency in assessing decisional capacity. Rather, it required	

#	Provision	Assessment of Status	Compliance
		primarily that those completing it be able to answer questions about the contents of the policy correctly in a true-false or fill-in-the blank format. The only questions regarding the Rights Assessment were very basic, requiring the respondent to indicate whether it was true or false that the Rights Assessment would be used by the IDT to determine decisional capacity and whether it was section J that had been expanded in the Rights Assessment. The ability to answer these two questions correctly would not indicate competency in completing an assessment of decisional capacity. The Monitoring Team requested for review a recent Rights Assessment completed by each QDDP since the training was completed. Two of the nine documents received were for the individuals who had the new format ISP during the site visit. There was no discernible difference in the process or outcomes from previous visits. Examples included: • For zero of the nine (0%) reviewed did the IDT conclude the individual was able to give informed consent in any of the seven areas listed. • In zero of nine (0%) instances did the IDT provide a rationale for these determinations. • If the individual had a guardian, the IDT typically did not respond to the expanded list of questions in each category. • In zero of the nine (0%) Rights Assessments did the IDT document any strategies to improve the individuals' decision-making skills. • In zero of nine (0%) Rights Assessments did the IDT provide any examples of decision-making input an individual could have. When there was narrative in this section, it usually what the individual could not do. • For zero of two (0%) new format ISP annual meetings attended 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. These findings would suggest the IDTs did not yet comprehend their obligation to assist individuals to continue, on an ongoing basis, to enhance their capacity to participate in decision-making. IDTs should provide in the Rights Assessment specific expectations for how staff will be expected to support individual's participation in decision-making, consistent with the assessment of the input they can provide. The Monitoring Team recommends additional training for the QDDPs and IDTs combined with a monitoring process that ensures the current Rights Assessment is being used in an appropriate manner. This might include samples of completed Rights Assessments that would demonstrate DADS' expectations for the process. <u>Conclusion:</u> This Provision was found to be not yet in compliance. The Facility did	

#	Provision	Assessment of Status	Compliance
		maintain a list of individuals it deemed to be in need of a guardian that was updated regularly. The list was prioritized according to criteria as described in policy, but the determination of need was not predicated on a standardized process or tool. An expanded Rights Assessment had been initiated, but it had had no discernible impact on IDT process as of yet.	
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.	Policies and Procedures related to obtaining LARs for individuals in need: No changes had been made to DADS Policy 019: Guardianship or the local Facility policy. DADS had issued Policy 057: Self-Advocacy, effective 05/30/12. The stated purpose of the policy was to ensure that individuals living in State Centers are provided the opportunity to participate in self-advocacy opportunities, including education surrounding self-advocacy and participation in self-advocacy meetings and events. The policy designated the HRO to serve as the Self-Advocacy Coordinator for the Facility. The policy focused almost exclusively on providing a variety of supports to formal self-advocacy groups. The only exception was the responsibility to conduct an annual self-advocacy in-service for individuals, families and LARs and State Center staff. RSSLC had also issued Policy C.18: Self-Advocacy which was effective 7/20/2012. This local policy appeared to be essentially identical to the statewide version. The supports for self-advocacy formalized in these policies are commendable, but the Monitoring Team also encourages DADS and the Facility to consider a broader vision of how self-advocacy may be incorporated into the everyday lives of individuals. Self-advocacy should not be seen as just a meeting, but should be incorporated into an ongoing program of active treatment for all individuals. Facility Efforts to Obtain LARs: RSSLC reported four new LARs had been obtained for individuals living at RSSLC during past six months, but the HRO indicated these were not as a result of any organized efforts by the Facility. The HRO did provide two examples of correspondence he had engaged in with potential guardians as a means of ensuring they had adequate information about the role. Otherwise, new processes prescribed by DADS Policy 019: Guardianship, effective 3/7/2012, were still in the early stages of planning. Findings included: • Guardianship Committee: The Facility did not yet have an operational Guardianship Committee as called for in Policy 019. The HRO reported he was continuing to recruit members to satisfy the policy membership requirements, but had thus far only two people identified. • Advocacy Program: The Facility did not yet have an operational Advocacy program. The HRO indicated the Facility was awaiting the promulgation of the statewide Advocacy policy which was reported to currently in draft status. • Self-Advocacy Program: The Facility continued to provide much support for self-advocacy. The HRO was designated as the Self-Advocacy Coordinator and was	Noncompliance

#	Provision	Assessment of Status	Compliance
		responsible for providing support for the Self-Advocacy program, which meets twice a month. There was some emphasis on community living options including, for example, a presentation by the two Transition Specialists at a meeting held during the monitoring visit. The Monitoring Team was also encouraged the Facility continued to support participation in the statewide Self-Advocacy Conference which was held in July 2012. In addition, the Facility had initiated a Self-Advocate Mentor program for the two homes that serve individuals described as medically fragile and less able to participate regularly in the standing program. The HRO had provided some training to staff on the afternoon shift in those homes on the self-advocacy process. • Other Activities of the HRO/ Guardianship Coordinator: Other activities included: o Attendance at relevant statewide training opportunities on guardianship and surrogate consent. o Continued and ongoing provision of training about guardianship and advocacy at new employee orientation. Conclusion: This Provision was found to be not yet in compliance. The Facility was to be commended for continuing to provide substantial support for self-advocacy as required in DADS Policy 057, but it needed to take concerted action to develop its Guardianship Committee as required in DADS Policy 019. Also, as part of undertaking an effective and appropriate large-scale effort to solicit guardians, RSSLC should ensure it has a valid methodology in place to determine the actual need for guardianship.	

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

1. DADS should provide an appropriate methodology to determine the actual need for guardianship that includes standardized and objective criteria through the formal promulgation of policy as soon as possible. (Provisions U1 and U2)
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 provide additional training on the use of the new Rights Assessment for the QDDPs and IDTs, combined with a monitoring process that ensures the assessment is being used in an appropriate manner. (Provision U1)
5. IDTs should provide in the Rights Assessment specific expectations for how staff are to support the individual's participation in decision-making, consistent with the assessment of the input they can provide. (Provision U1)
6. DADS and the Facility should consider a broader vision of how self-advocacy may be incorporated into the everyday lives of individuals. (Provision U2)
7. The Facility should take concerted action to develop its Guardianship Committee as required in DADS Policy 019. (Provision U2)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment 10/30/12 2. RSSLC Action Plans 10/15/12 3. Presentation Book for Section V 4. DADS Policy 004.1 Individual Support Plan Process draft, undated 5. DADS Policy 004.1 Individual Support Plan Process effective 11/20/12 6. DADS Policy 002.4 Incident Management, effective 11/20/12 7. RSSLC Policy A.1 Developing/Revising Policy or Procedure 2/14/12 8. RSSLC Policy A.6 Recordkeeping 10/15/12 9. RSSLC Policy A.06.1 Individual Notebooks 10/1/12 10. RSSLC Policy A.27 Virtual Client Folder 5/9/12 11. RSSLC Policy C.01 Incident Management 9/19/12 12. RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 9/19/12 13. RSSLC Policy D.8 Completing/Routing Client Injury Report 9/11/12 14. RSSLC Policy I.08 At-Risk Individuals (9/18/12) 15. RSSLC Policy C.18 Self-Advocacy 7/20/12 16. RSSLC Policy D.23 Using Bedrails & Alternatives (8/22/12) 17. RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation 11/17/11 18. RSSLC Policy (no number) Pre-Hospital Discharge Planning Policy 9/6/12 19. Active Record Order & Guidelines 10/3/12 20. Table of Contents of Master Record 4/18/12 21. Individual Notebook Equivalent & Guidelines 4/10/12 22. Guidelines for Monitoring Active Record 10/3/12 23. Monitoring Documentation Done by new Employees After NET (New Employee Training) and On-The Job Training (undated) 24. Checklist for Minimum Documents Included in Master Record 25. Section V Recordkeeping Active Records/Group Notebooks Internal/External Monitoring description (undated) 26. Section V—Recordkeeping Unit Clerk—Active Record Checklist (undated) 27. Minutes of Integrated Disciplines Workgroup of 10/10/12 28. Filing Priority Medical Documents meeting minutes 10/10/12 29. Individual Notebook (PECOS) meeting minutes 10/25/12 30. URC/Program Monitor meeting minutes of 8/8/12 and 8/10/12, 31. Section V Recordkeeping—Overflow procedure 7/19/12 32. Trinity, San Antonio, Leon Three Rivers, and Four Rivers Unit Random Sample Lists July, September, October, and November 2012 for audit of Overflow 33. Overflow checklists from July 2012, September 2012, October 2012, and November 2012 for Individuals #24, #25, #31, #40, #82, #109, #130, #142, #225, #284, #328, #344, #412, #477, #478, #501, #515, #561, #582, and #651

	34. Section V Recordkeeping—Master Record (undated) 35. Checklist for Minimum Documents included in Master Record for newly admitted Individuals #352, #391, #588, and #787 36. Active Record, Group Notebook, Master Record, and Overflow for Individual #558 37. Active Record for Individuals #655 and #787 38. Assessments in Virtual Client Folder for Individual #552 39. Record audits completed by Unified Records Coordinators for September 2012 audits of Individuals #23, #77, #99, #130, #173, #349, #382, #481, #546, and #655, including audit forms, emails requesting corrective actions, table titled Corrections Needed, table titled Corrections Needed for Group Notebook Audit, table titled Follow-up on Corrections Needed 40. Record audits completed by Unified Records Coordinators for October 2012 audits of Individuals #27, #57, #60, #157, #264, #265, #340, #391, #499, and #634 41. Facility Random Sample List for November 2012 42. Trend Analysis Report for Section V 8/1/12-10/31/12 **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 and Suzanne Royer 2. Brenda McClendon, Program Auditor, and Stacey Burdue, Director of Quality Assurance 3. Group interview of QDDPs Magnolia Taylor, Joseph Lopez, Vincent Bealo, and QDDP Educator/acting QDDP Coordinator Jacquelyn North 4. Tran Quan, M.D., Director of Medical Services 5. Ping Law, OTR, Director of Habilitation Therapies **Meeting Attended/Observations:** 1. Individual Support Plan (ISP) annual planning meeting for Individual #165 2. QA/QI Council 11/13/12 3. Records storage at Tejas Trail 5, Tejas Trail 6, and Lavaca
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V, dated 10/30/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. In conducting its self-assessment, the Facility used and reported on monitoring tools. • Although the tool for record review was not specified, the Facility stated it reviewed findings from Active record reviews; data were reported for 3/1/12-8/30/12 on requirements that had compliance scores (separated for those from URC audits and from program monitor audits) equal to or above 80% and on those that had compliance scores below 80%. Also reported were the total percents of items compliant as taken from the Trend Analysis reports for internal and external active record reviews from 3/1/12-8/30/12. Interviews and documents requested clarified that the data from those reviews was taken from the statewide Settlement Agreement Cross Referenced with ICF-MR Standards tool for Section V (referred to as "the monitoring tool"). This tool was used for audits conducted by the Unified Records Coordinators (internal audits) and

	Program Monitors (external audits). The tool included adequate indicators to allow the Facility to assess compliance with Provisions V1 and V3. Although not reported in the self-assessment, interviews and documents added that audits also involved use of the Active Record Review form, which listed the documents that were to be in the active record and where they were to be filed, and the Group Notebook Audit form, that listed many documents that were to be filed in the individual's tab in the group notebook. Information from these forms was used to provide the basis for completion of the monitoring tool. The Facility clearly stated that the data were reported from active records reviewed by URCs and program monitors during the past six months. Splitting the listings of a number of specific requirements into those that demonstrated high versus low compliance provided a meaningful and easy way to look at the information. The Facility reported an overall level of interobserver agreement between URCs and program monitors that was adequate to indicate the tools and audit process involved adequate instructions and guidelines for ratings. • The Section V Interview Tool was used to determine whether or not documents are used to make care, treatment and training decisions. However, data from use of this tool were not reported; instead, data from the monitoring tool formed the basis for the Facility's rating. While these data are useful, they did not provide a complete picture of use of records, and they did not match the activity reported by the Facility (but should be added as a second activity and should continue to be used in the self-assessment). In addition, data from the Interview Tools should be reported. For Provision V2, the self-assessment provided data on percent of facility procedures that were current, number of policies revised or newly implemented since 5/18/12, and State Office policies that need to be operationalized (only one of which was relevant to Settlement Agreement requirements). Other than these monitoring tools and policy information, the self-assessment did not use relevant data sources or key indicators and outcome measures. For example, there were no data relevant to Provision V4 that would give information on use of records, such as presence of records or use of information from records at IDT meetings, or percent of assessments filed timely in the active record or share drive so that they can be considered by IDT members prior to the annual ISP planning meeting. The Facility reported that none of the provisions of this Section were yet in compliance. The Monitoring Team concurs. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. The Action Plan provided a list of actions to be taken for each provision. These lists of actions were more thorough for some provisions than others. For example, for Provision V2, there was a list of completed steps related to revision of the process for developing and revising policies, and there was a list of steps noted as "In Process" or "Not Started" that involved developing and using a process to monitor efficacy of new policy/procedure, whereas for Provision V1, there was only a list of actions already completed, and these only involved updating and disseminating policy.
	Summary of Monitor's Assessment:

	Progress was evident in all provisions of this Section. Policies had been developed and revised, both for recordkeeping and for other requirements of the Settlement Agreement. Records were generally in order, a robust audit system was in place, and there was evidence that records were being used in making decisions. However, records still were not consistently accurate and complete, the corrective action process for addressing issues identified in the audit had not yet limited recurrence of similar errors, and availability of records did not consistently lead to accurate implementation of supports and services. Recordkeeping policy had been recently revised. The Facility maintained a Unified Record with all required components. 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. Active records contained most required documents, but neither record reviewed in detail by the Monitoring Team included all required documents; data for this small sample was reasonably consistent with the trends data reported by the Facility. Both reviews by the Monitoring Team and audits by the Facility identified a few requirements of Appendix D that were frequently problematic, including gaps in documentation (usually gaps of lines between entries or at the bottom of pages of notes or orders) and legibility. The Facility had a process in place in which Unified Records Coordinators each audited five randomly selected records per month, and Program Monitors performed reliability audits. Interrater reliability appeared adequate to permit confidence in the findings for the monitoring tool and Active Record. 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. The audit process had not resulted in limiting recurrence of similar errors. Active records were kept at each home in an area or cabinet that 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. Records were accessible but were not always used in delivering services and supports. Timeliness of completion and posting of routine assessments had improved but there was still some variability, and not all required assessments were posted timely and available for review. Although records were available at meetings, and information from records was regularly used, the Monitoring Team did not observe consistent reporting of actual data to be used in decision-making, and some information in the records was conflicting. Regarding policies, although much progress had been made in development and implementation of policies needed to address requirement of the Settlement Agreement, there were still areas that needed further development. The Facility needs to develop and implement an organized process for periodic routine review of current policies to determine any need for revision. The Facility is planning to establish a way to track all people who have been trained but have not yet developed a system.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Policies Governing Recordkeeping Recordkeeping was guided by RSSLC Policy A.6 Recordkeeping, which was revised 10/15/12. 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 change terminology to "intellectual disability" and to require certain priority documents to be filed within one day. In addition, RSSLC Policy A.27 Virtual Client Folder was initiated 5/9/12. This policy governs the use of the Virtual Client Folder.. It establishes uniform procedures including file names, adding new reports to the VCF and communicating that these are filed, and the process to monitor whether assessments have been entered. 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 section of the Group Notebook 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. The Facility was in process of piloting implementation of an Individual Notebook to supplement the Group Notebook and permit information to accompany the individual; this had been started at the Pecos unit, and RSSLC Policy A06.1 Individual Notebooks had been revised 10/1/12. The Individual Notebook will accompany the individual "to ensure more reliable delivery of services	Noncompliance

#	Provision	Assessment of Status	Compliance
		and, when possible, immediate documentation of significant events"; it will not replace other notebooks, and data will not be kept in it. 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. 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. A new monitoring process had been established to improve timeliness of sending documents to Medical Records for maintaining in Overflow. This involved use of the Overflow Checklist to check whether required documents has been purged from the active record and received by Medical Records. The checklist reviewed four items—Integrated Progress Notes (IPNs), Physician's Orders, MARs, and Observation notes. The checklist identified the month to be checked based on the guideline for retention in the active record, boxes to mark Y/N/NA, and a plce for comments. One individual record was selected for review randomly by computer for each living unit each month. Although improvement had not yet been seen on these checklists, they provide a process that can inform the Facility about patterns of lack of timely purging and possibly identify documents that are missing from the active record and have not yet been sent for archiving. The Facility had also implemented a process and checklist to identify any missing documents needed for newly admitted people so that action can be taken to ensure receipt of required documents. A checklist was provided for each individual admitted to the Facility since the last compliance visit. <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	

#	Provision	Assessment of Status	Compliance
		document they provided giving the steps in follow-up monitoring, a sample of employees receives a follow-up assessment in which URCs check documentation and follow-up training as needed. This process should lead to improved documentation. In addition, according to interview with records staff, the process of specialized training for newly employed nurses had continued; this training includes a written test and demonstration. <u>Accuracy and Completeness of Records</u> 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 #558 and #787, as well as the Group Notebook, Overflow, and Master Record for Individual #558. Individual #558 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. Individual #787 was selected from among the individuals admitted to the Facility since the last compliance visit. 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 Review. Many documents are not applicable in every record. For items that could have many pages or documents (for example, Observation Notes or SAPs), 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 a record documented use of a psychotropic medication, the Monitoring Team checked for presence of a comprehensive psychiatric evaluation and documentation of consent for use of psychotropic medication. For Individual #558, the Monitoring Team identified that 84% of applicable documents were present, with 81 documents present, 16 not present, and 59 not applicable. For Individual #787, 83% of documents were present, with 62 documents present, 13 not present, and 77 not applicable. This is an improvement over the findings at the last compliance visit, when review of a sample showed an average of 75% of documents present. For the Group Notebook, the Monitoring Team checked for the presence of each item on the Group Notebook Audit. For Individual #558, the Monitoring Team found all seven documents present; however, as reported below in Provision V3, the URC found four of	

#	Provision	Assessment of Status	Compliance
		seven documents not present. Consistency with Appendix D Requirements: For the two sampled records, the Monitoring Team completed the monitoring tool. In both records, several requirements were rated as not met. • Issues of legibility were found in both records. To improve legibility of signatures, physicians had used a name stamp to accompany signatures, which was a good procedure. Furthermore, most documents were legible, except for some signatures; however, two client injury reports and one integrated progress note for Individual #558 were not legible, as was an integrated progress note for Individual #787. Although this indicates records were generally legible, the Facility rightfully requires all records to be legible, as any single illegible record has the potential to lead to an inaccurate and possibly harmful decision. • In both, a signature legend was not available for the medication administration records (MARs). 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. • There were examples in each record of documents filed out of the order required by the Active Record Order and Guidelines. • Both records had many gaps in lines, at bottom of pages, or in whole pages between documentation in the observation notes and IPNs. These did not appear to be gaps in which documentation was not done but instead gaps in which lines and pages were left blank and not crossed through per policy and generally accepted practice. However, for Individual #558, the MAR missed initials indicating medications were given 1017/12 or an explanation why initials were not present. • For Individual #558, there were several out of date documents, including expired consents. The data for this small sample of two records was reasonably consistent with and corroborated the trends data reported in the self-assessment regarding requirements that had low compliance scores on audits. As the Monitoring Team reviewed a large number of records, a few additional errors were noted; however, these were not extensive. For example: • As reported in Provision J1, The Monitoring Team reviewed with the psychiatry assistant how changes in diagnosis were tracked. When the psychiatrist in the	

#	Provision	Assessment of Status	Compliance
		clinic made a change in diagnosis, the change in diagnosis was reflected in the psychiatrist's dictation for the individual reviewed. For several individuals, the psychiatrist noted that the changes in diagnosis he had made during previous clinics had not been reflected in documents brought to the meeting. It emerged that there has been a backup in dictations so that team members had to bring old and outdated forms to the meeting, likely then propagating new errors. • As reported in Provision M1, occasionally the Integrated Progress Notes were documented out of sequence, making it difficult to follow the continuity of care. In addition, several blank spaces without lines drawn through were found in the Integrated Progress Notes, which had the potential to contribute to entries documented out of sequence. This finding of blank spaces was consistent with the findings from Facility audits and trend reports about gaps as well as from the same finding by the Monitoring Team in reviewing records during this compliance visit, as noted above. Furthermore, also consistent with the trend data from audits, the time of the entries occasionally was not documented, and the the legibility of some nurses' handwriting was still difficult to read. • As reported in Provision M4, The Nursing Department audited a total of 779 Integrated Progress Notes for one month, from one unit, as part of a death review recommendation. The results of the audits found the most common mistakes were: mistaken entries and late entries not properly documented. Consequently, the nurses identified making the mistakes were retrained. Nonetheless, the active records were generally complete, easy to find documents, and in good condition. The Facility must improve monitoring by responsible staff to ensure issues found not to meet requirements are corrected quickly, and retraining and other improvement actions are taken. <u>Accessibility and Security of Records</u> Active records were kept at each home in an area or cabinet that 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 records at Tejas Trail 5, Tejas Trail 6, and LaVaca homes and found all records to be secure but accessible; at no time during other observations were records noted to be out and visible except when being used. In Provision V4 of the report of the last compliance visit, the PNMP at Three Rivers and Four Rivers did not accompany individuals if they separated from their groups for activities on and off grounds. In response, the Facility had initiated a pilot at Pecos of an Individual Notebook that would accompany individuals and contain information important for ensuring consistent implementation of supports and services.	

#	Provision	Assessment of Status	Compliance
		Use of Virtual Client Folder (VCF)/Share Drive Although not considered by the Facility to be part of the Unified Record, the VCF/Share drive provided the potential for accessibility to assessments by all members of the IDT. DADS Policy draft 004.1 (and the final policy implemented following this compliance visit) and RSSLC Policy F.5 on PSP documentation require 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, in no case were all assessments completed and posted timely prior to the annual ISP meetings for individuals, but there had been improvement in the percentage of assessments posted timely. There was significant variability among and within disciplines as to timeliness. For the most part, assessments were posted so that they could be reviewed by the IDT in advance of the annual meeting, but further improvement was still needed. Many other documents are also posted to the VCF, making them readily accessible to members of the IDT. Recently included in those is the Consultation Database, which provides information on consultations and resulting recommendations. Also, after visits to the hospital, all medical information was documented in each individual's Integrated Progress Notes and scanned into the shared drive to make it available to medical providers, nursing staff, and other relevant IDT members. As noted above, the Facility had implemented policy to improve standardization of the VCF and clarify responsibilities and processes for posting documents.	
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.	Facility Process to Develop and Revise Policies Per interview with Stacy Burdue, the Quality Assurance Director, and Brenda McClendon, the person responsible for maintaining the policy development process, there had been no changes in the process for developing policy. New and Revised Policies DADS policy development, revision, and implementation: DADS had continued developing and revising policies. New and revised policies included the following: • DADS Policy 054 Medical Peer Review 5/30/12 • DADS Policy 057 Self-Advocacy 5/30/12 • DADS Nursing Services, Policy, Effective 9/20/12, Replaces: 010.1 The Facility had also actively developed and revised policies, including the following: • RSSLC Policy A.6 Recordkeeping 10/15/12 • RSSLC Policy A.06 Individual Notebooks 10/1/12 • RSSLC Policy A.27 Virtual Client Folder 5/9/12	Noncompliance

#	Provision	Assessment of Status	Compliance
		• RSSLC Policy C.01 Incident Management 9/19/12 • RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 9/19/12 • RSSLC Policy D.8 Completing/Routing Client Injury Report 9/11/12 • RSSLC Policy C.18 Self-Advocacy 7/20/12 • RSSLC Policy D.23 Using Bedrails & Alternatives (8/22/12) • RSSLC Policy I.08 At-Risk Individuals (9/18/12) • RSSLC Policy K.01 Physical and Nutritional Management (9/21/2012) • RSSLC Policy (no number) Pre-Hospital Discharge Planning Policy 9/6/12 Many departmental policies and protocols were also revised, including: • DADS Procedure: Medication Administration Guidelines, Revised: October 2012 • RSSLC Nursing Services, Medication Administration Guidelines, A-1, Revised: 8/21/12 • RSSLC Nursing Services, Vascular Access Ports (VAP), A-4, Revised: 11/7/12 • RSSLC Nursing Services, Nursing Procedure: Diastat AcuDial, A-14, Revised: 8/15/12 • RSSLC Health Services, Nursing Protocol for "Real Time Data" Monitoring of Infections, Date: 7/23/12 These new policies and protocols established procedures or clarified responsibilities and requirements. For example, Facility PNMT policy K.01 (rev 9/21/12) defined the roles and responsibilities of the Physical and Nutritional Management Team (PNMT) and the collaboration that was intended to occur with the Interdisciplinary Team (IDT). Newly included in the policy was a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. Statewide policies that were identified as needed and in process were provided to the Monitoring Team when implemented shortly following the compliance visit. These were: • DADS Policy 004.1 Individual Support Plan Process effective 11/20/12 • DADS Policy 002.4 Incident Management effective 11/20/12 The Facility used a form called RSSLC Policy Approval that identifies who needs training, and what kind of training is to be provided. According to policy, and as reported in interview with the Program Auditor and Quality Assurance Director, an email is sent to the Contact Person (the person who developed and revised the policy and has the primary responsibility for its substantive content, as defined in Policy A.1), staff expected to implement the procedure, and their department heads; this email is to summarize changes and employee training requirements. Sign-in or sample sign-in training sheets are then provided to the Program Auditor. The Facility is planning to establish a way to	

#	Provision	Assessment of Status	Compliance
		track all people who have been trained but have not yet developed a system; such a system should define: • What type of training will be required (e.g., notice only, notice with written acknowledgement of requirements, classroom training, review of materials, competency demonstration), • Who will be responsible for developing training and any needed competency tests, • Who will be responsible for certifying that staff who need to be trained have successfully completed training, • What documentation will be necessary to confirm that such training has occurred, and • A timeframe or due date for completion of initial training (including whether training will be done immediately or incorporated into annual or refresher training, or both). <u>Areas in Which Efforts Are Needed</u> Although much progress had been made in development and implementation of policies needed to address requirement of the Settlement Agreement, there were still areas that needed further development. For example, DADS State Office had issued policy DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits, as discussed in detail in the previous monitoring report. No changes to this policy had occurred. 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 Facility had not yet implemented significant requirements of this policy; for example, the Facility did not yet have an operational Guardianship Committee as called for in Policy 019. DADS and the Facility need to continue to develop and revise policies to ensure all that are needed to implement Part II of the Settlement Agreement are in place. In addition to completing the development and implementation of new policies, the Facility needs to develop and implement an organized process for periodic routine review of current policies to determine any need for revision.	
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	<u>Audit Policy and Process</u> Each month, a set of 10 records is drawn through computer randomization and provided to the URCs. Each URC audits five records. The URCs begin by reviewing the Active Record, using the Active Record Review form to document. This form lists documents using the Active Record Organization and Guidelines (AROG) and has columns for the document name, the maintenance guidelines that state what is to be kept in the Active Record and for how long, checkboxes for Y/N/NA, and comments. The URC also audits	Noncompliance

#	Provision	Assessment of Status	Compliance
	consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	the Group Notebook section for the individual, using the Group Notebook Audit form. Based on information documented on these forms, the URC completes the monitoring tool, which provides the data for reporting and trend analysis. The URCs and Medical Records Director reported that the Facility is considering adding the data from the Active Record Review form to a new database for more thorough tracking; this would provide a great deal of information that would allow better assessment of what documents continue to need improvements in posting and filing. Review of audits from September and October 2012 confirmed that the Facility conducted audits of 10 individuals every month, which exceeds the requirements of this provision and provides both a larger sample for more representative data and the opportunity to correct errors in more records. Audits did not 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). These books must have documents that are consistent with those in the Active Record and Group Notebook (and this will also be the case for the Individual Notebook, if that is adopted after the pilot); the Facility should develop a process to ensure these are consistent. <u>Interobserver Agreement/Interrater Reliability</u> Program monitors selected five records each month from the 10 audited by URCs. These were not selected randomly; instead, the program monitors selected records so they would audit one record from each unit represented in the sample. URCs and program auditors conducted their audits of a record on the same day at the same time without discussion. They entered their item-by-item findings into the Record Keeping and General Plan Implementation Provisions 1, 3, and 4 database, which calculates agreement. After these are done each month, URCs and program auditors discuss the monitoring tool findings but also compare what they found on the Active Record Review. They discuss why there are differences and try to get an understanding. They do not change any answers. According to the Trend Analysis report for 8/1/12, the level of agreement on the monitoring tool between audits conducted by URCs and by program monitors was 94.96%, and improvement from the 84.48% agreement reported for 5/1/12-7/31/12. The more recent period showed a remarkably high level of agreement. Agreement was not reported for ratings on the Active Record Review or Group Notebook Audit. The Monitoring Team also audited one record along with the URC, for Individual #558. This was selected by computer randomization from among the five records that URC was assigned for November 2012 and had not yet audited. On the monitoring tool, the URC	

#	Provision	Assessment of Status	Compliance
		and Monitoring Team agreed on 74% of items. It should be noted that the URC reported "N" for four items on which the Monitoring Team rated "Y"; this indicated the Facility identified more errors. If disagreement occurs, it is good that the Facility is more critical and skilled at identifying errors. This finding was a turnaround from the last compliance visit, when most disagreements signified the Monitoring Team marked "No" and the URC marked "Yes" and is therefore an improvement. Furthermore, the URC rated "NA" for Individual notebook, which was consistent with ratings on the audits for September and October 2012; the Monitoring Team rated this "Yes" as there was an individual equivalent section of the Group Notebook which was included in the record audit. For the Active Record Review, the Monitoring Team and URC agreed on 87% of items, a level that indicates that definitions are clear and can lead to consistent rating. On the Group Notebook Audit, agreement was only 43%. Again, however, the URC rated four items "No" that the Monitoring Team rated "Yes." Review of the URC's comments on this form indicated that the "No" ratings were made due to errors in documents rather than to a document not being present; this definition was not provided to the Monitoring Team, which (for one item) made the same comment but still rated "Yes." Simply clarifying this would likely increase the level of agreement. The Monitoring Team agreement on the monitoring tool did not approach the agreement between the URCs and the program monitors. This could indicate that discussions between them had led to definitions that are clear to them but are not documented. The Facility should document the definitions to be followed and should revise those any time further discussion leads to clarifications. <u>Audit Findings</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 August 2012 through October 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 for all audits during the covered three months identified in internal audits, and graph from external audits • Graph of items with greater than or equal to 80% compliance during the covered three months identified in internal audits, and graph from external audits • Table of overall compliance identified in internal and external audits, and level	

#	Provision	Assessment of Status	Compliance
		of agreement between internal and external audits for the covered three months and the prior three months, along with a brief narrative of analysis • Table listing areas with low compliance identified in internal audits for the covered three month period and prior three month period, with analysis and description of steps taken so far to improve • Data analysis report listing each question on the monitoring tool and the number of Yes, No, and N/A ratings for the 30 audits conducted during the covered period According to the Trends Report for internal audits, level of compliance on the monitoring tool was 56% for August, 48% for September, and 56% for October 2012. The percent for September 2012 was confirmed by review of the audits themselves. <u>Corrective Actions</u> The Facility reported that the process for corrective actions for issues identified by the audits begins with the URCs sending an 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 requesting corrective actions. This email is accompanied by a table titled "Corrections Needed" and a table titled "Corrections Needed for Group Notebook Audit." These tables paste the line from the Active Record Review or Group Notebook for each item rated "N"; each line includes the Document, maintenance guidelines (for the Active Record Review), rating, and comments that describe the error. 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 and follows up again with another review. The emails state that the URCS must be notified when corrections are made (which was a new process since the last compliance visit); however, neither the emails nor the tables identify who is responsible for making the corrections and notifying the URCs, and the URCs receive notices for only some of the corrections. Identification of responsibility, and notice of completion to the URC, are important for three reasons. First, without specific responsibility for completion, corrective actions may not be done. 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). Third, it might make for more efficient use of URC time and permit more time for planning and implementation of systemic change. The Facility provided copies of the emails for each report in the September and October	

#	Provision	Assessment of Status	Compliance
		2012 audits. The Monitoring Team randomly by computer selected one individual record from among those audited by a URC in September 2012, Individual #655, and checked the Active Record and Group Notebook for corrections. Items that had been found by the URC to have been corrected at prior follow up audit of 10/18/12 were all found corrected by the Monitoring Team. Items not corrected at the prior follow up audit remained not corrected, except that the monthly flow sheet now provided 3 months of data. This check indicated two things. First, the URC had accurately checked for corrections. Second, follow up actions taken to request completion of corrections had not been effective. The Facility needs to ensure corrective actions are completed in a timely manner. Furthermore, the Facility needs to ensure that people assigned responsibility for corrections also carry out those corrections in a manner likely to reduce recurrence of the same deficient practices. For example, legibility and signatures remained rarely compliant. Review of audits for September and October 2012 showed at least some assessments missing or not current in many records. <u>Review of Trends and Use of Audit Information for Improvement</u> Based on review of trends, the Facility reported it carried out the following improvement activities: • Updated the Active Record Order & Guidelines • Identified priority medical documents and determined that need to be filed within one business day • Implemented a process for monitoring receipt of Overflow records in the Medical Records Department • Implemented monitoring of Master Records for newly admitted individuals to ensure all needed information is gathered and available Trends were reviewed at the QA/QI Council meeting held during this compliance visit. Decisions were to review the effect of these changes in three months. As these were all implemented within the last few months, it may take time for the effects to be evident, so this may have been appropriate. However, the Facility should also continue to consider other means to improve accuracy and usefulness of records. The audit process has not yet resulted in minimizing recurrence of similar deficient practices. <u>Additional Audits</u> The Facility conducts several other audits to evaluate whether required documentation is done and to implement corrective action as needed. • Each unit clerk reviews three randomly selected records from another unit, using a checklist that identifies specific items for review (but is different from the monitoring tool). Data are entered into a database that reports the compliance for each record.	

#	Provision	Assessment of Status	Compliance
		• Receipt of Overflow documents in the Medical Records Department is monitored for a sample, selected from the random database, of one person from each unit each month. The Medical Records staff determine, based on maintenance guidelines, which documents they should have received (for example, what is the latest month of IPNs that should have been purged from the Active Record and sent to the Medical Records Department), then check the Overflow documents to see if those have actually been received. This was started in July 2012. • Master record review for each new admission • Monitoring timeliness of posting assessments to the VCF/Share Drive for scheduled annual ISP planning meetings and entering data on the "PSP Disciplines Assessments Tracking Worksheet" <u>Rating and Rationale</u> The Facility had continued to use a robust and thorough process for audits. The process involved use of statewide monitoring tools, review of Active Records and the individual section of the Group Notebook and follow up on corrective actions needed. Interrater reliability appeared adequate to permit confidence in the findings for the monitoring tool and Active Record, although further definition may be needed for the Group Notebook. 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. The audit process had not yet resulted in minimizing recurrence of several deficient practices, as noted in the trend reports, review of recent audits of records by the Facility, and review by the Monitoring Team of a sample of records.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The Monitors and the parties agreed to a list of actions that the facilities would engage in to demonstrate substantial compliance with this provision item. These actions are categorized below, with report of their status at RSSLC. <u>Records are accessible to staff, clinicians, and others</u> The Facility was assessing this through the record audits. Audits of 20 records from September and October 2012, and the audits conducted by the Monitoring Team, found the record to be accessible in all 21 audits (100%). During observations by the Monitoring Team, Active Records and Group Notebooks were accessible. The Active Treatment book was available in day treatment areas. The Facility initiated a pilot of Individual Notebooks to accompany individuals and provide important information. The VCF/Share Drive made assessments readily available to clinical staff, residential directors, QDDPs, and others who might need to refer to them.	Noncompliance

#	Provision	Assessment of Status	Compliance
		However, the Monitoring Team observed that although records were accessible, they were not always used in delivering services and supports. For example: • As reported in Provision V1, not all required documents were found in the record, although this had improved. • As reported in Provisions O3 and O4, although PNMPs were provided at various locations (the active record, individual/group notebook, MAR, Infirmary, and at the workshop), staff were not observed referring to the PNMPs, and PNMPs were not implemented correctly. • As reported in Provision K11, observations showed implementation of PBSPs was not consistent. There was no evidence that staff accessed PBSPs to guide intervention. <u>Documents are filed in the record timely and accurately</u> The monitoring tool for record audits checked whether documents in the record were current. Trend data for that item on the Data Analysis Report provided to the QA/QI Council showed zero of 30 (0%) to be rated as current. Other than the record audits, the focus of assessment of timeliness was on the presence of assessments 10 days prior to the annual ISP planning meeting. As described above in Provision V3, the Facility was tracking timely completion and posting to the Share Drive. Since the last compliance visit, the VCF/Share Drive filing had been revised so all assessments were posted in a consistent single folder. The program monitors audited the folder 10 ays prior to the ISP annual planning meeting. For any overdue required assessments, they were to notify the discipline/department head and administration. At the time of this compliance visit, posting of assessments had improved, but not all required assessments were posted 10 days ahead of the meetings; therefore, IDT members could not review the findings and recommendations from all disciplines in preparation for the ISP planning meeting (although, as reported in Provision F1c, there had been recent improvement). The Annual Assessments Filed Within 10 Days report for meeting dates of 5/1/2012-9/30/2012, which tracked assessments by residence and by discipline reported that by residence, the overall percentages of timeliness ranged from 72%-89%, and the Monitoring Team noted there was significant variability among and within the disciplines as to timeliness. The Shared drive folder for Individual #552 was opened on 11/14/12 to determine the status of assessments due in preparation for the individual's upcoming ISP annual planning meeting on 11/20/12. Of 25 assessments listed in the folder as required, 24 (96%) were present. Of those 24, 23 (96%) had been posted 10 or more days prior to the scheduled ISP meeting, a significant improvement. For Individual #787, a recent admission (but over 30 days since admission), of 15	

#	Provision	Assessment of Status	Compliance
		assessments checked in the Active Record by the Monitoring Team, 14 (93%) were present. Two of those had been completed prior to admission, and all the rest had been completed within 30 days following admission. In addition to accurate and timely filing and posting of information, it is also essential that there be evidence that the data in records are accurate. As reported in Provision K4, Progress Notes did not reflect reliability data. Record reviews and interviews with staff revealed that efforts to measure data reliability at RSSLC were sporadic and isolated to a few settings or individuals. <u>Staff surveyed/interviewed indicate how the unified record is used</u> The Facility reported in the self-assessment that it assessed this item by reviewing the results from Section V Interview Tools. Each URC selected one 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. For the six interview tools completed during the period 8/1/12-10/31/12, the Data Analysis Report listed one (17%) rated "Yes" and five (83%) rated "No." For the four interview tools provided for September and October 2012, the following information was reported: • Individual #99 o Information was provided for six disciplines. o All six (100%) were rated "Y." o Although all gave responses that indicated use of the record, the responses were all general. For example, in response to the item "Give an example in which a report from another discipline helped you plan a treatment or intervention," responses included, "When completing the ICAP, reports that are helpful are the Pharmacy Annual Evaluation and the Annual Medica Summary" and "Dietary Evaluation is very useful." Neither of these provided a specific example of using a report from another discipline to plan a treatment or intervention for Individual #99 or any other individual. • Individual #157 o Information was provided for seven disciplines. o Four of seven (57%) were rated "Y." o Four of seven (57%) gave a specific example of how information from the record was used to make a decision about the individual.	

#	Provision	Assessment of Status	Compliance
		• Individual #264 o Information was provided for six disciplines. o All six (100%) were rated "Y." o Although all gave responses that indicated use of the record, the responses were all general. • Individual #546 o Information was provided for five disciplines. o Four of five (80%) were rated "Y." o Four of five (80%) gave a specific example of how information from the record was used to make a decision about the individual. The Monitoring Team interviewed three QDDPs and the QDDP Educator who is serving as acting QDDP Coordinator; the same questions were used. These staff provided several examples of using the unified record to make decisions about services for individuals; some were general, and some were examples of a specific decision about an individual. They indicated some difficulty in ensuring that assessments are posted by the due date and that all documents in the Share Drive get filed in the record. Overall, it was clear that they made use of both the unified record and the VCF/Share Drive. In addition, during interviews with the Director of Habilitation Therapies and the Director of Medical Services, these staff provided examples of use of the unified record. The Director of Habilitation Services indicated documents were used from the Share Drive more often than the paper record. The Director of Medical Services, in addition to providing examples of using the unified record, also provided a great deal of information on medical information in databases, including the Consultation Database and how it is used. <u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u> The Monitoring Team observed the annual ISP Planning meeting for Individual #165. The Active Record was not present at the beginning of the meeting, but the QDDP requested it, and it was brought shortly after. Many IDT members had with them information that was either directly from the record (e.g., assessments) or was summarized from information in the record. Although the Active Record was only referred to, a great deal of information from the record was brought, and the record was available if needed. Information reported from the record included information on seizures, diagnoses, and changes in medications. However, data were not presented in discussions of status. As reported in Provision J3, behavioral data were provided during PBMC meetings.	

#	Provision	Assessment of Status	Compliance
		However, as reported in Provision J2, there were many instances where different places in the record of a given individual provide different diagnoses. This could mean that clinicians did not attend to relevant information in other sections of the record and ensure reconciliation of discrepancies. Rating and Rationale Although significant improvement was noted, this provision is not yet in compliance. Records were accessible but were not always used in delivering services and supports. Timeliness of completion and posting of routine assessments had improved but there was still some variability, and not all required assessments were posted timely and available for review. Interview tools documented staff reports of using records to make decisions but based ratings, in some cases, on vague and general responses. Although records were available at meetings, and information from records was regularly used, the Monitoring Team did not observe consistent reporting of actual data to be used in decision-making, and some information in the records was conflicting.	

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

1. Improve monitoring by those management and supervisory staff responsible for documentation to ensure issues found not to meet requirements are corrected quickly, and retraining and other improvement actions are taken, as well as emphasize that the audits provide them with information that should guide them in acting to ensure improvements in documentation occur. (Provisions V1 and V3)
2. Implement a process to ensure documentation that is not part of the Unified Record is consistent with the Unified Record. (Provisions V1 and V3)
3. Implement a system to track who is required to be and who has been trained on new or revised policies. (Provision V2)
4. Develop and implement an organized process for periodic routine review of current policies to determine any need for revision. (Provision V2)
5. Document the definitions to be followed when auditing records and revise those any time further discussion leads to clarifications. (Provision V3)
6. Ensure corrective actions are completed in a timely manner. Establish a means to determine who is responsible for making each correction and notifying the URC of completion. (Provision V3)

List of Acronyms

Richmond State Supported Living Center
November 12-16, 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, Action Plan
APC	Admissions/Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
ART	Administrative Review Team
AS	Action Step(s)
AT	Assistive Technology
BAP	Behavioral Assessment Program
BCBA	Board Certified Behavior Analyst
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BMD	Bone Mineral Density
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
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
CPE	Comprehensive Psychiatric Evaluation
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/DSP	Direct Care Professional/Direct Support 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	Direct Support Professional, 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 Maintenance Plan
HOB/HOBE	Head of Bed/Head of Bed Elevation
HRC	Human Rights Committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy
IBW	Ideal Body Weight
IC	Infection Control
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICF/DD	Intermediate Care Facility for Persons with Developmental Disabilities
ICM	Integrated Clinical Meeting
ID/DD	Intellectual Disability/Developmental Disability
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IMC	Incident Management Committee
IMRT	Incident Management Review Team
IPN	Integrated Progress Note
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
MVC	Medication Variance Committee
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
OHCP	Oral Health Care Plan
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
PDD	Pervasive Developmental Disorder
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
RAD	Reactive Attachment Disorder
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 Plan
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