United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center
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Introduction

Background

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

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

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

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

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

Methodology

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

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

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available 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

As always, the Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators of the Facility for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The Facility Director, Mr. Barrera, was 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 Susan Steamer, Eileen Holmes, Samina Zaidi, Melissa Salina, and David Savage. 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 340 individuals.

Facility Self-Assessment. RSSLC continued to improve its process of assessing status of compliance, although this was somewhat variable across provisions, as noted in each Section of this report. The self-assessment described the activities engaged in to assess status, results (in some cases including data on status of processes or on outcomes), and the self-rating and rationale for the rating. The Monitoring Team provides, in this report, many specific reviews of the self-assessments to assist the Facility to select appropriate activities and measures of status and to describe reasons for discrepancies in ratings between this report and the self-assessment. The Facility should consider how it might expand use of its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. In particular, the Facility should analyze the findings of this report to help prioritize actions and to identify areas needing more in-depth review.

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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility might find it useful to define in each Section the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. This would change the focus of the Action Plans from measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. Sections of the Self-Assessment did not reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which would tie the Self-Assessment and Action Plans together. The Facility may want to consider how it could further the integration of these two documents, such that staff could visualize the results of the self-assessment, the specific action plan to address any identified deficiencies and the measurable outcome intended to be achieved.

Several administrative and management positions were now filled by new individuals, mostly by staff who had been working at RSSLC in other positions. These individuals were enthusiastic and presented plans for improving services. The development of these plans is encouraging. The Facility recognized that these plans were in early stages and requested that the Monitoring Team focus on review of recent documents and processes in order to assess whether these plans had potential to move the Facility toward compliance, which guided the process used by the Monitoring Team in conducting its review and preparing this report.

Terminology
The term Qualified Intellectual Disability Professional (QIDP) had begun to replace the term Qualified Developmental Disability Professional (QDDP). Because the Facility staff were using both terms, and the replacement was not complete in all documents, this report will use the terms interchangeably.

Specific Findings

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

Restraints
In its last report the Monitoring Team noted that the use crisis of intervention restraint at the Facility had been steadily increasing over the last two review periods. This trend had stopped and the use of crisis intervention restraint at the Facility had remained relatively constant when comparing six-month periods although there was a threefold increase in the use of chemical restraint.

- Positive Practices and Improvements Made
  - The Facility had made progress in decreased use of restraint for those Individuals who had lived at the Facility for a considerable period of time.
  - No use of prone restraint was identified.
- Improvements Needed
  - For individuals who were newly admitted, the Facility needs to determine how to reduce use of restraint.
  - Proper documentation of restraint use and review of restraint episodes, in general and specific to the use of medical restraint, remained problematic.
  - Compliance with Settlement Agreement requirements associated with the use of medical restraint remains problematic with little improvement observed since the last review nine months earlier.
  - Although no use of prone restraint was identified, Facility review of one restraint reported the use of an unapproved supine restraint. Several staff were unaware of the prohibition of prone restraint.
  - Policies were in place to require these reviews but they were apparently not consistently and/or fully operationalized, as the review process did not always ensure a substantive and well documented clinical and administrative review of each restraint episode.
  - Many individuals still lack needed plans to reduce the need for pre-treatment sedation.

Abuse, Neglect and Incident Management

The Facility had undergone important staff turnover that may have affected compliance with some Provisions. The Incident Management Coordinator (IMC) is new since the last review, as is the Quality Assurance Director (who supervises the IMC).

- Positive Practices and Improvements Made
  - The Facility policies governing abuse/neglect and incident management had been updated since the last review.
  - The Facility had a sufficient number of trained investigators to ensure an investigator is onsite 24 hours a day seven days a week.
  - The Monitoring Team did not find any instances of lack of cooperation between the Facility, DFPS, OIG or local law enforcement in its review.
  - All allegations of physical abuse received a law enforcement referral.
  - Reporting procedures for reporting abuse and neglect were prominently displayed throughout the Facility and the Facility had an effective monitoring system to ensure postings remained in place.
  - In every instance where an alleged perpetrator (AP) was known, the AP was immediately placed in no contact status.
  - 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 to ensure good communication and cooperation.
- Improvements Needed
  - 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; however, some of the Facility's administrative practices directed at abuse/neglect and incident management (reported throughout this section of the SA) appear to need additional management oversight to ensure the effectiveness of these policies and procedures in protecting Individuals and keeping them safe.
  - Timeliness of reporting of allegations remained problematic.
  - DFPS investigation were not always initiated within 24 hours and completed within 10 days of being reported.
  - Facility investigations of serious incidents were not always completed within 10 days of being reported.
  - Although training for staff on abuse and incident reporting was in place, and all staff was current in that training, staff knowledge of abuse/neglect reporting requirements needed improvement.

<u>Quality Assurance</u>

The Facility appointed a new QA Director on July 1. Little progress had been made in implementing a QA program since the last review. The QA program at the Facility was undergoing a major overhaul at the time of this review. The new QA Director was enthusiastic and presented plans for improving services. The development of these plans is encouraging. The Facility recognized that these plans were in early stages and requested that the Monitoring Team focus on review of recent documents

and processes in order to assess whether these plans had potential to move the Facility toward compliance, which guided the process used by the Monitoring Team in conducting its review and preparing this report.

- Positive Practices and Improvements Made
    - The QA/QI Council meeting observed by the Monitoring Team displayed enthusiasm and professionalism in the presentation of reports and in subsequent discussion.
    - Recent activity by the new QA Director included promulgation of several new and/or updated policies (see Documents Reviewed), formulation of Unit based QA/QI committees, and development of templates for meeting minutes and reports.
    - 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. Additional data reports, addressing other subject matter, were also being generated and presented at QA/QI Council meetings.
- Improvements Needed.
    - Processes for establishing Corrective Action Plans (CAPs) based on review of trends, tracking implementation and effectiveness of CAPs, and modifying CAPs as needed had not yet been put into place in an effective and consistent manner.

<u>Integrated Protections, Services, Treatments and Supports</u>
RSSLC indicated it was not in compliance with any of the components for these provisions, and the Monitoring Team concurred. The Facility requested the Monitoring Team focus its review on two ISP planning meetings held during the monitoring visit, and the resulting ISPs, to provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope.

There was improvement in the implementation of the ISP process, particularly in one of the on-site ISP annual planning meetings in which the IDT had a robust and creative integrated discussion around communication needs; however, significant deficits remained that continued to hamper efforts to develop and implement adequate planning for needed protections, services and supports. 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.

- Positive Practices and Improvements Made
    - A revised ISP format and process had been implemented and considerable training and coaching had been provided to the QIDPs and IDTs. The new process included an ISP Preparation meeting held approximately three months prior to the ISP annual meeting as a means of ensuring adequate IDT preparation for the latter. The Monitoring

Team found this to be a particularly promising practice that had already resulted in improved preparation and participation by IDT members as observed in the annual ISP meetings held during this site visit.
    - The Facility continued to devote considerable resources to training, monitoring, and coaching for QIDPs and IDT members.
- Improvements Needed
    - IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
    - There continued to be a significant incidence of failure to provide timely implementation of an ISP for each individual.
    - 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.
    - 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.
    - The Facility was not routinely implementing quality assurance processes to identify and remediate problems and to further ensure that the ISPs are developed and implemented consistent with the provisions of this section.

<u>Integrated Clinical Services</u>

RSSLC continued its progress toward providing clinical services in an integrated manner. Various committees and workgroups provided opportunities for integrated assessment and planning of supports and services at both the individual and systemic levels. There were numerous examples of integrated and collaborative planning and service provision; at the same time, there remained examples in which assessments, services, and supports were not yet integrated. As clinicians become more practiced at collaborative assessment and planning, a focus of improvement will need to be ensuring supports and services become integrated into the ISP.

- Positive Practices and Improvements Made
    - Meetings, committees, and workgroups that facilitated integrated clinical services included the Clinical Morning Report meeting, Grand Rounds, the Physical/Nutritional Management Team, the Skin Integrity Committee, and the Polypharmacy Review Panel.
    - The Clinical Morning Report brought together numerous disciplines two mornings per week. Reports were made, but there was also evidence of substantive discussion about both individuals and systemic issues. Follow up at these meetings continued on individuals and systemic issues as needed. There was evidence of referral of individual issues, including consultations, to the IDT.

- Grand Rounds brought clinicians from numerous disciplines and the IDT clinicians to review the cases of individuals who are experiencing a significant medical or behavioral issue (and, in some cases, both medical and behavioral issues).
- The Facility had appropriate processes in place to facilitate documentation of review of recommendations from non-facility clinicians, to make referrals to the IDT when appropriate (through both documentation and the Integrated Morning Report), and to communicate through the IPN process. In general, these processes were followed.

- Improvements Needed
  - There remained numerous examples in which assessments, services, and supports were not integrated into ISPs.
  - Although there was evidence that referrals of recommendations from consultants were made to the IDT and some evidence that there was follow-up to ensure IDT review, the Facility needs to develop means to ensure consultations are referred to the IDT as needed, and that the IDT provides evidence of integration with existing supports and services.

Minimum Common Elements of Clinical Care

RSSLC continued to progress on meeting the requirements of Section H. There had been significant progress in timeliness and, for some disciplines, in comprehensiveness of assessments. The identification and use of clinical indicators had expanded, particularly for healthcare conditions. Processes to monitor health status of individuals had been implemented more broadly and contributed to knowing the status of healthcare at the Facility.

- Positive Practices and Improvements Made
  - Completion of assessments in response to a change in status had continued to improve both in timeliness and content.
  - Diagnoses were consistent with codes of the current versions of the DSM and ICD classification systems, except that diagnosis of "seizures" was made without identification of type.
  - Diagnoses were consistent with assessments for osteoporosis, malignancy, pneumonia, and acute episodes of bowel obstruction and ileus, and there was improvement in identification of individuals with cerebral palsy.
  - Clinical pathways were provided for 12 conditions; these are an excellent beginning. The Facility should continue to review and revise these, and should identify for which conditions clinical indicators are not included and could appropriately be included.
  - The Facility had significantly increased the number of clinical indicators that were used its medical QA process, and included specific indicators for osteoporosis, preventive health care, neuromotor, musculoskeletal, infections, pneumonia, urinary tract infections, and medical consultation follow-up.
  - With some exceptions, medical care and action plans implemented for diagnosed health conditions indicated appropriate review and response to clinical indicators.

- The procedures for chronic care clinical pathways were a positive step to promote use of clinical indicators and recommended practices. All except the clinical pathway for aspiration syndrome had a section for the PCP to discuss and document recommendations to the IDT for an interdisciplinary approach to management of the condition.

- Improvements Needed
  - Timeliness of scheduled assessments had improved but continued to need further improvement. The Facility data on timeliness was not reliable, as it did not differentiate required assessments from others; as the ISP Preparation process evolves, the Facility should be able to establish processes to gather data that will be useful.
  - For psychiatric diagnoses, formulations of psychiatrists for changed diagnoses were reasonable. However, there also needed to be justification of each of the diagnoses in terms of the DSM criteria for each diagnosis made. Sometimes there were diagnoses that were reasonable and likely, but specifics supported the diagnosis were not offered.
  - The Facility had continued processes to ensure treatments and interventions were initiated timely and based on medical diagnoses. Improvement was variable across clinical disciplines, and improvement is still needed.
  - Outside of chronic health conditions, the use of clinical indicators had not yet progressed to the same degree.
  - Overall, for medical and psychiatric care, there was continuing improvement in revising treatments and interventions based on clinical indicators (in part reflecting the expansion of clinical indicators and expectations that they would be tracked). This was less true of other clinical disciplines. In regard to physical and nutritional management (PNM) for individuals, the use of clinical indicators was more variable.
  - In the chronic care clinical pathways, there might be consideration of how relevant clinicians may be involved in review of the condition and treatment plan before the PCP establishes the recommendations to be discussed.
  - There was no single policy that established requirements for integration, provided procedures to facilitate integration, or directed staff to the other policies that included requirements for integration.

<u>At-Risk Individuals</u>

Staff responsible for implementing various aspects of the At-Risk policy demonstrated an improved understanding of risk assessment policies and procedures. Progress in some areas had been noted but IDTs still struggle to consistently assess levels of risk accurately. The Facility continued to struggle with conceptualizing the risk assessment process beyond strict application of the State guidelines.

- 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, which was likely responsible for a significant improvement in many compliance scores.

- Although there remained some lack of clarity about data presented in discussion of risks, IDTs were incorporating clinical data and indicators into the risk assessment process.
- Plans to address risks were established and implemented timely.

- Improvements Needed
  - 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 had not been revised subsequent to the most recent revision to statewide policy.
  - The Facility continued to struggle with conceptualizing the risk assessment process beyond strict application of the State guidelines. 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. Rating of risk level must be based on the risks inherent in the condition.
  - The quality and comprehensiveness of plans to address risk need continuing improvement, including better integration between all appropriate disciplines and clear objectives to allow measurement of efficacy.

<u>Psychiatric Care and Services</u>

Progress has been made in a number of key areas. All individuals who require comprehensive psychiatric assessments now have them, and psychiatrists have started to do annual reviews of those assessments. Psychiatry is also gradually becoming better integrated with other medical and behavioral providers. For example, a good procedure for coordinated care with neurology is now newly in place. Progress in some areas - for example in the area of pre-treatment sedation - has been slow, but there has been good communication between the Monitoring Team and the Facility regarding what is needed to achieve compliance.

Overall The Monitoring Team rated the Facility in substantial compliance for three of the provisions in this section. Provision J15 is newly found to be in substantial compliance.

- Positive Practices and Improvements Made
  - Facility psychiatrists have the required qualifications and experience.
  - The Facility has a good system in place to monitor side effects of psychotropic medications. Administration of the DISCUS and MOSES screens was done by nurses who received good training on the tools and who received annual re-training to assure continued competence. The pharmacy supported DISCUS and MOSES administrations with excellent QDDR reports that included good discussion of matters that were rated on the MOSES and DISCUS.
  - There was good communication between the neurologist and psychiatrists around medications prescribed for both epilepsy and psychiatric indications.
- Improvements Needed

- All individuals who are seen by psychiatry now have comprehensive psychiatric evaluations (CPEs) in place. However, the Monitoring Team found that many diagnoses were not fully justified according to DSM IV criteria.
- Plans to improve treatment program description of the role of medication moved forward slowly. PBMC information about medication did not match PBMC narratives in many cases and adequate behavioral tracking for medication treatment efficacy was often lacking.
- Difficulties with development, implementation and tracking of supports to minimize the use of pre-treatment sedation persist, as do problems with documentation with monitoring for safety during and after pre-treatment sedation.
- 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.
- Further work on this provision is needed and efforts of the Facility should focus on improvements on combined case analysis and formulation.
- There needs to be evidence of IDT and psychiatrist evaluations and discussions of the modality or modalities of treatment that were best suited to the individual, and why.
- The Facility had not yet addressed adequately the requirements regarding risk benefit analyses and treatment alternatives.
- Required medication plans were not in place for either new or ongoing medications.

<u>Psychological services</u>

The Facility had made some good faith attempts to improve the quality of services related to Section K. In some instances, these efforts produced positive outcomes. In other areas, however, the Facility appeared to focus too narrowly when targeting areas for improvement. Of greatest concern, however, were the circumstances in which the Facility did not follow the specific requirements of the Settlement Agreement.

- Positive Practices and Improvements Made
  - The Facility continued to strive toward all qualified staff becoming certified as behavior analysts. At the time of the site visit, 100% of eligible staff were either board certified or actively pursuing board certification.
  - The Facility had greatly expanded the use of rating scales in determining the quality of SFAs and PBSPs. Although the Facility indicated the rating scales required further revision, it was positive that RSSLC was expanding efforts in this area.
  - Previous progress regarding behavior data graphs was maintained, with several areas rated at 100%.
- Improvements Needed
  - Even though efforts were underway to improve the quality of SFAs and PBSPs, at the time of the site visit, 39% of SFAs and PBSPs had not been reviewed within one year according to the Facility's tracking data.

- At the same time that the Facility had attempted to ensure that 100% of individuals were provided Psychological Evaluation reports, the Facility was not routinely assessing intelligence or adaptive skills. Furthermore, for at least half of individuals admitted to the Facility since the beginning of 2013, Psychological Evaluations were not provided within the required 30 days following admission.
- Although SFAs frequently mentioned symptoms of mental illness, there were few examples of empirical attempts to determine the relationship between environmentally based behaviors and the symptoms of mental illness.
- Despite having identified several people in need of counseling services and developing treatment plans for those individuals, those treatment plans consistently lacked the evidence-based approach to intervention required for substantial compliance.

Medical Care

The Facility had developed many new policies to help improve clinical practice at the Facility. The Policy for documentation has resulted in the Facility meeting acceptable practice standards for clinical documentation.

- Positive Practices and Improvements Made
  - The Facility had enhanced practice in the management of acute care conditions.
  - Clinical documentation of annual medical summaries, and IPNs maintained high standards.
  - Morning Report and Grand Rounds provided an interdisciplinary process to ensure continuity of care.
  - The Facility established a comprehensive and clinically relevant process to assess clinical services, at the level of a systems review. One component is a sound database and data analysis.
- Improvements Needed
  - The Facility must ensure that action plans are developed for all relevant clinical issues delineated at the morning report, and grand rounds.
  - Action plans developed by medical providers must include specific monitoring parameters and necessary services required to support the individual.
  - Potential treatments to prevent exacerbation of chronic medical conditions should be discussed by the IDT.
  - Medical conditions and support plan must be clearly delineated at the CLDP meeting and on the CLDP, including relevant monitoring parameters to assess individuals through the post move monitoring period.
  - Although the process to assess clinical service is sound, there was no evidence to support that action plans, and follow-up to the action plans were developed for necessary corrective actions.
  - The mortality review process must provide a comprehensive understanding of the cause of death, to determine if alternate medical treatments, or enhanced support services could improve the overall care of individuals at the Facility.

Nursing Care

The Nursing Department showed significant progress in Section M Provisions, more so in some than others. For Provision M.2, the guidelines for admission, annual, and quarterly nursing assessments were recently revised and continuing to evolve toward compliance. The same was true for Provisions M.3 and M.5 due to recent revisions to the ISP, Integrated Risk Rating, and Integrated Heath Care Plan processes and forms. There were no provisions found to regress. The Nursing Department recently revised the guidelines and forms for conducting annual and quarterly nursing assessments. The RN Case Managers were adapting to and implementing the new guidelines and forms, which were too recently changed to adequately assess the nursing assessments for quality and compliance. The RN Case Manager Supervisor, which is essential for providing oversight and direction to the RN Case Managers, was vacant. The lack of this position impacts the Nursing Department's ability to move forward toward substantial compliance with Provisions M.2, M.3, and M.5.

- Positive Practices and Improvements Made
    - If the requirements in Provision M1 for staffing, Hospital Liaison Nurses, Infection Control, and skin integrity activities were standalone activities they would be considered in substantial compliance.
    - Nursing Quality Assurance processes are well established, including inter-rater reliability processes.
    - The Nursing Department had in place a robust competency based educational program that tracked all required training to ensure the training was completed. There was evidence through interviews with nursing administration and management staff, and individuals' records reviewed that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed sufficient to meet individuals' health care needs.
    - The Facility had a robust system for identifying, reporting, tracking and analyzing nursing medication variances, as well as for taking corrective actions to mitigate medication variances.
- Improvements Needed
    - Requirements for documentation and assessment of acute change of status and emergency response showed progress but continue to need improvements in order to be considered in substantial compliance.
    - The Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. However, these processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance.

<u>Pharmacy Services and Safe Medication Practices</u>

The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with Provisions N.1, N.4, and N.7. The Monitoring Team has significant concern over the Facility's lack of further compliance. The Facility demonstrated areas of exemplary work but also areas in which improvement is needed.

- Positive Practices and Improvements Made
    - The Facility continued to provide necessary review of new medication orders.

- For the single patient drug interventions reviewed, there was evidence to support that the medical provider documented either agreement with the recommendations, or documented a clinically appropriate alternate action.
- The Facility had a good system in place to monitor side effects of psychotropic medications. Administration of the DISCUS and MOSES screens was done by nurses who received good training on the tools and who received annual retraining to assure continued competence. The pharmacy supported DISCUS and MOSES administrations and QDDR reports included good discussion of matters that were rated on the MOSES and DISCUS.
- Drug utilization evaluations (DUEs) are of high quality. However, the pharmacy will need to complete DUEs for all clinically relevant FDA advisories in order to retain compliance at subsequent reviews.

- Improvements Needed
  - Review of the quarterly drug regimen (QDRR) reviews did not included important clinical information. Medical providers did not consistently follow through with recommendations for which they indicated agreement. There was delay in the medical providers, and psychiatrists, review of the QDRRs. Formal recommendations were buried within the pharmacist's narrative, and not easily discoverable.
  - Adverse drug reaction (ADR) reviews did not provide pharmacists' comments or recommendations.
  - The medication variance process did not include an analysis, or summary, of medication variances by medical providers and pharmacists.
  - The drug utilization evaluation (DUE) processes were not developed for all clinically relevant FDA warnings.
  - Physicians did not consistently review MOSES and DISCUS screenings timely and consistently complete the physician review section on the forms.
  - Although there were excellent training materials developed for the identification of ADRs for medical providers, there was no evidence of the specific training initiatives for other health care professionals, such as nurses and pharmacist. Only 19 nurses and pharmacists were documented as having training on the ADR process.
  - The Facility must ensure that the medication variance committee reports not only on nursing variances, but also summarizes medication variances for medical providers and pharmacists, and documents corrective actions, follow-up to corrective actions, and remediation steps.

<u>Physical and Nutritional Management</u>

Overall, significant improvement was noted throughout all provisions. The PNMT continued to improve their process as well as their assessments. PNMPs showed significant improvement and contained the most of the components needed to mitigate risk pending staff implementation. Additionally, the PNMPs were reviewed by the IDT and/or PNMT in response to a change in status and implemented and trained in a timely manner. Staff knowledge as well as proper implementation continued to be a concern of the Monitoring Team but improvement was noted.

- Positive Practices and Improvements Made
  - The comprehensiveness of the PNMT evaluation continued to show improvement.

- PNMPs showed significant improvement and contained the most of the components needed to mitigate risk pending staff implementation. PNMPs demonstrated information to guide staff in mitigating risks associated with PNM.
- PNMPs were revised in a timely manner and there was evidence of review of the PNMP as indicated by a change in status as part of the ISPA and/or PNMT minutes as well as training and implementation of the PNMP in a timely manner.

- Improvements Needed
  - The PNMT policy should include a clear method in which the PNMT would participate in the analysis of trends related to PNM.
  - Missing from the PNMPs was consistent information regarding how staff should communicate with the individual as well as how the individual may express discomfort or other wants/needs.
  - There was still not a QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed.
  - Lack of evidence regarding IDT follow-up was noted to be a concern.
  - Staff was observed not consistently implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were not consistently provided with safe dining or positioning strategies. While implementation continues to be an issue, improvement was noted especially as it related to positioning in bed. Per interview, staff was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being.
  - Because the monitoring tools could show high compliance even though the PNMP was not being implemented accurately, data suggesting high compliance was potentially inaccurate.
  - There was not a clear process or guidelines in place that ensured those individuals who were at a risk level other than "high risk" were provided with consistent monitoring.
  - There was a lack of evidence of indicators being integrated as part of the Integrated Health Care Plans (IHCPs) to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy).
  - QDDP monthly reviews also only stated if changes were made to the PNMP and provided no information regarding status of the individual or if the individual had any issues related to PNM.
  - Individuals receiving enteral nutrition were not consistently provided with assessments that identified the medical necessity of the tube and pathways to oral intake. A new process was just being implemented; the Monitoring Team looks forward to seeing how the system progresses.

<u>Physical and Occupational Therapy</u>

Overall, there continued to be improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at RSSLC. Assessments continued to improve and did a respectable job in providing a comprehensive review of the individual.

- Positive Practices and Improvements Made
  - Assessments were completed in accordance to the schedule set forth by RSSLC and contained the components necessary to identify issues with functional mobility as well as other therapy needs.
- Improvements Needed
  - While Provision P.1 was considered to remain 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 remained aware of this needed area of improvement through discussion with the Monitoring Team as well as through their self-assessment and audit process.
  - OT/PT plans of care and PNMPs were not consistently integrated into the ISP nor was there evidence of review that focused on the effectiveness of the plans of care.
  - A large majority of staff had yet to complete the PNM Core Competency Training.
  - Although policy for PNMP training and monitoring identified frequency of monitoring for high risk individuals, it did not include frequency of monitoring for individuals who were not at a high risk, resulting in lack of a system that ensured all individuals at an increased risk or potentially requiring increased OT/PT related supports were monitored on a regular basis.

<u>Dental Services</u>

The Monitoring Team noted some improvements in dental services, such as ensuring robust monitoring by the living area nurse of individuals prior to and following anesthesia, and the Facility's initial stages of developing a dental QA program to assess the efficacy and adverse outcomes secondary to the provision of oral health care at the Facility. The Facility must continue to further develop dental services, and should strongly consider enhancing its process of tracking and trending oral health care services, so that relevant information about dental services can be efficiently tracked for completion, and to assess efficacy. Also, the Facility should enhance the communication of oral health care related issues, such as monitoring parameters following dental treatments, to the living area staff.

- Positive Practices and Improvements Made
  - The Facility has made some improvement in the area of pre and post anesthesia assessments by the living area nurse, and provides excellent monitoring of individuals who undergo TIVA for dental services.
  - The Facility has begun initial development of a dental QA program, to assess the efficacy and potential adverse outcomes secondary to the provision of oral health care assessments and treatments. Substantial compliance will require further development of the dental QA process.
- Improvements Needed

- The Facility must enhance methods to track and trend dental services, including scheduling.
- The Facility needs to develop a mechanism to regularly assess the provision of oral health care treatments at the living area.
- Emergency dental evaluations and treatments must be promptly provided.
- Living area staff need to be provided with clinically relevant information regarding dental visits, including the reason why the individuals was seen by the dentist, treatment provided, monitoring parameters, and follow for the dental issues.
- Collaboration with other departments to develop and implement sound clinical processes to help reduce the need for sedation must be enhanced.

Communication

RSSLC showed overall improvement with Provision 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 continued to be reviewed and implemented in a more functional manner but implementation continued to be severely lacking.

- Positive Practices and Improvements Made
  - Although there was a lack of consistent integration of the communications strategies into the PBSP; however this has shown significant improvement since the previous review.
- Improvements Needed
  - Direct and Indirect programs continued to need to be expanded to those Individuals who are most in need.
  - Monitoring of programs once in place was also an area that was in need of review to ensure appropriateness. There was no a clear policy that outlined how individuals would be provided with the needed monitoring to ensure staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution.
  - Assessments that were provided were not consistently comprehensive in identifying methods to expand communicative functioning.
  - Communication strategies and programs were not consistently integrated into the ISP, and 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

Due to ongoing changes at the Facility, it was agreed that the review of Section S would be limited to the two most recent ISPs as those ISPs were the first to involve a new ISP methodology. A sample of two records is not sufficient to determine global

performance or compliance with the Settlement Agreement. The two ISPs, however, did allow for a limited comparison between the previous practices and the new methodology. In this capacity, there were suggestions of positive changes.

- Positive Practices and Improvements Made
    - There were some indications that assessments were better integrated into the ISP documentation.
    - The ISP documentation from the new process was modestly better at supporting the need for SAPs.
    - SAPs developed under the new ISP process reflected improvement in some areas relative to the status of ISPs at the previous site visit.
    - The percentage of observed locations with functional engagement for more than half the individuals present increased and was well above baseline data. Nevertheless, improvement is still needed in functional engagement at most homes.

- Improvements Needed
    - Most of the SAPs reviewed did not include specific instructions, operational definitions of targets, adequate documentation procedures, or necessary consequences for correct and incorrect responses.
    - SAP development did not make use of task analyses where appropriate, and there at times discrepancies between the assessments and the SAPs those assessments were intended to support.

<u>Most Integrated Setting</u>

The Facility requested the Monitoring Team to focus its review on two ISPs held during the monitoring visit to provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope. The findings and recommendations found below and throughout this section should be read within this context. Overall, the Monitoring Team was impressed with the effort and resources devoted to this initiative and believed it held promise for future development. Positive developments noted included increased integrated discussion by Interdisciplinary Teams (IDTs) and additional 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. It was noted that RSSLC was making significant changes to its approaches to the interdisciplinary processes supported the ISP planning. More work remained to ensure transitions were effectively planned and successfully implemented.

- Positive Practices and Improvements Made
    - The Monitoring Team did find substantial compliance for Provisions T1c2 and T1h. Respectively, these addressed the identification of Facility staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed and, the issuance of the Community Placement Report.
    - PMM Checklists were completed in a timely manner,

- 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. 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.
    - RSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDP.

Consent

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 initiated its Guardianship Committee. It also continued to provide substantial supports for self-advocacy and had begun using materials from a formal decision-making curriculum designed for adults with intellectual disabilities, which the Monitoring Team commends.

- Positive Practices and Improvements Made
    - The Facility maintained a prioritized list of individuals needing guardians.
    - The Facility had initiated its Guardianship Committee.
    - The Facility continued to provide substantial supports for self-advocacy and had begun using materials from a formal decision-making curriculum designed for adults with intellectual disabilities, which the Monitoring Team commends.
- Improvements Needed
    - The Facility lacked use of a methodology or tool founded in objective criteria to assess capacity for decision-making.
    - Although an expanded Rights Assessment form was still in use, the specific probes in each of seven categories of informed consent were not being used effectively by IDTs to provide a thoughtful assessment of the input each individual was able to provide.

Recordkeeping and General Plan Implementation

The Facility maintained all required components of a Unified Record and continued to implement a thorough audit process. 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 there have been no systemic initiatives to improve compliance with Appendix D requirements. One significant change occurred since the last compliance visit; an Individual

Notebook was implemented. This implementation was completed in August 2013, and direct support staff still made more use of the individual section of the Group Notebook that had already been in place.

- Positive Practices and Improvements Made
  - Facility audits and Monitoring Team reviews found all individuals monitored had an Active Record, an Individual Notebook (as well as an individual section of a Group Notebook), and a Master Record.
  - 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.
- 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 problematic, including gaps in documentation (usually gaps of lines between entries or at the bottom of pages of notes or orders) and legibility; these were consistent with findings from Facility audits.
  - There needs to be greater emphasis on the responsibility of staff who document or supervise documentation for accurate completion of documentation. Furthermore, the Facility had not identified and acted on areas of need for systemic improvements to recordkeeping processes. 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.
  - Although staff interviews reported records were available at IDT meetings, observations by the Monitoring Team did not find this consistently to be the case. Furthermore, observations of meetings showed use of information from the records was variable.
  - 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 has begun to implement a database that would track status of revisions.

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.

Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment 8/9/13 2. RSSLC Action Plan 8/7/13 3. RSSLC Section C Presentation Book 4. DADS Policy #001: Use of Restraint 4/10/12 5. RSSLC Policy J.1: Use of Restraint 7/16/12 6. PMAB Training Curriculum 7. Facility training materials for restraint monitors 8. Sample C.1: 29 crisis intervention restraint records which consisted of 15% of the crisis intervention restraints reported by the facility as having occurred between 1/1/13 and 6/30/13. This included restraint of 16 different Individuals, including the two most frequently restrained Individuals (the sample included six restraints for one and five the other) 9. Sample C.2: training transcripts and related documentation for a sample of 24 Direct Support Professionals 10. Sample C.3: 22 medical restraints including 20 (12 TIVA) for dental procedures and two for medical procedures 11. Sample C.4: a subsample of Sample C.1 of four records associated with use of chemical restraint for crisis intervention. This sample of four represented 25% of the chemical restraints between 1/1/13 and 6/30/13. 12. Sample C.5: records of restraint for the three incidents of use of restraint off-grounds 13. Sample C.6: documentation associated with those Individuals restrained four or more times within a rolling 30 day period. 14. State report "Percent of All Employees Completing Courses of Training Program" 8/1/13 15. Restraint related monitoring/QA forms and reports 16. List of individuals with a Crisis Intervention Plan (undated) 17. List of individuals injured during restraint (7/23/13) 18. Crisis Intervention Restraint log 1/1/13 to 6/30/13 19. Facility Restraint Trend Analysis 7/31/13 20. Minutes from 10 randomly selected Incident Management Meetings 21. List of staff approved as Restraint Monitors (undated) 22. Restraint Monitors training transcripts 23. Direct Support Professional (DSP) training transcript for a sample of 24 employees **People Interviewed:** 1. Lloyd Robert Buckner, MS, BCBA – Behavior Services Director 2. Pat Newell, Psychology Assistant

	3. Georgette Brown, Quality Assurance Director 4. Donald Pavliski, CTD Director 5. Dr. Tran Quan, Medical Director 6. Charlene McCurry, Chief Nursing Executive 7. Cynthia Fannin, Assistant Director of Programs 8. Ugo Nweke, Nurse Educator 9. Eleven Direct Care Professionals **Meetings Attended/Observations:** 1. Incident Management Team (IMRT) 8/27 and 8/28/13 2. Four Rivers Unit Morning Meeting 8/27/13 3. Leon Unit Morning Meeting 8/28/13 4. Quality Assurance/Quality Improvement (QA/QI) Council 8/27/13 5. Restraint Elimination Committee 8/28/13
	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. For Section C in conducting its self-assessment, the Facility: • Did not report if it used any specific monitoring/auditing tool in its review of a 20% sample of the 191 crisis intervention restraints that occurred between 1/1/13 and 6/30/13. The self-assessment also did not report the use of any inter-rater reliability in its assessment of restraint practices and documentation. Through interview this was confirmed. Data collected and recorded from the self-assessment review conducted by the Behavioral Services Department was informal and not organized into a report or other similar document summarizing results. o The absence of use of any type of monitoring/auditing tool resulted in the absence of indicators to allow the Facility to determine compliance with the Settlement Agreement. o The Self-Assessment identified the sample(s) sizes, including 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). The sample sizes were adequate to consider them representative samples. • Although in reviewing the self-assessment it was not clear how data was collected or who analyzed/reviewed these data, the Facility presented data in a useful way. Specifically, the Facility's Self-Assessment: o Presented findings based on specific, measurable indicators. o Measured the quality as well as presence of items. o Did not, however, distinguish data collected by the QA Department versus the program/discipline. Upon interview it was determined all data was collected and analyzed by the Behavioral Services Department. • The Facility rated itself as being in compliance with the following provisions of Section C: Provisions C.1, C.2, C.6, C.7.b, C.7.e, and C.7g. This was not consistent with the Monitoring Team's

	findings. The Monitoring Team found the Facility in compliance with only Provision C.2. Noncompliance ratings were determined as a result of insufficient and/or incomplete documentation, inadequate clinical practices with respect to frequently restrained Individuals, insufficient staff knowledge with respect to restraint policy, and, in the case of medical restraint, practices which were not consistent the requirements of the Settlement Agreement. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. • Actions were reported complete**,** in process, complete and ongoing, or not started**.** • The Facility data identified areas of needed improvement. For example, the Facility self-assessment reported a problem with the development of individualized plans to reduce dental sedation and the Action Plan identified steps to address this problem. • The actions did not always provide a set of detailed steps likely to lead to compliance with the requirements of this Section. For example, an action step to address deficient practice in the development of individualized plans to reduce dental sedation was "develop an assessment protocol." Actions needed to accomplish this were not listed. Actions could have included steps such as a review of the literature, seeing what other Facilities used, contacting State and/or national dental associations, etc. 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. For the time period of this review the QA Department did not conduct any audits of restraint documentation.
	Summary of Monitor's Assessment: In its last report the Monitoring Team noted that the use crisis of intervention restraint at the Facility had been steadily increasing over the last two review periods. This trend had stopped and the use of crisis intervention restraint at the Facility had remained relatively constant when comparing six-month periods although there was a threefold increase in the use of chemical restraint. The Facility had made progress in decreased use of restraint for those Individuals who had lived at the Facility for a considerable period of time. The current restraint landscape is dominated by Individuals recently admitted to the Facility. Proper documentation of restraint use and review of restraint episodes, in general and specific to the use of medical restraint, remained problematic. Compliance with Settlement Agreement requirements associated with the use of medical restraint remains problematic with little improvement observed since the last review nine months earlier. The RSSLC's self-assessment reported that the Facility was in substantial compliance with Provisions C.1, C.2, and C.6; however the Monitoring Team was only able to confirm substantial compliance with Provision C.2, which requires that restraints be terminated as soon as the individual is no longer a danger to him/herself or others. In its last review the Monitoring Team found compliance with Provision C.6 which

	addresses, primarily, supervision of Individuals while in restraint. During this review this Provision was not in compliance primarily due to issues related to medical restraint. 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; however, Facility review of one restraint reported the use of an equally dangerous, and unapproved, supine restraint. This restraint incident was investigated by the Department of Family Protective Services (DFPS) which returned a finding of confirmed physical abuse. Only four of 11 (36%) of staff queried were unaware of the prohibition of prone restraint. As noted in the Monitoring Teams last report the restraint monitoring and review process at the Facility was deficient in that it did not always ensure a substantive and well documented clinical and administrative review of each restraint episode. In this regard, policies were in place to require these reviews but they were apparently not consistently and/or 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, these tapes had not been used with regularity as part of the restraint review process. 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.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans</td><td>Data provided by the Facility for the past two six month periods, showed:

<table>
<tr><th>Type of Restraint</th><th>7/1/12 to 12/31/12</th><th>1/1/13 to 6/30/13</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>172</td><td>179</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>4</td><td>14</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>9</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>185</td><td>192</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>28</td><td>25</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>15</td><td>11</td></tr>
<tr><td>Medical restraints/dental
Medical restraints/medical procedures</td><td>97
35</td><td>142
47</td></tr>
<tr><td>TOTAL individuals restrained for</td><td>132</td><td>189</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	medical/dental reasons*	

*NOTE: The Monitoring Team could not validate the data reported by the Facility with respect to medical restraint as necessarily accurate due to conflicting information received in interviews during the review.

The use of crisis intervention restraint had remained high and as noted in the last report was attributable primarily to new admissions. 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.

Prone Restraint

Based on Facility policy review, prone restraint was prohibited.

Based on review of other documentation (trend reports and lists of restraints) use of prone restraint was not identified.

A sample, referred to as Sample C.1, was selected. (A list is provided in the Documents Reviewed Section above). Based on a review of the restraint records for individuals in Sample C.1 involving 16 Individuals none showed use of prone restraint. In reviewing Sample D.1 (investigations) the investigation associated with UIR 117 (Individual #287) reported use of an equally dangerous, and unapproved, supine restraint. This incident was investigated by the Department of Family Protective Services (DFPS) which returned a finding of confirmed physical abuse.

Based on questions with 11 direct support professionals, only four (36%) were aware of the prohibition on prone restraint. These 11 staff were from four different residential areas. Examples of responses to the query "under what circumstances is it OK to use prone restraint?" included: "when an Individual poses harm to self and others", "if the person is so out of control other restraints don't work", and "while using four point restraint".

Other Restraint Requirements

Based on document review, the Facility and State policies do state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to

#	Provision	Assessment of Status	Compliance
		treatment. Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 29 of the 29 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • For the 29 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 29 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. • In 29 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. • Facility policies do identify a list of approved restraints. Based on the review of 29 restraints, involving 16 Individuals, 29 (100%) were approved restraints. However, as noted above in reviewing Sample D.1 (investigations) the investigation associated with UIR 117 (Individual #287) reported use of an unapproved supine restraint. In 29 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. At the time of the review the Facility reported that one Individual (#624) was the subject of physical mechanical restraint for self-injurious behavior (PMR-SIB). This restraint (use of a helmet) was initiated on 8/15. The Monitoring Team determined that not all requirements of PMR-SIB policy had been followed. For example, there was insufficient documentation to validate on site observation by psychology staff and restraint monitors. There also was insufficient documentation to validate that required circulation checks occurred within prescribed timeframes. As noted in the last several reports, crisis intervention restraint used at the RSSLC continued to be highly restrictive. From the Monitoring Teams sample of 29 restraints, 27 (93%) were basket-hold, horizontal side-lying, or chemical. This pattern of use of highly restrictive restraint techniques was noted by the Monitoring Team in its last three 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	

#	Provision	Assessment of Status	Compliance
		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 reviewed four Individuals who used abdominal binders related to G/J tube placement (Individuals #787, #621, #500, and #351). In each case the Individuals most recent ISP Addendum explaining the purpose of the abdominal binder did not reference a need to control the Individual's behavior and cited reasons such as "prevent accidental pulling", or, "moves around independently while in bed." The Monitoring Team believes this is appropriate and does not represent behavioral restraint. Based on this review this Provision was not in substantial compliance. This Provision had previously been in compliance; however, the failure to properly adhere to policies associated with the use of PMR-SIB, the use of an unapproved restraint technique (supine), and insufficient staff knowledge with respect to the prohibition of use of prone restraint demonstrate regression in compliance with this Provision.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the 16 individuals in Sample C.1 were reviewed. Of these, five of the individuals had Crisis Intervention Plans at the time of restraint that defined the use of restraint. For the five Individuals who had Crisis Intervention Plans (CIP), four (80%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. The restraint checklist for restraint of Individual #287 (1/8/13) did not report the proper release code. The five Individuals with CIPs were restrained a total of 10 times. Therefore the compliance rate for this metric was 90%. For the 11 individuals who did not have Crisis Intervention Plans at the time of restraint, 10 (91%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. These 11 Individuals were restrained a total of 19 times. Therefore the compliance rate for this metric was 95%. Based on this review this Provision was in substantial compliance.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas:	Noncompliance

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	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.	• Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample C.2 was selected from a current list of staff. A description of Sample C.2 is provided in the Documents Reviewed section above. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: • 24 of the 24 (100%) had current training in RES0105 Restraint Prevention and Rules. • 24 of the 24 (100%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training. • 24 of the 24 (100%) had completed PMAB training within the past 12 months. The Monitoring Team also reviewed a State report "Percent of All Employees Completing Courses of Training Program." This report indicated the following completion rates for RSSLC employees: • 100% RES0105 Restraint: Prevention and Rules for Use at MR Facilities • 100% RES0110 Applying Restraint Devices • 100% PMA0320 – PMAB Basic • 100% PMA0400- PMAB Restraint • 100% PMA0700 –PMAB Prevention • 100% PBS0100 – Positive Behavior Support In order to evaluate staff knowledge in the area of restraint, 11 Direct Care Professionals were asked a series of questions. The 11 staff were selected by the Facility and included both am and pm staff, and staff from four different residential units. Each response was evaluated by one member of the Monitoring Team, the Facility's CTD Director, and the Facility's Quality Assurance Director. Consequently, for each question, responses were subjected to 33 evaluations (eleven individuals' times three raters). Based on responses to questions, 11 direct support professionals provided satisfactory responses to the following questions as follows: • "Policies governing the use of restraint require that restraint should only be used if the Individual poses a ____and after_____." Fourteen of 33 responses were evaluated as satisfactory (42%);	

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		• "Describe an example of a verbal redirection technique." Twenty-two of 33 responses were evaluated as satisfactory (67%); • "Describe two restraint techniques approved for use at the Facility." Seventeen of 33 responses were evaluated as satisfactory (52%); • "What level of supervision is usually required when an Individual is in restraint?" Twenty-eight of 33 responses were evaluated as satisfactory (85%); and, • "Under what circumstances is it OK to use prone restraint?" Twelve of 33 responses were evaluated as satisfactory (36%). The above data suggests staff is not retaining information learned in formal training classes. The Facility needs to engage in additional strategies to reinforce key provisions of restraint policy. Staff should be able to articulate that restraint is only to be used if the individual poses an immediate and serious risk of harm to him/herself or others and after a graduated range of less restrictive measures has been exhausted, state at least one example of a verbal redirection technique, two examples of approved restraint techniques, that 1:1 supervision is ordinarily required when a person is in restraint, and that there is no circumstance where prone restraint is allowable. In 29 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Based on this review this Provision was not in substantial compliance because staff training had not resulted in demonstrated staff understanding of basic restraint policy.	
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.	Based on a review of 29 restraint records (Sample C.1), in 29 (100%) there was evidence that documented that restraint was used as a crisis intervention. In review of 14 Positive Behavior Support Plans, in 14 (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. The Facility did not maintain a "Do Not Restrain" list. 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. The intended	Noncompliance

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		use of this form has been in place since 2004. The Monitoring Team asked the Facility to produce a copy of this form for each of the 16 Individuals in Sample C.1. For Individual #475 this form was present but was dated after restraints on 2/26/13 and 3/2/13. For Individual #314 this form was present but dated after all six restraints of this Individual in Sample C.1. For Individual #287 this form was not present. For Individuals #787, #278, #267, #630, #511, and #151 this form was present and in each case the physician noted "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)." No evidence was provided to the Monitoring Team that would confirm whether or not the IDT discussed the physician recommendation and followed up accordingly. As a result of this review the Monitoring Team determined that for 9 of 16 Individuals (56%) in Sample C.1 restraint use did not address the SA requirement that restraint not be used that is prohibited by the individual's medical orders. 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. In seven of 16 restraint records reviewed (44%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders as validated on the Physician/Nurse Practitioner Assessment for Identifying Potential Health Risks for Restraint. In 16 of 16 restraint records reviewed (100%), there was no evidence that the restraint used was in contradiction to the individual's ISP, PBSP, or crisis intervention plan. In reviewing 22 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • Twenty-one (95%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • Two (9%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and	

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		• One (5%) of the treatments or strategies developed to minimize or eliminate the need for restraint was implemented as scheduled. For Individual #306, no information was provided to verify the plan was implemented. Additional information regarding medical restraint is provided in Provision J.4 of this report. Based on this review this Provision was not in substantial compliance.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed 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	Review of Facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. This training was competency-based. Based on review of training records, 16 staff at the Facility who performed the duties of a restraint monitor for restraints in Sample C.1 16 (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. This included the following classes: • 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 Based on a review of 29 restraint records (Sample C.1), a face-to-face assessment was conducted: • In 28 out of 29 incidents of restraint (97%) by an adequately trained staff member. For restraint of Individual #787 (2/27/13) the Facility reported no restraint monitor had been assigned to the restraint episode. • In 26 out of 29 instances (90%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included: Individuals #787 (2/27/13), #630, and #74. • In 27 instances (93%), the documentation showed that an assessment was completed of the application of the restraint. For Individual #368 (3/4/13 and 6/5/13) data recorded on the restraint checklist was not always consistent with	Noncompliance

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	shall specify the schedule and type of monitoring required.	data recorded on the debriefing form (the time of arrival of the restraint monitor). • In 29 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint. In no case had a physician ordered an alternative monitoring schedule. Based on a review of 29 restraint records for restraints that occurred at the Facility (Sample C.1), of which four of 29 (14%) restraint records were for chemical restraint and 25 of 29 (86%) were for physical restraints. There was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the physical restraint in 22 of 25 (88%). Records that did not contain documentation of this included: o Individual #543: On 6/11/13 at 4:07 p.m., Individuals #543 was physically restrained. The nurse was not notified of the restraint episode until 5:00 p.m., and then the nurse began monitoring. o Individual #314: On 2/26/13 at 12:55 p.m., Individual #314 was physically restrained. The nurse was not notified of the restraint episode until 2:20 p.m., and then the nurse began monitoring. o Individual #475: On 2/26/13 at 1:25 p.m., Individual #475 was physically restrained. The nurse was notified of the restraint at 1:25 p.m., but did not begin monitoring until 2:24 p.m. • Monitored and documented vital signs in 19 of 25 (76%) of the instances of physical restraint. Records that did not contain documentation of this included: o Individual #511: On 3/17/13 at 12:22 p.m., the nurse documented that Individual #511 refused to allow pulse and blood pressure monitoring. o Individual #368: On 3/4/13 at 4:31 p.m., the nurse documented that Individual #368 refused to allow a full set of vital sign monitoring. o Individual #368: On 3/6/13 at 10:55 p.m., the nurse documented that Individual #368 refused to allow a full set of vital sign monitoring. o Individual #475: On 2/26/13 at 2.24 p.m., the nurse documented that Individual #475 refused to allow a full set of vital sign monitoring. o Individual #306: On 5/23/13 at 5:00 p.m., the nurse documented that Individual #306 refused to allow pulse and blood pressure monitoring. o Individual #314: On 2/26/13 at 12:55 p.m., the nurse documented that Individual #314 refused to allow a full set of vital sign monitoring. • Monitored and documented mental status in 25 of 25 (100%) of the instances of physical restraint. • Conducted monitoring at least every 15 minutes from the initiation of the	

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		chemical restraint for at least two hours, according to policy for Post-Med Monitoring of Chemical Restraint, in one of four (25%). Records that did not contain documentation of this included: o Individual #475: On 3/2/13 at 1:38 p.m., Individual #475 received chemical restraint but was not monitored every 15 minutes from the initiation of chemical restraint for at least two hours. o Individual # 475: On 4/23/13 at 5:21 p.m., Individual #475 received chemical restraint but was not monitored every 15 minutes from the initiation of chemical restraint for at least two hours. o Individual #475: On 6/8/13 at 6:00 p.m., Individuals #475 received chemical restraint but was not monitored every 15 minutes from the initiation of chemical restraint for at least two hours. • Monitored and documented vital signs in one of four (25%) of the instances of chemical restraint. Records that did not contain documentation of this included: o Individual #475: On 3/2/13 at 1:38 p.m., Individual #475 received chemical restraint but refused all monitoring of vital signs. Vital Signs were not monitored every 15 minutes for at least two hours. o Individual # 475: On 4/2/13 at 5:21 p.m., Individual #475 received chemical restraint, with the exception of respiration monitoring, refused monitoring of all other vital signs. Vital Signs were not monitored every 15 minutes for at least two hours. o Individual #475: On 6/8/13 at 6:00 p.m., Individuals #475 received chemical restraint but refused most all monitoring of vital signs. Vital Signs were not monitored every 15 minutes for at least two hours. • Monitored and documented mental status in four of four (100%)of the instances of chemical restraint. • Completed the Sedation Nurse Monitoring (for Chemical Restraint) section on the Post-Med Monitoring Checklist in two of four (50%) of instance of chemical restraint. • Monitored and documented whether restraint-related injuries occurred for both chemical and physical restraint episodes. In 23 of 29 (79%) instance of restraints the Restraint Checklists for Injury were documented. Four of 29 (14%) restraint episodes indicated that minor injuries were sustained, of which two restraint episodes resulted from restraint use, and each of the four documented minor injuries sustained prior to and/or during restraint from aggressive/self-injurious behaviors. Two restraint episodes did not document whether injuries occurred. Records that did not contain documentation of this included: o Individual #511: On 3/17/13 at 12:22 p.m., Individual #511 was physically restrained.	

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		o Individual #475: On 3/2/13 at 1:38 p.m., Individual #475 received chemical restraint. There should be documentation from nursing describing the individual that objectively indicates that he or she appeared medically stable, such as comments regarding gait, behavior, and mental status. Merely documenting "refused" is not acceptable. Respirations should be obtained; they do not require an individual's cooperation and the nurse should be able to determine whether the individual was having any respiratory distress. The mental status section should include specific behaviors that support the current mental status description. "Alert and oriented" or "back to baseline" are inadequate. For chemical restraint, the vital signs have to be taken at some point because a common side effect of psychotropic medication is postural hypotension. If this was impossible to do, an objective nursing assessment would be necessary to document the individual's medical status post chemical restraint. In addition, the nurses should be notified timely of physical restraint episodes. Based on documentation provided by the Facility, three restraints had occurred off the grounds of the Facility in the last six months. A sample of three was reviewed (Sample C.5). A licensed health care professional: • Conducted monitoring within 30 minutes of the individual's return to the Facility in three out of three (100%). • Monitored and documented vital signs in one of three (33%). Records that did not contain documentation of this included: o Individual #543: On 6/9/13 at 2:00 a.m., the nurse documented that Individual #543 refused to allow pulse and blood pressure assessments. The Respirations were assessed. o Individual #113: On 2/7/13 at 10:56 a.m., the nurse documented that Individual #113 refused to allow a full set of vital sign assessments. o Monitored and documented mental status in three of three (100%). • Monitored and documented whether injuries occurred during the restraint episodes. In one of three (33%) restraint episodes, the results of assessment by a licensed health care professional the check box for injury was marked indicating no injury was sustained as a result of the restraint episode. Records that did not contain documentation of this included: o Individual #113: On 2/7/13 at 10:56 a.m., the Injury Report check box was not marked to indicate whether an injury occurred as a result of the restraint episode. o Individual #151: On 4/7/13 at 6:10 p.m., the Injury Report check box	

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		was not marked to indicate whether an injury occurred as a result of the restraint episode. Injuries to Individuals subjected to restraint, both on and off-campus, are of concern to the Monitoring Team. 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. In instances where video recorded the restraint episode review of the video would likely be helpful in this regard. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 6% of the individuals for whom medical restraint was used. (Sample C.3 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In seven out of 22 (32%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • In zero out of 22 (0 %), the physician specified the type of monitoring required if it was different than the facility policy. • In 13 out of 22 of the medical restraints (59%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Based on this review this Provision was not in substantial compliance.	
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	A sample (Sample C.1) of 29 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 29 (100%), continuous one-to-one supervision was provided; • In 29 (100%), the date and time restraint was begun; • In 29 (100%), the location of the restraint; • In 14 (48%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. Those that did not contained incomplete information. Note: the Restraint Checklist in the section labeled Description of Behaviors Prior to Restraint includes the prompt, "Describe the individual's environment, actions, and interactions with others <u>in the time before you began taking steps to avoid the use of restraint</u>" (emphasis added)." In 15 restraints (52%) information addressing this was either overly general or nonexistent. • In 26 (90%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. This was not the case for Individuals #314 (3/4/13) and #787 (2/27/13 and 4/23/13). • In 29 (100%), the specific reasons for the use of the restraint;	Noncompliance

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	extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	• In 29 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • In 29 (100%), the names of staff involved in the restraint episode; • Observations of the individual and actions taken by staff while the individual was in restraint, including in 29 (100%), the observations documented every 15 minutes and at release (Note: all restraints were of short duration. None exceeded 15 minutes and most were less than five minutes.) • In 29 (100%), the level of supervision provided during the restraint episode; • In 29 (100%), the date and time the individual was released from restraint; and • In 13 (45%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. In six instances there was no entry in the required space on the Restraint Checklist and in another seven instances data entered on the checklist was contradictory to data reported on the restraint debriefing form. • In a sample of 29 records (Sample C.1), restraint debriefing forms had been completed for 29 (100%). Data recorded on debriefing forms was not always consistent with data recorded on the restraint checklist. In 27 instances (93%), the documentation showed that an assessment was completed of the application of the restraint. For Individual #368 (3/4/13 and 6/5/13) data recorded on the restraint checklist was not consistent with data recorded on the debriefing form (the time of arrival of the restraint monitor). None of the 29 crisis intervention restraint records in the sample had an alternative physician-ordered monitoring schedule. A sample of 22 individuals subject to medical restraint was reviewed (Sample C.3), and in 13 (59 %), there was evidence that the monitoring had been completed as required by the physician's order. Sample C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last on-site review. One Individual had chemical restraint four times. In none (0%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review this Provision was not in compliance. This Provision had previously been in compliance; however, the failure to consistently note injuries that occur related to restraint use and to provide information about what happened before restraint use, including what was happening prior to the change in the behavior, and the lack of	

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		documentation of contact with the psychologist prior to the use of chemical restraint, led to the use of restraint demonstrate regression in compliance with this Provision.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to Facility documentation, during the six-month period prior to the onsite review, nine individuals were placed in restraint more than three times in any rolling 30-day period. A sample (Sample #C.7) of nine of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. • For none of the nine individuals (0%) was there documentation of an ISPA following each episode of the individual having more than three restraints in a rolling 30 days. o For four of the nine individuals (44%), there was no documentation of an ISPA following any application of restraint. o For Individual #368, there was documentation of an ISPA for 87% of restraint applications that were a part of more than three applications within a rolling 30-day period. o Of the remaining four individuals (44%), documentation reflected an ISPA review for between 9% and 48% of restraint applications that were a part of more than three applications within a rolling 30-day period • Of the nine individuals reviewed, none (0%) of individual's teams (as reflected in ISPAs) discussed each individual's adaptive skills and biological, medical, and psychosocial factors and raised questions about all of these variables, thereby acknowledging the possibility of these variables affecting the individual's behavior. • Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in none of the cases (0%).	Noncompliance
	(b) review possibly contributing environmental conditions;	Of the nine individuals reviewed, none (0%) of individual's teams (as reflected in ISPAs) discussed the possibly contributing environmental conditions.	Noncompliance

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		Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in none of the cases (0%).	
	(c) review or perform structural assessments of the behavior provoking restraints;	None (0%) of these ISPAs reflected a discussion of potential environmental antecedents to the behaviors that provoke restraint, • Seven of the nine individuals (78%) had not been provided a structural assessment prior to the site visit. Of these seven, three (43%) were not documented as having been provided a structural assessment by the end of the site visit. The four remaining individuals (57%) were provided structural assessments, but not for weeks to months following the restraint applications. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in none of the cases (0%).	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	None (0%) of these ISPAs reflected a discussion of the variable or variables that potentially are maintaining the behavior provoking restraints, • Seven of the nine individuals (78%) had not been provided a functional assessment. Of these seven, three (43%) were not documented as having been provided a functional assessment by the end of the site visit. The four remaining individuals (57%) were provided functional assessments, but not for weeks to months following the restraint applications. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in none of the cases (0%).	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such	For three of the nine individuals (33%), there was a PBSP and a Crisis Intervention Plan (CIP). • Three of the nine individuals (33%) had been provided a PBSP. • Four of the nine individuals (44%) had been provided a CIP. • Five of the nine individuals (56%) had neither a PBSP nor CIP. Of these three PBSPs: • Three (100%) had operationally defined target behaviors. • Three (100%) contained functional replacement behaviors (when practical and possible). • None (0%) specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint. • Three (100%) contained interventions to weaken or reduce the behaviors that provoked restraint that were clear, precise and based on a functional	Noncompliance

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	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;	assessment. Of the four CIPs: • Four (100%) delineated the type of restraint authorized. • Four (100%) specified the maximum duration of restraint authorized. • Four (100%) specified the designated approved restraint situation. • Four (100%) specified the criteria for terminating the use of the restraint.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the nine individuals (0%) was there treatment integrity data. Therefore, the Monitoring Team could not determine whether the treatment plans were implemented with a high level of treatment integrity, consistently, and fully.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	In none of the cases (0%) was there a review of the PBSP in the ISPA for individuals having more than three restraints in a rolling 30 days	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	If an individual does not have a Crisis Intervention Plan (CIP), RSSLC does not require that the IDT meet and review each use of restraint. Most typical restraint review by the IDT for individuals without a CIP occurs at their next regularly scheduled monthly ISP review. This is contrary to DADS restraint policy which states, "For restraints used in response to a behavioral crisis with an individual who does not have a Crisis Intervention Plan, the IDT meets to review the use of restraint within one working day of release." Within three business days of the start of each episode of restraint, other than medical/dental restraint, the Facility required that the circumstances under which the restraint was used was to be reviewed at the Unit morning meeting and at the Incident Management Review Team Meeting (IMRT). Restraint Checklists were to be reviewed at Unit Meetings to ensure completeness, with the Unit Director or designee assigning responsibility for corrections needed. The Monitoring Team found very little evidence that these reviews resulted in specific referrals to the individual's IDT with respect to the specific restraint being reviewed in the Unit morning meeting or the IMRT. A subsample of documentation related to five of the 29 incidents of crisis intervention restraint was reviewed (from Sample C.1 – selected restraints number five, 10, 15, 20, and 25 from the list of 29), including the Unit morning meeting minutes, IMRT meeting	Noncompliance

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		minutes, ISP addenda, debriefing meeting minutes, etc.. This documentation showed that: • In four (80%), the review in the Unit morning meeting occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist. Documentation for restraint of Individual #287 did not. • In four (80%), the review by the IMRT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist. Documentation for restraint of Individual #287 did not. • In five (100%), the circumstances under which the restraint was used was determined and was documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • In none (0%), the review conducted in the Unit morning meeting and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. For restraint of Individuals #475 (6/8/13), #314 (5/1/13), and #287 (1/8/13) the Facility was unable to produce evidence (e.g. meeting minutes) of either the Unit morning meeting review or the IMRT review. For restraint of Individuals #600 and #511 meeting minutes were provided but did not include sufficient data to measure compliance with this requirement. Data was either nonexistent or overly general. • In one (20%), referral was made to the IDT, as appropriate (Individual #475). ISPA documentation which was timely and complete was provided to the Monitoring Team. • In four cases (80%) appropriate changes could not have been considered and made to the individuals' ISPs and/or PBSPs in a timely manner as required by this Provision. In three of those four cases (Individuals #314, #600, and #511) a Monthly Review document, which included among many other things, brief information on restraint, was provided to the Monitoring Team. In all three of these cases the monthly review occurred at least 12 days after the restraint episode. Based on this review this Provision is not in compliance.	

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 8/9/13 2. RSSLC Action Plans 8/7/13 3. RSSLC Section D Presentation Book 4. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 12/3/12 5. DADS Policy 02.3 Incident Management 11/20/12 6. RSSLC Policy C.01 Incident Management 2/11/13 7. RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 4/18/13 8. RSSLC Policy C.19 Injury Audits 4/1/13 9. RSSLC Policy D.8 Completing/Routing Client Injury Report 6/14/13 10. RSSLC Policy E.17 Completing Incident Information Reports 2/11/13 11. Unusual incidents log 1/1/13 to 6/30/13 12. Log of serious injuries 11/13/12 to 6/30/13 13. Log of serious incidents 11/1/12 to 8/26/13 14. Log of witnessed Injuries 1/1/13 to 6/30/13 15. Log of discovered Injuries 1/1/13 to 6/30/13 16. Log of peer to peer injuries 7/1/12 to 6/30/13 17. CMS 2567 survey reports since the last review 18. Twelve Incident management meeting minutes since the last review (in addition to minutes reviewed associated with Samples D.1 and D.2) 19. Individual training records for RSSLC investigators 20. Individual training records for DFPS investigators 21. Documentation of volunteer background checks 22. Documentation of employee background checks 23. RSSLC Criminal Background Checks report 10/12 24. Training curriculum for Abuse, Neglect, and Exploitation 25. Acknowledgement of Reporting signed forms for 24 randomly selected employees 26. Log of Department of Family and Protective Services (DFPS) cases 11/13/12 to 6/30/13 27. Sample D.1: included a sample of DFPS investigations of abuse, neglect, and/or exploitation, as well as the corresponding Facility investigation reports. This sample was selected from the document the Facility submitted listing the allegations/investigations completed over the last six months. The sample was 20% of reported investigations initiated and completed over the last six months and included DFPS cases 42647130, 42698332, 42699052, 42715491, 42720797, 42721864, 42727660, 42754076, 42758356, 42761471, 42770081, 42777299, 42779589, 42785895, 42786282, and 42787787. The sample represented investigations that resulted in confirmed, unconfirmed, inconclusive, and administrative referral findings. 28. Sample D.2: included a sample of Facility-only investigation reports selected from the document the

	Facility provided listing investigations completed over the last six months. The sample was 20% of reported investigations initiated and completed since the last compliance visit. Sample D.2 included UIRs 124, 159, 194, 153, 187, 196, 212, and 251. The sample included three discovered serious injuries, two unauthorized departures, and one credible suicide threat. 29. Sample D.3: included a subsample of the investigations included in Samples D.1 and D.2. This included investigation reports in which programmatic recommendations were made (UIRs 143, 175, 235, 234, and 159) 30. Sample D.4: a sample of 31 completed Record Audits to determine whether significant injuries had been reported. 31. Other DFPS investigation reports and related documents for cases 42779589 and 42611963 32. DFPS/OIG/RSSLC coordination meeting minutes since the last review (2/13/13 and 6/26/13) 33. OIG case log 11/1/12 to 8/26/13 34. Materials used to educate individuals, LARs, and family members on Abuse, Neglect, and Exploitation 35. ISPs for Individuals #106, #379, #344, #452, #399, #621, #787, #500, #351, and #499 36. DADS report MHMR0102 Percent of All Employees Completing Course of Training 8/1/13 37. List of employees/dates placed in No Direct Contact status (undated) 38. QA/QI meeting minutes 4/30/13 39. Staff Training Records (24 randomly selected employees) 40. Abuse/neglect quiz used by campus administrators (undated) 41. Self-Advocate meeting minutes for eight meetings since the last review 42. RSSLC Trend Reports 7/31/13 **People interviewed:** 1. Robert Muhammad, Incident Management Coordinator 2. Georgette Brown, Quality Assurance (QA) Director 3. Al Barrera, Facility Director 4. Donald Pavliski, Competency Training and Development Director 5. Eleven Direct Support Professionals **Meetings attended/Observations:** 1. Incident Management Team Meeting (IMRT) 8/27 and 8/28/13 2. Four Rivers Unit Morning Meeting 8/27/13 3. Leon Unit Morning Meeting 8/28/13 4. Quality Assurance/Quality Improvement (QA/QI) Council 8/27/13 5. Observations at Leon and Four River residential units and Angelina Workshop
	Facility Self-Assessment: The Facility had undergone important staff turnover that may have affected a thorough self-assessment and compliance with some Provisions. The Incident Management Coordinator (IMC) is new since the last review, as is the Quality Assurance Director (who supervises the IMC). 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.

	For Section D, in conducting its self-assessment: 1. The Facility did not report if it used any specific monitoring/auditing tool in its review of a 21% sample of the 95 abuse/neglect investigations or the 36% sample of the 56 Facility only investigations which occurred between 12/1/12 and 6/30/13. The self-assessment also did not report the use of any inter-rater reliability in its self-assessment of Section D. This was confirmed through interview. 2. The Facility did not specify how the review was done, how the investigations 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. Through interview it was determined that QA monitoring data was not used in the self-assessment. 3. Data collected and recorded from the self-assessment review conducted by the Incident Management Coordinator (IMC) was informal and not organized into a report or other similar document summarizing results. 4. The absence of use of any type of monitoring/auditing tool resulted in the absence of indicators to allow the Facility to determine compliance with the Settlement Agreement. 5. The Self-Assessment identified the sample(s) sizes, including 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). The sample sizes were adequate to consider them representative samples. 6. Although in reviewing the self-assessment it was not clear how data was collected or who analyzed/reviewed these data, the Facility generally presented data in a useful way using specific, measurable indicators and in some instances measuring the quality as well as the presence of items. 7. The Facility rated itself as being in compliance with the 20 of the 22 Provisions in Section D. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following 14 provisions: D.1, D.2.b, c, d, e, f, g, and h, D.3a, b, c, d, and j, and D.5. Generally, the Facility's self-assessment did not include all of the components included in specific provisions of the Settlement Agreement (e.g., provisions often include multiple requirements, and the self-assessment did not always address all of them) or the Facility did not probe with sufficient thoroughness to determine compliance. 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 complete, in process, and complete and ongoing. The Facility data identified areas of needed improvement. For example, the Facility self-assessment reported a need to develop a revised audit injury auditing process. The actions did not always provide a set of detailed steps likely to lead to compliance with the requirements of this Section. For example, an action step to develop a revised audit procedure did not include any detail with regard to how this was to happen. An additional action step was reported as "implement revised process" with no detail as to steps necessary for this to occur.

	Summary of Monitor's Assessment: The Facility had undergone important staff turnover that may have affected compliance with some Provisions. The Incident Management Coordinator (IMC) is new since the last review, as is the Quality Assurance Director (who supervises the IMC). As noted in the Facility Self-assessment summary above, the RSSLC self-assessment reported substantial compliance with 20 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) 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. Six 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.3.e, which addresses timely initiation and completion of investigations. 3. Provision D.3.f, which addresses investigation report content. 4. Provision D.3.g, which addresses Facility review of investigation reports 5. Provision D.3.h which addresses preparation of Facility reports 6. Provision D.3.i which addresses administrative follow-up subsequent to investigation findings 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; however, some of the Facility's administrative practices directed at abuse/neglect and incident management (reported throughout this section of the SA) appear to need additional management oversight to ensure the effectiveness of these policies and procedures in protecting Individuals and keeping them safe. Timely reporting of allegations remained problematic at the RSSLC, as only 36% of investigations (DFPS and Facility investigations of serious incidents) in the Monitoring Team's samples were reported within one hour of discovery as required by policy. Serious incidents were not always reported within one hour of discovery. DFPS investigation were not always initiated within 24 hours and completed within 10 days of being reported. Facility investigations of serious incidents were not always completed within 10 days of being reported. The Facility was unable to produce adequate justification for instances in which DFPS returned confirmed findings of physical abuse and the Facility did not terminate staff employment. The Facility was unable to produce adequate justification for an instance in which OIG returned a

	confirmed finding of criminal conduct related to physical abuse and the Facility did not terminate staff employment. The Facility policies governing abuse/neglect and incident management had been updated since the last review. 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 investigating abuse and neglect and other serious incidents but it was not always used in instances when it could have been helpful in the conduct of specific investigations. 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 two reports, staff knowledge of abuse/neglect reporting requirements needed improvement. All allegations of physical abuse received a law enforcement referral. Reporting procedures for reporting abuse and neglect were prominently displayed throughout the Facility and the Facility had an effective monitoring system to ensure postings remained in place. In every instance where an alleged perpetrator (AP) was known, the AP was immediately placed in no contact status. 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 to ensure good communication and cooperation.

#	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	The Facility's policies and procedures did: 1. Include a commitment that abuse and neglect of individuals will not be tolerated, 2. Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	are required to report abuse or neglect of individuals.	for abuse, neglect, or exploitation of individuals. 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 did not always appear 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; however, although policies were in place as required for compliance with this provision, some of the Facility's administrative practices directed at abuse/neglect and incident management appear to need additional management oversight to ensure their effectiveness in protecting Individuals and keeping them safe. For example: 1. As reported in Provision D.2.a, the Monitoring Team was only able to validate timely reporting to DFPS of three of 14 (21%) allegations of abuse/neglect. 2. As reported in Provision D.2.a, the Monitoring Team was only able to validate timely reporting to the Facility Director/designee of five of eight (63%) other serious incidents. 3. Collectively only eight of 22 (36%) serious incidents were reported timely. This was a significant decrease from 67% noted in the last review. 4. As reported in Provision D.2.a, the Monitoring Team, in questioning staff on abuse and neglect policies, was provided with unsatisfactory responses more than half of the time. 5. As reported in Provision D.3.i, there were several instances of confirmed physical abuse cases, including one in which the Office of Inspector General (OIG) substantiated criminal conduct, for which the staff involved remained working at the Facility. 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 provisions of Section D. Therefore, 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		

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:</td><td></td><td></td></tr>
<tr><td></td><td>(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 report these and all other unusual incidents, using standardized reporting.</td><td>Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether, for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.

According to data the Facility provided in a report prepared for the Monitoring Team the numbers of abuse/neglect/exploitation allegations for the past year were:

<table>
<tr><th></th><th>7/1/12 to 12/31/12</th><th>1/1/13 to 6/30/13</th></tr>
<tr><td>Total abuse allegations</td><td>75</td><td>89</td></tr>
<tr><td>Physical</td><td>45</td><td>58</td></tr>
<tr><td>Verbal/Emotional</td><td>30</td><td>31</td></tr>
<tr><td>Abuse substantiated</td><td>10</td><td>9</td></tr>
<tr><td>Physical</td><td>10</td><td>6</td></tr>
<tr><td>Verbal/Emotional</td><td>0</td><td>3</td></tr>
<tr><td>Abuse inconclusive</td><td>10</td><td>10</td></tr>
<tr><td>Physical</td><td>7</td><td>5</td></tr>
<tr><td>Verbal/Emotional</td><td>3</td><td>5</td></tr>
<tr><td>Total neglect allegations</td><td>55</td><td>62</td></tr>
<tr><td>Neglect substantiated</td><td>8</td><td>8</td></tr>
<tr><td>Neglect inconclusive</td><td>3</td><td>2</td></tr>
<tr><td>Total exploitation allegations</td><td>0</td><td>2</td></tr>
<tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr>
<tr><td>Exploitation inconclusive</td><td>0</td><td>0</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		According to data the Facility provided in a report prepared for the Monitoring Team the numbers of Unusual Incidents investigated over the past two years included: **7/1/12 to 12/31/12** / **1/1/13 to 6/30/13** Deaths: 4 / 4 Serious Injuries: 39 / 20 Sexual Incidents: 1 / 1 Suicide Threat (credible): 20 / 9 Unauthorized Departure: 7 / 4 Choking: 2 / 0 Other: 1 / 1 Based on the Monitoring Teams' review of DADS revised policies, including Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy 002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements. According to RSSLC Policy C.01 Incident Management (2/11/13) and RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (4/18/13), staff were required to report abuse, neglect, and exploitation within one hour by calling the DFPS 1-800 number. This was consistent with the Settlement Agreement requirements. With regard to unusual/serious incidents, the Facility policy entitled C.01 Incident Management (2/11/13) and RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (4/18/13), required staff to report unusual/serious incidents within one hour to the Facility Director/designee. This policy was consistent with the Settlement Agreement requirements. In order to evaluate staff knowledge in the area of abuse and neglect reporting 11 Direct Care Professionals were asked a series of questions. The 11 staff were selected by the Facility and included both am and pm staff, and staff from four different residential units. Each response was evaluated by one member of the Monitoring Team, the Facility's CTD Director, and the Facility's Quality Assurance Director. Consequently, for each question responses were subjected to 33 evaluations (eleven staff times' three raters). Based on responses to questions, 11 direct support professionals provided satisfactory responses to the following questions as noted:	

#	Provision	Assessment of Status	Compliance
		"Describe the reporting procedure and timeframe when abuse/neglect is suspected." Fifteen of 33 responses were evaluated as satisfactory (46%). "Describe the reporting procedure and timeframe for other serious incidents." Ten of 33 responses were evaluated as satisfactory (30%). The above data suggests staff is not retaining information learned in formal training classes and may contribute to the problem the Facility identified in its self-assessment (and confirmed by the Monitoring Team) of late reporting. As noted in previous reports the Monitoring Team determined that the Facility did not regularly and routinely report allegations of abuse /neglect and other serious incidents within the timeframes required in State and Facility policy and by the Settlement Agreement. Based on a review of 14 investigation reports (two of the 16 did not report a time/date of the alleged incident) included in Sample D.1: ▪ Three (21%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. These were 42699052, 42720797, and 42785895. ▪ Three (21%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ▪ For the 11 allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, no UIRs/investigation folders (0%) included recommendations for corrective actions. Based on a review of eight investigation reports included in Sample D.2: ▪ Five (63%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. Those that were not were UIRs 159, 187, and 215. ▪ Five (63%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. ▪ For the three unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, no UIRs/investigation folders (0%) included recommendations for corrective actions. Collectively only eight of 22 (36%) serious incidents were reported timely. This was a significant decrease from 67% noted in the last review. In its last report the Monitoring Team noted that timely reporting of allegations had	

#	Provision	Assessment of Status	Compliance
		improved since the prior review but remained problematic. This review suggests timely reported has regressed and is at an unacceptable level. The Facility self-assessment sampled 40 cases (both DFPS and Facility UIRs) and found the one-hour reporting compliance rate to be 90%. As noted above, the Monitoring Team, in its sample of DFPS cases, found one-hour reporting compliance to be lower (21%). In its sample of Facility investigations the Monitoring Team also found the one-hour reporting compliance rate to be lower (63%). The Facility did have a standardized reporting format. Based on a review of 24 investigation reports included in Samples D.1 and D.2, all (100%) contained a copy of the report utilizing the required standardized format and were completed fully. The Facility had experienced significant turnover in the Incident Management Coordinator (IMC) position. The current incumbent shared many of his planned improvements with the Monitoring Team. The Monitoring Team looks forward to observing the effect of these improvements at its next review. As was the case in its last review the Monitoring Team found that DADS regulatory further validated evidence of late reporting. This occurred in a survey completed on 8/2/13. This incident occurred on 7/18 at 7:30pm and was not reported until 7/19 at 11:54am. 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. Based on this review this Provision was not in substantial compliance.	
	(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	Based on a review of the 16 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 12/1/12. 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 two reports, 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	from direct care responsibilities and as a result places 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. There was no evidence this occurred. Review of 16 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 16 investigation files in Sample D.1, it was documented that adequate additional action was taken to protect individuals in each case once an allegation was known and reported. For example: nursing assessments were done and treatment rendered as appropriate, alleged perpetrators were put in NDC status, and psychology staff conducted emotional assessments of victim trauma. Based on this review this Provision is in substantial compliance.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	RSSLC policies C.01 Incident Management (2/11/13) and RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (4/18/13), require 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 (8/1/13), which reported a 100% compliance rate for staff completion within the last 12 months for ABU0100 and for UNU0100.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. 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 three reports 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. Based on this review this Provision is in substantial compliance.	
	(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.	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 May and June 2013, and, for a random sample of 24 employees. Form 1020 is required by State policy. The 44 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. Instances of late reporting were noted in Provision D.2.a of this report. Those that were identified by the Facility through its investigation report review process (including review by the Incident Management Committee and Incident Management Review Team) resulted in the employees being 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. Based on this review this Provision is in substantial compliance.	Substantial Compliance
	(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	ISP meetings attended by the Monitoring Team included presentation of information on, or discussion of, abuse and neglect identification and reporting procedures. Ten ISP documents were reviewed by the Monitoring Team (Individuals #106, #379, #344, #452, #399, #500, #621, #787, #351, and #499). Nine of 10 (90%) included 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	invitation to join the Family and Friends organization. Self-advocate meetings occurred monthly at the Facility. In reviewing minutes the Monitoring Team found agenda topics relevant to this provision was presented in eight of eight (100%) meetings. In reviewing reported allegations the Monitoring Team noted that 10 reported allegations were made by family members and 35 reported allegations were made by Individuals living at the Center. This further confirms that family members and Individuals are generally knowledgeable of abuse and neglect provisions and know how to report. Additional validation of compliance with this Provision was provided in a survey completed by the Independent Ombudsman which included a four day site review. This survey occurs annually. This survey included an interview with 36 Individuals. From this survey it was reported: • 75% of respondents reported they had been informed of their rights but only 25% could name some of their rights. • 75% reported they know what to do if they have a rights concern. • 100% reported they are comfortable speaking up for themselves. Based on this review this Provision is in substantial compliance.	
	(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.	A review was completed of the postings the Facility used. The Facility used two posters. The posters are 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 two of five living units and the on campus workshop confirmed that the postings of individuals' rights were generally present and in areas to which individuals regularly had access. Additionally, 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.	Substantial Compliance

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		As reported in Provision D.2.e, a review completed by the Independent Ombudsman, which included an interview with 36 Individuals, reported: • 75% of respondents reported they had been informed of their rights but only 25% could name some of their rights. • 75% reported they know what to do if they have a rights concern. • 100% reported they are comfortable speaking up for themselves. Based on this review this Provision was in substantial compliance.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	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 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 four allegations of Physical Abuse in Sample D.1 (100%) law enforcement notification occurred. Based on a review of eight 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. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	Based on interviews with Facility administrative staff, including the 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. In past reviews DFPS and OIG investigators reported they did not discover any situations of real, or perceived, retaliation in the course of conducting their investigations (no investigators were onsite to interview during this review). The Facility reported there had been no instances of reported retaliation since the last review. Based on this review this Provision was in substantial compliance.	Substantial Compliance

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The Facility policy C.19 (effective 4/13/13) did define sufficient procedures to audit whether significant injuries are reported for investigation. The Facility had conducted audits at least semi-annually, during the preceding 13 months. According to Policy C.19 the semi-annual review should consist of a sample of 20% of the Individuals living at the Facility. For Richmond this would be approximately 68. Thirty-one Injury Audit Record Reviews were provided to the Monitoring Team, about half of what would be required by policy. Thirty-one Injury Audit Record Reviews were reviewed by the Monitoring Team and were generally sufficient to determine whether significant resident injuries had been reported for investigation. None of these 31 audits discovered any significant injuries that had not been reported for investigation. The Monitoring Team suggests that random sampling for D.2.i audits be supplemented with a sampling methodology that targets individuals who have had discovered injuries of certain types and certain locations and therefore could have been considered "injuries of unknown source" and therefore "significant injuries" that should have been investigated. The Facility could choose to use such a process to increase the audit reviews to meet the number required by Policy C.19. Two suggested methods for this type of sampling are described below. 1. The discovered injury report provided to the Monitoring Team (for the period 1/1/13 to 6/30/13) reported 1019 injuries of which 771 were coded non-serious and 12 serious. The rest were coded no treatment required, no injury found on exam, or none apparent. Data sorting could take these 783 injuries and identify those that involved certain locations (e.g. back, genitalia, buttocks, face) and certain types (e.g. bruise, scratch, redness). These are not necessarily suspicious injuries but could be similar in definition to the "injuries of unknown source" described in policy. Sampling from this smaller data set would likely be more targeted to actual injuries of unknown source. 2. Another method of targeting the D.2.i sample would be using the Facility's Client Injury data base which can identify (from the data reported on the Client Injury Report) injuries that should have been reported for investigation and were not. This could be accomplished by pulling from the data base those injuries noted in the "Discovered Injury Evaluation" section of the Client Injury Report as "yes" to either of the two probes that ask if the injury is located in an area of the body not generally vulnerable to trauma and whether the extent of injuries or the number of injuries at one particular point in time or the incidence of injuries over time raise suspicions of potential abuse or neglect; and, also "no" to the reliable reporter question in the "Description of Incident" section. Every injury	Noncompliance

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		that meets those data requirements should have been (by policy) immediately reported to the Facility Director/designee for further investigation for a Non-Serious Injury Investigation. This procedure would also have the added benefit of checking to make certain these three important pieces of data are completed on each CIR. The Monitoring Team used this methodology to determine, in part, compliance with this Provision. Only two discovered non-serious injuries met the data requirements described above (it was reported by the Facility that many CIRs were missing one or more of the three necessary data elements). In one case (Individual #623) there was no evidence that the injury was reported to the Facility Director/designee and subsequently investigated as required by policy. In the other case (Individual #483) there was no evidence that it was reported but a Non-Serious Injury Investigation occurred anyway, although it was incomplete and did not contain sufficient information from which reasonable conclusions as to cause and/or abuse/neglect could be determined. Based on the sample not meeting policy requirements for a large enough sample to be representative (including discovered non-serious injuries of a type/location that should lead to investigation), this Provision was not in substantial compliance.	
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	The RSSLC policies C.01 Incident Management (2/11/13) and RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (4/18/13), 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	Substantial Compliance

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	supervision of the alleged perpetrator.	required that investigators have training in working with people with developmental disabilities, including persons with mental retardation. This was accomplished through successful completion of People with MR (MEN0300). The Monitoring Team believes this training, if completed as described, should be adequate for the conduct of investigations at RSSLC. Finally, the Facility policy required that investigators be outside of the direct line of supervision of alleged perpetrators. The Monitoring Team reviewed current material used by DFPS in training its investigators. The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 4. Time and Stress Management In reviewing the materials associated with these modules the Monitoring Team believes 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.	

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		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 four investigators that worked the RSSLC cases in Sample D.1. The training records for these investigators were reviewed. All four (100%) completed the requirements for investigations training. RSSLC had five staff designated as investigators and were involved in the cases in Sample D.2. The training records for these staff were reviewed. All five (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. Based on this review this Provision is in substantial compliance.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The Monitoring Team did not detect any instances of lack of cooperation in its review of the 18 DFPS investigations in Sample D.1. 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 meetings that were held on 2/13/13 and 6/26/13. In past reviews both DFPS and OIG investigators reported receiving excellent cooperation from Facility staff in the conduct of their investigations (no investigators were on site during this review). Based on this review this Provision is in substantial compliance.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any	The Monitoring Team did not find any issues with lack of coordination with law enforcement agencies.	Substantial Compliance

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	investigations completed by law enforcement agencies so as not to interfere with such investigations.	A Memorandum of Understanding including multiple agencies with potential law enforcement roles, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy 002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ In 16 of 16 (100%) investigation records from DFPS (Sample D.1) no evidence of interference by one agency or the other was identified. Of the eight 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. Based on this review this Provision is in substantial compliance.	
	(d) Provide for the safeguarding of evidence.	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) physical evidence was safeguarded in 23 of 24 (96%) investigations. The exception was DFPS case 42758356 where some soiled clothing has been accidently thrown away by unit staff prior to commencement of the investigation. This did not appear to materially impact the outcome of the investigation. 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. According to Facility policy, steps are to be taken to preserve physical evidence and should prioritize the collection of evidence that is most at risk of contamination. The	Substantial Compliance

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		Facility policy further states that "in most cases the highest priority will be to identify interviewees and physically separate them until they have been interviewed." This statement is also in DADS policy. The Monitoring Team found little evidence that would suggest that component of the Facility and DADS policy (separation of witnesses until they are interviewed) was being followed. In reviewing Sample D.1 (DFPS investigations) there was no indication that collateral witnesses had been physically separated pending interview. As a practical matter this would be difficult since DFPS usually does not complete interviews of collateral witnesses or alleged perpetrators (APs) until days after the allegation was reported. In some cases the first witness interviews did not occur until 5-7 days after the reported incident. Based on this review the Monitoring Team determined this Provision was in compliance. The Facility and DADS should review its policy with respect to testimonial evidence. It would be helpful if DADS provided guidance to the Facility as to how this policy should be implemented, or change the policy such that it establishes requirements that can be reasonably administered**.**	
	(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.	The Monitoring Team reviewed the DFPS document provided by DADS that 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. The definition of Class I includes abusive acts that "could have" resulted in serious injury. No allegations at the RSSLC were reported to be Class I violations. As described in the last report, 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 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	Noncompliance

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		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 evidence is secure, a determination if there is likely video surveillance evidence to review, and the development and review of a preliminary investigation plan. This format was not consistently used in investigations reviewed for Sample D.1. Twelve of 16 (75%) cases in Sample D.1 documented these type of activities took place within the first 24 hours. Those that did not were cases 42715491, 42770081, 42777299, and 42786282. In these cases the type of administrative activity described as occurring within the first 24 hours was not timely or was incomplete; for example, case 42715491 was reported on 4/17 and the first investigatory activity was on 4/19. For case 42770081 administrative activities within the first 24 hours did not represent substantive investigatory activity, listing only a call to the Facility to confirm the client was safe and a call to local law enforcement. More typically, initiation activity includes at least conversation with a Facility investigator to ensure the scene is secure, any witnesses have been (or are in the process of) being identified, ascertaining whether any video evidence exists, or ensuring any alleged perpetrators have been reassigned. All 16 (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 eight 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 16 DFPS investigations in the sample: Twelve of 16 (75%) commenced within 24 hours or sooner, if necessary. This was	

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		determined by reviewing information included in the intake and 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. Those that did not were 42715491, 42777299, 42770081, and 42786282. In the case of the last two some investigatory activity took place within 24 hours but the standard set of initial investigatory activity required by DFPS protocol was not sufficiently described and documented. 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. Eight of 16 investigations (50%) were completed within 10 calendar days of the report of the incident. Based on documentation provided by the Facility for six of the eight that were not completed within 10 days, approved extension requests were provided. In two cases (42754076 and 42787787) the extension report provided to the Monitoring Team was incomplete or the investigation was completed after the extension date. Consequently, 14 of 16 (88%) investigations were completed within 10 days or had approved extensions. Even though the Facility was in most instances able to provide approved extensions the Monitoring Team is concerned with the high number of cases requiring extensions. It is not always clear that "extraordinary circumstances" exists in every case. For example, in one case (42754076 Inconclusive Physical Abuse) the first staff interview did not occur until the seventh day after the allegation was reported. This investigation was completed 27 days after it was reported. Case 42677130 took 40 days to complete. Case 42777299 took 32 days to complete. The circumstances associated with "extraordinary circumstances" should be closely examined by DFPS administrators and reviewed with the RSSLC Facility Director. Both agencies are responsible for ensuring compliance with this Provision. Following the compliance visit, the Facility informed the Monitoring Team that the units carrying out the investigations had been affected by staffing shortages, had been assisted by assignment of staff from other regions, and were in process of becoming fully staffed. The Facility expects the resolution of the staffing shortages to result in an increase in timely completion and a drop in extensions. All 16 (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. In eight (50%) DFPS had concerns and recommendations for corrective action noted in the report. In each case the recommendations were appropriate to address issues	

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		identified by the DFPS investigator. Facility Investigations (Sample D.2) The following summarizes the results of the review of Facility investigations of serious incidents: Four of eight (50%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing the UIR section 7 "Chronology of the Incident/Injury" and determining the time of the first entry indicating any on site work activity by a facility investigator. Those that did not included UIRs 194, 153, 212, and 215. In the case of UIR 212 the information contained in the UIR was insufficient to determine whether or not an investigation occurred. Five of eight (63%) were completed within 10 calendar days of the incident, including sign-off by the supervisor (IMC). Those that were not included UIRs 124, 153, 187, 212, and 215. 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. In the case of UIR 212 the information contained in the UIR was insufficient to determine whether or not an investigation occurred. Seven (88%) resulted in a written report that included a summary of the investigation findings. In the case of UIR 212 the information contained in the UIR was insufficient to determine whether or not an investigation occurred. 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 eight (100%) included recommendations for corrective action. Based on this review this Provision was not in substantial compliance.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of	Based on the Monitoring Teams' review of DADS revised Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. DFPS Investigations The following summarizes the results of the review of DFPS investigations:	Noncompliance

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	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.	▪ In 12 out of 16 investigations reviewed (75%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Neither the DFPS supervisor nor the Facility questioned any of these investigations. Those that did not included: o Case 42699052 (the nature of the allegation was not clearly stated on the Referral Form at the start of the narrative making it difficult to determine if investigatory steps were appropriate to the circumstances.); o Case 42715491 (this allegation of physical abuse was deemed an administrative referral based on the testimony of the alleged victim without any corroborating staff witness interviews or statements. Allegations of physical abuse with a named alleged perpetrator should be fully investigated.); o Cases 42720797 and 42727660 (the nature of the allegation is not presented on the Referral Form making it difficult to determine if investigatory steps were appropriate to the circumstances); o Case 42770081 (the finding of inconclusive physical abuse was not correctly investigated). Although the report did not provide a clear basis for the conclusion, further information provided to the Monitoring Team clarified that the contents were adequate but were inaccurately written. The incident was alleged to have happened on 5/25 and was reported on 6/6. The Investigator stated in the case report she looked at home shift logs from 6/19 to 6/25 to determine which staff needed to be interviewed. Additionally, the investigation did not attempt to establish when the Individual was last seen without the injury and when first seen with the injury to establish a timeline for interviewing staff and reviewing video evidence). Following the compliance visit, the Monitoring Team was informed that the dates of 6/19 to 6/25 were in error; the actual dates of home shift logs reviewed were 5/19-5/25. Given the importance of this issue, the Monitoring Team would have expected this kind of error would have been caught during review to ensure the appropriate information was reviewed during the investigation. • The report utilized a standardized format that set forth explicitly and separately: o In 14 (88%), each unusual/serious incident or allegations of wrongdoing. Those that did not were cases 42720797 and 42727660; o In 14 (88%), the name(s) of all witnesses. Those that did not were 42699052, and 42715491; o In 16 (100%), the name(s) of all alleged victims and perpetrators; o In 16 (100%), the names of all persons interviewed during the investigation;	

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		o In 12 (75%), 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. Those that did not were 42699052, 42715491, 42720797 and 42727660; o In 16 (100%), all documents reviewed during the investigation; o In 12 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. Those that did not were 42699052, 42715491, 42720797 and 42727660; o In 16 (100%), the investigator's findings; and o In 16 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • In three out of eight investigations reviewed (38%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that did not include: o UIR 196 (the investigation established a probable cause of the serious discovered injury without probing alternative hypotheses such as someone hit the Individual and the investigation coded the injury "determined cause" with insufficient evidence to do so); o UIR 212 (the investigation of this serious discovered injury was coded "determined cause" with no supporting evidence and the investigation did not include staff interviews, video review, or other standard investigatory techniques); o UIR 215 (the investigation of this serious discovered injury included suspicion of PICA related ingestion but the investigation did not probe potential level of supervision issues) . • The report utilized a standardized format that set forth explicitly and separately: o In eight (100%), each unusual/serious incident or allegations of wrongdoing; o In seven (88%), the name(s) of all witnesses (UIR 124 did not); o In eight (100%), the name(s) of all alleged victims and perpetrators; o In eight 100%), the names of all persons interviewed during the investigation; o In five (63%), 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. Those that did not included UIRs 153, 212, and 215; o In eight (100%), all documents reviewed during the investigation; o In eight (100%), all sources of evidence considered, including previous	

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		investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In eight (100%), the investigator's findings; and o In eight (100%), the investigator's reasons for his/her conclusions. Based on this review this Provision was not in substantial compliance.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The Facility policy and procedures did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. The Facility policy did require that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ The DFPS investigations in Sample D.1 did not meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; ▪ The Facility Incident Review Team (IRT) did accept at least ninety-four percent of the investigations over the six months prior to the onsite review. ▪ For four of the DFPS investigation files the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f. Based on a review of the Facility's IRT data, for none (0%), the Facility IRT correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In eight out of eight investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ For none, the supervisor had identified and documented concerns. ▪ For the three investigations noted above for which the Monitoring Team identified deficiencies, the supervisory review did not appear to address these deficiencies. Based on this review this Provision was not in substantial compliance.	Noncompliance
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of	The Facility-only investigations did not meet the requirements outlined in Section D.3.f. Based on this review this Provision was not in substantial compliance.	Noncompliance

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	subparagraph g, for each unusual incident.		
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes. Through interview, the Monitoring Team determined the Facility did not have a mechanism in place to effectively track and document "corresponding outcomes" as required in this Provision. The IMC had recently developed a tool to do this and expects to have improved practices in place for the next review. For one out of five of the investigations reviewed (Sample D.1) in which disciplinary action was warranted in four (80%), prompt and adequate disciplinary action had been taken and documented. This was not the case with DFPS case 42779589. In this case of confirmed physical abuse (and substantiated criminal conduct by the Office of Inspector General) the employee remained employed at the Facility after receiving a 10 day suspension. The Monitoring Team asked for correspondence and related documents between the Facility and DADS central office that might explain the rationale and decision-making process that led to the decision to not discharge the employee. The information provided in response to this request was for a different DFPS case (42809393), The Facility apparently agreed with the DFPS and OIG findings of confirmed physical abuse and substantiated criminal conduct as no evidence was presented to the Monitoring Team that would have indicated the Facility questioned and/or appealed these findings by DFPS and OIG. No documentation was provided to the Monitoring Team that would explain specifically the mitigating circumstances or other criteria used and the process and criteria that led to the decision to not discharge the employee. Consideration of appropriate discipline was not thorough. The Facility informed the Monitoring Team that the decision was made in accordance with DADs policy and Texas Administrative Code and included legal review. In reviewing other documents provided by the Facility (DFPS case 42611963) the Monitoring Team identified two staff where DFPS had confirmed findings of physical abuse and the staff was not terminated from employment. Both were returned to work after retraining. As with case 42779589 the Facility apparently agreed with the DFPS findings of confirmed physical abuse as no evidence was presented to the Monitoring Team that would have indicated the Facility questioned and/or appealed these findings and no documentation was provided to the Monitoring Team that would explain mitigating circumstances or other criteria used that led to the decision to not discharge the employee. Consideration of appropriate discipline was not thorough.	Noncompliance

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		Based on a review of a subsample of investigations for which recommendations for programmatic action were made, the following was found: ▪ For five out of five of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented. ▪ For five out of five investigations (100%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. Based on this review this Provision was not in substantial compliance.	
	(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.	Data systems at the RSSLC enable an investigator to quickly identify individuals and staff who have been the subject of prior investigations. The file storage in the IMC's office was organized and up-to-date. Based on this review this Provision is in substantial compliance.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of 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.	For all categories of unusual incident categories and investigations, the Facility did have a system that allowed tracking and trending by: ▪ 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. Over the past two quarters, the Facility's trend analyses: ▪ Were conducted at least quarterly; ▪ Did address the minimum data elements; ▪ Did use appropriate trend analysis procedures; ▪ Did provide a narrative description/explanation of the results and conclusions; and ▪ Did**,** as appropriate, contain recommendations for corrective actions. As reported in Section E of this report the Facility's QA system was undergoing major overhaul at the time of this review. As a result many elements of corrective action	Noncompliance

#	Provision	Assessment of Status	Compliance
		planning were sporadic, disorganized, and not centrally coordinated. Despite this the IMC had taken positive steps to review data, identify trends, and develop some corrective action plans. Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified in some cases corrective action plans were developed. As appropriate, corrective action plans were developed both for specific individuals and at a systemic level. The trend reports and/or minutes did not always show that corrective action plans were implemented and tracked to completion. The report/minutes did not always review, as appropriate, the effectiveness of previous corrective actions. No formal Corrective Action Plans were provided to the Monitoring Team. Informally, the IMC reported he had initiated a Performance Improvement Team (PIT) for falls and a project resulting in reformatting a section of the ISP template to ensure issues related to abuse and neglect get reviewed and discussed. Because of the current informality of corrective action planning the Monitoring Team was unable to determine if plans could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness or that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. Based on this review this Provision was not in substantial compliance. This Provision had previously been in compliance; however, the overhaul of the Facility's QA system (and staff turnover in the IMC position) resulted in regression with compliance. The Facility's self-assessment also reported noncompliance with this Provision.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and	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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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 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 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. Based on this review this Provision is in substantial compliance.	

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 8/9/13 2. RSSLC Action Plan 8/7/13 3. RSSLC Section E Presentation Book 4. DADS Policy 003.2-Quality Assurance 5/22/13 5. RSSLC Policy A.28 Quality Assurance 7/31/13 6. RSSLC Policy A.29 Discipline Department Head Monthly Quality Assurance 7/26/13 7. RSSLC Policy A.30 Unit Quality Assurance Monthly Meeting 7/31/13 8. RSSLC Policy A.31 Program & Residential Services (PRS) Quality Assurance Team Meeting 8/19/13 9. RSSLC Quality Assurance/Quality Improvement (QA/QI) meeting calendar 10. RSSLC Corrective Action Plan Manual (undated/not yet implemented) 11. Draft Data Collection list 12. Draft Quality Indicators list 13. Facility Trend Reports 7/31/13 14. QA/QI Council Meeting Minutes for 10 meetings between 1/1/13 and 6/18/13 **People Interviewed:** 1. Georgette Brown, 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 8/27/13 2. Leon Unit QA/QI meeting 8/28/13 3. Restraint Reduction Committee 8/28/13 1.
	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 had undergone significant turnover in its QA Director position. The current incumbent was appointed to the position July 1st. This self-assessment consisted primarily of a review of documents and processes partially implemented under the previous QA Directors. In its self-assessment the Facility reported little progress had occurred since the last review and the QA program at the Facility was deficient by all measures and was undergoing major overhaul. The Facility self-assessment reported noncompliance with all five Provisions in Section E. 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 integrated 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 in reviewing QA/QI Council minutes and from direct

	observation of the QA/QI meeting conducted during the week of this review. 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 or in process. Many of the action steps in the Action Plan were overly general ("refine the CAP coding system") and in need of more detail in order to establish a QA program sufficient to meet compliance with the SA.
	Summary of Monitor's Assessment: The Facility appointed a new QA Director on July 1st. Little progress had been made in implementing a QA program since the last review. The QA program at the Facility was undergoing a major overhaul at the time of this review. The new QA Director was enthusiastic and presented plans for improving services. The development of these plans is encouraging. The QA/QI Council meeting observed by the Monitoring Team displayed enthusiasm and professionalism in the presentation of reports and in subsequent discussion. The Facility recognized that these plans were in early stages and requested that the Monitoring Team focus on review of recent documents and processes in order to assess whether these plans had potential to move the Facility toward compliance, which guided the process used by the Monitoring Team in conducting its review and preparing this report. Recent activity by the new QA Director included promulgation of several new and/or updated policies (see Documents Reviewed), formulation of Unit based QA/QI committees, and development of templates for meeting minutes and reports. The Monitoring Team was able to observe a Unit based QA/QI meeting and was encouraged by the enthusiasm demonstrated by unit administrative and professional staff.

#	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>State QA policy</u> There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases.	

#	Provision	Assessment of Status	Compliance
		Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. The state policy called for a statewide QA/QI Council and for statewide discipline QA/QI committees. Neither was in place at this time. <u>Facility QA policies and practices</u> The Facility appointed a new QA Director on July 1st. Little progress had been made in implementing a QA program since the last review and the new QA Director reported the Facility's entire QA program is undergoing a major overhaul. In this regard in its self-assessment the Facility reported: "There are not any data inventory lists available for review at the time of this assessment. The QA Plan has not been edited or finalized since the last monitoring visit; it will need to be developed to describe the quality assurance system for the facility in terms of organizational structure, functional responsibilities of management and staff, resources that are available at the facility to conduct data to identify trends, the processes that each department measures to accomplish goals and the focus of the facility to provide quality service. There is not a QA Matrix available for review at the time of this assessment. At this time there is not an organized system in place to track the monitoring tools that the QA department is responsible for. QA tools need to be improved to identify internal department monitoring tools. At this time there is not an organized system in place that tracks the activities of the external department activities to track data. There is not any documentation at this time of assessment that verifies training has been completed with QA staff. At this time there is only a list of active committees on campus, but it excludes the details of the committee's activities such as; meeting frequency, memberships, or activities conducted by workgroup. None of the QA/QI meeting minutes reflect deliberation or discussion involving the analysis of data to proactively identify potential systemic issues requiring attention. There will be a new system put in place to address the functioning of the QA/QI Council meetings." The Monitoring Team reviewed the self-assessment with the QA Director and confirmed the accuracy of the self-assessment.	

#	Provision	Assessment of Status	Compliance
		The new QA Director was enthusiastic and presented plans for improving services. The development of these plans is encouraging. The QA/QI Council meeting observed by the Monitoring Team displayed enthusiasm and professionalism in the presentation of reports and in subsequent discussion. The Facility recognized that these plans were in early stages and requested that the Monitoring Team focus on review of recent documents and processes in order to assess whether these plans had potential to move the Facility toward compliance, which guided the process used by the Monitoring Team in conducting its review and preparing this report. Recent activity by the new QA Director included promulgation of several new and/or updated policies, formulation of Unit based QA/QI committees, and development of templates for meeting minutes and reports. The Monitoring Team was able to observe a Unit based QA/QI meeting and was encourage by the enthusiasm demonstrated by unit administrative and professional staff. 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. Additional data reports, addressing other subject matter, were also being generated and presented at QA/QI Council meetings. Examples include a trend report for missed medical consultation and diagnostic appointments and reporting monitoring tool data for Section I and S of the Settlement Agreement. The Facility did not have a viable and reliable method for analyzing and assessing these data which would have resulted in the formulation of Corrective Action Plans. The Facility reported that any CAPs currently in place were independent of a formal process and developed independent of the QA process primarily at the initiation of a conscientious administrator. Despite the lack of formal organization the Facility was tracking and trending much data, including incidents of peer to peer aggression, medication variances, urinary tract infections, skin integrity checks, 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. At this point in time there would be no point in trying to assess the Facility's compliance with Section E using the criteria ordinarily assessed by the Monitoring Team. The Monitoring Team looks forward to its next visit and reviewing expected substantial progress. The new QA Director is aware of the criteria proposed by the Monitoring Team for Section E and has received training/mentoring and support from one of the other SSLCs monitored by this team. Additionally, the Facility has excellent support from its data analyst staff.	

#	Provision	Assessment of Status	Compliance
		Based on this review this Provision was not in compliance.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	Please refer to comments presented under Provision E.1. Based on a review of the Facility's self-assessment, and confirmed through interview with the QA Director, the Monitoring Team determined that since the last review: 1. There was not an organized system in place to review trend reports and related information on a regular basis. 2. QA/QI Council meetings were generally unsuccessful in identifying trends or other concerns that needed to be addressed. Data used to develop CAPs was not organized in a manner that would help identify systemic issues. 3. No CAPs addressed systemic issues. 4. The CAPS tracking system was not being utilized properly or to the full extent of its capabilities. For example, it was not being used to assess the timeliness of CAP completion or the effectiveness of a CAP. 5. There was little evidence of a collaborative QA work effort between the QA Department and discipline and department heads. The Facility reported it plans to develop a CAP process sufficient to meet the requirements of this Provision. However, some actions to develop and track CAPs were already in place. The Nursing Department had initiated a Plan of Improvement (POI) Committee. Since the last compliance review, the POI Committee had continued to make significant improvements with regard to quality assurance efforts. The Nursing POI Committee continued to meet weekly or as needed to review completed Nursing Care Monitoring Tools and Protocol Card Audit Tools. Internal (Nursing Department) and external (QA Nurses) auditors monitored the same records for the same time periods to ensure the accuracy of the data. They reviewed and discussed the completed monitoring/audit tools, identified the tools and/or items within the tools that fell below the established threshold of 80% compliance, and made recommendations for corrective action plans (CAPs) to meet compliance. This information was sent to the QA Department. The progress of the implementation of the CAPs was tracked by the QA Department through to resolution. The POI committee continued to monitor the progress of the CAPs and provided the QA Department updates. Based on this review this Provision was not in compliance.	
E3	Disseminate corrective action plans to all entities responsible for their	Please refer to comments presented under Provision E.1.	

#	Provision	Assessment of Status	Compliance
	implementation.	The Facility was unable to provide evidence that CAPs had been disseminated to all entities responsible for their implementation. Through interview the Facility reported there were 10 CAPS in the data system that were currently considered active and that were disseminated to the responsible party by virtue of the fact the person responsible for implementation was also the person who created the CAP. The Monitoring Team was not provided with any documentation to support this. The Facility reported it plans to develop a CAP process sufficient to meet the requirements of this Provision. Based on this review this Provision was not in compliance.	
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.	Please refer to comments presented under Provision E.1. The Facility was unable to produce any documentation that would adequately demonstrate that implementation of the 10 active CAPs was being monitored by the QA Department or the QA/QI Council. The Facility reported it plans to develop a CAP process sufficient to meet the requirements of this Provision. Based on this review this Provision was not in compliance.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Please refer to comments presented under Provision E.1. The Facility was unable to produce any documentation that would adequately demonstrate that implementation of the 10 active CAPs were being monitored by the QA Department or the QA/QI Council. Consequently, there was no evidence that any CAPs were modified to ensure their effectiveness. The Facility reported it plans to develop a CAP process sufficient to meet the requirements of this Provision. Based on this review this Provision was not in compliance.	

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 8/09/2013 2. Richmond State Supported Living Center Action Plans, updated 8/07/2013 3. Richmond State Supported Living Center Settlement Agreement Presentation, dated August 2013 4. Section F Presentation Book materials 5. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/2012 6. Draft DADS Policy 017: Habilitation, Training, Education and Skill Acquisition Programs, effective 5/10/12 7. DADS Policy 004 Personal Support Plan Instructions, dated 7/30/10 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 I.08: At-Risk Individuals, revised 08/15/2013 11. Annual Assessments Filed 10 Days Prior to Meeting, Meeting dates of 11/1/2012-8/6/2013 dated Tuesday, August 06, 2013 12. Monthly Attendance by Discipline 11/1/2012-8/6/2013, PSPs only 13. PSP Attendance Tracking Log, 11/1/2012-8/6/2013 dated Tuesday, August 06, 2013 14. Number of ISPs Not Filed within 30 days, dated Tuesday, August 06, 2013, covering the period of 6/1/2013-6/30/2013 15. Alphabetical list of ISP dates, the date on which the ISP document was completed , the date ISP was filed and the date of the previous ISP, dated Tuesday, August 06, 2013 16. 30-Day ISPs and Assessments for Individuals #1, #66, #524, and #589 17. Sample of recent Individual Support Plans (ISPs) and assessments for Individuals #27, #82, #106, #107, #120, #155, #264, #320, #630, and #753 18. Preferences and Strengths Inventory (PSI) for #1, #66, #524, and #589 19. Sample of Monthly/Quarterly Reviews for Individuals #27, #82, #106, #107, #120, #155, #264, #320, #630, and #753 20. Section I and Section F Monitoring Tools 21. Section F Presentation for QA/QI meeting on 8/27/2013 **People Interviewed:** 1. Angela Hernandez, QIDP Educator and Interim QIDP Coordinator 2. Leroy Thompson, incoming QIDP Coordinator 3. Georgette Brown, Director of Quality Assurance (QA) 4. Davondra Brown, Director of Education and Training 5. Carol Elliot, MS CCC-SLP **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #120 and #264 2. ISP Preparation meeting for Individual #324

	3. Community Living Discharge Plan (CLDP) for Individual #165
	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, for purposes of conducting its self-assessment, the Facility had not used monitoring/auditing tools, including the Section F Monitoring Tool. The QA Plan has not been edited or finalized since the last monitoring visit and needed to be developed to describe the quality assurance system for the Facility. It did not contain any of the following components upon which an accurate self-assessment could be based: Department and QA audits with the Section F monitoring tool, conducting observations of staff implementation of plans, and audits on timeliness of assessments. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. This would change the focus of the Action Plans from measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. Sections of the Self-Assessment did not reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which would tie the Self-Assessment and Action Plans together. The Facility may want to consider how it could further the integration of these two documents, such that staff could visualize the results of the self-assessment, the specific action plan to address any identified deficiencies and the measurable outcome intended to be achieved.
	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. Positive developments included progress in the timeliness of assessments and attendance at ISP annual planning meetings, as well as RSSLC's recent emphasis on developing increased integrated planning, including significant changes to its approaches to the interdisciplinary processes that supported ISP planning. The Facility requested the Monitoring Team focus its review on two ISP planning meetings held during the monitoring visit, and the resulting ISPs, to provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope. The findings and recommendations found below and throughout this section should be read within this context. The Monitoring Team found there was improvement in the implementation of the ISP process, particularly in one of the on-site ISP annual planning meetings in which the IDT had a robust and creative integrated

	discussion around communication needs; however, significant deficits remained that continued to hamper efforts to develop and implement adequate planning for needed protections, services and supports. 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. A revised ISP format and process had been implemented and considerable training and coaching had been provided to the QIDPs and IDTs. The new process included an ISP Preparation meeting held approximately three months prior to the ISP annual meeting as a means of ensuring adequate IDT preparation for the latter. The Monitoring Team found this to be a particularly promising practice that had already resulted in improved preparation and participation by IDT members as observed in the annual ISP meetings held during this site visit. The Facility had also recently begun to plan for and implement some further enhancements to the ISP process, with a focus on the development of integrated, practical and functional Skill Acquisition Plans (SAPs) that were also founded on individuals' preferences and strengths. The Monitoring Team commends this initiative and was impressed with some of the very early results. Overall, however, the revised ISP process was still meeting with limited success specific to the requirements of this section of the SA. IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. 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. The Facility continued to devote considerable resources to training, monitoring, and coaching for QIDPs and IDT members. 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 implementation of an ISP for each individual. The Facility was not routinely implementing quality assurance processes to identify and remediate problems and to further ensure that the ISPs are developed and implemented consistent with the provisions of this section. The Facility did have monitoring tools available, including the Section F and I Monitoring Tools and the Q Construction monitoring tool, but these were not currently being implemented in a formal or consistent manner. A new QA Director had been appointed prior to this monitoring visit, however, and planning was currently underway to develop and implement these processes.

#	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 Intellectual Disabilities Professional (QIDP) was the one person assigned to each individual to facilitate the work of each IDT. <u>Staffing of QIDP Department:</u> The Facility reported that it currently had 20 QIDPs, with one current vacancy. Three had been hired during the past six months. The Facility also had a newly hired QIDP Educator who was serving as the interim QIDP Coordinator as well after the retirement of the incumbent. A new QIDP Coordinator had been identified and was to shortly take on the responsibilities of this role. The QIDP Educator had created a QIDP Manual that served as a resource to each of these staff and was updated on an ongoing basis, and was holding QIDP meetings on a regular basis. As a part of this, the QIDP Educator had realized the QIDP staff were not familiar with content of the SA monitoring reports and had made a priority to inform them of the needs identified. <u>Process of determining competency of QIDPs in the facilitation process</u> Based on the list provided, none of the QIDPs (0%) had been deemed fully competent in facilitation. The Facility had available the Q Construction Facilitation curriculum for training in this area, although the current focus was on hands-on modeling and mentoring being provided by the QIDP Educator. The Facility was not currently using this tool or any other to formally evaluate competence. RSSLC had devoted considerable resources to training for QIDP staff, as described further in Provision F2e. As requested, the Monitoring Team focused most of its attention in this provision on the two ISP annual meetings observed during the monitoring visit. Progress observed included: • There was a continued improvement in the organization of meetings observed, and there was increased responsiveness to assessment information. • There were also some signs that IDTs were developing aspects of integration in the ISPs. This was based on a very small sample as described above, but the Monitoring Team deemed this to be encouraging. See Provision F2a3. • There was progress noted in preparing individuals to participate in the ISP annual planning meeting, and in the facilitation process to enhance participation of the individual.	Noncompliance

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		Continuing needs were identified in the following areas: • Despite the focus on the development of integrated Action Plans, the resulting Skill Acquisition Programs (SAPs) were not sufficiently robust in many aspects, including integration, methodologies and even quantity. Integration of the IRRF and the development of the Integrated Health Care Plans with the development of the Action Plans were also not well facilitated. This was particularly evident in the area of behavioral health needs. See Provision F2a. • The QIDPs needed additional training on the intent of the Integrated Risk Rating Form (IRRF), as one that measured inherent risk rather than risk as mediated by interventions, and on facilitation of this process. For Individual #264, the QIDP Educator was facilitating the meeting and it was clear that she misunderstood the risk rating process, as though the goal was to show progress and achieve lowering of scores. In review of aspiration risk, the Registered Nurse indicated the risk should be scored as medium, while the Occupational Therapist favored a high rating due to a pureed diet, eating and drinking too quickly and some recent history of seizures. The QIDP Educator actually wanted to make the rating low because the pureed diet was the person's preference. This did not adequately take into account the inherent risks if a pureed diet were not offered. The QIDP must have a clear understanding of the process in order to facilitate effectively. The QIDP Educator indicated all the QIDPs would be getting additional training. • The assigned QIDP also remained responsible for ensuring the monitoring and revision of treatments, services, and supports. The Monitoring Team found the QIDP 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. <u>Conclusion:</u> This provision was found to be not in compliance.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	<u>Composition and Participation of IDT:</u> The Facility tracked the attendance of IDT members at annual ISP meetings. The Facility provide a document for review, entitled PSP Attendance Tracking, Meeting Log dated Tuesday, August 06, 2013 and covering ISPs held from 11/1/2012 - 8/6/2013. The data were provided by living unit, but the document was not particularly useful as it appeared to simply indicate actual attendance, not required attendance. The Facility also provided a document entitled Monthly Attendance by Discipline 11/1/2012-8/6/2013, PSPs only that tracked attendance by discipline for each living unit. The overall unit scores for attendance during this period ranged from 97-100%. In the Self-Assessment for Section F, the Facility reported it was not tracking attendance by required IDT members as compared to the ISP Preparation document, so it was not clear how these data reported	Noncompliance

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		above were arrived at. Beginning to track required attendance as it is prescribed in the ISP Preparation document should assist the Facility in obtaining accurate and useful data. The Monitoring Team did note in a review of documents described in the paragraph below, that the ISP Preparation sheet and the ISP sign in sheet, both of which had fields for indicating required attendance, sometimes designated different disciplines as those required to be in attendance for the ISP meeting. This made it difficult to determine who was actually required to attend the meeting. In another case, the Local Authority (LA) was listed on the pre-ISP sheet as required to attend the ISP meeting, yet the LAR had indicated previously, and the ISP sign-in sheet reflected. that the LA was not to be present at the ISP meeting. Both of these issues will also require clarification to more accurately ascertain attendance compliance in the future. The Monitoring Team reviewed the signature sheets for eight recent ISP annual planning meetings to compare the actual attendance with that designated in the ISP Preparation Meeting. Of the eight ISPs reviewed, two contained pre-ISP meeting sheets that did not indicate which individuals should be present at the ISP meeting. Of the six ISPs that did adequately complete this section, a total of 68 individuals were required to be in attendance, and 58 actually were in attendance (85%). Zero of six (0%) had 100% attendance compliance, however. In a review of all eight attendance sheets, it was noted that in only one case did the IDT require the primary care provider (PCP) to be in attendance; the lack of PCP presence at any of the other ISP annual planning meetings was concerning. <u>Extent of Individual participation in ISP:</u> For two ISP annual planning meetings observed as a part of this focused review, the QIDPs had developed some materials such as posters to represent interests and goals of the individual, which were posted in the room and referred to throughout the meeting. While the individuals were not always clear about what was on the posters and what they signified, overall it was a promising first step at using these kinds of tools. The Monitoring Team applauds the QIDPs for this effort. <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	<u>Policy:</u> DADS Policy #004.1 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	Noncompliance

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	and needs.	objectives listed in the "Action Plans" section of the ISP." In Section II.E, the policy stated: "IDT members prepare for the initial 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 be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting. <u>Extent to which assessments are conducted routinely:</u> Assessments for the ISP were still not routinely completed on a timely basis, but there was improvement noted. The expectations remained that assessments would be posted no later than ten working days prior to the meeting. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. There was evidence the IDTs were making use of this function, as six of eight (75%) recent ISPs clearly defined the assessments that were to be completed. As reported in Provision V4, the Facility assessment tracking tool did not provide accurate data. The Annual Assessments Filed 10 Days Prior to Meeting log, dated Tuesday, August 06, 2013, and encompassing the meeting dates of 11/1/2012 - 8/6/2013, included only those assessments that had been filed prior to ten days before ISP annual planning meeting; thus it did not fully capture timeliness data for all required assessments when they were filed after that timeframe. In order to assess the actual timeliness of assessments, the Monitoring Team reviewed assessments for sample of eight completed ISPs and for a sample of nine upcoming ISPs to be held during the week following the monitoring visit. While timeliness remained a concern, there was evidence that the Facility was achieving progress in this area. Findings included: • In the sample of eight ISPs completed prior to the monitoring visit, one (13%) had all assessments completed on a timely basis, at least ten working days prior to the ISP annual meeting. Of the 87 required assessments, however, 61 were completed according to the timeliness requirements. Overall for this sample, the rate of timeliness was 70%. It was not possible to ascertain assessments that might be missing altogether for two of the individuals, as the ISP Preparation meeting documentation did not clearly prescribe the required assessments;	

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		therefore the timeliness compliance rate provided above is based on whether the assessments available in each packet were completed prior to ten working days before the ISP annual meeting was held. • Some assessments were not simply late, but were not completed at all. For the six individuals in this sample for whom the IDT had clearly defined those assessments that were required, there were 74 total prescribed but only 55 (70%) present in the assessment packets provided to the Monitoring Team. • For a sample of nine individuals who had upcoming ISPs during the week following the monitoring visit, only one (11%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. The overall compliance rate was improving, however; 100 of 116 (86%) required assessments were completed 10 working days prior to the ISP date. It should be noted that for three individuals in this sample, the only assessment that was deemed to be not timely was for audiology. Each of these assessments was completed in September (2) or October (1) of 2010 and scheduled for re-assessment every three years. Given that these annual ISP meetings were to be held in the first week of September of 2013, it should be expected that the assessments would be available for the 2013 annual meeting, rather than the 2014 meeting a year later, in order to be useful to the IDT for planning purposes. • As reported in Provision V4, the Monitoring Team also viewed the assessments available on the shared drive for Individual #154, who had an annual ISP planning meeting scheduled within the next ten working days. For 15 assessments that were required per the ISP preparation meeting, 12 (80%) current or updated assessments were posted, and nine (60%) had been posted by 10 working 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. <u>Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs/ assessments are conducted in response to significant changes:</u> Although progress was noted in discipline specific assessment processes and outcomes throughout this report, noncompliance was found in the following provisions related to the quality of assessments: J6, K5, L1, M2, O2, O8, R2, S2, T1b1, T1b3, T1d. and U1. These findings, taken together, demonstrated assessments were still not routinely of sufficient quality overall to reliably identify the individual's strengths, preferences and needs. Examples included: • As reported in Provision U1, the Facility did not routinely use standardized or valid instruments and/or processes to assess functional decisional capacity. The	

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		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, nor implemented in such a manner as to result in any discernible difference in the deficient process or outcomes from previous visits. • As reported in Provision T1e, assessments prepared for the Individual #165, whose CLDP was held during the monitoring did not adequately address significant issues that could impact a safe transition to community living. • As reported in Provision K5, although 309 of the 340 individuals living at the Facility (91%) had been provided a Psychological Evaluation Report or a Psychological Evaluation Update Report within the year prior to the site visit, the Facility reported that no testing of adaptive skills or intellectual ability had been conducted as part of those 309 reports. The Facility indicated that intellectual and adaptive skill assessments were not routinely conducted at RSSLC. This was also true for individuals newly admitted to the Facility. Also, as reported in this provision, there had been some improvement in quality and comprehensiveness of Structural and Function Assessments, but substantial lapses remained. • The Monitoring Team reviewed Comprehensive Psychiatric Evaluations for the 15 individuals in Sample J1. Diagnoses were assessed to be adequate for nine of 15 individuals (60%). • As reported in Provision M2, although the procedure and forms for the nursing assessments were changed, the Monitoring Team found that the actual content and requirements for compliance did not change significantly. Monitoring Team review of a sample of Quarterly Nursing Assessments found a significant improvement in compliance with requirements on the Facility's monitoring tool. Some requirements fell below 90% compliance, including updating of current active medical diagnoses, documentation of current and required immunization and TB screening, and end of life issues. There was significant improvement in concisely summarizing raw clinical data to reflect the health status for each Nursing Diagnosis/Problem in terms of improving, maintaining and/or regressing, as well as the effectiveness of their care plans. <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> The two focus ISPs were reviewed to evaluate progress noted in the use of assessments to develop, implement, and revise as necessary. As reported in Provision S1, adequate assessment is essential for understanding an individual's capabilities, 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	Noncompliance

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		successful or meaningful to the person who is to participate in the training. It appeared that the new ISP process included some potential improvements over previous findings. For example: o Two of the four SAPs (50%) were supported by information provided in the ISP. o One of the four SAPs (25%) was clearly supported by the assessments submitted as part of the ISP documentation. o Two of the four SAPs (50%) reflected an individualized process for selected SAP targets and procedures. In each case, the improvements noted were in the SAPs for Individual #264, which may provide the Facility with a basis for evaluating how it may continue to progress. Overall, 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. See Provisions F1e and F2a <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).	<u>Adequacy of process to develop each ISP in accordance with ADA and Olmstead decision:</u> 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 eight 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 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. The Monitoring Team found the presence of the required determination was improving, but still not being consistently provided. • Of the eight ISPs reviewed, for none (0%) did all of the assessments include the applicable statement/recommendation. Of the 68 total assessments that were reviewed, 33 (49%) included a determination of whether the individual could be	Noncompliance

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		served in a more integrated setting. • In most cases, when 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. Of the 33 assessments that included a determination, seven (21%) included substantive recommendations for how the individual's needs could be met in a more integrated setting. • Of the eight ISPs reviewed, none of the individuals (0%) had been referred for transition to the community. Seven of eight ISPs (88%) included an independent recommendation from the professionals on the team to the individual and LAR. Of these seven ISPs, however, none (0%) adequately identified the protections, services and supports that would be needed by the individual in the most integrated setting. • The Facility typically did not yet 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 prior to a referral being made. The Facility was developing strategies to address this issue. As also described in Provision T1b2, IDTs did not develop individualized plans for education and awareness that would be sufficient to meet the learning needs of the individuals residing at the Facility. In Provision T1b1, 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 a review of the two focus ISPs, as an example of the IDTs' process in identifying and addressing obstacle to transition, these meetings still failed to demonstrate proficiency. In both cases, the disciplines did not identify barriers in their assessments, but went on to conclude as the Facility's professional team that obstacles did exist, in that the individuals' preferences were unknown. Both IDTs developed Action Plans related to individual awareness, but these tended to be written as staff interventions and/or service objectives (SOs), without an adequate methodology for evaluating change in the individuals' awareness or ability to communicate a preference. There was some improvement noted in the creativity and integration of the IDT strategies that could serve as the basis for an adequate plan, however.	

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		Overall, the Facility was not yet effectively identifying or addressing obstacles. 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: • None of eight (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 eight (0%) that identified LAR or individual choice as a barrier were there specific, individualized action plans developed to address these specific barriers. 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 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 to movement. If the IDT members have reached a general consensus that the individual could be served in a community setting, it is incumbent upon them under the SA and Olmstead to address what would be needed to facilitate that, regardless of whether a referral is made. If the team does not address these needs because a referral is not made, this results in little likelihood of a referral being made. Engaging the IDT, including the individual and family/LAR in a discussion of both obstacles and opportunities is an essential component of an ISP developed in accordance with the ADA and Olmstead. <u>Conclusion</u>: This provision was found to be not in compliance. To move in the direction of substantial compliance, the Facility should focus its efforts over the next six months on the following: • Additional policy guidance and training should be provided to require, as a part	

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		of the ISP process, the IDT to not only make a determination regarding the most integrated setting appropriate to an individual's needs, but also describe what would be needed in that setting, including supports and potential obstacles in terms of their availability . This process should help to facilitate a discussion and inform the individual and LAR of the potential advantages of community living, such as having more privacy, or living in closer proximity to family. Having accomplished that, the determination of whether or not a referral will be made can be completed in which individual and/or LAR preference would take final precedence. • Clarification should be provided to IDT members as to the intent of the policy guidance regarding their role to make an appropriate independent assessment of the most integrated setting appropriate to an individual's needs.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	<u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u> DADS Policy 004.1 describes the PSI as an on-going integrative assessment process that provides a written record of the resident's preferences, strengths, goals, programs, and supports provided at the State Supported Living Center and as the cornerstone of the facility's person-centered processes. In previous reports, the Monitoring Team had found that there were significant deficiencies as to the extent to which ISP builds on the individual's preferences and strengths and prioritized needs. The ISP process relied, and continues to rely, heavily on the Preferences and Strengths Inventory (PSI) process to identify preferences and strengths, a process which did not involve formal assessment of preferences or reinforcers, but relied largely on anecdotal information. A widely recognized procedure or tool for identifying preferences was not used. According to DADs policy 004.1, prior to the Individual Support Plan (ISP) Preparation Meeting, the QDDP was to update	Noncompliance

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		the PSI with the information gathered throughout the year and validate the information in the PSI by seeking input from the resident, the resident's LAR/family, and those who know him or her best. The Monitoring Team requested the assessments to be used for all ISP annual planning meetings to be held during the monitoring visit, but did not receive the PSIs. Apparently, this was because the PSI was no longer considered an ISP assessment since it was completed at an earlier time. The Monitoring Team's request for all ISP assessments for four new admissions specifically included the PSI, so this group was chosen as the sample for PSI review. For only one of four (25%) was the PSI provided. For that PSI, for Individual #1, there were deficiencies in the process of administering the process that continued to call its validity and reliability into question. The document included the following responses: • To a question as to whether there were times the individual did not get enough privacy, the individual's response was documented as "sometimes." There was no additional probing documented that would have defined the individual's actual needs and or preferences regarding private time, information that would have been important in structuring her daily schedule and living environment. • When asked the following: "Are you learning or gaining anything from your job. Do you find it interesting or boring?" the answer documented was simply "yes." • When asked the following: "Which job do you like the most?" Least?", the answer documented was again simply "yes." As the PSI lacked an evidence base and, in particular a standardized administration in its actual practice, there was only limited information to suggest that the ISP and SAPs were based upon the preferences of the individuals. The Monitoring Team also noted in previous reports that even when strengths and preferences were identified, the ISP was not consistently built around these. The Facility had been developing plans for a concerted effort to ensure preferences were more consistently represented in ISPs, however. The QIDP Educator and Director of Education and Training had proposed initiatives that included: • Addition of a labeled section in each discipline-specific assessment template that required detailed input and recommendations related to an individual's preferences and goals. It was suggested that the QA Department form a Performance Improvement Team (PIT) to coordinate this process. • QA monitoring of all assessments to verify the inclusion of this section and then ongoing sampling thereafter to ensure its appropriate use. • A proposed revision to the ISP Action Plan template that would specify the preferences/strengths and assessments used in the development of each action	

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		plan. This revision had been forwarded to DADS for consideration and approval. • As described in Provision F1b, the development of person-centered materials based on each individual's preferences that would be used to support individuals' preparation for and participation in the ISP annual planning meeting and to keep the IDT focused on those preferences throughout the meeting. The focus ISP annual planning meetings featured the first attempts in using these materials. Overall, the Facility appeared to have developed an approach that has good potential to improve the ISPs it develops as it relates to the integration of individuals' preferences and strengths. The Monitoring Team looks forward to viewing the results at the time of the next visit. <u>Extent to which ISP provides an explanation for any need or barrier that is not addressed:</u> For the two ISPs observed during the monitoring visit, there was discussion related to prioritizing needs for both individuals. For example, for Individual #264, a number of SAPs from the previous year were discontinued based on an IDT decision to prioritize communication skills. Unfortunately, this failed to take into account that virtually all learning needs involve communication and could be the vehicles for implementing functional and practical communication strategies. Having prioritized thusly, however, the IDT developed only two SAPs for the individual for the coming year, neither of which was so rich, complex or time-consuming as to justify this level of exclusion of other needs. For Individual #120, the ISP also included only two SAPs, the content of which that would also not justify such a limited skill acquisition approach. <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. There was improvement noted in the discussion of community integration by the IDT at the ISP annual planning meeting for Individual #264, but this was not sufficiently developed into a single comprehensive Action Plan that included any measurable outcome for the individual's ability to actively participate in the community. The Action Plan should not address simply what staff will do, but should provide a defined outcome expectation and a measurement methodology. 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, preferences, and strengths. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or	

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		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. Conclusion: 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;	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, meet needs, and overcome identified barriers to living in the most integrated setting: Overall, RSSLC IDTs did not consistently develop such a comprehensive complement of individualized goals and objectives that were relevant to and likely to lead toward attainment of outcomes related to each preference, meet identified needs and overcome barriers to living in the most integrated setting. Examples included: • For the two focus ISPs, the Monitoring Team noted progress as well as continuing limitations, as described in Provisions F2a1, F2a3, F2a5 and T1b1. Although there was expanded emphasis on incorporating preferences in the development of the ISP, a commendable initiative, in both cases the IDTs failed to develop a robust and comprehensive array of supports related to these. Only two SAPs were developed for each of the individuals. As noted in Provision F2a1, there were many other opportunities for appropriate SAP development based on identified needs, such as activities of daily living, which were not sufficiently addressed. • As reported in Provision R3, for zero of three individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • In the section that addresses Provision T1b1, 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 barriers. This also requires the development of action plans in ISPs. In summary, barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. ISPs 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 eight (0%) recent ISPs reviewed evidenced	Noncompliance

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		proficiency in this regard. Also see Provision F1e above. <u>Conclusion:</u> 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;	<u>Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions:</u> 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. Overall, adequate integration should be demonstrated through: • Integration of various plans (e.g., PNMP, PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, integrated health care plans, etc.,) in a measurable way into the ISPs through, for example, measurable objectives; • Individuals' personal goals, preferences and/or needs are integrated across and throughout Action Plans; • Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.) • Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary The Monitoring Team noted the Facility was focusing much of its efforts in ISP development on integration of all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. Overall the Monitoring Team found that these ISPs still did not reflect an integrated plan that set forth the full array of protections, supports, and services individuals required as described in the bullets above There was progress noted in the focus ISPs, however. While it would not have risen to the level of substantial compliance, particularly in the	Noncompliance

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		execution of the Action Plans, the Monitoring Team was pleased to observe one IDT, take important strides in this area. For Individual #264, who was deaf, much of the ISP was devoted to how communication strategies could be utilized to enhance the ability to make choices, to learn work-related skills, to reduce self-injurious behaviors and to support her relationships with family. A number of creative strategies were devised and appeared to form the basis for a very integrated ISP and related plans. The resulting ISP, Action Plans, IHCPs, individualize schedule and Special Considerations did not provide the level of integration required. The Monitoring Team was also concerned of what appeared to be an increasingly bifurcated approach to the ISP narrative summary and Action Plans vs. the IRRF and the IHCPs. These appeared in some ways to be two different albeit related plans. In the case of the psychological assessment and input for these two individuals, this was particularly concerning. A reading of the ISP Narrative did not include input from the Psychologist or discussion of the individual's Positive Behavior Support Plan (PBSP), although there were occasional references to the individuals' behaviors under other headings. The section of the narrative entitled Integrated Risk Discussion was only a template statement and referred to the IRRF, with no summary. Information from the psychologist was found only in the IRRF and the PBSP was included with the IHCP. There were two problems with this approach that limited the effective integration of the ISP as a whole, as observed in the two focus ISP annual planning meetings and completed documents: • It appeared input from the psychologist was envisioned only, or at least primarily, as risk-related. It did not address the need for this input to also focus on learning and skill acquisition, which is found in the narrative and Action Plans • It did not facilitate an integrated approach in which, for example, it would be clear that behavioral supports must be intertwined with all other ISP strategies, including communication, work, community integration, activities of daily living, etc. For example, in an integrated approach, carefully chosen replacement behaviors should be integrated throughout many, if not most, of the individual's SAPs and daily activities. One option the Facility may want to consider would be how the Integrated Risk Discussion section might at least summarize and prioritize the key strategies developed from the IRRF such that it provides an integrated narrative. This, in turn, will likely lead to improved integration in the Action Plans and IHCPs. 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:	

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		• As reported in Provision O2, for two of nine individuals (33%), all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. • As reported in Provision M5, two of six (33%) IHCPs were sufficiently integrated among all appropriate disciplines. Conclusion: This provision was found to be not in compliance.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Extent to which ISP identifies: • Methods for implementation: There was some evidence of progress in this area, including that, as reported in Provision M3, 11 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. Findings related to the methods of implementation for SAPs, as indicated by the review SAPs generated of the two focus ISPs included: o None of four SAPs (0%) reflected development based upon a task analysis even though the skills being taught and structure of the SAP suggested a task analysis to be appropriate. This was suggested to be a regression from the previous site visit. o One of four SAPs (25%) included adequate operational definitions of behavior. This was suggested to be a modest increase from the previous site visit. o None of four SAPs (0%) included specific instructions on how to implement the SAP. This was essentially unchanged from the previous site visit. • Timeframes for completion: ISP Action Plans for the two focus ISPs typically documented an implementation date, and a projected timeframe and overall projected completion date. • Responsible Staff: The two focus ISPs typically indicated by position who would be responsible for documentation and data review. Conclusion: This provision was found to be not in compliance.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Extent to which interventions, strategies, and supports are practical and functional: To establish compliance in this provision, IDTs must develop individualized action plans that effectively address the individual's assessed needs for services and supports and to promote increased independent functioning both at the Facility and in the community, as well as design interventions, strategies and supports that can be practically implemented both at the Facility and in community settings. • As reported in Provisions S1 and S2, each of the focus ISPs resulted in two SAPs for each individual. It was not evident that the necessary consideration had been	Noncompliance

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		given to identifying specific needs or to developing interventions that were likely to increase either individuals' skills. Only one of the four SAPs (25%) was clearly derived from the provided clinical assessments, and none of the four SAPs (0%) reflected the use of a task analysis. Furthermore, SAPs appeared to emphasize training each individual to comply with requests rather than to develop skills that might lead to greater independence. Based upon this review of the ISPs and SAPs, it was not apparent that the skill acquisition plans addressed the specific needs of each individual. In addition, the focus upon compliance rather than skill acquisition substantially limited the degree to which the SAPs were functional for the individuals. • As reported in Provision S3b, the Facility did not provide specific information about the provision of skill acquisition training in the community. RSSLC indicated that the new SAP development process would target both Facility and community SAPs. However, of the four SAPs submitted by the Facility, none (0%) included a specific strategy for implementation in the community. In consideration of the skills targeted, such as coming to the medication cart when called and completing a specific job sequence, it was not evident that any of the SAPs could be taught as described in any location other than at RSSLC. It therefore did not appear that the Facility had considered the need for or process of providing community instruction when developing the SAPs. • As reported in Provision R3, ten of twenty general use AAC devices (50%) noted had a clear function within that setting/situation. <u>Conclusion:</u> This provision was found to be not in compliance.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	<u>Extent to which ISP identifies data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress:</u> 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. For example, as reported in Provision S1, for the two focus ISPs, none of four SAPs (0%) included adequate procedures for documenting program implementation. <u>Extent to which ISP identifies the persons responsible for the data collection and the persons responsible for data review:</u> For ten of ten ISPs reviewed (100%), including both recently completed and the focus ISPs, the Action Plans defined the person(s) responsible for data collection. Similarly, for ten of these ten ISPs (100%), the Action Plans also clearly defined the person(s) responsible for data review. This did not appear to be sufficient to achieve the outcomes of ensuring program review was accomplished as required, however, as evidenced by the	Noncompliance

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		findings described in Provision F2d below. Conclusion: This provision was found to be not in compliance.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	Extent to which goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP: This provision requires that disciplines work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. The Facility continued to implement initiatives toward coordination among staff, including the development and monitoring of the IRRF, the Integrated Health Care Plans (IHCPs) and a variety of routinely scheduled cross-discipline meetings. 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 report and this Section F. Examples of circumstances in which coordination of services could have been achieved, but was not, included: • As reported in Provision T1b2, the Facility should have, but did not create comprehensive coordinated plans for community living education and awareness for individuals. Such 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. • As reported in Provision J4, that requires pre-treatment sedation to be coordinated with other medications, supports and services, difficulties continued with development, implementation and tracking of supports to minimize the use of pre-treatment sedation persist and with documentation for monitoring for safety during and after pre-treatment sedation. Conclusion: This provision was found to be not in compliance.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that	Extent to which ISP is accessible to staff: Staff generally reported that the ISP was accessible. The ISP was placed in the individual notebook. However, as reported in Provision M5, the IHCP was located in the Active Record, and the Monitoring Team was informed that the DSP Instruction Sheet is also	Noncompliance

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	each ISP is accessible and comprehensible to the staff responsible for implementing it.	placed in the Active Record. Review of the table of contents of the active record and individual notebook confirmed that IHCP is to be filed in the Active Record; it was not listed as to be filed in the Individual Notebook. Furthermore, the DSP Instruction Sheet is not listed in either record, nor was there a separate binder in the home for these sheets. Although this reduces the potential for error when plans or instructions are updated, it also reduces the usability of the record for ensuring staff providing direct support are familiar with the supports they are to provide to individuals with healthcare needs. <u>Extent to which ISP is comprehensible to staff:</u> For the two ISPs reviewed, the ISP was not written in a manner that facilitates understanding of who is supposed to do what, particularly direct support professionals, or how these activities would support an overall vision for the individual's life. One of the two, for Individual #264, represented improvement over previous ISPs in terms of comprehensibility, but still failed to fully and accurately represent the ISP proceedings in a manner that would have facilitated staff overall understanding. There were improvements, in that both did provide a picture of the services and supports the individual requires over the 24-hour day through an individualized schedule, as well as included a Special Considerations document that provided brief summaries of needs in a variety of domains, including, for example, communication, vision and hearing, mobility, independent living and many others. These could be useful tools for staff in having an overall understanding of an individual's needs and how best to support them across each day and in all settings. It is essential, however, they provide staff with accurate and easily understood information. For Individual #264, the Special Considerations domain for communication accurately states the individual was nonverbal, uses gestures and some signs, but does not indicate the individual is deaf. In the next section on vision and hearing, it indicates the individual does not have "audiological function bilaterally." The IDT also developed much of the individual's plan around communication and its impact on choice-making, behavioral needs, etc., but there was no reference back to these strategies, something that could be easily accomplished in a single sentence. In addition, the individualized schedule indicated that the use of the communication boards, the singularly most important strategy of the ISP, was optional for direct care staff in most instances. It is not unusual for optionality to lead to a lack of implementation. This should be re-considered. Overall, as well, observations and review of program data indicated that ISPs did not appear to be comprehensible to the staff responsible for implementing them. In addition to the findings of the review for the two focus ISPs, that the ISP was not adequately comprehensible to staff was affirmed by additional findings. For example, as reported in Provision K11, RSSLC reported that readability scores were not routinely monitored for staff instructions in PBSPs and a sample of six PBSPs selected to assess readability indicated these plans tended to be written well above the grade level of 8.0 that is	

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		generally considered the upper range of easily accessible writing. There also continued to be 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 did not engage in safe mealtime practices, as indicated by the following: Per observations conducted by the Monitoring Team, nine of 24 individuals' (37%) dining plans/PNMPs in sample O.4 were implemented as written. In addition, 15 of 23 individuals' positioning plans (65%) were implemented as written. • As reported in Provision S2, based upon the observations conducted during the current site visit, it was evident that overall functional engagement was at 48% of individuals; this was a slight increase over the previous monitoring period. Observations also indicated that eight of the 17 observed locations (47%) reflected functional engagement for at least 50% of the individuals present during the observation. • As reported in Provision R3, three of eight staff interviewed (38%) were knowledgeable of the individuals in Sample R.4 and R.5 and their communication related programs. Direct support professionals had difficulty with the following questions o Stating whether the individual had an AAC system. o Stating whether there was a communication program. o Describing the communication program goal. o Describing the schedule for implementation of the communication program. o Identifying how communication skills in the program were addressed throughout the day. <u>Conclusion:</u> This provision was found to be not in compliance.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as	<u>Monthly review of progress</u>: The Monitoring Team requested QIDP Monthly/Quarterly Reviews for the past three months for eight individuals. The Monitoring Team found for one of the eight individuals (13%) was there evidence any meaningful review had taken place in which actions were taken based on documented progress or lack thereof. One, for Individual #82, had no data or monthly reviews provided, although the most recent ISP was held in May, 2013. In most cases, the reviews documented the same basic assessment, such as "Progress" and "Continue" over and over. For four of the ISPs, the Monthly Reviews appeared to be virtually identical in almost all aspects for several months in a row. Overall, the Monitoring Team found that QIDP Monthly Reviews were not consistently completed in a way that provided for meaningful evaluation of progress or program revision. As a note of progress, however, the Monitoring Team found that the Monthly Reviews for	Noncompliance

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	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.	Individual #106 were thoughtful and evaluated progress using actual data related to the criteria for program modification. The three Monthly Reviews provided were each clearly individualized based on current progress rather than simply continued from previous periods. The Monitoring Team commends this QIDP for her efforts. In addition to these findings, the Monitoring Team found other concerns related to monthly review of progress: • As reported in Provision R3, zero of four individuals (0%) receiving indirect Speech Services were provided with comprehensive progress notes that contained each of the indicators • As reported in Provision K4, data graphs and progress notes reflected several weaknesses limiting their utility in determining adequate response to treatment. As a result, it was difficult to determine when or if PBSPs were revised in a timely manner. If those limitations are ignored, however, then data reflected that procedures for six of the 10 PBSPs (60%) were adequate, as data reflected progress and no revisions to the PBSP were implemented. Of the remaining four individuals, data suggested a substantial increase in one or more targets without any consideration of the need to review or revise the PBSP. • As reported in Provision P2, for 0 of 16 individuals with PNMPs in Samples P.1 and P.2 (0%), was there evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly, <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 programs with very little progress noted and very little modification made for many months. Absent those reviews, no meaningful modification could have taken place. <u>Conclusion:</u> 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-	<u>Extent and adequacy of competency-based training for staff responsible for development of ISPs:</u> 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, QIDPs were provided training in facilitation skills using the Q Construction curriculum. The Facility had not yet begun to implement a structured approach to assessing competencies in the Q Construction skills, but was providing hands-on training in small groups and continuous coaching at ISP annual planning meetings. The QIDP Educator had created an Education Record which allowed for tracking of competency training for each QIDP. This was in a very early stage	Noncompliance

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	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.	of development but appeared to hold promise The QIDP Educator was working closely with the Director of Education and Training toward training QIDPs to design practical, functional SAPs. There was also a plan underway to develop training to enhance critical thinking and brainstorming skills. Extent and adequacy of competency-based training for staff responsible for implementation of ISPs: The Facility continued to work towards other competency-based training for staff responsible for implementation of ISPs. For example, as reported in Provision M4, the Facility was found to have achieved substantial compliance in competency-based training for nursing. Overall, however, the Monitoring Team found staff were not yet adequately provided with competency-based training. Examples included: • As reported in Provision R3, to determine whether the Facility had a process to determine whether staff had been trained on their communication devices, the Monitoring Team requested evidence that all assigned staff for the five individuals in Sample R.4 had received training related to Communication SAPs and programs. One of 5 (20%) individual's staff assigned had completed competency check-offs regarding the individuals' communication programs. RSSLC was unable to provide evidence of training records that verified staff had received training regarding the devices utilized by the other four individuals. • As reported in Provision K12, the Facility reported that a new process for providing competency-based training on PBSPs had just commenced at RSSLC. Consistent implementation had not been achieved throughout the Facility, and there was currently no mechanism for tracking training or staff performance. 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, as described in Provisions F2c above. Conclusion: 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	Extent to which ISPs are developed within 30 days of admission: RSSLC reported 13 admissions between 2/4/13 and 7/17/13. For each, it was reported the ISP was developed within 30 days of admission. The Monitoring Team reviewed the ISP and assessments for a sample of four of these. The ISP annual planning meeting was held for each of these within 30 days of admission. It was not clear that assessments were consistently completed on a timely basis for this sample. Of the four ISPs reviewed, one had no assessments provided as requested and one case included only four assessments. Of the total 22 assessments provided for these four individuals, 17 (77%)	Noncompliance

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	into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	were completed five days prior to the ISP meeting. Extent to which ISPs are revised annually and as needed and put into effect within thirty days of preparation: 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 an alphabetical list of ISP dates, the date on which the ISP document was completed, the date ISP was filed and the date of the previous ISP, dated Tuesday, August 06, 2013. These data indicated that for the first 60 names on the list who had an ISP that had occurred in the six months prior to the monitoring visit, only 20 (33%) had been "filed" within 30 days. This appeared to be a continuing issue as the Facility also provided a list of Number of ISPs Not Filed within 30 days, dated Tuesday, August 06, 2013, covering the period of 6/1/2013-6/30/2013, which indicated there were 21 ISPs completed in June that had not been filed timely. Two of four new admission ISPs described in the paragraph above were also not put into effect within 30 days. In addition, there was evidence that discipline specific plans were not always implemented on a timely basis. For examples as reported in Provision R3, zero of four individuals' indirect plans (0%) (i.e., SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. Although plans were identified in the SLP assessments as skill acquisition programs, there was no evidence of actual implementation. Conclusion: This provision was found to be not in compliance. There appeared to be a significant incidence of failure to provide timely 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.	It was reported the Facility was not routinely implementing quality assurance processes to identify and remediate problems and to further ensure that the ISPs are developed and implemented consistent with the provisions of this section. The Facility did have monitoring tools available, including the Section F and I Monitoring Tools and the Q Construction monitoring tool, but these were not currently being implemented in a formal or consistent manner. A new QA Director had been appointed prior to this monitoring visit, however, and planning was currently underway to develop and implement these processes. As reported in Provision F2a1, an initiative had been proposed that the QA Department form a Performance Improvement Team (PIT) to coordinate a process to enhance discipline-specific assessment templates to require detailed input and recommendations related to an individual's preferences and goals. It was also suggested that QA monitor all assessments to verify the inclusion of this section and then ongoing sampling thereafter to ensure its appropriate use. This had not yet	Noncompliance

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		been implemented. Conclusion: This provision was found to be not in compliance.	

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.d	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment 8/9/13 2. RSSLC Action Plan 8/7/13 3. RSSLC Presentation Book for Section G 4. DADS Draft Policy 005 Minimum and Integrated Clinical Services 1/12/10 5. DADS Policy 009.2 Medical Care 5/15/13 6. RSSLC Policy I.31 Providing Health Care Services: Chronic Clinical Indicators 10/12/11 7. RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 1/30/12 8. RSSLC Policy PCP Consultation Letter Policy (no number) 7/2/12 9. RSSLC Policy I.00a Medical Services 5/15/13 10. RSSLC Policy I.12 Routing of Of-Campus Consultations 1/6/11 11. RSSLC Policy I.13 Routing of On-Campus Consultations 1/6/11 12. RSSLC Policy PCP Consultation Letter Policy (no number) 7/2/12 13. RSSLC Policy I.44 Morning Report 6/28/13 14. RSSLC policies guiding integrated services a. RSSLC Policy I.00a Medical Services 1/21/11 b. RSSLC Policy F.04 Individual Support Plan Process 12/11/12 c. RSSLC Policy At Risk Individuals 5/11/12 d. DADS Policy 043 Death of an Individual (undated) e. RSSLC Pharmacy Policy 03.05.03 Concurrent Drug Regiment Reviews 5/12/11 f. RSSLC Policy J.06 Psychological and Behavioral Services 2/20/12 g. DADS Policy 007.3 Psychiatry Services 5/1/13 h. RSSLC Policy C.01 Incident Management 2/11/13 i. RSSLC Policy The Morning Report 6/28/13 (no number) j. RSSLC Policy Integrated Neurology Clinic 4/17/12 (no number) k. RSSLC Policy I.29 Grand Rounds 9/7/11 l. RSSLC Policy I.31 Chronic Clinical Indicators 10/12/11 m. RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 1/30/12 n. RSSLC Policy I.01 Emergency Response 5/2/12 o. RSSLC Pharmacy Policy 1.05.20 Medication Variances 11/2/11 p. RSSLC Pharmacy Policy 03.05.04 Polypharmacy Review Policy 7/26/13 q. Infection Control Committee 1/22/13 (no number) r. Wound Care Committee (no date or number) s. RSSLC Policy I.6 Providing Acute Health Care 10/10/11 t. RSSLC Policy Pre-Hospital Discharge Planning 9/6/12 (no number) u. RSSLC Policy K.01 Physical Nutritional Management 3/11/13

	15. List and copies of policies in response to a request for "A copy of any State or Facility policy or procedure guiding integrated clinical services. 16. Clinical Morning Report minutes for 8/20/13, 8/22/13, 8/27/13, and 8/29/13 17. Email referral to Interdisciplinary Team (IDT) for Individual #309 following Integrated Morning Meeting 18. PSP Attendance 4/1/13-8/26/13 19. ISP Preparation Meeting document for Individual #711 20. Forms used to document and review responses to recommendations from non-Facility clinicians, including Consultation Report and screenshots from Medical Follow Up Database 21. Medical Follow Up Database with new addition for non-medical consultation tracking screenshots 22. Consultation Appointments 5/25/13-8/25/13 23. Example of RSSLC Consultation Letter for Individual #57 24. Example of RSSLC Consultation Report Form 8529 for Individual #678 25. Example of Consultation Letter for Followup Consultation for Individual #84 26. Medical consultation reports for Individuals #27 (x2), #43, #44, #286, #296 (x2), #309, #351, #378, #389, #410, #465, #525, #564, #666 (x2) **People Interviewed:** 1. Tran Quan, D.O., Medical Director and Raj Thakur, Medical Compliance Coordinator **Meeting Attended/Observations:** 1. Integrated Support Plan (ISP) Annual Planning Meeting for Individual #120 2. ISP Preparation Meeting for Individual #711 3. Clinical Morning Report of 8/27/13 4. Meetings attended by Monitoring Team members noted in several report Sections, including: a. Grand Rounds b. Neuropsychiatry conference c. Psychiatry and Behavior Management Clinic d. Physical and Nutritional Management Team
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section G. 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 G, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. 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 the external and internal medical audits. o These monitoring/audit tools did not entirely include adequate indicators relevant to determine compliance with the Settlement Agreement and also a number of indicators relevant to other Sections of the Settlement Agreement but not to the requirements of

	Section G (particularly several indicators from the internal and external medical reviews). The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. Furthermore, the Facility identified the need for more involvement of the IDT to address clinical status changes but did not report how that was assessed. Specifically, for Provision G1, the Facility should identify indicators of integration of supports and services into ISPs. For Provision G2, the Facility should assess referral of consultations to the IDT as appropriate, and whether the IDT reviewed the referrals and took action as needed. o The Self-Assessment identified the sample(s) size, which was 100% of the external and internal audits. This sample sizes were not adequate to consider them representative samples of the total number of consultations performed but could supplement other information. However, this was supplemented by a review of a sample of 20 consults; although this may be adequate to serve as a representative sample, the Facility has a database that may provide some useful information for all consultations and could be included as part of the Facility's regular quality assurance system. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically competent in the relevant area(s). o Adequate inter-rater reliability between the various staff responsible for the completion of the tools was not reported. ▪ Used other relevant data sources and/or key indicators/outcome measures. Such data included: o Attendance of clinicians at a sample of ISPs, gathered from the Auditor's Tool for ISP Tracking in which data is entered by Program Monitors. o Number/% of clinical meeting minutes that included documentation of integration. o Number/% of outside consultations acknowledged by PCPs within five days. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Presented findings consistently based on specific, measurable indicators. However, no specific criteria were established for review of whether meeting minutes had documentation supporting integration, nor was any interobserver reliability reported; therefore, it is not clear how valid those measures are. o Did not measure the quality as well as presence of items. Attendance, while essential, does not indicate that clinicians participated actively in the sampled meetings, used information from assessments and objective data in discussions, or collaborated in decision-making. The Facility did not indicate whether it measured the quality of documentation that the review determined to be supportive of integration. Interestingly, the reason for the self-assessment for Provision G1 of noncompliance was due to a quality issue not reported in the data. o Except for external and internal audits and information from the program monitors, the self-assessment did not indicate who collected the data. ▪ The Facility rated itself as not being in compliance with Provision G1 but being in compliance with Provision G2. This was consistent with the Monitoring Team's findings.

	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, In Process, and Completed and Ongoing. The Monitoring Team confirmed actions identified as completed had been implemented. ▪ The Facility data identified an area of need/improvement for Provision G1, the need for more involvement of the IDT to address clinical status changes and for ISP addendum to consistently document clinical discussions of health care status changes. The Action Plan did not include actions to address this issue. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. As noted in the bullet above related to Provision G1, there was no action to address the need for more involvement of the IDT to address clinical status changes and document such discussions. For Provision G2, the Facility needs to identify an action for the related issue of ensuring referrals of recommendations to the IDT occur, and that there is documentation the IDT addresses those.
	Summary of Monitor's Assessment: RSSLC continued its progress toward providing clinical services in an integrated manner. Various committees and workgroups provided opportunities for integrated assessment and planning of supports and services at both the individual and systemic levels. There were numerous examples of integrated and collaborative planning and service provision; at the same time, there remained examples in which assessments, services, and supports were not yet integrated. As clinicians become more practiced at collaborative assessment and planning, a focus of improvement will need to be ensuring supports and services become integrated into the ISP. Provision G1: The Facility did not yet have a single policy to guide integration of clinical services. Several policies governing specific meetings and work groups did include requirements for integration. Meetings, committees, and workgroups that facilitated integrated clinical services included the Clinical Morning Report meeting, Grand Rounds, the Physical/Nutritional Management Team, the Skin Integrity Committee, and the Polypharmacy Review Panel. The Clinical Morning Report brought together numerous disciplines two mornings per week. Reports were made, but there was also evidence of substantive discussion about both individuals and systemic issues. Follow up at these meetings continued on individuals and systemic issues as needed. There was evidence of referral of individual issues, including consultations, to the IDT. Grand Rounds brought clinicians from numerous disciplines and the IDT clinicians to review the cases of individuals who are experiencing a significant medical or behavioral issue (and, in some cases, both medical and behavioral issues). The Grand Rounds Meetings served as an excellent method for focusing on individuals who have complex behavior and medical problems for the interdisciplinary teams to identify issues and explore treatment strategies.

	There remained numerous examples in which assessments, services, and supports were not integrated into ISPs; ensuring assessment results lead to appropriate decisions on services and supports, and integrating those services and supports so they are part of the ISP and, therefore, of a coordinated plan of care, is an area needing improvement. Provision G2: The Facility had appropriate processes in place to facilitate documentation of review of recommendations from non-facility clinicians, to make referrals to the IDT when appropriate (through both documentation and the Integrated Morning Report), and to communicate through the IPN process. In general, these processes were followed. There was evidence that referrals were made to the IDT and some evidence that there was follow-up to ensure IDT review; however, the Facility needs to develop means to ensure consultations are referred to the IDT as needed, and that the IDT provides evidence of integration with existing supports and services.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility has taken steps to provide integrated clinical services. These included development of policy that requires or facilitates integrated assessment and planning for specific committees and workgroups, and regular meetings between medical and other clinical services (such as the participation of several disciplines at Grand Rounds and at Psychiatric and Behavior Management Clinics). However, clinical supports and services were not consistently integrated into ISPs, and there remained examples in which improved collaborative assessment and planning across disciplines is still needed. As reported in Provision F2a3, integration of services and supports requires them to be 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. <u>Policy</u> The report of the last compliance visit stated, "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." For this visit, the Facility provided an extensive set of policies related to specific areas, including committees and areas of care, in response to a request for "any State or Facility policy or procedure guiding integrated clinical services." However, there was no single policy that established requirements for integration, provided procedures to facilitate integration, or directed staff to the other	Noncompliance

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		policies that included requirements for integration. Furthermore, the only requirements in several policies that were relevant to integrated clinical services were lists of the responsibilities of various disciplines relative to the topic of the policy, without any discussion of how these were to integrate beyond completing the responsibilities; an example of that was RSSLC Policy I.6 Providing Acute Health Care, which lists the responsibilities of the nurse and physician but does not indicate how other clinicians or the IDT should or could be involved in either treatment or in evaluating whether the condition affects other aspects of clinical services. Instead of providing such a list of policies, the Facility should identify those policies that actually guide integrated services or develop such a policy, and then should review the remainder of the policies to see what revisions should be made to comply with such policy. It should be noted that several of the policies did, in fact, include requirements or actions that involved collaboration across disciplines. • RSSLC policy on the Morning Report required a number of disciplines to have representation. It provided a meeting agenda and order. See discussion of Integrated Morning Meeting below for additional detail. • RSSLC Policy I.29 Grand Rounds stated that notice of the individual to be discussed would be sent to all department heads "and other members of the individual's Personal Support Team." It states the "PST should engage in collaborative discussions during this meeting." More detail about this meeting is found below. • RSSLC Policy K.01 Physical Nutritional Management describes the composition and role of the Physical Nutritional Management Team (PNMT). Core members include those required by Provision O1 of the Settlement Agreement, and the policy lists other disciplines who may be included. The policy requires active participation of PNMT members and also requires collaborating with the IDT and integrating PNMT recommendations into the ISP. More information about the PNMT and about the status of its integration across disciplines and with the IDT may be found in Section O of this report. <u>Morning Meeting</u> Since the last compliance review the Facility had continued to expand the Clinical Morning Report meeting to include more disciplines and had formalized a template and agenda for conducting and reporting issues reviewed and discussed during the meetings. Meetings were held on Tuesdays and Thursdays. As noted above, policy had been implemented that increased the disciplines that participate in the meeting and established a standard agenda. The agenda included, among other topics: • On-call Report by the on-call PCP • Hospital liaison report	

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		• Infirmary report • Behavioral/psychiatry report, including restraints used, changes in psychotropic and dual-use (psychiatric and neurological) medications, and changes in behavioral status of individuals • Medical consultations • Non-Medical consultations • Significant Diagnostic Studies • Interdisciplinary Team (IDT) Report, including follow up on referrals from the Clinical Morning Report meeting • Reports from Wound Care and Infection Control Nurses • Physical Nutritional Management report The Monitoring Team attended the Clinical Morning Report meeting on 8/27/13. The disciplines in attendances included Nursing, Behavioral, Habilitation, Residential, Hospital Liaison Nurse, Quality Assurance, /dental, Pharmacy, QIDP, and Dietitian. All of the psychiatry and medical providers were in attendance. The meeting was conducted efficiently and the agenda was followed. The Medical Care Coordinator took minutes. Observation of the meeting indicated a robust process whereby clinical issues that occurred since the last meeting were reported. Observations noted the following: • Minutes reflected summary documentation of the events discussed at the meeting, and in some instances there were comments indicating that a particular team member would follow through with an action; however, there was no consistent process to ensure that action plans would be developed for all relevant clinical issues discussed, and there was no indication that follow-up, to ensure implementation of the action plan, was completed. • It was unclear from the minutes whether the on-call report was only from the evening before or covered the entire time following the last meeting. Dates of events should be made clear in minutes. • The Hospital Report for 8/22/13 included two phone call updates that occurred in the afternoon. One was undated. The other was noted as "Phone call received today @ 3:34 pm 8/22/13…" The minutes did not state that this was added to the minutes following the meeting, although the time and date were after the meeting. Similarly, the 8/29/13 minutes reported in the Hospital Report, "Onsite visit 8/29/13 for four individuals and "phone call update 8/29/13" for one individual; it is possible these occurred before the 8:30 am meeting; if not, the minutes should clarify what updates were added following the meeting. • Although there were no consultations reported that required referral to the IDT, there was discussion of one that was awaiting IDT review of mobility and pain management, indicating not only that referrals are made to the IDT but also that	

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		follow up discussions were held until resolution of the issues reported at the meeting. As additional evidence, there was discussion of IDT discussion of trends in UTIs and pneumonia at one unit, with review of recommendations made by the IDT. There was also notice that the PNMT and IDT will be meeting about one individual. • The Wound Care Nurse reported on discussion with a hospital, and training provided to hospital staff, regarding actions the hospital needed to take to prevent decubiti. This indicated the Morning Report and the actions of the Wound Care Nurse involved identification of, and action to address, a systemic issue. • A follow up was reported regarding the need for more assertive action regarding hydration, and referral of this concern to the Assistant Director for Programs. As reported in Provision M1, information from the Morning Report was discussed during the Incident Management Meeting the same day. <u>Grand Rounds</u> The Facility continued to hold a weekly integrated review; the name of this review had changed to Grand Rounds. RSSLC Policy I.29 Grand Rounds guided the purpose, participants, and process of this meeting. Medical grand rounds occurred once per week, chaired by the medical director. Participants consisted of medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, quality assurance, dental, and pharmacy services. The purpose of the meeting is to review the case of one or more individuals who are experiencing a significant medical or behavioral issue (and, in some cases, both medical and behavioral issues). The Grand Rounds Meetings served as an excellent method for focusing on individuals who have complex behavior and medical problems for the interdisciplinary teams to identify issues and explore treatment strategies. Review of the meeting minutes for the grand rounds, dated 5/1/2013, 3/20/2013, 5/29/2013, 7/3/2013, and 7/31/2013, indicated a comprehensive review of the individuals discussed; however, although clinical recommendations were made, there was no action plan or mechanism for follow-up to ensure that the recommendations were carried through to implementation. The Monitoring Team attended the grand rounds on August 28, 2013, and is complimentary to the Facility for developing, and implementing this process. The meeting enabled an integrated discussion of the supports, and services provided to Individual #140. The focus of the meeting centered on a thorough review of Individual #140's clinical course for her psychiatric condition, current management plan, and	

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		elicited further strategies for management and treatment, resulting in a better understanding of the individual's clinical condition by the participants. That presentation and discussion included a presentation of that individual's sleep difficulties and a discussion about whether those difficulties were properly attributed to the individual's bipolar disorder or whether another disorder – medical or psychiatric – that should also be considered. <u>Other Integrated Committees and Workgroups</u> The Facility had several other committees and workgroups that brought together numerous disciplines for interdisciplinary reviews of individuals and systemic issues. These included the following committees and workgroups. Skin Integrity Committee: The Skin Integrity Committee membership included: Skin Integrity Coordinator, chair, Medical Director, Physicians, Dietitians, Habilitation Therapist, Behavior Analyst, Clinical Pharmacist, Chief Nurse Executive, Program Compliance Nurse, Nurse Educator, Quality Assurance Nurse, Nurse Managers, Infirmary Director Infection Control Nurse, RN Case Managers, and Data Analyst. The Monitoring Team's review of the Skin Integrity Committee meeting minutes showed that relevant disciplines consistently attended the meetings. For more information on the activities of the Skin Integrity Committee, please refer to Provision M1. Physical Nutritional Management Team (PNMT): RSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Another method in which the PNMT was made aware of changes in status was through participation by the PNMT RN in the morning medical meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. For more information on the activities of the PNMT, please refer to Provision O1. Psychiatric and Behavior Management Clinics: Psychiatric Evaluations were a focus at Psychiatric and Behavior Management Clinics (PBMCs), the term used at the Facility for the psychiatric clinic. All individuals supported by psychiatry were seen at least quarterly at PBMC. PBMC participants included the individual, the psychiatrist, and key members of the IDT, typically the psychologist, the nurse case manager, qualified developmental disability professionals (QDDPs), direct support professionals (DSPs), the clinical pharmacist and at times, a habilitation therapist. For more information on PBMC, please refer to Provision J2. Polypharmacy Review Panels: At the last review the Monitoring Team discussed with the Facility the need to have monthly reviews of polypharmacy, per the language of the SA. The Facility had been responsive to that need and such reviews were now in place. The meeting	

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		is known as polypharmacy review panels (PRP) and participation included pharmacists, primary care physicians, nurse case managers, psychiatrists, psychologists and others. Examples of Integrated Planning Hospital Liaison Nurse: The Hospital Liaison Nurse attended Pre and Post Hospital Discharge ISP meetings; and provided IDTs with reports on hospitalized individuals. The IDT members were notified as soon as pending discharges were known in order to discuss any necessary training or equipment needed upon discharge to ensure a smooth transition back to home. The Skin Integrity Nurse accompanied the Hospital Liaison Nurse on a total of eight hospital visits to provide additional assessment; these included visits for Individuals #77, #99, #351, #477, #489, and #538. Psychiatry/Psychology interaction: Psychiatrists attended some but not all of Behavior Support Committee (BDC) meetings. The fact that psychiatric diagnoses were explored and discussed in many IDT and interdisciplinary processes throughout the Facility showed a maturation of the clinical process at the Facility and a deepening of the staff's commitment to a comprehensive understanding of individuals supported by the Facility. Although there had been improved interaction and collaboration, structural and functional assessments still did not adequately assess the relationship between mental illness and environmental factors that affect behavior; this is an area for greater collaboration on case formulation. Training on Medication Administration for Individuals with Dysphagia: The new state mandated Medication Administration for Individuals with Dysphagia was taught jointly by the Nurse Educators, Habilitation Therapy and Physical and Nutritional Management Team Nurse. Individual #523: The IDT met to review this individual, who was diagnosed with aspiration pneumonia. The IDT revised risk ratings and developed an action plan that included revision of the PNMP and acquisition of a "Vest" as a preventive measure. Examples of Need for Improved Integration The Monitoring Team also identified opportunities for greater integration, such as the following: • PNMT met to discuss Individual #192. Recommendations were received for more intensive monitoring of sedation due to a history of vomiting. The PCP stated sedation and vomiting were unrelated, and there was not further discussion of this issue. • Individual #161: The physician quarterly reviews did not indicate	

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		polypharmacy as a potential risk factor for the Individual's fall and fracture risk; this issue was especially noteworthy because the PT/OT assessment documented that the Individual appeared lethargic secondary to his medications. For Individual #264, who was deaf, much of the ISP was devoted to how communication strategies could be utilized to enhance the ability to make choices, to learn work-related skills, to reduce self-injurious behaviors and to support her relationships with family. A number of creative strategies were devised and appeared to form the basis for a very integrated ISP and related plans. Unfortunately, the resulting ISP, Action Plans, IHCPs, individualize schedule and Special Considerations did not provide the level of integration required. <u>Integration of Services in ISPs and Programs</u> For integrated planning to occur, clinicians must participate in interdisciplinary meetings, such as the ISP annual planning session. The Facility provided a PSP Attendance table for 4/1/13 to 8/26/13. However, the Director of Quality Assurance stated this does not provide a count of who was actually required to attend. The table lists the disciplines and other possible IDT members, the total meetings required, the total attended in whole or part, and the percent of compliance. However, the numbers of meetings required do not appear accurate. For example, the QMRP is listed as being required for 345 meetings, the most of any category and likely the total number of such meetings. The Nurse is listed as required for one meeting (with a compliance percentage of 100%), Nursing for one meeting (also rated as 100% compliant), another Nursing for 328 meetings (also 100% compliant, and RN for one meeting (again, 100% compliant). Nurses are generally required at all ISP annual planning meetings, but this would add up to only 331 out of the 345 meetings. Similarly, Physician is listed as required for 66 meetings, and Nurse Practitioner for two meetings, and both are rated as 100% compliant. Only a few IDT members are rated at less than 100%. Direct Contact Professional is listed as required for 212 meetings and in attendance for 156 (in addition to listing "direct support professional" for one meeting and "Direct Support Staff" for one meeting). In general, direct support professionals would be expected to be represented at nearly all such meetings. Thus, this table cannot be relied on for accurate tracking of attendance when required. The Facility also provided a document entitled PSP Attendance Tracking, Meeting Log dated Tuesday, August 06, 2013 and covering ISPs held from 11/1/2012 - 8/6/2013. The data were provided by living unit, but were not particularly useful, as they appeared to simply indicate actual attendance, not required attendance. The Facility also provided a document entitled Monthly Attendance by Discipline 11/1/2012-8/6/2013, PSPs Only, which tracked attendance by discipline for each living unit. The overall unit scores for attendance during this period ranged from 97-100%. In the Self-Assessment for Section	

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		F, the Facility reported it was not tracking attendance by required IDT members as compared to the ISP Preparation document, however, so it was not clear how these data were arrived at. Beginning to track required attendance as it is prescribed in the ISP Preparation document should assist the Facility in obtaining accurate and useful data. The Facility should develop and use a single tracking and reporting system to ensure data used for decision-making are consistent. Based on the number of meetings attended, as reported on the PSP Attendance table, numerous clinical disciplines attended many or most meetings. In particular, QiDPs (who lead these meetings) attended nearly all, and attendance was routine for nurses, psychologists/behavior analysts, and social workers. It could not be determined from this document whether physical therapists and occupational therapists split their attendance so that one or the other would represent habilitation services, or whether there was overlap of attendance at some meetings and a concomitant lack of any habilitation attendance at other meetings; as reported in Provision P2 for a sample of 16 ISP annual meetings, either an OT or a PT was present. Many disciplines, such as physicians and speech pathologists, attended few meetings, especially given the medical and communication needs of many individuals who live at the Facility. As reported in Section F, the Monitoring Team also reviewed the signature sheets for eight recent ISP annual planning meetings to compare the actual attendance with that designated in the ISP Preparation Meeting. Of the eight ISPs reviewed, two contained pre-ISP meeting sheets that did not indicate which individuals should be present at the ISP meeting. Of the six ISPs that did adequately complete this section, a total of 68 individuals were required to be in attendance, and 58 actually were in attendance (85%). Zero of six (0%) had 100% attendance compliance, however. In a review of all eight attendance sheets, it was noted that in only one case did the IDT require the primary care provider (PCP) to be in attendance, and the actual lack of PCP presence at any of the ISP annual planning meetings was concerning. In addition to attendance, integration of clinical services into PBSPs was variable. Examples of such integration included: • From a sample of 16 ISPs or ISPAs sampled by the Monitoring Team, sixteen (100%) integrated the OT/PT interventions and consistently described the supports based on the rationale provided in the therapy assessment. Integration was primarily in the form of PNMP review and acceptance. • Three cases cited in provision j15 (Individuals #712, #346, and #379) represent good integration of neurology, psychiatry, pharmacy and general medical care. Examples of lack of such integration included: • As reported in Provision I3, for a sample of 16 Integrated Risk Rating Forms, the plans for nine (56%) showed adequate integration between all of the	

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		appropriate disciplines, as dictated by the individual's needs. • At the ISP Preparation meeting for Individual #711, the Skin Integrity Coordinator reported the individual was picking and opening a wound. A remote control car was provided that he could play with if he didn't pick. This was a creative and positive approach. However, there was no indication that the psychologist/behavior analyst was involved in assessment or development of this support. Furthermore, in the ISP Preparation Meeting document, skin picking was not included as a target of the positive behavior support plan (PBSP), nor was any suggestion made that this be included in the updated psychological assessment to be done prior to the ISP annual planning meeting. • As reported in Provision J9, for Individual #91 the Psychiatry and Behavior Management Clinic notes of 05/23/13 stated "IDT had had determined that the treatment plan integrates pharmacological treatment with behavioral and other interventions and that the plan includes the least intrusive and most positive interventions and that these interventions best serve the patient through a combination of behavioral pharmacological and other interventions." But that statement simply restated the requirements of the provision. It did not provide relevant specifics, and a reading of the overall note did not suggest that the IDT and psychiatrist had discussed this matter on 05/23/13, and the note did not indicate where or when such a discussion had taken place. • As reported in Provision O1, for two of nine individuals (33%) in Sample O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. • Review of a sample of 18 ISPs found that eight of 18 ISPs reviewed (44%) included how communication interventions were to be integrated into the individual's daily routine, and 11 of 18 ISPs reviewed (61%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. The Facility had continued to take many actions leading toward greater integration of planning at both the individual and systemic levels. As this continues to evolve and clinicians become more practiced at collaborative assessment and planning, a focus of improvement will need to be ensuring supports and services become integrated into the ISP.	
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	<u>Policy</u> DADS Policy 009.2 was implemented 5/15/13. This policy describes the responsibility of the attending primary care physician (PCP) to write initial consultation referrals, and the required content of the referrals. It provides a timeline of five working days for response to routine medical/surgical consultation recommendations. It identifies IDT responsibilities to document implementation of recommendations.	Substantial Compliance

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	documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The following Facility policies addressed aspects of consultation and review of recommendations from non-Facility clinicians. • RSSLC Policy I.33 Tracking/Trending Medical Consultations and Significant Diagnostic Studies 1/30/12 • RSSLC Policy I.12 Routing of Of-Campus Consultations 1/6/11 • RSSLC Policy I.13 Routing of On-Campus Consultations 1/6/11 • RSSLC Policy PCP Consultation Letter Policy (no number) 7/2/12 • RSSLC Policy The Morning Report 6/28/13 (no number) • RSSLC Policy Integrated Neurology Clinic 4/17/12 (no number) Policies I.12 and I.13 provide steps to be taken for routing off-campus and on-campus consultations. For off campus consultations, the policy begins at the point of delivery of the consultation documents to the medical coordinator, who is to send the original to the Primary Care Physician (PCP) and a copy to the unit case manager and is to flag any needed follow up appointments, lab work, and medical studies for the unit case manager. The medical coordinator is to schedule follow up appointments and send notices to the unit case manager. The PCP is to document "whether to accept, reject, or other on the back of the consultation form" 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	

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		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. Per interview with the Medical Director, all consultations in the past six months were medical consultations that were ordered by the PCP. These facility policies appear to meet all the requirements of DADS policy except that they require the PCP to "enter the data" (this follows two bullets that require the PCP to acknowledge the consultant's recommendation and plan of care, and to classify the consultation as acute, routine, or preventive) within "5 to 7 business days of receipt of the data," whereas DADS policy requires response to recommendations within five working days. The Facility should review all related policies to ensure they are consistent with DADS revised policy. Because there is overlap across policies, it might be wise also to review all the relevant policies and ensure they are consistent throughout. For example, Policy I.12 requires the unit case manager to present the signed consultation 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." 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. <u>Procedures and Forms</u> For all medical consultations, the Facility required use of a Consultation Report form that included information from the consultation, including consultant findings and recommendations. 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 PCP to sign and date. The Consultation Report form directed the consultant to "See PCP Consultation Letter" for the reason for the requested consultation. It also contained a checkbox for "Refer this patient to IDT for discussion." Procedures for referral, receipt and documentation of consultant recommendations and results of significant diagnostic studies are described above as stated in policy. In	

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		addition, the agenda of the Morning Report included agenda items for reporting medical and nonmedical consultations; these reports, per policy, were to include reporting consultations needing to be addressed with the IDT and consults in which the PCP or referring clinicians do not agree with the consultant's recommendations. <u>Review of Consultations by Facility Clinicians</u> The Monitoring Team reviewed a sample of 17 consultation reports for 13 individuals; 13 reports for ten individuals were for medical consultations (Individuals #27, #43, #44, #286, #296, #309, #351, #389, #564, and #666), and four were for modified barium swallow study (MBSS) consultations (Individuals #378, #410, #465, and #525). Of the 17 sampled reports: • For 16 (94%), review was documented on the consult form. • For 11 of 13 medical consults (85%), the PCP documented on an IPN; seven of these (54%) were documented within five working days. For one of four MBSS consultations (25%), the PCP documented on an IPN; this was done within five working days. These data are not fully consistent with data from the sample reported in the Self-Assessment, which found all consultations/diagnostic studies were acknowledged in IPNs/Notes within five days, the external medical audit finding that 83% were addressed in IPNs within five business days, and the internal medical audit finding that 100% were addressed in the IPNs within five business days. • Twelve of 13 medical consultations (92%) documented agreement with consultant recommendations; the remaining one was referred to the IDT. This meant that all 13 (100%) had documentation of a decision to agree or refer to the IDT. All four MBSS consultations (100%) had documentation of agreement. • Only one consultation specifically documented referral to the IDT. As noted above, all consultations are to be reported at the Clinical Morning Report; participants at this meeting included representation from Residential Services. Furthermore, the unit case managers are to report at the unit morning meeting. Both of these would provide information to the IDT, which could then choose to review further. The Monitoring Team could not determine whether that was done consistently. To assess whether this was occurring, the Monitoring Team reviewed Clinical Morning Report minutes of 8/20/13, 8/22/13, 8/27/13, and 8/29/13 and did find documentation of referral to the IDT and follow-up responses regarding IDT action, as noted below: o Thirteen consultations were reported. Of these, five were follow-ups to prior consultations noted on these minutes. Therefore, reports of consultations were made for eight separate individuals. o For two of the eight individuals (25%), referral to the IDT was reported in the minutes. Because reported consultations for some of the	

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		individuals were part of an ongoing set of consultations and diagnostic tests for individuals or results and recommendations were not yet available, referral to the IDT for decision-making would have been premature; therefore, there would not be an expectation that most individuals would have been referred for IDT decisions. o Of the two individuals referred, the minutes reported an IDT meeting for one (50%). In addition, the minutes reflected IDT review and decisions for one individual who had been referred prior to 8/20/13, and review by the IDT of three other individuals regarding DNR (as follow up to referral from the Clinical Morning Report prior to 8/20/13). o Attached to the minutes of the 8/29/13 Clinical Morning Report was an email stream regarding consultation recommendations, including consultation documentation and notice of the scheduled IDT meeting. The Consultations Database does have a box to note if the IDT reviewed the PCP's Acknowledgment of Consultation, and a place to check if documentation of that was submitted for filing in the medical chart. According to the Medical Director, this is currently used only for missed appointments. The Monitoring Team suggested the Facility consider using this for all referrals to the IDT. The report provided to the Monitoring Team from this database did not include those fields. This could provide the Facility with a means to check whether a consultation was reviewed by the IDT and how regularly, either for one individual or in the aggregate, the IDT(s) review consultations and take action. The Facility must ensure consultations are referred to the IDT as needed, and that the IDT provides evidence of integration with existing supports and services. Because documentation of review and acceptance of recommendations was routinely found on consultation forms and in IPNs, and the minutes of Clinical Morning Report meetings documented examples of follow up with IDTs, this provision is found to be in substantial compliance.	

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 8/9/13 2. RSSLC Action Plan 8/7/13 3. RSSLC Presentation Book for Section H 4. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10 5. DADS Policy 009.2 Medical Care 5/15/13 6. DADS Policy 004.1 Individual Support Plan Process 11/20/12 7. RSSLC Policy I.31 Chronic Clinical Indicators 8/20/13 8. RSSLC Policy I.41 Developmental Disability Preventive Healthcare Screening Database 10/23/12 9. RSSLC Procedure Clinical Pathway for Standard of Care and Documentation Guideline Policy 4/15/13 10. RSSLC Policy F.04 Individual Support plan Process 12/11/12 11. RSSLC Policy I.08 At Risk Individuals 5/11/12 12. RSSLC Policy I.19 Responding to Weight Loss/Gain 2/11/10 13. RSSLC Policy I.00a Medical Services 1/21/11 14. RSSLC Policy K.01 Physical Nutritional Management 3/11/13 15. RSSLC Policy The Morning Report 6/28/13 (no number) 16. RSSLC Policy Healthcare Trend Report to QA/QI Council (no date or number) 17. RSSLC Policy Pre-Hospital Discharge Planning Policy 9/6/12 (no number) 18. Pre-Hospital Discharge Discussion summaries for 4/10/13 19. Database Screenshots a. Medical Follow-up Database b. Developmental Disability Preventive Healthcare Screening c. Diabetes d. Osteoporosis e. Neuromotor Musculoskeletal Disorder f. Pneumonia g. Infection Control, with Infection Type-Urinary Tract report 20. Clinical Pathways a. Osteoporosis b. Diabetes mellitus c. Dyslipidemia d. Seizure disorder e. Constipation f. Hypertension g. Chronic Kidney Disease h. Chronic Obstructive Pulmonary Disease (COPD) i. Gastroesophageal Reflux Disease (GERD) j. Downs (sic) Syndrome

	k. Cerebral Palsy l. Degenerative Spine Disease m. Aspiration Syndrome 21. Documentation for samples of individuals selected by the Facility for the following conditions. Documentation included (as appropriate for condition and individual): Annual Medical Summary or Psychiatric Assessment, relevant integrated progress notes (IPNs), clinic notes, (including Psychiatric and Behavior Management Clinic—PBMC), radiology and lab reports, physician's orders, chronic care database reports by individual, and seizure frequency graphs: a. Osteoporosis b. Diabetes mellitus c. Hyperlipidemia d. Seizure disorder e. GERD f. Obsessive Compulsive Disorder g. Schizophrenia, Disorganized Type h. Autistic Disorder i. Major Depressive Disorder, recurrent severe without psychotic features j. Bipolar I, most recent episode manic with psychotic features 22. Annual Assessments Filed 10 Days Prior to Meeting for Meeting dates of 11/1/12-8/6/13 23. Annual Assessments to be Filed 10 Days Prior to PST Compliance by Unit 6/1/13-6/30/14 graph 24. Annual Assessments to be Filed 10 Days Prior to PST Compliance by Assessment 6/1/13-6/30/14 graph 25. Health Trend Report to QA/QI, August 2013 26. Trend Analysis Reports a. Diabetes 8/15/13 b. Preventive Healthcare Screening 8/15/13 c. Osteoporosis /15/13 d. Neuromotor Musculoskeletal Disorder 8/15/13 e. Medical Follow up 6/18/13 and 8/15/13 f. Pneumonia 8/15/13 g. UTI 8/15/13 27. Daily Sick Call Log sample for self-assessment, with Integrated Progress Notes (IPNs) 28. 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, Medical Compliance Coordinator **Meeting Attended/Observations:** 1. QA/QI Council 2. Integrated Support Plan (ISP) Annual Planning Meeting for Individual #120 3. ISP Preparation Meeting for Individual #711
	Facility Self-Assessment:

	The Facility submitted a Self-Assessment for Section H. 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 H, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. 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 the external and internal medical audits. o These monitoring/audit tools included adequate indicators relevant to determine compliance with some requirements of the Settlement Agreement. o The Self-Assessment identified the sample(s) sizes, including the percent of individuals in the overall population. This sample sizes were adequate to consider them representative samples. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically competent in the relevant area(s). o Adequate inter-rater reliability between the various staff responsible for the completion of the tools was not reported. ▪ Used other relevant data sources and/or key indicators/outcome measures. These included: o Number and percent of assessments completed timely. o Number and percent of quarterly summaries completed timely. o Number and percent of applicable individuals for whom post-hospitalization PNMT assessments were completed. o Number and percent of cases in which nursing and PCP integrated progress notes (IPNs) were present to respond to acute changes. o Number and percent of quarterly assessments that ensured treatment to be clinically appropriate. o Number and percent of Pre-Hospital Discharge that had clinical assessments completed and documented in IPNs by appropriate disciplines and had healthcare plans and IDT evaluations as indicated. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Generally presented findings consistently based on specific, measurable indicators. However: ▪ It was not clear how "ensured treatment to be clinically appropriate" was defined. o Did not consistently measure the quality as well as presence of items. For many items, only timeliness was measured. o Except for external and internal audits and information from the program monitors, the self-assessment did not indicate who collected the data. ▪ The Facility rated itself as being in compliance with the following provisions of Section H: Provisions H2 and H3. This was not consistent with the Monitoring Team's findings. The

	Monitoring Team found the Facility in compliance with no provisions of Section H. o For Provision H2, the self-assessment stated that 82% of Active Problem Lists had correct psychiatric diagnoses. While relatively consistent with the findings of the Monitoring Team, the importance of psychiatric diagnoses in making treatment decisions makes that percentage inadequate for a finding of substantial compliance. Furthermore, there were still too many individuals for whom comprehensive psychiatric evaluations needed completion in order to ensure the diagnoses are fully justified. o Likewise, for Provision H3, the Facility reported that 80% of sampled Physician Quarterly Assessments showed treatment to be clinically appropriate, and 4 of 10 did not provide a comprehensive assessment with addressing lab work and clinical indicators. Given the serious consequences that could occur with inappropriate treatment, this percentage is too low to permit a finding of substantial compliance. Furthermore, the self-assessment was limited to physician, nursing, and psychiatric assessments, and QDRRs. However, Provision H3 requirements cover all clinical disciplines. The Facility should review this report to determine what other measures need to be considered in the self-assessment. o Although the Facility and the Monitoring Team concurred in finding noncompliance for Provision H6, the Facility only addressed the Pre-Hospital Discharge Meetings. The Facility should review this report to determine what else should be assessed. 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 or In Process. ▪ The Facility data identified areas of need/improvement. These were not necessarily derived from the results of the self-assessment. For example, for Provision H1, the Facility rated noncompliance because not all assessments were completed in response to a change of status, but that was not part of the measures for assessments. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. However, some additional specification of steps in process may be needed. It is unclear whether the steps that call for evaluating trends and monitoring procedures need to be more fully developed.
	Summary of Monitor's Assessment: RSSLC continued to progress on meeting the requirements of Section H. There had been significant progress in timeliness and, for some disciplines, in comprehensiveness of assessments. The identification and use of clinical indicators had expanded, particularly for healthcare conditions. Processes to monitor health status of individuals had been implemented more broadly and contributed to knowing the status of healthcare at the Facility. Provision H1: Timeliness of scheduled assessments had improved but continued to need further improvement. The Facility data on timeliness was not reliable, as it did not differentiate required assessments from others; as the ISP Preparation process evolves, the Facility should be able to establish processes to gather data that will be useful. Assessments for several disciplines had become more

	comprehensive, although improvement must still be made, and such improvements need to be consistent for all clinical disciplines. Completion of assessments in response to a change in status had continued to improve both in timeliness and content. One way the Facility periodically assessed individuals for changes in status was through quarterly physician, nurse, and psychiatry assessments. The Facility also completed PNMT post-hospital assessments. Discussion of changes in status at the morning medical report meeting made disciplines aware of changes in status that would need assessment. Assessments in response to a change in status were adequate for physical and nutritional management concerns but were not consistently adequate for nursing assessments. Provision H2: Diagnoses were consistent with codes of the current versions of the DSM and ICD classification systems, except that diagnosis of "seizures" was made without identification of type. Diagnoses were consistent with assessments for osteoporosis, malignancy, pneumonia, and acute episodes of bowel obstruction and ileus, and there was improvement in identification of individuals with cerebral palsy. For psychiatric diagnoses, formulations of psychiatrists for changed diagnoses were reasonable. However, as discussed during several previous visits, there also needed to be justification of each of the diagnoses in terms of the DSM criteria for each diagnosis made. Sometimes there were diagnoses that were reasonable and likely, but specifics supported the diagnosis were not offered. Nevertheless, clarity in the records about psychiatric diagnoses has been gradually improving. The Facility has come close to substantial compliance with this provision. It will be important to continue improving the clinical justification for psychiatric diagnoses through completion of comprehensive psychiatric evaluations and through clear statement of the basis for diagnosis when diagnoses are changed. Provision H3: The Facility had continued processes to ensure treatments and interventions were initiated timely and based on medical diagnoses. Improvement was variable across clinical disciplines, and improvement is still needed. The Facility ensured prompt and appropriate triage of acute medical conditions. Medical providers promptly assessed and developed meaningful medical action plans for reported acute seizure activity. However, it was not always clear that all necessary supports and services were provided timely. Provision H4: The Facility had made great progress in identifying clinical indicators of efficacy of treatments that affect health conditions but less progress in doing so for behavioral and other clinical treatments and interventions. Clinical pathways were provided for 12 conditions; these are an excellent beginning. The Facility should continue to review and revise these, and should identify for which conditions clinical indicators are not included and could appropriately be included. The Facility had significantly increased the number of clinical indicators that were used its medical QA process, and included specific indicators for osteoporosis, preventive health care, neuromotor, musculoskeletal, infections, pneumonia, urinary tract infections, and medical consultation follow-up. Outside of chronic health conditions, the use of clinical indicators had not yet progressed to the same

	degree. Provision H5: Overall, for medical and psychiatric care, there was continuing improvement in revising treatments and interventions based on clinical indicators (in part reflecting the expansion of clinical indicators and expectations that they would be tracked). This was less true of other clinical disciplines. The Facility had made significant progress in establishing a system to monitor health status of individuals. Furthermore, this system was being used to identify status of healthcare at the Facility and to identify areas to address for possible improvement. Included in this system are the clinical pathways. The Facility demonstrated review of such data in annual assessments, quarterly reviews, and database reports and graphs. In regard to physical and nutritional management (PNM) for individuals, the use of clinical indicators was more variable. Clinical indicators were identified, primarily to identify triggers to be reported, but there was little use of the indicators to assess status of individuals, to identify when referrals should be made to the PNMT, or to monitor progress. Also, the Facility had significantly increased the number of clinical indicators that were used its medical quality assurance (QA) process, and included specific indicators for osteoporosis, preventive health care, neuromotor, musculoskeletal, infections, pneumonia, urinary tract infections, and medical consultation follow-up. The Facility needs to continue to develop indicators for clinical conditions as appropriate, to ensure clinical pathways document the clinical indicators to be monitored, and ensure all clinical disciplines providing health care use clinical indicators to monitor status on individuals. Provision H6: The development of clinical indicators had continued, along with expansion of the database of chronic conditions that made data readily accessible for decision-making. With some exceptions, medical care and action plans implemented for diagnosed health conditions indicated appropriate review and response to clinical indicators. Data were reviewed in psychiatric quarterly assessments. However, behavioral data did not always lead to changes in programs when indicated, although there had been improvement. The Facility had not conducted the necessary "as needed" reviews of behavior interventions associated with individuals for whom restraint had been applied more than three times in a rolling 30 day period. Documentation provided by the Facility reflected that adequate reviews of PBSPs had not been conducted for any individual restrained more than three times in a 30-day period. Furthermore, documentation illustrated that for six of the nine people meeting the restraint frequency criteria presented above (67%), no PBSP had been implemented despite multiple applications of restraint. In relation to PNM issues, although there were some individuals for whom progress was measured, measurable objectives against which to measure progress and determine need for program revision were not available. For communication, measures of progress were available and tracked for some individuals, but revisions were not made to programs based on those measures. Provision H7: The Facility and DADS had developed numerous policies that included requirements for integrated clinical services. There was no single policy that established requirements for integration, provided procedures to facilitate integration, or directed staff to the other policies that included requirements for integration. Furthermore, the only requirements in several policies that were relevant to integrated clinical services were lists of the responsibilities of various disciplines relative to the topic of the

	policy, without any discussion of how these were to integrate beyond completing the responsibilities. The procedures for chronic care clinical pathways were a positive step to promote use of clinical indicators and recommended practices. All except the clinical pathway for aspiration syndrome had a section for the PCP to discuss and document recommendations to the IDT for an interdisciplinary approach to management of the condition. While the Monitoring Team compliments the Facility for including this, there might be consideration of how relevant clinicians may be involved in review of the condition and treatment plan before the PCP establishes the recommendations to be discussed.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	<u>Policy</u> DADS Policy 004.1 continued the requirement that IDT members complete required assessments and place them in the shared drive for IDT review no later than 10 working days before the annual ISP meeting and no later than five days prior to the initial admission ISP. Requirements of RSSLC Policy F.04 Individual Support plan Process were consistent with DADS policy. <u>Extent to which assessments are conducted routinely</u> Assessments for the ISP were still not routinely completed on a timely basis, but there was improvement noted. The expectations remained that assessments would be posted no later than ten working days prior to the meeting. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. There was evidence the IDTs were making use of this function, as six of eight (75%) recent ISPs clearly defined the assessments that were to be completed. The Facility provided in the Self-Assessment for Section H data on timeliness of a sample of clinical assessments for ISPs. Timeliness ranged from 38% for Psychiatry Assessments (the only assessment below 70%) to 100% for Dental Assessments, with the remainder between 70% and 95%. Assessments for the ISP were still not routinely completed on a timely basis, but there was improvement noted. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. There was evidence the IDTs were making use of this function, as six of eight (75%) recent ISPs clearly defined the assessments that were to be completed. The Facility provided a log of assessments due and dates completed for these meetings occurring from 11/1/12 through 8/6/13. In addition, the Facility provided a summary table by unit of the number of assessments provided and the number provided 10 days	Noncompliance

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		prior to the annual ISP planning meeting. Per interview, although this stated it was for 10 days prior, it actually reflected presence of assessments 10 working days prior to the meeting. This table showed percentages of timely posting of assessments ranging across units from 87% to 100%. However, based on the numbers of assessments reported, those figures were inaccurate. Although some assessments are required for only a few individuals, some assessments are required for all individuals. For example, annual medical assessments are required for all individuals, but they were not all provided timely (except for the two individuals at the Infirmary), with percentages as low as 69% (33 of the 48 ISP meetings) for Three Rivers. The table reported similar findings for Nursing, Pharmacy, Nutritional, and Rights Assessments, among others. To make this table useful, the Facility should ensure the calculations are based on the assessments required per policy and per the results of the ISP preparation meetings. In any case, given the lack of timely completion of assessments that are required per policy, improvement is needed. As reported in Provision F1c, the Monitoring Team reviewed the assessments for sample of eight completed ISPs and for a sample of nine upcoming ISPs to be held during the week following the monitoring visit. While timeliness remained a concern, there was evidence that the Facility was achieving progress in this area. The Monitoring Team also viewed the assessments available on the shared drive for Individual #154, who had an annual ISP planning meeting scheduled within the next ten working days. For 15 assessments that were required per the ISP preparation meeting, 12 (80%) current or updated assessments were posted, and nine (60%) had been posted by 10 working days prior to the meeting. This was slightly lower than the percentages reported in the sample reviewed for Provision F1c. No evidence was provided of systemic actions being taken to improve timeliness of assessments. Additional information for disciplines includes the following: • As reported in Provision M1, review of the trend report for monthly monitoring tool audits showed timely nursing assessments to be recorded in at least 97% of audits each month (with no data from April, May, and June 2013 due to a change in assessment procedures). As reported in Provision M2, six of six (100%) Annual Comprehensive Nursing Assessments reviewed were completed at least 10 working days prior to the ISP meetings. • As reported in Provision L1, 18 out of 18 annual medical summaries (100%) were completed at least ten days prior to the annual ISP meeting. • As reported in Provision P1, fifteen of 16 individuals' OT/PT assessments in	

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		sample P.1 and P.2 (93.75%) were dated as having been completed at least 10 days prior to the annual ISP. • As reported in Provision R2, eleven of 15 individuals in Sample R.1 (73%), communication assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. However, although facility policy does not require a full communication assessment annually, a master plan exists for completing full assessments; Individuals #154 and #429's assessments were last completed in 2008 although they were identified as having severe communication deficits and were to have received a new assessment. • Three hundred nine of the 340 individuals living at the Facility (91%) had been provided a Psychological Evaluation Report or a Psychological Evaluation Update Report within the year prior to the site visit. This was a modest decrease from the previous year. Furthermore, many Structural and Functional Assessments had not been reviewed in more than a year. • The psychiatrists have also started to do required annual updates of the Comprehensive Psychiatric Evaluations (CPEs). Screening had been done for all individuals who live at the Facility. As reported in Provision J7, seven individuals whose screening scores reached or exceeded designated cutoffs were still pending a CPE. For new admissions, the Monitoring Team reviewed completion of assessments within 30 days following admission for several disciplines. • As reported in Provision J2, of 11 admissions to the Facility for individuals who took psychotropic medications prior to admission, all individuals (100%) were seen by psychiatry within 30 days. • As reported in Provision M2, four of four (100%) Admission Comprehensive Nursing Assessments reviewed were completed within 30 days of admission. • As reported in Provision P1, sixteen of 16 individuals admitted since the last review (100%) received an OT/PT assessment within 30 days of admission or readmission. • As reported in Provision R2, sixteen of 16 individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission. • Seven of 16 individuals admitted since the last review (44%) were provided with a Psychological evaluation report within 30 days of admission. Three individuals (19%) were not reflected in Facility tracking information as having been provided with a Psychological Evaluation report. The average span between admission and Psychological Evaluation for those newly admitted to RSSLC was 47 days.	

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		The Facility will need to: • Determine a way to track which assessments are required prior to annual ISP planning meetings in order to determine whether required assessments are completed timely, and whether any improvement actions need to be taken. • Ensure all disciplines required to provide assessments for new admissions due so at least five days prior to the initial ISP is developed. • Implement improvement and corrective action plans for identified concerns. <u>Comprehensiveness of Scheduled Assessments</u> Assessments for several disciplines had become more comprehensive, although improvement must still be made, and such improvements need to be consistent for all clinical disciplines. Although progress was noted in discipline specific assessment processes and outcomes throughout this report, noncompliance was found in the following provisions related to the quality of assessments: J6, K5, L1, M2, O2, O8, R2, S2, T1b1, T1b3, T1d. and U1. These findings, taken together, demonstrated assessments were still not routinely of sufficient quality overall to reliably identify the individual's strengths, preferences and needs. • As reported in Provision K5, although 309 of the 340 individuals living at the Facility (91%) had been provided a Psychological Evaluation Report or a Psychological Evaluation Update Report within the year prior to the site visit, the Facility reported that no testing of adaptive skills or intellectual ability had been conducted as part of those 309 reports. The Facility indicated that intellectual and adaptive skill assessments were not routinely conducted at RSSLC. This was also true for individuals newly admitted to the Facility. Also, as reported in this provision, there had been some improvement in quality and comprehensiveness of Structural and Function Assessments (SFAs), but substantial lapses remained. For example, SFAs did not consistently reflect the use of an accepted functional assessment process or identify specific antecedents or potential functions of a targeted behavior. • The Monitoring Team reviewed Comprehensive Psychiatric Evaluations for the 15 individuals in Sample J1. Diagnoses were assessed to be adequate for nine of 15 individuals (60%). • As reported in Provision M2, although the procedure and forms for the nursing assessments were changed, the Monitoring Team found that the actual content and requirements for compliance did not change significantly. The Monitoring Team review of a sample of Quarterly Nursing Assessments found a significant improvement in compliance with requirements on the Facility's monitoring tool. Some requirements fell below 90% compliance, including updating of current active medical diagnoses, documentation of current and required immunization and TB screening, and end of life issues. There was significant improvement in	

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		concisely summarizing raw clinical data to reflect the health status for each Nursing Diagnosis/Problem in terms of improving, maintaining and/or regressing, as well as the effectiveness of their care plans. However, the guidelines and forms were too recently changed to adequately assess the nursing assessments for quality and compliance. • As reported in Provision O2, components required in assessments were nearly all present in all sampled assessments. The exception was the lack of measurable outcomes related to baseline clinical indicators. • As reported in Provision U1, the Facility did not routinely use standardized or valid instruments and/or processes to assess functional decisional capacity. • As reported in Provision T1e, assessments prepared for the Individual #165, whose CLDP was held during the monitoring did not adequately address significant issues that could impact a safe transition to community living. <u>Assessments and Evaluations in Response to Changes in Status</u> Completion of assessments in response to a change in status had continued to improve both in timeliness and content, although further improvement was needed in some areas. One way the Facility periodically assessed individuals for changes in status was through quarterly physician, nurse, and psychiatry assessments. The Facility provided in the Self-Assessment for Section H data on timeliness of a sample of quarterly assessments, which were 95% for Nursing and 100% for Physician and Psychiatry. Nine of nine PNMT assessments/reviews for individuals in Sample O.2 (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). The Facility also completed PNMT post-hospital assessments and reported on a sample. Of 13 hospitalizations in the sample, five were identified as requiring assessment per PNMT policies and protocols, and all five (100%) had evaluations conducted. RSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Another method in which the PNMT was made aware of changes in status was through participation by the PNMT RN in the morning medical report meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. Psychiatric Evaluations were also a focus at Psychiatric and Behavior Management Clinics (PBMCs), the term used at the Facility for the psychiatric clinic. All individuals supported by psychiatry were seen at least quarterly at PBMC. Diagnoses were changed	

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		when appropriate as part of this process, although these did not generally include new CPEs; 11 of 16 (68%) of the changes in diagnosis were accompanied by full justification. As reported in Provision I2: • For seven individuals determined to have had a change in condition meriting risk assessment review by the IDT (Individuals #296, #192, #686, #284, #106, #379, and #43) 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 five (71%). • For six individuals (Individuals #106, #569, #379, #177, #43, and #486,) for whom assessments had been completed to address the individuals' at risk conditions, three (50%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Those that did not included Individuals # 569, #43, and #177. The nursing assessments for the other three Individuals were either not thorough, did not reflect interdisciplinary review and discussion, or did not include sufficient data that could have led to productive review, discussion, and decision-making. • For four Individuals (Individuals #296, #192, #686, and #284) for whom assessments had been completed to address the individuals' at risk conditions, all four (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. Additionally, nine PNMT assessments were reviewed for individuals in Sample O.2 and all nine (100%) were initiated within five working days of the referral (or sooner as specified in the PNMT policy) Use of Information from Assessments Examples were found both of use of information from assessments and of lack of use of the information. • As reported in Provision O2: o In nine of nine individuals' plans reviewed (100%), the plans addressed the individual's identified Physical and Nutritional Management needs as presented in the PNMT assessment. o In nine of nine individuals (100%) for whom Head of Bed Elevation (HOBE) assessments were conducted or reviewed, the HOBE recommendations were integrated into individuals' plans. • As reported in Provision S1, skill acquisition plans were not consistently supported by the assessments submitted as part of ISP documentation. • As reported in Provision V4, observation of the ISP annual planning meeting for Individual #711 found much of the discussion included impressions of various IDT members, but data were not consistently provided; thus, useful information	

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		from the assessments was not consistently provided. Although IDT members should be able to get this information from assessments that were, per policy, to be posted 10 working days in advance of the ISP meeting, and although there was improvement in timeliness of completing assessments, not all were available in time for review by IDT members.	
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 codes of the current versions of the DSM and ICD classification systems, except that diagnosis of "seizures" was made without identification of type. As reported in Provision L1 in review of clinical management of medical conditions, diagnoses were consistent with assessments for osteoporosis, malignancy, pneumonia, and acute episodes of bowel obstruction and ileus, and there was improvement in identification of individuals with cerebral palsy. However, for seizures, the type of seizure was not consistently provided in the diagnosis. Regarding psychiatric diagnoses, as reported in Provision J2, formulations of psychiatrists for changed diagnoses were reasonable. However, as discussed during several previous visits, there also needed to be justification of each of the diagnoses in terms of the DSM criteria for each diagnosis made. Sometimes there were diagnoses that were reasonable and likely, but specifics supported the diagnosis were not offered. Overall, 11 of 16 (68%) of the changes in diagnosis were accompanied by full justification. Clarity in the records about psychiatric diagnoses has been gradually improving. In previous reports the Monitoring Team described circumstance where numerous and sometimes conflicting diagnoses were cited in different parts of the record, where the psychiatrist doing the CPE was not the treating psychiatrist, where for some individuals there simply was no psychiatric evaluation and so forth. This is the first time that the Facility has been able to document that all individuals receiving medication have had a psychiatric evaluation. It is important for the most recent CPE to include a brief statement that clarifies the basis for each of the diagnoses of record. The Monitoring Team reviewed the use of DSM diagnoses in the CPEs of 15 individuals in Sample J1 and the informed consent for medication for 10 individuals in Sample J2. In all case there was a consistent use of DSM codes. The Monitoring Team reviewed the use of DSM diagnoses in APs for the 15 individuals in Sample J1. These too all used appropriate DSM codes. However among the individuals in Sample J1 who had lived at the Facility for some time, conflicting diagnoses were located in 6 of 10 (60%) of the records, most often in the PBSP. Once a supported diagnosis is selected and codified in the APL, efforts should be made to correct the various conflicting reports throughout and record.	Noncompliance

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		The Facility has come close to substantial compliance with this provision. It will be important to continue improving the clinical justification for psychiatric diagnoses through completion of comprehensive psychiatric evaluations and through clear statement of the basis for diagnosis when diagnoses are changed. To move toward substantial compliance in the next six months, the Monitoring Team also recommends the Facility do a focused review of consistency of diagnoses throughout records or, at a minimum, require reconciliation of the diagnoses in PBSPs with those in APLs; it might be possible or useful to do that on a continuing basis through use of the facility databases.	
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 treatments and interventions were initiated timely and based on medical diagnoses. Improvement was variable across clinical disciplines, and improvement is still needed. The Facility ensured prompt and appropriate triage of acute medical conditions. The Monitoring Team compliments the nursing staff for ensuring continuing of care by providing clinically relevant pre-hospital and post-hospital assessments, and consistent acute hospital follow-up via the hospital liaison process. Medical providers were consistent in providing efficacious pre and post hospital clinical assessments. The Facility provided an exceptional level of management of acute medical conditions. Medical providers appropriately assessed and triaged individuals for the diagnosis of malignancy. The Facility must, however, enhance the IDTs' involvement in such cases, by ensuring that the risks of malignancy are well explored, and that all necessary supports and services are identified, and provided. Similarly, medical providers promptly assessed and developed meaningful medical action plans for reported acute seizure activity. However, it was not always clear that all necessary supports and services were provided timely. • Individual #712 was noted to have significant increase in seizure activity, and the medical provider referred the case for an IDT meeting. The IDT minutes reflected that no addition safeguards, or change in status, would be done until follow-up with the neurologist. There was no additional documentation that indicated follow-up by the IDT. Seizure can be life-threatening, and cause bodily injury, and for this reason, a recent increase in seizure activity warrants assertive action by the IDT to enhance necessary supports and services to help prevent against adverse outcome from seizures; therefore, in this case increased supervision, and perhaps staff training to alert them of worsening seizure disorder, should have been considered by the IDT.	Noncompliance

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		There were examples and conditions for which improvement is needed. • For pneumonia, there was prompt initial triage of acute pneumonia, and the medical provider closely monitored the individuals through full resolution of the acute episode of pneumonia. For recurrent pneumonia, there was not evidence consistently across individuals of consideration for treatment to help mitigate recurrence. • For Individual #676, as of 12/13/2012, the general surgeon indicated that the Individual's colostomy could be removed within three months following the surgery; however, there was no documentation indicating that the colostomy was removed, and as of 7/24/2013, the annual medical summary indicated that the colostomy bag was still in place, and no mention of having the colostomy removed. • For two of nine individuals (33%) in Sample O.2, all recommendations by the Physical and Nutritional Management Team (PNMT) following assessments were addressed/integrated in the Integrated Support Plan Addendum (ISPA), Action Plans, Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs). • During the current site visit, the Facility reported that 18 individuals had been identified as requiring counseling services. Of those 18 individuals, RSSLC provided initial counseling treatment plans for 10 individuals (56%). • As reported in Provision K9, the average duration from submission of a Positive Behavior Support Plan (PBSP) to the Behavior Support Committee (BSC) and approval by BSC (according to a tracking worksheet) was 10 days, an acceptable timeframe. However, the tracking worksheet did not provide information to permit determination of the elapsed days between submission to the BSC and the date of implementation. • For three of three individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. Two of three individual's direct intervention plans (67%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. The SLP recommended that Individual #651 utilize a switch to activate a sensory device in October 2012; however as of this review the objective had yet to be implemented. • Zero of four individuals' indirect plans (0%) (i.e., SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. Although plans were identified in the SLP assessments as skill acquisition programs, there was no evidence of actual implementation.	
H4	Commencing within six months of the Effective Date hereof and with	RSSLC provided a tremendous amount of documentation to demonstrate the determination and use of clinical indicators related to medical care, as well as	Noncompliance

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	full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	information on the use of such indicators both for individual healthcare and for improvement of health care systems. The Facility had made great progress in identifying clinical indicators of efficacy of treatments that affect health conditions but less progress in doing so for behavioral and other clinical treatments and interventions. To evaluate whether clinical indicators of efficacy were determined in a clinically justified manner, the Monitoring Team reviewed: • RSSLC Policy Clinical Pathway for Standard of Care and Documentation Guideline Policy 4/15/13 • Clinical pathways for: Osteoporosis a. Diabetes mellitus b. Dyslipidemia c. Seizure disorder d. Constipation e. Hypertension f. Chronic Kidney Disease g. Chronic Obstructive Pulmonary Disease (COPD) h. Gastroesophageal Reflux Disease (GERD) i. Downs (sic) Syndrome j. Cerebral Palsy k. Degenerative Spine Disease l. Aspiration Syndrome Of the 12 conditions for which a clinical pathway was provided, clinical indicators of care were stated in three (25%), including diabetes mellitus, dyslipidemia, and seizure disorder. In addition, severity classifications (which include possible objective clinical indicators) were provided for COPD and chronic kidney disease. Furthermore, although not specifying a particular measure of, or process to, measure pain, the clinical pathway instructs the medical provider to "Discuss a specific plan for scheduled pain assessment" and to "Discuss and document the following recommendations to the IDT…Signs and symptoms of pain for direct care staff to recognize" and "Signs and symptoms of neurological and motor changes for direct care staff to recognize." These signs and symptoms would presumably be clinical indicators at the individual level, and are not specified in the clinical pathway because they may be specific to the individual. An example for which a clear statement of clinical indicators might be useful is for GERD. The clinical pathway has an instruction to discuss "if the individual's current GERD symptoms are controlled with the current medical management." It would be useful for the Facility to consider whether objective measures of presence, frequency, or severity of any specific and common symptoms should be included in such a discussion. The Facility had significantly increased the number of clinical indicators that were used its medical QA process, and included specific indicators for osteoporosis, preventive	

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		health care, neuromotor, musculoskeletal, infections, pneumonia, urinary tract infections, and medical consultation follow-up. All nine clinical indicators were reviewed by the Monitoring Team, and determined to be clinically relevant. Furthermore, the Facility's policy, Chronic Clinical Indicators, revised 8/20/2013, indicated that the medical director would continue to develop additional clinical indicators in the future. Outside of chronic health conditions, the use of clinical indicators had not yet progressed to the same degree. • Progress had been made in identifying behavioral data to assess progress of PBSPs. Behavioral data for assessing progress on both behaviors targeted for reduction and replacement behaviors were generally sufficient to assess progress. However, for counseling programs, measurable objectives were not evident. • In the previous report the Monitoring Team was informed 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. In Sample J1 appropriate measures were in place for six of fifteen (40%) individuals. • For zero of three individuals' records (0%) reviewed for direct communication intervention, there were measurable objectives related to individual functional communication outcomes included in the ISP. For two of three individuals (67%), information was present regarding whether the individual showed progress with the stated goal; however, this information was not based on clinical indicator data. However, as reported in Provision I3, for a sample of 16 Integrated Risk Rating Forms, plans included the clinical indicators to be monitored and the frequency of monitoring in nine (56%) cases.	
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 made significant progress in establishing a system to monitor health status of individuals. Furthermore, this system was being used to identify status of healthcare at the Facility and to identify areas to address for possible improvement. <u>Maintenance of a system to monitor health status of individuals</u> The Monitoring Team reviewed the clinical pathways noted in Provision H4. The Facility provided samples of documentation for the following 10 conditions: • Osteoporosis • Diabetes • Hyperlipidemia • Seizure Disorder	Noncompliance

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		• GERD • Obsessive Compulsive disorder • Schizophrenia • Autistic Disorder • Bipolar I, most recent episode manic with psychotic features For medical conditions, documentation was provided for a sample of five individuals; for mental health conditions, documentation was provided for a sample of two individuals. Documentation included, for each individual, the admission or annual medical summary or psychiatric assessment, quarterly reviews or psychiatric & behavior management clinic reports, relevant integrated progress notes (IPNs), and database reports or data graphs for health conditions. Review of a sample of this documentation showed data on clinical indicators of medical conditions was reflected in the medical summaries for osteoporosis, diabetes mellitus, and seizure disorder and used in consideration of actions to be taken. For example, regarding diabetes for Individual #748, database documentation of common complications and graphs of A1c, microalbumin, and LDL were all documented in the annual medical summary for both normal findings and levels needing attention. For mental health conditions, the PBMC notes included graphs of target behaviors, replacement behaviors, and/or psychiatric symptoms for eight of the ten cases (80%). In regard to physical and nutritional management (PNM) for individuals, the use of clinical indicators was more variable. Clinical indicators were identified, primarily to identify triggers to be reported, but there was little use of the indicators to assess status of individuals, to identify when referrals should be made to the PNMT, or to monitor progress. • In nine of the nine individuals' plans reviewed (100%), the plans included the specific clinical indicators of health status to be monitored. • Zero of the nine individuals' records in sample O.2 (0%) contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy). • Three of the 18 individuals' records in Samples O.1 and O.2 (16%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. Regarding individuals receiving direct OT/PT services, eight of nine sampled individuals were provided with comprehensive progress notes (IPNs) that contained information	

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		regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). The Morning Report, as documented in Provision G2, also provided an opportunity to discuss possible changes in status and refer those to clinicians and to the IDT as appropriate. The Hospital Liaison Nurse reported at each Morning Report, including reporting on individuals returning from hospitalization. The on-call PCP provided a report. These provided notice of possible change in status to a variety of clinicians. <u>Maintenance of a system to monitor Facility healthcare status</u> As reported in Provision L3, the Facility had significantly increased the number of clinical indicators that were used its medical quality assurance (QA) process, and included specific indicators for osteoporosis, preventive health care, neuromotor, musculoskeletal, infections, pneumonia, urinary tract infections, and medical consultation follow-up. All nine clinical indicators were reviewed by the Monitoring Team, and determined to be clinically relevant. Further more, the Facility's policy, Chronic Clinical Indicators, revised 8/20/2013, indicated that the medical director would continue to develop additional clinical indicators in the future. The Facility's electronic database, which was utilized to store and help analyze clinical indicator data, was noted to be efficient, and effective in helping the Facility analyze systems issues related to medical QA. The database was kept current by each medical provider entering required data, at the time of completing the individual's annual medical assessments. The medical director established a schedule to review clinical indicator trends analysis, and conducted regularly scheduled trends analysis meetings, which were attended by the medical staff, and other relevant clinical departments. The Facility provided the Health Trend Report presented to the QA/QI Council at the August 2013 meeting (during the compliance visit). The focus of this specific report was on urinary tract infections (UTIs). Data on UTIs was reported by month for 13 months, by unit, and by use of catheter or not (and whether these were straight or indwelling). The Medical Director provided analysis of the data that showed that most UTIs were found at one unit of medically fragile individuals. The data and trends analysis included assessment of the incidence of UTIs at the Facility, with breakdown by living area; the presence and type of urinary catheters used, and a specific breakdown of all UTIs at the level of the individuals, with analysis of recurrent UTIs, identified organism, comorbidities, initial presenting symptoms, use of incontinent pads, antibiotic use, and culture results. The trends analysis was noted to be comprehensive and efficacious. For example the data analysis was able to determine that there were kidney stones identified in six out the ten cases of recurrent UTIs, and consequently, these individuals were referred to urologists for further evaluation, and medical providers had been instructed	

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		to assess for the presence of kidney stones when evaluating recurrent UTIs. In addition, the data analysis indicated that UTIs were more common in the summer months, which in turn resulted in the Facility developing recommendations to enhance hydration during the summer months. The Medical Director reported a corrective action plan (CAP) had been started. This was an excellent example of how data on occurrence of a medical condition (UTIs) was used to identify not only the number of infections but also where they were occurring most frequently, allowing for monitoring and for prioritizing where to address a CAP. Prevention-oriented action was taken as a result of review of clinical indicators, rather than waiting to react to and provide care for an individual with a UTI. RSSLC has developed clinical indicators, some guidance for use of those indicators, and processes (including an impressive database) to track status of indicators for individuals and to aggregate data on indicators to determine status of healthcare in the aggregate. The Facility needs to continue to develop indicators for clinical conditions as appropriate, to ensure clinical pathways document the clinical indicators to be monitored, and ensure all clinical disciplines providing health care use clinical indicators to monitor status on individuals.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The development of clinical indicators had continued, along with expansion of the database of chronic conditions that made data readily accessible for decision-making. In general, reports in Provision L1 of medical care and action plans implemented for diagnosed health conditions indicated appropriate review and response to clinical indicators. Follow up was continued through to resolution of acute conditions. The possible exception was related to seizure management. • Individual #712 was noted to have significant increase in seizure activity, and the medical provider referred the case for an IDT meeting. The IDT minutes reflected that no addition safeguards, or change in status, would be done until follow-up with the neurologist. There was no additional documentation that indicated follow-up by the IDT. Frequency of seizures is one of the clinical indicators listed in the clinical pathway for seizure disorder. • Individual #475 was known to have pseudoseizures, and possible epilepsy. During the reporting period the Individual experienced an increased in possible seizures; however, staff were not able to distinguish neurological seizures versus pseudoseizures, and there was no documented evidence to indicate that the IDT met to develop possible ways differentiating between the two types of seizures. For psychiatric services, the PBMC provided a quarterly review. Prior to the visit the Monitoring Team requested information from the Facility about changes in diagnoses	Noncompliance

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		made since the last review. There were 16 such changes and the Facility provided the Monitoring Team with copies of PBMCs during which the changes were made. In some cases, changes involved removal of diagnoses and in other cases new diagnoses. In many cases, severity levels changed. In general, these changes were based on DSM IV criteria (although, as noted in Provision J2, these were not always fully justified according to those criteria). Behavioral data and, for some cases, data on symptoms were generally presented at the PBMC. It is also necessary, when reviewing behavioral and mental health conditions, to conduct thorough reviews of the available data and to introduce changes in the treatment process when data indicate changes are necessary. The information submitted during the current site visit to RSSLC reflected that the Facility had improved modestly in some areas, but had not built upon earlier progress and even regressed in other areas. In past reviews, there was little to no evidence that programs were modified if there was no progress over three months; at this visit, for 60% of the sampled programs, there was either evident progress or the program was modified timely. In addition, as documented in Provision C.7 of this report, the Facility had not conducted the necessary "as needed" reviews of behavior interventions associated with individuals for whom restraint had been applied more than three times in a rolling 30 day period. Documentation provided by the Facility reflected that adequate reviews of PBSPs had not been conducted for any individual restrained more than three times in a 30-day period. Furthermore, documentation illustrated that for six of the nine people meeting the restraint frequency criteria presented above (67%), no PBSP had been implemented despite multiple applications of restraint. There were four sampled individuals for whom data suggested a substantial increase in one or more targets without any consideration of the need to review or revise the PBSP. For example: • For Individual #576, physical aggression demonstrated an increasing trend beginning in January 2013. Although the frequency of physical aggression dropped in April, it peaked in July. During the brief ebb in physical aggression, inappropriate sexual behavior had increased. In addition, in May 2013 the individual had made statements of wanting to commit suicide and claimed to have a handgun for that purpose. At various times during this period, the individual was placed on increased supervision to prevent self-harm and sexual contact. At no point did the progress note reflect a recommendation that the PBSP should be reviewed or revised. In relation to PNM issues, although there were some individuals for whom progress was measured, measurable objectives against which to measure progress and determine	

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		need for program revision were not available. In zero of the nine individuals' plans reviewed (0%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. Although indicators had been listed for some, objectives were not established. For communication, measures of progress were available and tracked for some individuals, but revisions were not made to programs based on those measures. For two of three sampled individuals (67%) receiving direct communication services, recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. However, quarterly documentation for zero of four individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. Overall, for medical and psychiatric care, there was continuing improvement in revising treatments and interventions based on clinical indicators (in part reflecting the expansion of clinical indicators and expectations that they would be tracked). This was less true of other clinical disciplines.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility and DADS had developed numerous policies that included requirements for integrated clinical services, including: • DADS Policy 009.2 Medical Care 5/15/13 • DADS Policy 004.1 Individual Support Plan Process 11/20/12 • RSSLC Policy I.31 Chronic Clinical Indicators 8/20/13 • RSSLC Policy I.41 Developmental Disability Preventive Healthcare Screening Database 10/23/12 • RSSLC Procedure Clinical Pathway for Standard of Care and Documentation Guideline Policy 4/15/13 • RSSLC Policy F.04 Individual Support plan Process 12/11/12 • RSSLC Policy I.08 At Risk Individuals 5/11/12 • RSSLC Policy I.19 Responding to Weight Loss/Gain 2/11/10 • RSSLC Policy I.00a Medical Services 1/21/11 • RSSLC Policy K.01 Physical Nutritional Management 3/11/13 • RSSLC Policy The Morning Report 6/28/13 (no number) • RSSLC Policy Healthcare Trend Report to QA/QI Council (no date or number) • RSSLC Policy Pre-Hospital Discharge Planning Policy 9/6/12 (no number) The report of the last compliance visit stated, "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." For this visit, the Facility provided the above	Noncompliance

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		set of policies related to specific areas, including committees and areas of care, and several others noted in Section G in response to a request for "any State or Facility policy or procedure guiding integrated clinical services." There was no single policy that established requirements for integration, provided procedures to facilitate integration, or directed staff to the other policies that included requirements for integration. Furthermore, the only requirements in several policies that were relevant to integrated clinical services were lists of the responsibilities of various disciplines relative to the topic of the policy, without any discussion of how these were to integrate beyond completing the responsibilities; an example of that was RSSLC Policy I.6 Providing Acute Health Care, which lists the responsibilities of the nurse and physician but does not indicate how other clinicians or the IDT should or could be involved in either treatment or in evaluating whether the condition affects other aspects of clinical services. The procedures for chronic care clinical pathways were a positive step to promote use of clinical indicators and recommended practices. All except the clinical pathway for aspiration syndrome had a section for the PCP to discuss and document recommendations to the IDT for an interdisciplinary approach to management of the condition. While the Monitoring Team compliments the Facility for including this, there might be consideration of how relevant clinicians may be involved in review of the condition and treatment plan before the PCP establishes the recommendations to be discussed. A draft DADS state policy was available that addressed Provisions G and H together. The policy was not yet completed or disseminated. Information about this draft policy can be found in the report of the last compliance visit.	

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 8/9/13 2. RSSLC Section I Action Plan 8/7/13 3. RSSLC Section I Presentation Book 4. DADS At Risk Policy 006.1 (2/1/13) 5. RSSLC Policy I.08 At-Risk Individuals (5/11/12) 6. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 6/11/13) 7. RSSLC Policy K.01 Physical and Nutritional Management (rev: 3/11/13) 8. RSSLC Policy D.23 Using Bed Rails (5/8/13) 9. Records for Sample O.1: Individuals #192, #228, #268, #284, #296, #378, #523, #538, and #686 10. Records for Sample O.2: Individuals #10, #77, #192, #239, #251, #254, #286, #553, and #686

	11. Records for Sample O.3: Individuals #77, #107, #184, #235, #284, #286, #515, #553, #564, and #765 12. Records for Sample O.4: Individuals #8, #23, #73, #76, #84, #86, #106, #117, #125, #142, #173, and #176, #215, #235, #251, #265, #268, #286, #302, #340, #360, #384, #402, #410, #413, #426, #436, #471, #512, #515, #535, #553, #604, #623, #646, #649, #675, #701, #711, #714, #719, #724, #736, #745, #747, and #753 13. Records for Sample O.5: Individuals #585 and #787 14. Records reviews for compliance analysis for Individuals #238, #475, #524, #106, #569, #379, #177, #43, #486, #296, #192, #686, and #284 15. Integrated Risk Rating Form and accompanying Risk Action Plan for Individuals #475, #314, #368, ##787, #278, #267, #600, #306, #543, #630, #511, #151, #25, #66, #74, #107, #379, #418, #106, #43, #612, #788, #632, #499, #399, #569, and #177 16. List of Top 10 individuals causing injury to peers 17. List of Top 10 injured individuals. 18. List of individuals supported with bedrails 6/4/13 **People Interviewed:** 1. Ping Law OTR Habilitation Therapies Director 2. Charlene McCurry, Chief Nursing Executive 3. David Taylor OTR PNM Lead 4. Sally Eastwood PNMT RN 5. Brandie Rabe PNMT SLP 6. Jean Cuevo PNMT PT 7. Dana Hatter QDDP/PNMT 8. Eight DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meetings Attended/Observations:** 1. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon) 2. PNMT meeting (8-28-13) 3. Annual Meeting for Individuals #120 and #264
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. 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 I, in conducting its self-assessment, the Facility: ▪ Did not indicate whether or not the self-assessment used monitoring or audit tools. ▪ Reported that it "examined" a sample of five Integrated Risk Review Forms (IRRFs) ▪ Reported that it "reviewed" a sample of five Action Plans ▪ Reported that it reviewed policies ▪ Reported that it reviewed staff training records ▪ Reported that it conducted five record reviews The Self-Assessment did not indicate the methodology for selecting the documents referenced above, the methodology for the review of data, who conducted the review of the documents/data (re: discipline staff,

	QA staff, or both), whether or not there were written instructions or guidelines associated with the review of data to ensure consistency, or whether there was any inter-rater reliability conducted. The Monitoring Team could not determine whether the scope of the Facility's examination of the sampled data was or was not sufficient to determine compliance with the Settlement Agreement. The Facility Self-Assessment for Provision I.3 did not address the substance of Provision I.3 (establish and implement a plan within 14 days, including preventive interventions to minimize the condition of risk). The self-assessment for Provision I.3 addressed only bedrail use. The Facility Self-Assessment did not address outcomes or clinical indicators related to Section I and did not present data in a meaningful or useful way, reporting primarily only on the presence or absence of data on a particular form. Qualitative self-assessment was not present. The Facility rated itself as being in noncompliance with the three Provisions in Section I. This was consistent with the Monitoring Team's findings. 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 complete or in process. The Facility data identified areas of needed improvement but the Action Plan described action steps to address these needed improvements in general and overly broad terms. For example, "continue efforts to fully implement the IRRF and IHCP", or, "monitor effectiveness of implementation". The Action Plans did not contain sufficiently targeted steps that would likely lead to compliance with this Section of the SA.
	Summary of Monitor's Assessment: Staff responsible for implementing various aspects of the At-Risk policy demonstrated an improved understanding of risk assessment policies and procedures. Progress in some areas had been noted but IDTs still struggle to consistently assess levels of risk accurately. The Facility continued to struggle with conceptualizing the risk assessment process beyond strict application of the State guidelines. 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 had not been revised subsequent to the most recent revision to statewide policy. The Facility continued to struggle with conceptualizing the risk assessment process beyond strict application of the State guidelines. 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. Rating of risk level must be based on the risks inherent in the condition. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred, which was likely responsible for a significant improvement in many compliance scores. While these improvements are noted, compliance scores remain at an unacceptable level.

	Although there remained some lack of clarity about data presented in discussion of risks, IDTs were incorporating clinical data and indicators into the risk assessment process. Plans to address risks were established and implemented timely. The quality and comprehensiveness of these plans need continuing improvement, including better integration between all appropriate disciplines and clear objectives to allow measurement of efficacy.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The statewide risk assessment procedure, with guidelines for rating risk, was reported to be in use at the Facility. The Statewide policy had been updated effective 5/1/13; however, it was unclear if the Facility policy addressing at-risk Individuals had been updated to reflect the current state policy. The Facility reported it was following the current State policy, and had modified the Facility policy; however, an updated Facility policy was not provided to the Monitoring Team. Facility policy for implementation of the State directed at risk policy had been in place for over a year. 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. As reported in Provision I.3, this has resulted in thorough assessments, the Facility becoming more consistent (but still at an unacceptable level) in accurate risk identification, and effective risk action plans. Risk screening was reviewed annually at the ISP planning meeting. Despite the improvements noted above, as reported under Provisions I.2 and I.3, IDTs still struggled to consistently assess levels of risk accurately. For example, Individual #686 had a diagnosis of aspiration pneumonia within the last year but was listed as being at low risk. Individual #192 had multiple episodes of vomiting due to constipation but was only listed as being at a medium risk for constipation. The Facility also continued to struggle with conceptualizing the risk assessment process beyond strict application of the State guidelines. For example, when different disciplines apply 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 state guidelines. 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. A concern arose in the Monitoring Team observation of the ISP annual planning meeting risk review for Individual #264, in which there was indication that the Facility understood risk to be rated based on risk guidelines when treatment and support was in place or when an individual indicated a preference for a	Noncompliance

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		specific support (as reported below), rather than on inherent risks that require that treatment and support. The Monitoring Team did observe that in some instances the IDTs were incorporating clinical data and indicators into the process. In its observation of the ISP annual meeting risk review for Individual #120 the Monitoring Team noted that clinical indicators and other data were discussed in assessing some risk levels, although this was not consistent across all areas of risk. Further, the Monitoring Team noted interdisciplinary discussion on some risks and IDT members seemed comfortable raising issues that stimulated discussion. In its observation of the ISP annual meeting risk review for Individual #264, the Monitoring Team also noted use of clinical data for some areas of risk. However, there was lack of clarity about some of the data, for which a description of a trend was given, but not specific data. Of concern in the observation of the meeting for Individual #264 was a tendency to rate the risk lower when there was difference of opinion. For example, when rating risk of aspiration, the discussion was about whether to rate high or medium. The individual was on a pureed diet. The QIDP Educator said the pureed diet was the individual's preference, and the decision was to rate this risk medium. Following the meeting, the Monitoring Team met with the QIDP Educator, who indicated that there was some feeling that it was appropriate to identify risks as lower. Medical assessments did not always document comprehensive assessment for risk. For example, related to risk of fractures, in zero out of five cases (0%), the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture. • The annual medical summary for Individual #614 did not include an assessment specific for fall and fracture risks, such as previous history of fracture, and the fall and fracture risks were inappropriately rated as medium. There were examples in which risk screening did not result in accurate assessment of risk. • Individual #614 was diagnosed with multiple compression fractures of the spine. By review of the Individual's clinical records, it was noted by the Monitoring Team that the Individual had significant fall and fracture risk factors, including polypharmacy, seizure disorder, severe osteoporosis, a history of a previous serious fracture, and functional changes secondary to Alzheimer's disease. The annual medical summary did not include an assessment specific for fall and fracture risks, such as previous history of fracture, polypharmacy, functional decline, seizure disorder, and Alzheimer's disease. Despite these multiple risk factors for fall, and fracture, the IRRF list both fall and fracture risk as a medium risk.	

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		• Individual #661 had been referred to gastroenterology to assist in the management of ileus. The most recent IRRF, dated 9/5/2013, did not indicate ileus as a risk, and there was no additional evidence to indicate an IDT (interdisciplinary team) review of chronic ileus. Many of the compliance scores reported in Provision I.2 and I.3 had improved significantly from that reported in the last report by the Monitoring Team but still remain at an unacceptable level. A regular risk screening, assessment and management system used to identify individuals whose health or well-being is at risk should produce consistently reliable and valid results.. Based on this review this Provision was not in compliance.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	Review of seven records for individuals determined to have had a change in condition meriting risk assessment review by the IDT (Individuals #296, #192, #686, #284, #106, #379, and #43) 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 five (71%). Those that did not were for Individuals #379 and #43. Based on a review of records of a sample of six individuals (Individuals #106, #569, #379, #177, #43, and #486,) for whom assessments had been completed to address the individuals' at risk conditions, three (50%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Those that did not included Individuals # 569, #43, and #177. The nursing assessments for the other three Individuals were either not thorough, did not reflect interdisciplinary review and discussion, or did not include sufficient data that could have led to productive review, discussion, and decision-making. For example, for Individual #569 clinical data regarding post-menopausal status and visual impairment that could have contributed to the risk assessment for fractures and falls was not considered. Refer to Section M for additional information. Based on a review of records of a sample of four Individuals (Individuals #296, #192, #686, and #284) for whom assessments had been completed to address the individuals' at risk conditions, all four (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. Additionally, nine PNMT assessments were reviewed for individuals in Sample O.2 and all nine (100%) were initiated within five working days of the referral (or sooner as specified in the PNMT policy). RSSLC's PNMT RN provided assessment upon return from the hospital in an effort to identify any concerns noted with PNM. Results of the assessment were discussed at the PNMT at the weekly meeting or sooner if indicated.	Noncompliance

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		Referrals that were submitted by the IDT outside of a return from hospitalization were discussed at the following PNMT weekly meeting with members of the PNMT attending the IDT if indicated. Refer to Section O, Provision O.1 for additional information. Based on a review of records of three individuals (Individuals #238, #475, and #524) with polypharmacy risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, all three (100%) included an adequate risk assessment to assist the team in developing an appropriate plan. Refer to Section J for additional information. Based on a review of records of three individuals (Individuals #238, #475, and #524) with challenging behavior risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, all three (100%) included an adequate risk assessment to assist the team in developing an appropriate plan. Refer to Section J for additional information. 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. Four of nine individuals in Sample O.1 (45%) were not provided with an accurate risk score related to all of the physical nutritional management risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). Examples of individuals who were not provided with accurate risk scores included: • Individual #686 had a diagnosis of aspiration pneumonia within the last year but was listed as being at low risk. • Individual # 192 had multiple episodes of vomiting due to constipation but was only listed as being at a medium risk for constipation. Assessments of risk factors for falls and fractures were not comprehensive. • In zero out of five cases (0%) in a sample reviewed for Section L, the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture. • Individual #614 was diagnosed with multiple compression fractures of the spine. By review of the Individual's clinical records, it was noted by the Monitoring Team that the Individual had significant fall and fracture risk factors, including polypharmacy, seizure disorder, severe osteoporosis, a history of a previous serious fracture, and functional changes secondary to Alzheimer's disease. The PT/OT summary did not provide clinically appropriate assessment	

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		of fall and fracture risk, and functional decline. The assessment should have clearly delineated all risks associated with potential falls and fracture. The medical provider did not clearly document the potential etiology of the fall, and fracture. Based on this review this Provision was not in compliance.	
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.	Based on a review of 16 records for individuals determined to be at risk (Individuals #238 (two categories of risk), #475 (two categories of risk), #524 (two categories of risk), #106, #569, #379, #177, #43, #486, #296, #192, #686, and #284), 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 13 (81%)) cases. Records that did not contain documentation of this included Individuals #43 and #524 (2x). This was a significant improvement from the 25% compliance rate noted in the last report by the Monitoring Team. • Implemented a plan that met the needs identified by the IDT assessment in 10 (62%) cases. Records that did not contain documentation of this included Individuals #106, #569, #43, #486, and #524 (2x). This was a significant improvement from the 25% compliance rate noted in the last report by the Monitoring Team. • Included preventative interventions in the plan to minimize the condition of risk in nine (56%) cases. Records that did not contain documentation of this included Individuals #106, #569, #43, #177, #486, and #524 (2x). This was an improvement from the 44% compliance rate noted in the last report by the Monitoring Team. • When the risk to the individual warranted, took immediate action in three of five (60%) cases. Records that contained documentation that this did not occur included Individual #524 (2x). This was an improvement from the 40% compliance rate noted in the last report by the Monitoring Team. • Integrated the plans into the ISPs in 14 (88%) cases. Records that did not contain documentation of this included Individual #524 (2x). This was a significant improvement from the 31% compliance rate noted in the last report by the Monitoring Team. • In nine (56%), the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. Records that did not contain documentation of this included Individuals #192, #379, #177, #43, #486, and #524 (2x). This was a significant improvement from the 25% compliance rate noted in the last report by the Monitoring Team. • In 11 (69%) appropriate functional and measurable objectives were	Noncompliance

#	Provision	Assessment of Status	Compliance
		incorporated into the ISP to allow the team to measure the efficacy of the plan. Records that did not contain documentation of this included Individuals #192, #686, #43, #486, and #524 (2x). This was a significant improvement from the 38% compliance rate noted in the last report by the Monitoring Team. • Included the clinical indicators to be monitored and the frequency of monitoring in nine (56%) cases. Records that did not contain documentation of this included Individuals #192, #686, #106, #43, #486, and #524 (2x). This was a significant improvement from the 31% compliance rate noted in the last report by the Monitoring Team. Further information on these individuals may be found in Sections J, M, and O of this report. In addition to the data noted above the Monitoring Team noted issues related to the integration of PNMT recommendations into IHCPs and/or ISPs: For two of nine individuals (22%) in Sample O.2, all recommendations by the PNMT were addressed and /integrated in the ISPA, Action Plans, IRRFs and IHCPs. Examples of recommendations not integrated included: • Individual #239 had a recommendation to turn on his side when having a seizure to help prevent aspiration but this was not evident in the IHCP. • Individual #553 had a recommendation to include "rocking head back and forth" as a trigger but the trigger was not included as part of the IHCP. • Individual #286 had a recommendation to increase water flushes during medication administration to provide additional hydration and discourage constipation. This was not included as part of the IHCP. With regard to plan implementation for Individuals in Sample O.2: • In zero of nine individuals' documentation reviewed (0%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days of the plan's finalization, or sooner as needed, although the PNMT utilized a PNMT-IDT discharge plan that identified the steps to be taken by the IDT post PNMT discharge. The IDT and PNMT held a joint meeting, and tasks were identified. However, there was still no evidence that the IDT met to discuss the completion of these tasks or their results or that monthly monitoring reviewed and considered completion of the action plan tasks and effectiveness. • In zero of nine individuals' plans reviewed (0%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps. The issue noted was that once the action plan was handed down to the IDT, the tracking of steps to ensure completion was not evident.	

#	Provision	Assessment of Status	Compliance
		Action plans for significant medical conditions must provide for adequate monitoring and care required on a daily basis. This was not always done. For example, IRRFs for individuals with diagnosed malignancy did not consistently include a clinically rational plan. • Individual #389 was diagnosed with a form of leukemia, and the individual had an elevated platelet count. The IRRF only reported the need for follow-up with the consultant, and labs every six months, and there was no comment on the need for close monitoring for potential bleeding abnormalities, thrombosis, stroke, and infections. • Individual #275 was diagnosed with skin cancer, and the only recommendation made on the IRRF was to follow-up with the consultant, and there was no comment about the need to ensure appropriate protection against exposure to the sun, or need for regular skin assessments during the interim period until follow-up with the dermatologist. Additional information can be found in Sections O and M of this report. Based on this review this Provision was not in compliance.	

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment (08/09/13) 2. RSSLC Action Plans (08/07/2013) 3. Facility Presentation Book for Section J 4. DADS Policy and Procedures 007.3 Psychiatry Services (05/01/2013) 5. RSSLC Policy and Procedures: Psychiatry Services 1.00d (revised 08/30/2011) and guidelines for the Policy (2012/2013) 6. RSSLC Procedures for Psychiatry Services (09/13/12) 7. RSSLC Psychiatry Treatment Plan (undated, newly developed) 8. RSSLC Integrated Neurology Clinic Policy (4/17/12) 9. A description of RSSLC use of REISS Screen 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. Since the last visit, 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 the most recent administration of DISCUS and MOSES evaluations.
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. Sample J1: Individuals #27, #35, #48, #66, #91, #101, #232, #238, #316, #530, #475, #524, #568, #588, and #764. The sample was comprised of individuals considered by the Facility to be stable on their medications, and individuals admitted in 2013. Materials reviewed included
    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 Monitoring of Side Effect (MOSES) and Dyskinesia Identification Scales (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
25. Sample J2: New medication plans: Individuals #1 (Seroquel), #19 (Trileptal), #137 (Lorazepam), #238 (Saphris), #314 (Haldol), #368 (Invega), #447 (Lorazepam), #530 (Remeron), #542 (Risperdal), #645 (Zyprexa). These were individuals who had psychotropic medications approved by the Human Rights Committee (HRC) since the last visit. Materials reviewed included: Information from the clinical record (e.g. IPNs, CPE, PBMC notes) that helped the Monitoring Team understand the reasons/clinical rationales for choice of the medication, and consents for the use of psychotropic medication
26. Sample J3: Individuals who had episodes of medical restraint. Individuals #585 (03/05/13), #238

	(04/29/13), #267 (02/14/13), #535 (02/07/13) #344 (06/03/13), #612 (02/14/13), #498 (01/14/13), #470 (02/18/13), #379 (02/20/13), #787 01/18/13), #19 (05/02/13), #471 (06/12 13), #535 (05/08/13), #711 05/02/13), #582 (06/12/13), #306 (06/14/13), #646 (03/27/13), #213 (02/19/13), #645 (05/01/13), and #180 (03/21/13). 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. Lloyd Robert Buckner, MS, BCBA – Behavior Services director 2. (08/26/13) 3. Sylvia Ikes, Pharm D., Clinical Pharmacist (08/26/13) 4. Roger Joe, MD, Lead Psychiatrist (08/26/13) 5. Ugo Nweke, RN, Nurse Educator (08/27/13) 6. Damola Olatoregam, Psychiatry Assistant (08/26/13) **Meetings Attended/Observations:** 1. PBMC clinic (08/27/13) 2. Behavior Support Committee (BSC) (08/26/13) 3. Grand Rounds (08/28/13) 4. ISP Preparation meeting, Individual #717 (08/26/13) 5. Discussion about pre-treatment sedation, with key RSSLC staff and DADS representatives (08/27/13) 6. Quality Assurance/Quality Improvement (QA/QI) Council (08/27/13)
	Facility Self-Assessment: Facility Self-Assessment: The Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) self-rating. For Section J in conducting its self-assessment, the Facility did not report on the use of monitoring/auditing tools although during the visit the Monitoring Team was informed that a Section J Monitoring tool has been in use since February. The tool was administered by both QA and psychiatry department staff. For the period of February 1, 2013 until July 31, 2013 there were eight record audits by QA staff and six by psychiatry department staff. There were 34 questions on the tool. Most of the questions related to the presence of documentation in the record. Ratings of 80% or above were present for 20 of the items with a level of agreement of 66.67% between the psychiatry assistant and QA staff audits. The Monitoring Team also learned that record audits were done for medical restraints (Provision J4). Five record audits for episodes of medical restraint were completed by the Nursing Department and one audit was completed by the QA Department. The audits found an 87.5% compliance with audit questions, and the overall level of agreement between internal and external audits was 100%. The Monitoring Team found that these audits were not consistent with the findings of the Monitoring Team. There is a discussion of monitoring of

	individuals following medical restraints under Provision J4. For future visits it would be helpful for the Facility to include information about QA activities in the Self-Assessment section. In the Self-Assessment the Facility did report ongoing tracking data for polypharmacy (Provision J11). That was in the form of a list of the number of individuals who received various forms of polypharmacy (psychiatric, medical, and mixed between psychiatric and medical). The list was updated on a monthly basis and reported that as of July 2013 there were 58 individuals who were treated with the psychiatric polypharmacy that was the focus of the Settlement Agreement. The Self-Assessment did include other relevant data sources. For example, the Facility reported on data from databases and spreadsheets for: • All individuals followed by psychiatry that included dates of completion of initial and annual psychiatric evaluations, assignment to staff psychiatrist for ongoing care and clinical diagnoses • Dates of completion of required MOSES and DISCUS evaluations • Completion of PBSP, medication plans, and informed consent, • Use of chemical restraints • Pharmacy and psychiatry tracking for dual purpose medications • Facility wide tracking of individuals diagnosed with tardive dyskinesia • Chart reviews for 25 of 248 (10%) of individuals followed by psychiatry, for the presence of required elements for Provisions J2, J3, J6, J8, J9, J10, and J13 Overall, the self-assessment organized the presentation and the supporting data in a manner that was responsive to the items addressed by the Monitoring Team in the recent visit. It was helpful that the Self-Assessment presented data on both areas of strength and weakness. For example, in Provision J4 the Facility stated "there is not currently a mechanism in place to determine if all individuals who receive medical restraints have an Action Plan (AP) to minimize or eliminate restraints, such as a desensitization plan. A system is currently being developed to address this issue at the Center by first delineating which medical restraints were for routine procedures (versus non-routine procedures) and then a tracking system for ISP documents to identify strategies and supports to reduce or eliminate restraints for non-routine medical procedures." Reporting this in the Self-Assessment alerted the Monitoring Team to matters under development and allowed the Monitoring Team to provide feedback to the Facility during the visit. A general comment about the presentation of information in the Self-Assessment was that the Facility often reported on the presence of required items but did not measure the quality of those items. This matter was discussed with the Facility during the visit, and the Monitoring Team informed the Facility that whenever possible, the self-assessment should include an evaluation of the quality of clinical items. The Facility rated itself as being in compliance with Provisions J1, J5, J11, J14, and J15. The Monitoring

	Team found Substantial Compliance for Provisions J1, J11 and J15. For Provision J5 the Monitoring Team could not determine if the Facility had sufficient psychiatry FTEs to provide the services required by the SA. For Provision J14 the Monitoring Team found a number of deficiencies in the consent process. Progress was found by the Monitoring Team on Provisions J2, J3, J9, J10 and J12 even though those provisions did not come into compliance during the review period. The Facility also provided as part of its self-assessment an AP that reported step being taken to achieve compliance. As with the Self-Assessment, the AP items focused on the items identified by the Monitoring Team as in need of improvement. That was helpful. However, the steps were broadly stated and did not include specific actions that would move the Facility toward compliance.
	Summary of Monitor's Assessment: Progress has been made in a number of key areas. All individuals who require comprehensive psychiatric assessments now have them, and psychiatrists have started to do annual reviews of those assessments. Psychiatry is also gradually becoming better integrated with other medical and behavioral providers. For example, a good procedure for coordinated care with neurology is now newly in place. Progress in some areas - for example in the area of pre-treatment sedation - has been slow, but there has been good communication between the Monitoring Team and the Facility regarding what is needed to achieve compliance. Overall The Monitoring Team rated the Facility in substantial compliance for three of the provisions in this section. Provision J15 is newly found to be in substantial compliance. Findings for each Provision of Section J are as follows: Provision J1: The Facility has employed two psychiatrists, each of whom had the required qualifications and experience. Provision J2: All individuals who are seen by psychiatry now have CPEs in place. However, the Monitoring Team found that many diagnoses were not fully justified according to DSM IV criteria. That was problematic, since a key element to overall compliance with Section J is the ability to link clinical diagnoses, behavioral symptoms of the diagnosis, and the medications used to treat those symptoms. The diagnosis is the foundation for such necessary linkages and it needs to be firm. Provision J3: Plans to improve treatment program description of the role of medication moved forward slowly. PBMC information about medication did not match PBMC narratives in many cases and adequate behavioral tracking for medication treatment efficacy was often lacking. Provision J4: Difficulties with development, implementation and tracking of supports to minimize the use of pre-treatment sedation persist, as do problems with documentation with monitoring for safety during and after pre-treatment sedation. For these reasons the provision remains in non-compliance with the requirements of the SA.

	Provision J5: 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. Provision J6: All individuals had CPEs but they were in the required appendix B format in only 73 of 138 (52%) of CPEs Provision J7: The Facility had not yet achieved compliance since psychiatric evaluations had not been completed for individuals whose initial screens exceeded the designated cut-offs for the Reiss Screen, and there was no agreed upon policy for change of status evaluations. Provision J8: Further work on this provision is needed and efforts of the Facility should focus on improvements on combined case analysis and formulation. Provision J9: The Monitoring Team needs assurances that psychiatrists are meaningful participants in the determinations required by the Provision. There needs to be evidence of IDT and psychiatrist evaluations and discussions of the modality or modalities of treatment that were best suited to the individual, and why. Provision J10: The Facility had not yet addressed adequately the requirements regarding risk benefit analyses and treatment alternatives. Provision J11: The Facility had achieved a rating of substantial compliance; this will be continued. Good results to date notwithstanding, the Facility should continue to focus on establishing the best ways to review and monitor polypharmacy practices. Provision J12: The Facility has a good system in place to monitor side effects of psychotropic medications. Administration of the DISCUS and MOSES screens was done by nurses who received good training on the tools and who received annual re-training to assure continued competence. The pharmacy supported DISCUS and MOSES administrations with excellent QDDR reports that included good discussion of matters that were rated on the MOSES and DISCUS. Adequate physician reviews were not yet in place due to the lack of timely review and difficulties with the physician review section on the MOSES and DISCUS forms. Provision J13: Required medication plans were not in place for either new or ongoing medications. Provision J14: Some progress was evident, but adequate presentation of treatment alternatives and risk/benefit statements were not individualized. Provision J15: There was good communication between the neurologist and psychiatrists around medications prescribed for both epilepsy and psychiatric indications.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications and Experience of the Psychiatrists Psychiatric staffing at the Facility has not changed since the last visit. Roger Joe, MD joined the staff in July 2012. He is employed by the Facility on a full-time basis as a contract psychiatrist and is the Lead Psychiatrist for the Facility. Dr. Joe graduated from the St. Matthew University School of Medicine in 2006 and he completed his psychiatry residency at the University of Arizona in 2011. Dr. Joe also completed a fellowship in forensic psychiatry at the Louisiana State University and he has been board certified in psychiatry since 2011. Dr. Hugh Pharies also joined the staff during summer 2012 and he is employed by the Facility on a full time basis as a contract psychiatrist. He is 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 was on the staff of the Mental Health and Mental Retardation Authority (MHMRA) of Harris County, Texas from 1993 until 2012. Dr. Pharies has been board certified in psychiatry since 1987. Both Dr. Joe and Dr. Pharies have experience working with individuals with intellectual disabilities. Dr. Pharies had 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. Joe gained experience in intellectual disability when he worked at the Pinecrest Facility in Louisiana, as part of his fellowship. Monitoring Team's Compliance Rating The Facility psychiatrists have appropriate credentials and experience and the Facility is in substantial compliance with the requirements of this provision.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a	Individuals who Received Psychotropic Medications One hundred and thirty eight of 340 (40%) individuals who lived at the Facility took psychotropic medications. The focus of this provision was to assure that all individuals treated with psychotropic medications had received appropriate psychiatric evaluations and diagnoses. The Process in Place for Evaluation and Diagnosis Psychiatric evaluation and diagnosis were part of many Facility processes and were built into many IDT processes. During the visit the Monitoring Team observed a number of such activities. • The Monitoring Team attended an ISP Preparation meeting for Individual #711 that took place on August 27, 2013. The IDT discussion for that individual included a focus on symptoms that helped differentiate the diagnosed schizoaffective disorder from	Noncompliance

	board-certified or board-eligible psychiatrist.	other psychotic and affective disorders that could also have accounted for his symptoms. • The Monitoring Team also observed an excellent grand rounds presentation and discussion of Individual #140 that took place on August 28, 2013. That presentation and discussion included a presentation of that individual's sleep difficulties and a discussion about whether those difficulties were properly attributed to the individual's bipolar disorder or whether another disorder – medical or psychiatric – that should also be considered. • Psychiatry diagnoses were a key topic at the Behavior Support Committee meeting that took place on August 26, 2013. At that meeting there was a clinical discussion of Individual #576 (a new admission). One of the key topics was whether the "voices" reported by that individual did or did not reflect psychopathology. There was also an exploration and discuss of the symptoms that were the basis for the diagnosis of Individual # 302 with an Impulse Disorder, and discussion of how that diagnosis might be resolved in favor of a more specific diagnosis. Psychiatrists attended some but not all of these meetings. The fact that psychiatric diagnoses were explored and discussed in many IDT and interdisciplinary processes throughout the Facility showed a maturation of the clinical process at the Facility and a deepening of the staff's commitment to a comprehensive understanding of individuals supported by the Facility. The Monitoring Team paid particular attention to Facility processes where psychiatric evaluation and diagnosis was a primary focus. The most important of these was the Comprehensive Psychiatric Evaluation. These were generated by the psychiatrist on the basis of a face-to-face mental examination, discussions with other staff with family members and others, and a review of documents and records. CPEs (and annual updates of the CPE) are now done in the Appendix B format; they are discussed in detail under Provision J6 where they are the sole focus. Psychiatric Evaluations were also a focus at Psychiatric and Behavior Management Clinics (PBMCs), the term used at the Facility for the psychiatric clinic. All individuals supported by psychiatry were seen at least quarterly at PBMC. PBMC participants included the individual, the psychiatrist, and key members of the IDT, typically the psychologist, the nurse case manager, qualified developmental disability professionals (QDDPs), direct support professionals (DSPs), the clinical pharmacist and at times, a habilitation therapist. The general format for the PBMC presentation was that the nurse first reported on medical and nursing issues and the psychologist/behavior analysis reported on behaviors of concern and replacement behaviors. The psychiatrist then conducted a mental status examination of the individual, examined the QDDR and other documents, and then led a general discussion on matter of interest. <u>Psychiatric Diagnoses in the PBMC Observed by the Monitoring Team</u> Psychiatric diagnosis was a key part of PBSP discussion for many of the individuals observed by	

		the Monitoring Team. For example: • Individual #27 had been variably viewed as having cyclothymia, dementia, and most recently mood disorder due to complex partial seizure disorder. The psychiatrist inquired with several IDT members about symptoms that helped establish the current diagnosis of mood disorder. • Individual #91 was diagnosed with dementia and was treated with Risperdal for presumed hallucinations. Here too there was a useful discussion about the hallucinations, and how they fit into the overall diagnostic picture. • Individual #456 had buccal oral facial dystonia of uncertain etiology. During the clinic the psychiatrist considered whether an additional diagnosis of neuroleptic induced acute dystonia was needed. In an earlier appointment the psychiatrist had ordered a reduction in Risperdal in the hope of differentiating medication side effects from a possible static encephalopathy (in turn in the setting of a history of brain injury). • Individual # 328 was diagnosed with Bipolar Disorder and earlier in the year had experienced a psychotic episode for which he was treated at an outside hospital. The relationship between his psychiatric symptoms, the mood disorder and medical problems including epilepsy was discussed. In all the above discussions, the psychiatrist asked pertinent questions about psychiatric diagnoses that confirmed the existing diagnosis. As a result, during the PBMC observed by the Monitoring Team no new diagnoses were made. <u>Record review of past PBMCs</u> Prior to the visit the Monitoring Team requested information from the Facility about changes in diagnoses made since the last review. There were 16 such changes and the Facility provided the Monitoring Team with copies of PBMCs during which the changes were made. The most common changes made during the clinic were modifications of severity criteria for individuals with major affective disorders, such as changes in the fourth or fifth digit qualifiers on the DSM diagnosis. For example, Individual #232's diagnosis was changed from major depression, (moderate) to major depression, (mild). There were also changes in subtypes of disorders. For example, Individual #712's diagnosis was changed from schizophrenia, paranoid type to schizophrenia, disorganized type. In a number of re-evaluations the psychiatrist concluded that fewer diagnoses were needed to account for the individual's symptom, and one or more diagnoses were removed. An example of that was Individual #180, for whom the diagnosis of pervasive developmental disorder was removed while the diagnosis of major depression was retained. There were also many examples where new diagnoses were introduced that were not directly related to existing diagnoses. Examples were: • For Individual #542, the diagnosis was changed from autism to dementia due to head	

		trauma • For Individual #655 the diagnosis was changed from anxiety disorder NOS to posttraumatic stress disorder • For Individual #618 the diagnosis of obsessive compulsive disorder was changed to autism (it was later changed back, as described below). The Monitoring Team evaluated each of the 16 changed diagnoses and examined the new diagnoses with relevant DSM criteria in mind. In all cases, the formulations of the psychiatrists were reasonable. However, as discussed during several previous visits, there also needed to be justification of each of the diagnoses in terms of the DSM criteria for each diagnosis made. Sometimes there were diagnoses that were reasonable and likely, but specifics supported the diagnosis were not offered. An example of one was Individual #618, above. That individual was initially diagnosed with obsessive compulsive disorder and the differential diagnosis included autism. In the end the psychiatrist and IDT concluded that the individual did not have autism and reverted to the initial diagnosis of obsessive compulsive disorder, but the psychiatrist's note did not state the basis for that diagnosis (see also comments for Provision J3). Overall, 11 of 16 (68%) of the changes in diagnosis were accompanied by full justification. Clarity in the records about psychiatric diagnoses has been gradually improving. In previous reports the Monitoring Team described circumstance where numerous and sometimes conflicting diagnoses were cited in different parts of the record, where the psychiatrist doing the CPE was not the treating psychiatrist, where for some individuals there simply was no psychiatric evaluation and so forth. The exit from that unfortunate circumstance is still taking place, and this is the first time that the Facility has been able to document that all individuals receiving medication have had a psychiatric evaluation. At the end of the process of sorting out the appropriate diagnosis – or lack of diagnosis – for each individual it is important for the most recent CPE to include a brief statement that clarifies the basis for each of the diagnoses of record. <u>Use of Diagnostic and Statistical Manual (DSM) Diagnoses throughout the Clinical Record:</u> The Monitoring Team reviewed the use of DSM diagnoses in the CPEs of 15 individuals in Sample J1 and the informed consent for medication for 10 individuals in Sample J2. In all case there was a consistent use of DSM codes. The Monitoring Team reviewed the use of DSM diagnoses in APs for the 15 individuals in Sample J1. These too all used appropriate DSM codes. However among the individuals in Sample J1 who had lived at the Facility for some time, conflicting diagnoses were located in 6 of 10 (60%) of the records, most often in the PBSP. Once a supported diagnosis is selected and codified in the APL, efforts should be made to correct the various conflicting reports throughout and record. The will take time but that process should commence. <u>Required CPE's</u> The Facility reported that CPEs were in place for all 138 individuals who received ongoing	

		support from psychiatry. CPEs were not in place for seven individuals who required them on the basis of Reiss Screen results (see provision J7). The Process of Bringing CPEs in the Appendix B Format. In the Self-Assessment the Facility reported that its own review found that 73 of 138 CPEs (52%) were in the Appendix B format. That matter is the focus of Provision J6. The Use of NOS Diagnoses Review of the Department of Psychiatry database showed three individuals in the data base with NOS diagnoses, a number that was unchanged from the last visit. Two of the three instances were in Individuals who were newly admitted and for whom more definitive diagnoses may be pending. Appendix B guidelines permit up to six months for such considerations. Timeliness of Psychiatric Evaluations for New Admissions Between the last visit and 08/09/13 there were 11admissions to the Facility for individuals who took psychotropic medications prior to admission. These individuals were seen by psychiatry within 30 days. Overall Evaluation of Psychiatric Evaluation and Diagnosis Since the last visit, the two Facility psychiatrists have worked hard to clarify individual's diagnoses, so that they properly reflect observable symptoms that are the focus of medication treatments. To do so, they have reflected carefully on the current diagnoses and have tried to retain diagnoses that best capture behavioral signs of psychopathology. Their work was assisted by good processes that are place at the Facility that promote good clinical understandings of individuals. The psychiatrists have also started to do required annual updates of the CPEs. That too is positive and the CPE updates will provide a place to capture the year's key developments – including the efforts at re-diagnosis – for the permanent record. While the above activities were positive steps the work is not complete. The Monitoring Team found that many diagnoses were not fully justified according to DSM IV criteria. That was problematic, since a key element to overall compliance with Section J is the ability to link clinical diagnoses, behavioral symptoms of the diagnosis, and the medications used to treat those symptoms. The diagnosis is the foundation for such necessary linkages and the basis for the diagnosis needs to be clear. Monitoring Team's Compliance Rating Progress has been made but a continued focus remains on resolving outstanding differences between the most recent CPE/departmental databases.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic	PBSP documentation Psychotropic medications were given to 138 of 340 (40%) of the individuals who lived at the Facility. The key requirement of the provision was that such medications should not be used as a substitute for a treatment program. At the Facility that was the PBSP.	Noncompliance

	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.	The Monitoring Team first compared the list of individuals who took psychotropic medications with the list of individuals who had PBSPs. All individuals who took psychotropic medicine had PBSPs, although not all were up to date: The Facility Self-Assessment acknowledged that only 42% of the 14 charts reviewed had current PBSPs. The Monitoring Team reviewed the treatment programs of the 15 individuals in Sample J1, all of whom took psychotropic medications. • Psychiatric Diagnosis: PBSPs for 15 of 15 (100%) of the individuals contained the individual's diagnosis or diagnoses. In all cases it was in the DSM format and the cited diagnoses were consistent with the information contained in the psychiatric evaluations. • Identification of the problem and need for behavior supports: This PBSP section typically outlined the general problems the individuals experienced and the interventions used to provide needed supports. This section was present for 11 of 15 (73%) of the individuals and in all cases psychotropic medications were identified in the PBSC section as one of those supports. • Psychiatric case formulations: These were present in 13 of 15 (87%) of the PBSPs. • Differentiation of learned problem behaviors and psychiatric symptoms/behavioral characteristics: In order to understand the role of psychotropic medication in the overall treatment it was important to understand whether the behavioral characteristics that were the target for the medication treatment were understood by the treatment team to be the result of learned behavior, psychopathology, or both. 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. To help better integrate behavioral care, the Facility put in place a new format for the Structural and Functional Analysis (SFA) that included a section called "Differentiation of Behavior." The process of putting this section in place in PBSPs has been slow. Most of the PBSPs reviewed in Sample J1 did not have them. During the BSC meeting attended by the Monitoring Team the section was present in one of two reviewed (50%) cases. The Behavior Services Director clarified that the section in question was being introduced during the annual cycle as programs were reviewed for annual ISP meetings. An example of a clearly written "differentiation of behavior" statement from the current visit was Individual #576 for whom the psychologist wrote in the PBSP "hallucinations are being tracked as a psychiatric indicator. However, social positive environmental factors cannot be ruled out as a possibility because after he states that he has had a hallucination he is given attention by direct care staff and professional staff." • Information describing the medication and how it is used: In the previous visit the Monitoring Team reported that PBSPs presented information about psychiatric treatment and medications in many different ways and there were often inconsistencies	

		between information in PBSPs and other parts of the record. During the current visit the Monitoring Team reviewed the 15 records in Sample J1 for information about medication treatments. The Monitoring Team found that PBMC information about medication matched PBMC narratives in only seven of fifteen (46%) of records. This challenge was discussed with the Facility. The Monitoring Team learned that the Facility will soon start using a document called Psychiatric Treatment Plan (PTP) that will include information on the diagnosis, symptoms, and medications. Psychiatrists will complete that document and it will serve as a common reference for key psychiatric information. • <u>Monitoring for treatment efficacy:</u> In the previous report the Monitoring Team was informed 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. The deployment of PTPs will further that process but PTPs are not yet in place. In Sample J1 appropriate measures were in place for six of fifteen (40%) individuals. <u>Information from PBMC clinics:</u> During the visit the Monitoring Team attended two PBMCs. The following observations were made about medication use and the assessment of medication effects. • Individual #538 was diagnosed with cyclothymia, medicated with Zyprexa, and behavioral tracking for psychiatry was for self-injury and sleep. It is possible that sleep alone was a sufficient measure for clinical status but a measure of mood would be helpful. The note from the clinical pharmacist was very helpful and drew attention to concurrent medical issues and the treatment of an older individual with antipsychotics. • Individual #27 was diagnosed with a mood disorder and he was treated with Seroquel. Individual #538 was diagnosed with cyclothymia, and psychiatric monitoring was in place for sleep. The QDRR had an excellent discussion of metabolic syndrome and the possibility of extrapyramidal side effects. • Individual#91 was diagnosed with dementia and treated with Risperdal for hallucinations. The plan called for measurement of hallucinations and that was appropriate. No data was reported, however. During the meeting the Monitoring Team asked why and was told that there were no reports of hallucinations. That data was needed, since it could be the needed evidence of Risperdal efficacy, compared to baseline data. Further analysis was not possible since there was no baseline data. A useful discussion followed in which the psychologist commented that her focus was on aggression and related behavior, not on hallucinations. The discussion was cordial and pleasant, but it appeared to the Monitoring Team that further education is needed to help staff understand that data is needed to assist the psychiatrists, not only to track externalizing behaviors that are the focus of the behavior plan. The Quarterly Drug Regimen Review (QDRR) had an excellent discussion of the risks of using Risperdal in the elderly including the black box warning, and a discussion about the DISCUS scores. • Individual #456 was diagnosed with dementia, treated with Risperdal and tracking was	

		in place for aggression to others. It appeared that the Risperdal was being used for behavior control. The QDRR discussed MOSES and DISCUS findings and alerted the clinician to the possibility of early stages of dyskinesia from Risperdal – for example via tongue thrusting. • Individual #328 was diagnosed with bipolar disorder and was treated with Zyprexa, Lamictal and Valproic acid for irritable mood. Tracking was in place for irritable mood (with operational definitions), and work and personal care refusal. That was appropriate. The QDRR review was excellent; there was a discussion of MOSES and DISCUS findings including possible causes for the individual's drooling, and labs findings. For the above five individuals the Monitoring Team found that good tracking was in place for one of five individuals (20%); some tracking was provided for an additional two individuals (40%), tracking was planned but not provided for a fourth (20%) and was missing for the fifth (20%). <u>Medications used for staff convenience/punishment</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>Chemical Restraints</u> The Monitoring Team reviewed a sample of four administrations of chemical restraints. There was no reason to question the need of the restraints in an individual in question, but in each case the Post Chemical Restraint Clinical Review was incomplete (see discussion under Section C). <u>Overall Comments – Appropriate Use of Medications</u> Plans to improve treatment program description of the role of medication moved forward slowly. PBMC information about medication did not match PBMC narratives in many cases and adequate behavioral tracking for medication treatment efficacy was often lacking. The incoming PTPs may provide a vehicle to structure treatment efforts, to make sure that medication use is appropriate. <u>Monitoring Team's Compliance Rating</u> For the above mentioned reasons, the provision remains in noncompliance with the requirements of the SA.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18	<u>Monitoring for Safety during Medical Restraint</u> The Facility reported that between 01/01/13 and 06/30/13 there were 69 uses of oral pre-treatment sedation for routine dental procedures, 56 uses of pre-treatment sedation for routine medical procedures, and 102 administrations of TIVA for routine dental procedures. Facility	Noncompliance

	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.	nurses monitored individuals for safety before and after administration of pre-treatment sedation (either oral or via TIVA). The details of monitoring (including oxygen saturations, blood pressures and other vital signs, REACT scores etc.) were spelled out in nursing protocols for pre and post sedation and post anesthesia care. The Monitoring Team reviewed a sample of 20 individuals who received pretreatment sedation procedures on specified dates (Sample J3) and it included example of oral pretreatment (medical), oral pretreatment (dental) and TIVA. In all cases appropriate informed consent was obtained. In 19 of 20 (95%) procedures, physician orders specified the kinds of monitoring for safety to be used (typically the Facility protocol). Vital sign monitoring followed the nursing protocol guidelines in 11 of 20 (55%) of the procedures. The Facility QA and Nursing Departments had established an audit of the monitoring for safety, and data was provided to the Monitoring Team for the period of 8/1/2013 through 8/26/2013. There were six audits, five internal by the Nursing Department and one external audit by Quality Assurance staff. The level of compliance was reported to be 88% for both internal and external audits (with a reported level of agreement between the two sources of 100%). Those results were considerably different than what was found by the Monitoring Team. The Monitoring Team was not able to discuss this matter with the Facility while on-site, but the Facility had provided the Monitoring Team with a copy of the audit tool and that was inspected by the Monitoring Team. The reason for the difference may be that item #4 on the audit tool enquired whether a (single) full set of vital signs was obtained upon the individual's arrival back to the home. However, the nursing protocols required many sets of vital signs, at specified intervals, over a period of 24 hours (for oral sedation) or 72 hours (for TIVA). The Monitoring Team rated on the basis of whether that extended monitoring was done as required. In the course of the review the Monitoring Team noted that nurses did not document the monitoring for safety in a uniform manner. Many different forms were used variably, including forms for "acute care plans/actions taken," for "condition of individual," for "vital sign flow chart," for "post anesthesia recovery," on IPNs, on a "nursing medical monitoring form," and others forms as well. The medical restraint form that was developed by DADS and which includes prompts for the time intervals at which vital sign measurement were required was rarely used. The Monitoring Team is aware that monitoring for up to 72 hours spans multiple locations (for example the dental suite, the infirmary recovery area and the home) and many different staff members. It seems that for this reason alone the Facility should mandate an agreed- upon process for documentation, including a uniform way for data entry into the different sections of the DADS Medical Restraint form. A productive meeting took place on 08/27/13 that included the Monitoring Team, the Facility and DADS central office staff who were on site. At the meeting the above-mentioned issues were discussed and all participants agreed on the need to solve the practical issues at hand. <u>Plan to reduce the need for pretreatment sedation</u>	

		The Facility clarified that there is not currently a tracking mechanism in place to determine if all individuals who receive medical restraints have an ISP action plan to minimize or eliminate restraints including strategies or treatments to reduce restraints, such as a desensitization plan. In the self-assessment the Facility also clarified that there is a plan for a tracking system for ISP documents to identify presence of strategies and supports to reduce or eliminate restraint for non-routine medical procedures. The Monitoring Team reviewed the 20 individuals who received pretreatment sedation procedures (Sample J3). The Facility provided plans to reduce the need for pretreatment sedation, for three of 20 (15%) of the Individuals. Two additional individuals were included in a Facility list of individual who had plans to reduce the need for pretreatment but they were not provided to the Monitoring Team. <u>Monitoring Team's compliance rating</u> Difficulties continue with development, implementation and tracking of supports to minimize the use of pre-treatment sedation persist and with documentation for monitoring for safety during and after pre-treatment sedation. For those reasons the provision remains in non-compliance with the requirements of the SA.	
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.	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 138 of 340 (41%) individuals who lived at the Facility. Caseloads were 87 of 138 (63%) individuals for the lead contract psychiatrist and 51 of 138 (37%) for the second contract psychiatrist. The psychiatrists saw all individuals on a quarterly basis, and some were reviewed monthly. Three individuals assisted the psychiatrists in the work. Mr. Damola Olatoregu, Psychiatric Assistant, gathered information for writing psychiatric evaluations, prepared paperwork for clinics (past clinic notes, medication profiles, problem lists, and symptom checklists) and 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. Ms. Pat Newell maintained the MOSES and DISCUS database. Ms. Denese Daniels did scheduling for the Department and she was familiar with the schedule for the PBMC clinic. <u>Determination of Required FTEs</u>	Noncompliance

		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 Psychiatric time is also needed to complete the transition of CPEs to the Appendix B format; per Provision J6 these are in place for only 73 of 138 (52%) of individuals with CPEs. Compliance Rating 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. For the next visit the Facility should provide an estimate for the number of hours needed to provide adequate staffing, as described above.	
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.	Appendix B Evaluations The Monitoring Team reviewed Appendix B evaluations for the15 individuals who were part of Sample J1. The length of the evaluations ranged from six to eleven single typed pages. • Use of the Appendix B format: In the Self-Assessment the Facility reported that all CPEs had been reviewed and that 73 of 138 (52%) had Appendix B formats. • Quality of CPEs: The Monitoring Team reviewed CPEs for the 15 individuals in Sample J1. Diagnoses were assessed to be adequate for nine of 15 individuals (60%). They were Individuals #35, #66, #91, #101, #238, #475, #524, #568, and #588. Among that group, Individual # 524 had justification for the diagnosis of schizophrenia but not ADHD, and the diagnoses for Individuals #35, #238, and #475 were assessed as adequate on the basis of provisional acceptance of the (recent) admission diagnosis, but more detail/support will be needed to justify ongoing use of those diagnoses. Annual Updates of CPEs These are now being done across the campus, and they are a proper place to include information about significant events such as changes in diagnosis and the justification for those changes in DSM terms, new treatment trials and their success or failure. The reason for this is that annual CPE updates are more readily accessed than other record materials such as IPN/PBMC notes. Generally, the Monitoring Team will look to the CPE/CPE updates for key information like diagnosis and justification. For such matters IPN/PBMC notes will be needed only if there has been a change since the last annual update of the CPE. CPE's Use Across the Campus 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.	Noncompliance

		Seven of those had not been completed at the time of the visit (for details, see discussion under Provision J7). <u>Case Formulation Section</u> See prior reports regarding the preference for case formulation over a case summary. Generally, it would be help to cite salient item features from the various sections of the evaluation, in support of the overall understanding of the case, that bests explains current symptoms, overall case presentation and course of the illness. <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	<u>Reiss Screens for Individuals who lived at the Facility</u> As described in previous reports, Reiss Screens were given to all individuals who lived at the Facility. Twenty-two individuals had Reiss screen scores that reached or exceeded the designated cutoffs, and full psychiatric evaluations were required. Such evaluations were still pending for Individuals #95, #109, #112, #634, #748, #780, and #797. <u>Reiss Screens for Recent Admissions</u> There were 16 admissions between the last visit and 08/09/13. Eleven of those had psychiatric diagnoses and took psychiatric medicines. Individuals #228, #411, #589, #594, and #782 did not have psychiatric diagnosis and did not take psychiatric medications. Reiss screens for the first four individuals were negative. Individual #782 was admitted on 08/09/13, after materials were prepared for the Monitoring Team. His Reiss screen was not reviewed and that will be done at the next visit. <u>Change of Status Evaluations</u> The Facility informed the Monitoring Team that the Facility has decided on a procedure for change of status evaluations. If a behavioral change is noted by the IDT the individual will be given a Reiss Screen as part of the initial evaluation by the IDT psychologist. All individuals who screen positive will be referred to psychiatry; individuals with negative screens can still be referred, at the discretion of the IDT. The Facility anticipates that a written description of the protocol will be provided to the Monitoring Team at the time of the next visit. <u>Monitoring Team's Compliance Rating</u> The Facility had not yet achieved compliance since psychiatric evaluations had not been completed for individuals whose initial screens exceeded the designated cut-offs, and there was as 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

	warranted) in a clinically justifiable manner.		
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	<u>Policy and Procedure</u> RSSLC Psychiatry Policy 1.00d (revised 08/30/2011) stated that "*RSSLC must develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined case analysis and case formulation."* The policy also stated that "*The neurologist and psychiatrist must coordinate the use of medications, through the PST process, when medications are prescribed to treat both seizures and a mental health disorder."* RSSLC also provided a "Point of Guidance" Policy (09/13/2012) that addressed Provision J8 of the SA. The policy clarified that "the behavioral health team will comprise of the clinical pharmacist, psychiatrist, behavioral health psychiatric assistant, behavioral healthcare nurse, behavioral analyst, direct care staff and QDDP." The Policy provided the following steps: 1. The Psychiatrist will attend the appropriate psychiatric clinic and evaluate the patients assigned to their case load. The behavioral psychiatric assistant will notify the psychiatrist in advance. 2. The residential direct care staff (nursing, behavioral analyst, QDDP, psychiatric assistant and individual's direct care staff) will attend the psychiatric clinic to provide the clinician with the relevant psychiatric history and data. 3. The clinical pharmacist will review the medications prescribed for the psychiatric Clinic for all individuals scheduled, polypharmacy patients will be identified and will be review (sic) on a monthly basis. 4. The psychiatrist, clinical pharmacist residential direct care staff and other disciplines in attendance will sign an attendance sheet to monitor integration of services. 5. The psychiatrist will document the integrated encounter in the IPN and in the quarterly review note. The psychiatric follow-up data base will be updated so that the interdisciplinary team will have access to the assessment and plan of the evaluation from the intergraded (sic) psychiatric services encounter. <u>Integrated care at PBMC</u> During the visit the Monitoring Team observed the process described above by observing a PBMC on 08/27/13. Participants included the psychiatrist, psychologists, nurse case managers, clinical pharmacist, and DSPs. Individuals #538, #27, #91, #456 and #328 were reviewed. Nurses and psychologists reported on individual's progress and the psychiatrist then asked for further details and clarifications. The meeting was physician directed, and while it was multidisciplinary, it was not interdisciplinary. For the venue to become a place in which combined case analysis and case formulation can take place, psychologists and others must be encouraged to go beyond reporting information and to become fuller participants in the assessment process. An example of one such a productive discussion was the exchange between the psychiatrist and psychologist about the diagnoses of autism and obsessive compulsive disorder for Individual #618 discussed under Provision J3; that example was included in the	Noncompliance

		material provided to the Monitoring Team along with materials on changes in diagnosis. Structural and Functional Assessment (SFA) Section on Differentiation of Behavior Last year the Facility put in place a section in the SFA called "Differentiation of Behavior" that attempted to articulate how psychiatric and psychological factors came together for behaviors which were the targets of both psychological and psychiatric care. For such circumstances the SFA writer was prompted "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." The writer was then guided to "indicate how the behavior is a demonstration of the psychiatric illness and (to) identify why it may also be reinforced/maintained by environmental variables." As per the examples provided in the last report of the Monitoring Team, that section could be a place where the results of discussion between psychologists and psychiatrists about combined analysis and case formulation could be documented. However, none of the individuals in Sample J1 had an updated SFA with the differentiation of function section. Integration of Psychiatric and Neurological Care There was considerable improvement in integrated care between neurology and psychiatry, as described under Provision J15. Psychiatrists now attend the neurology clinic and there is a good and open discussion about co-management of individuals with both neurological and psychiatric care. That was evident not only in the neurology clinic but at the PBMC as well. Examples of that were at the PBMC attended by the Monitoring Team were Individual #328 for whom PBMC discussion included analysis of his Lamictal and Depakote, that were prescribed for his seizure disorder, for Individual #27, for whom a diagnosis was recently changed to reflect the psychiatrist's opinion that the individual had a mood disorder that was linked to complex partial seizures, and for Individuals # 91 and #456, both of whom were diagnosed with dementia. While the above was encouraging, the Monitoring Team found that there was sometimes confusion about whether anticonvulsants were used for neurological indications, psychiatric indications, or both. For Individual #157 the 06/27/13 PBMC note mentioned that she becomes catatonic when off Phenobarbital, but that medication is not listed as a psychotropic and there is no informed consent. For Individual #101 PBMC documentation reported that Depakote was used for epilepsy, but on 04/24/13 the neurologist opined that that the Depakote was used for psychiatric purposes. It is likely that such differences will be resolved over time, now that psychiatrists and the neurologist have a chance to review such matters in face-to-face discussions. Integrated Care at Facility-Level Activities The Monitoring Team attended a Grand Rounds presentation on 08-28-13 that was attended by members of many professional disciplines and others as well. It was an excellent presentation and discussion of Individual #140 who had acute psychiatric, psychological and medical difficulties, and received supports from numerous departments and disciplines. The	

		presentation was directed by the Medical Director, and there was collegial discussion between professional and direct care staff bout how to best support the Individual during the period of difficulty. The discussion led to creative solutions to core programs. For example, the Individual had trouble leaving her home for activities outside the home or center. A proposal was made for 1:1 or 2:1 support from nursing which seemed reasonable to participants; however, home based staff proposed that the Individual would do better if supported for those activities by home based staff with whom she was more familiar. That recommendation was accepted and the group worked together as a whole to generate new approaches that crossed discipline lines. <u>Overall Impressions</u> Work products and specific outcomes that will satisfy Provision J8 can be provided in many different ways and venues, reflecting the nature of integrated care. Nonetheless the Facility must provide tangible evidence for the specified requirements of the Provision, such as combined formulation and case assessments. Psychiatry is now well integrated into the Facility process. But there is not yet evidence of psychology and psychiatry integration, and that is needed to fulfill requirements of Provisions J3, J9, J10, J11, J13, and J14. Ultimately, there is a need for the combined behavioral healthcare plan to be further integrated into the overall ISP process in a more meaningful way. Steps are being taken to do so, for example via the IRFF process, but progress to date has been slow. <u>Monitoring Team's Compliance Rating</u> For the reasons outlined above, further work on this provision is needed and efforts of the Facility should focus on improvements on combined case analysis and formulation.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology,	<u>Policy and Procedures</u> Facility guidelines to RSSLC Psychiatry Policy stated that "before a proposed Positive Behavior Support Plan for individuals receiving psychiatric care and services is implemented, the interdisciplinary team (IDT) including the psychiatrist shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will be best served primarily through behavioral, pharmacological or other interventions, in combination or alone. If it is concluded that the individual is best served through the use of psychotropic medication, the individual support plan (ISP) must also specify non-pharmacological treatment, intervention or support to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible." Psychiatric participation in that process included participation and input via the PBMC clinic, which was considered an IDT meeting. <u>Psychiatrist Participation in IDT Determinations about the Least Intrusive and Most Positive Interventions to Treat the Behavioral or Psychiatric Condition, and Whether the Individual will be Best Served Primarily Through Behavioral, Pharmacological or Other Interventions, in Combination or Alone</u>	Noncompliance

	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.	To evaluate psychiatrist participation in these determinations, the Monitoring Team reviewed the PBMC notes for the past six months for each of the 15 individuals in Sample J1, observed the PBMC meeting on 08/27/13, and reviewed past PBMC notes for individuals reviewed in that clinic. During the PBMC clinic deliberations (summarized under Provisions J2 and J3) the Monitoring Team did not witness any discussions about what were the least intrusive treatments. There were of course discussions about medications and sometimes other treatments, but what was required were IDT and psychiatrist evaluations and discussions of the modality or modalities of treatment that were best suited to the individual, and why. Those discussions were not present. In the written materials provided, the Monitoring Team found many references that made clear the psychiatrists were aware of the Provision requirements, and provided assurances that the IDT had made the appropriate determinations. For example, for Individual #91 the PBMC notes of 05/23/13 stated "IDT had had determined that the treatment plan integrates pharmacological treatment with behavioral and other interventions and that the plan includes the least intrusive and most positive interventions and that these interventions best serve the patient through a combination of behavioral pharmacological and other interventions." But that statement simply restated the requirements. It did not provide relevant specifics, and a reading of the overall note did not suggest that the IDT and psychiatrist had discussed this matter on 05/23/13, and the note did not indicate where or when such a discussion had taken place. Another example is for Individual #27, also from the PBMC of 05/23/13. In that note the psychiatrist stated "The active records contain quarterly reviews of risk versus benefits, the continued use of psychotropic medication as well as appropriateness of drug selection and effect, dosage, and the presence or absence of side effects. This is found in the QDRR. This provider had documented the rationale for initiating and continuing the current medication prescribed in the active record." While the Monitoring Team agrees that QDRRs at RSSLC contain key information and thoughtful comments, they are written in advance of a meeting by the pharmacist who may or may not attend the meeting. For this Provision what was needed was evidence of IDT and psychiatrist discussion/determination, not referral to other sources. <u>Direct Participation of Psychiatrists in PBSP Preparation</u> For many individuals reviewed at PBMC clinics a PBSP was of course already in place. PBSPs are reviewed annually; however the psychiatrist did not sign that document and did not routinely participate in the preparation of the PBSP. <u>HRC Review of least intrusive and most positive alternatives:</u> HRC reviewed determinations of least restrictive and most positive alternative as part of review of informed consent. That positive practice is reviewed under Provision J14. It is related to but not the same as the requirements of this Provision.	

		ISP Specification of Non-Pharmacological Treatments to Minimize the Need for Medication The Monitoring Team reviewed ISPs for 15 individuals in Sample J1, all of whom took psychotropic medications. All ISPs specified non pharmacological treatments that could minimize the need for medication. Overall Impressions/Conclusions In the Self-Assessment the Facility commented that substantial compliance was not being requested since in eight of 14 records reviewed by the Facility, needed documentation could not be found. As illustrated in the comment above, the Monitoring Team also needs assurances that psychiatrists are meaningful participants in the process. The Monitoring Team cannot provide guidance about how the Facility should provide what is required by this provision, but notes that other DADS facilities use templates for quarterly reviews in the psychiatric clinics, that guide participants toward discussion of required particulars. Monitoring Team Compliance Rating For the reason outlined above, further work on this provision is needed.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	Policy and Procedure DADS policy and procedure "Psychiatry Services" dated 05/01/ 2013 noted that the State Center responsibilities included that " before the non-emergency administration of a new psychotropic medication or a significant change in the dosage of a psychotropic medication, the IDT, including the psychiatrist primary care physician, nurse, individual and legally authorized individuals (LAR) must determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of the medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medication. This determination may occur in person or through telephonic communication, including during the psychiatric clinic, and the determination must be documented in person." 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. The relevant determinations were then recorded in the informed consent for medication that was presented to the LAR, as described under Provision J14. Monitoring Team Review Since the last compliance visit, 39 new medication treatments were approved for 24 individuals. Ten medications were selected in haphazard fashion for further analysis (Sample J2). For each medication the Monitoring Team reviewed progress notes, psychiatric treatment reviews, and ISPAs provided 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	Noncompliance

		forms for use of the Psychotropic Medication, and Human Rights Committee reviews of the psychotropic medication. <u>Risk/Benefit Analyses for New Medication</u> In eight of 10 (80%) cases, review of IDT notes showed that the medications had been carefully considered, psychiatric care was being provided, and good selections were made about medication choices. Reasonable choices regarding risks and benefits of treatment could be inferred by the Monitoring Team psychiatrist. For example: • Individual #447 had been treated with Depakote and the dose had been gradually lowered in order to provide him with the lowest dose of medication needed to treat his illness. However, at a point of the taper the dose was too low and the individual became significantly anxious and agitated to the point that crisis management, including emergency restraint was needed. The consent form for use of Ativan was explicit in stating that the medication dose was being "added temporarily while the Depakote will be titrated up." This information was sufficient to state the many dangers of withholding treatment with Ativan, the risks associated with its use, and the favorable risk vs. risk analysis in favor of the use of medication. However, the risk vs. risk section of the medication consent form contained only the standard language used on all consent forms: <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.* In time, the IDT and PBMC clinic notes will be thinned from the record. If there is a need for the individual to remain on Ativan, memory of the notes cited above will be lost. A brief but individualized comment about risk and benefit was needed on the consent form; if necessary, that could be carried forward in renewals. The information about the failed attempt to taper Depakote should be included in the annual update of the CPE to guide future use of Depakote. • Individual #46 was admitted from another DADS Facility and treatment with Depakote was in place. Per the IPN and PBMC notes the psychiatrist wisely chose to defer to the judgment of the previous psychiatrist and continued the existing medication while the Facility staff learned more about the individual. In the consent form for medication, however, the reason for use of the medication was stated as only "to reduce symptoms of mood disorder" and for the risk vs. risk statement, the standard language cited was as above. Here too an individualized statement could have been made, perhaps mentioning the risks of a precipitous change in long standing medication in a newly admitted client who was not familiar to Facility staff. • Individual #410 had been treated in the past with Zoloft and that medication had been	

		stopped. Per the PBMC clinic note of 02/12/13 since discontinuation the individual experienced increased rates of rectal digging, urinating outside offices, along with masturbating and rubbing semen on his face. These matters were cited in the medication consent as reasons to restart the medication and could have been the basis for a meaningful individualized statement about risk vs. risk. Again, the language contained was the standard statement cited above. • Individual # 136 had been treated with Lithium and experienced lithium toxicity. In an IPN on 04/13 the psychiatrist documented the reasons that it was best to discontinue lithium and the need for treatment for the individual's bipolar disorder. That was the basis of the decision to stop lithium and replace it with a medication from another class. Here too, the decision making was good but the risk statement was not individualized. • Individual #137 was seriously ill to the point of catatonia and loss of ability to provide for basic needs including his diet. Ativan was introduced in a general emergency room and seemed a reasonable approach to augmenting existing medication in a situation in which there were many dangers associated with a decision to withhold that treatment. Here too, the risk vs. risk discussion consisted only of a citation of the standard language on risk. <u>Risk/Benefit Analyses for New Medication</u> During the PBMC on 08-27-13 the Monitoring Team did not evidence discussion of ongoing risk and benefits for particular medications although quarterly review is required by DADS. As per discussion under Provision J9 a prompt on the quarterly review mandate might be helpful. <u>Alternative Treatments</u> The eight of 10 (80%) consent forms that used the current form in use at the Facility had sections titled "Other possible choices of (type of medication)" that listed alternative medicines. However, in no case did the consent consider reasonable alternative treatments other than medication. Each individual's circumstance will vary, but the focus should be broader than a list of available medications. Reasonable alternatives could include non-pharmacological treatments and in some cases a reasonable alternative could even be 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 noncompliance.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system	<u>Facility Process for Polypharmacy Review</u> The Facility continued to rely on a multi-tiered system of review. The pharmacy provided quarterly QDRR consultations, clinical pharmacists participated in many psychiatry and neurology clinics, and monthly Polypharmacy/Medication Review panels were being held. <u>QDRR reviews for polypharmacy</u> QDRR reviews provided by the pharmacy were very substantive and helpful. Comments were	Substantial Compliance

	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.	data based and cited standards of care. Clinicians were offered practical suggestions about pharmacological management of complex regimens, including reductions in polypharmacy. Examples are provided in the discussion of QDRRs under Provision J13. <u>Clinical meetings</u> The pharmacy participated in selected psychiatry and neurology clinics, as reported above. The Monitoring Team observed the process by attending the PBMC clinic on 08/27/13 and observed clinical reviews for five individuals. A clinical pharmacist attended each of the reviews. For each individual discussed, 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. Details are provided under Provision J3. <u>Polypharmacy Review Panels</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. At the last review the Monitoring Team discussed with the Facility the need to have monthly reviews of polypharmacy, per the language of the SA. The Facility had been responsive to that need and such reviews were now in place. The meeting is known as polypharmacy review panels (PRP) and participation included pharmacists, primary care physicians, nurse case managers, psychiatrists, psychologists and others. Meeting minutes were maintained. In the entry interview the Facility reported that so far this year 23 of 52 (44%) individuals with polypharmacy had been reviewed. (Of note, the slightly different figures reported on this page about the number of individuals with psychiatric polypharmacy reflected that the number fluctuates, mostly in response to changes in clinical condition and individuals' clinical needs. Different sources tapped data at slightly different time points.) PRP case reviews of individuals were both detailed and broad. One such example was the discussion on 04/26/13 of Individual #714, who took four psychotropics, including two antipsychotics. The minutes stated: "The topic of (the individual's) psychiatric polypharmacy has been reviewed numerous times over the past three years by five psychiatrists (named). Upon extensive review by the patient's clinical presentation (sic) of his illness the pattern has remained the same in that the patient remains relatively stable to the extent that we attempt to reduce one of this present medications - usually an antipsychotic agent and then within days the patient decompensates and then it takes several weeks of adjustments to the psychotropic medications to maintain stabilization. This has resulted in our realization that we need to continue to treat the patient with the ongoing polypharmacy… which allows him to have a symptom control without any overt s/s of medication intolerance or negative side effects…." The presentation went on to state that "we have not given up hope of possibly	

		lessening the total polypharmacy load over time and marking an example being that since we were able to stabilize the patient last year and we did in fact lessen the lorazepam dosage in 2012 from 1 mg BID down to 0.5 mg BID and the patient has continued to remain stable. However, past history tell us we have had no success in downward cross tapering of two neuroleptics Zyprexa and Mellaril as much as we wanted to as all previous attempts have failed. The success of the combined antipsychotic regimen may be due to the differences in CNS footprint of each agent with their difference in neurotransmitter receptor affinities on D2, D3, D4, 5HT, 7HT and others." Comments were also provided in the discussion of Individual #714 regarding clinical augmentation for psychosis generally and in particular the choice of use of an atypical to augment an older typical neuroleptic such as thioridazine. The broad case review should not replace a focused statement regarding the need for polypharmacy in the individual's record, typically at the annual CPE update <u>Frequency of Polypharmacy</u> The pharmacy provided a breakdown of polypharmacy information across the campus. The Facility reported that as of July 18, 2013, 58 of 138 (36%) individuals seen by psychiatry had polypharmacy, as defined by the SA. That contrasted to previous report of 80 of 154 (52%) of individuals in November, 2012, and to 90 of 155 individuals (58%) in April 2012. This continued a pattern of overall declines in rates of polypharmacy. <u>Monitoring Team's Compliance Rating</u> The Facility had achieved a rating of substantial compliance and it will be continued. Good results to date notwithstanding, the Facility should continue to focus on establishing the best ways to review and monitor polypharmacy practices.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	<u>Policy and Procedure:</u> DADS Policy 007.3 Psychiatric Services (05/01/2013) addressed the matter of side effect screening. DISCUS and MOSES evaluations needed to be completed every three and six months respectively, and that psychiatrists needed to review the results of the scale within seven working days of completion of the screen. The policy clarified that a side effect screen may also be done within 30 days of a medication dose change, as determined clinically necessary by the psychiatrist. <u>Process in Place for Side Effect Screening</u> The system in place for side effect monitoring at the Facility was for side effect screening with MOSES to be done every six months and DISCUS examinations to be done on a quarterly basis. The examinations were done by each individual's nurse case manager. The nurse case manager then presented the forms for review and signature to the psychiatrist. Side effect screens were also reviewed in the QDRR that was presented at the time of the PBMC.	Noncompliance

		Quality of IDT Discussions about Side Effects During the visit, the Monitoring Team observed discussion about side effects during a PBMC clinic. Nurse case managers had a standardized sheet for presentation of information that included MOSES and DISCUS scores. For Individual #91 there had been a question about a possible medication induced dystonia and his medication dose had been reduced. For that individual there was a close examination of the side effects screen forms and those were correlated with examination of the Individual during the clinic. Individual Case Reviews: The Monitoring Team reviewed MOSES and DISCUS since the last visit for all the individuals in Sample J1. Standard DISCUS forms were completed until mid-March, 2013. For those, psychiatrists completed the physician review section on six of 13 (46%) of the forms. Administrations done in mid-March 2013 and later were done on an electronic form that did not include a section for physician comments. MOSES screens were completed at least every six months for all 15 individuals in Sample J1. Five of 15 (33%) of individuals had additional screenings due to a change of medication dose. Screens that included a physician review section were properly completed in eight of 14 (57%) screens done before mid- March 2013. Similar to the DISCUS forms, newer MOSES screens were done on an electronic form that did not include a section for physician comments. In the Self-Assessment the Facility did not self- assess for substantial compliance since physician signatures were delayed and did not meet the new DADS guidelines that review for completion within 10 days. During the visit the Monitoring Team noted that the Facility now used a computerized form for both MOSES and DISCUS side effect screens. However in each case some of the content of each side effect screen (the physician review section) was omitted. The Monitoring Team was informed that the section will be introduced into the new form later this year. A complete administration and documentation of the screen is needed for these exams to be complete. Facility-Level Review of DISCUS scores and diagnoses The Facility reported that two individuals were diagnosed with tardive dyskinesia. In addition, there were a number of individuals – for example Individuals # 25, #101, #144, and #465- who over the past several years have had repeatedly high DISCUS scores. Individuals #101 and #465 were also treated with dopamine blocking medications. The Facility should consider periodic Facility-level review of all individuals with elevations on the DISCUS. In the case of Individual #25 who had a recent DISCUS score of zero, the physician could have had indicated whether the score represented masked dyskinesia. That was one of the items that were not yet included in the version of DISCUS that is being administered.	

		DISCUS Monitoring for Individuals taking Metoclopramide Metoclopramide is a medication used for gastrointestinal indications but is structurally related to antipsychotics and, like them, can produce movement problems including tardive dyskinesia. In DADS Policy and Procedure 007.3 Psychiatry Services (05/01/13) metoclopramide is listed as one of the medications that required DISCUS evaluations every three months. There were 10 individuals at the Facility who took metoclopramide. They were Individuals #107, #149, #169, #179, #330, #352, #502, #535, #661, and #765. The Monitoring team reviewed DISCUS screens/ratings for each. None showed signs of dyskinesia. Training for Administration of the MOSES and DISCUS side effect screens: 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 as 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. Only nurses who had completed the training provided the side effect screens. Nurses participated in annual retraining on the two side effect screens that was similar to the initial training described above. The most recent retraining took place on 02-28-2013. The Nursing Department reported that 74% of the nurse case managers participated in the training. The Monitoring Team was told that completion of the training for other case managers was pending due to a staff vacancy the Facility hoped to soon fill. During the visit the Facility enquired about the relationship of Provisions J12 and N5 and the role of the pharmacy in particular. In the previous report the Monitoring Team noted that Provision N5 is assessed as a component of Provision J12. Provision J12 includes not only monitoring but responding to side effects of psychotropics. As such, it spans responsibilities for several clinical departments including psychiatry, nursing, and pharmacy. Provision J12, like all others, spelled out requirements for the Facility, not for particular departments. Monitoring Team compliance ratings: The Facility had a good system in place to monitor side effects of psychotropic medications. Administration of the DISCUS and MOSES screens was done by nurses who received good training on the tools. Annual retraining was needed to assure continued competence and that was not fully in place at the time of the visit. The pharmacy supported DISCUS and MOSES administrations with excellent QDDR reports that included good discussion of matters that were rated on the MOSES and DISCUS. Adequate physician reviews were not yet in place due to the	

		lack of timely review and the cited difficulties with the physician review section on the MOSES and DISCUS forms.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	The language of the provision detailed what was required for psychotropic medication plans, and the same requirements were also cited in Facility Policy 1.00d *Psychiatry Services* (revised 08/30/2011.) The required elements were: • Clinically justified diagnosis • Expected timeline for treatment effect • Objective symptoms to be monitored for treatment efficacy • By whom, where, and when the monitoring would take place • Ongoing monitoring based on the individual's current status and/or changing needs In the Self-Assessment the Facility clarified that the requirements for treatment plans for psychotropic medication were met through • Psychiatrist's notations in the CPE • Psychiatric follow-up at least quarterly in PBMC • PBSP for monitoring parameters of psychiatric symptoms • ISP inclusion of the psychiatric plan into the overall ISP The Monitoring Team reviewed the records of the 15 individuals in Sample J. <u>Clinically justified diagnoses</u> These were found by the Monitoring Team in the CPEs of 10 of 15 individuals in Sample J1 (67%). That was less than the 14 of 14 (100%) found by the Facility in its own record review. In many cases diagnoses had been changed since the CPE had been completed. <u>Expected time lines for treatment effects</u> These were found by the Facility in none of records reviewed. In several PBMC notes Facility psychiatrists had commented that it is difficult to provide such information for medications that have been in place for many years. Such time lines are reasonable to expect for new medications, however. For that, the Monitoring Team turned to the sample of new medication plans (Sample J2). The Monitoring Team examined the consent forms, PBMC notes, and IPN notes provided by the Facility for those new medication plans. Expected time lines for treatment effects were found in 0 of 10 (0%) of those medications (see Provision J14) <u>Objective symptoms to be monitored for treatment efficacy</u> In the Self-Assessment sample, the Facility found that six of 14 (43%) individuals had a PBSP with the required elements. The Monitoring Team Similarly found that the PBSPs had identified at least one psychiatric symptom that reflected a key symptom of the proposed psychiatric illness in six of 15 (40%) of individuals in Sample J1. For those individuals the data on that symptom was also reported in the PBMC note.	Noncompliance

		By whom when and where the monitoring would take place Current Facility policy is for the substantive monitoring to take place at PBMC reviews that are attended by psychology, psychiatry and nursing along with other members of the IDT and the individual being reviewed. The format is an excellent forum during which the psychiatrist conducts mental status examinations, IDT members share impressions, and psychologists can present data on monitoring. For more information, see discussion under Provision J3. Monitoring Team's Compliance Rating In discussions with Monitoring Team during the visit the Facility made clear that it recognized that the required medication plans were not in place for either new or ongoing medications. The Facility outlined a plan to put in place PTPs that had a medication plan component that would answer to the requirement of this Provision. The Facility did not self -rate for compliance on this provision and the Monitoring Team concurs with that assessment.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure DADS Policy and Procedure 007.03 Psychiatry Services (05/01/13) detailed that "before prescribing psychotropic medications to individuals and/or before significant changes in the individual's psychotropic medication regimen, the state center must provide information about the psychotropic medication to the individuals, their families, and/or their legally authorized representatives (LARs). The information must address characteristics of the medication, including expected benefits, potential adverse side effects, dosage, and standard alternative treatments; legal rights; and any questions the individual, the family and /or LAR may have." Additionally, the Policy and Procedure states that "the state centers must obtain informed consent (except in the case of emergency) prior to administering psychotropic medications or other restrictive procedures." Facility Practice RSSLC Psychiatry Services Policy required that the Facility must obtain informed consent (except in the case of emergency medications) prior to the administration of psychotropic medications. During previous reviews the Facility clarified that HRC approval was obtained prior to the administration of the medication, and that consent for medication was re-obtained on an annual basis. In 2011 the Monitoring Team confirmed with the Lead Psychiatrist that psychiatry had assumed responsibility for the informed consent and that the psychiatrist spoke directly with the guardian/LAR about the medication. That was a positive practice since it provided the psychiatrist with the opportunity to review with the LAR /guardian the information that was contained in the informed consent, and to answer any questions. The Facility has not kept the practice in place during the past several years, and during the review period consents were typically obtained by a psychologist. The Monitoring Team reviewed the reasons why the psychiatrist should contact the guardian for discussion about the medication	Noncompliance

		and consent. The Monitoring Team was informed that going forward, the psychiatrist will obtain consent. The current informed consent form in use by the Facility had the following sections: Medication Name, Target Symptoms and Behaviors, Reason for Starting (the medication), Other Possible Choices (from the same class of medication), Expected Duration of Therapy, Expected Benefits of Treatment, Dosing (titration), Monitoring (for safety), and Side Effect / Risk vs. Risk information. <u>Review of Consent for New Medications</u> Since the last period 39 new medication treatments were approved for 24 individuals. Ten proposed medications were selected at random for further analysis (Sample J2). For each of these treatments the Monitoring Team received information from the clinical record (e.g., progress notes, psychiatric treatment reviews, ISPAs) 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: Informed consent form: Eight of 10 (80%) of the informed consents used the current medication form. Two of 10 used an outdated form that had previously been determined inadequate. Diagnosis: The psychiatric diagnosis that was related to the medication could be determined in five of 10 (50%) of the consents. An example of individuals where that was not clear was Individual #314 who was diagnosed with two psychiatric diagnoses and the rationale for adding Haldol was "her psychiatric condition had destabilized and we are proposing to add Haldol to help her." Medication Name: Present in 10 of 10 (100%) of the consents. Target Symptoms and Behaviors and Reason for Starting (the medication): The text was adequate to provide guidance needed for monitoring in seven of 10 (70%) cases. Examples that were not were plans for Individuals #19 and #137. Those plans did not specify which of the individuals' numerous behavioral symptoms would be the focus of treatment. Expected Duration of Therapy: This was present for eight of 10 (80%) of the individuals. The two that did not were the two that used the outdated form that did not inquire about this matter. Expected Benefits of Treatment: In four of 10 (40%) cases the expected benefits were clear. Examples of consents that were not adequate were consents for Individuals #19, #137, #1, and #447, all of which contained identical and standardized language related to elimination of self-	

		injurious, aggressive, and noncompliant behaviors, and replacement with socially appropriate acceptable and adaptive behaviors, learning of new skills, participation in leisure activities and access to less restrictive setting. For those individuals there needed to be more specific and individualized benefits. Monitoring (for safety) was adequate for eight of 10 consents (80%). The two that were not were those that used the older form that did not contain this information. Side effect and risk vs. risk. Common side effects were provided for all individuals. All consents contained standard language stating the medicine will be stopped "if the medicine is not effective or if the risks from the side effects outweigh (1) the risk from not taking the medication (2) the benefits of taking the medication." The matter of individualized risk/benefit analysis is a focus of Provision J10 and is discussed in more detail under that provision. Four of 10 (40%) of the individuals had LARs who provided consent. For six of ten (60%), consent was obtained from the RSSLC director. HRC review was part of the process for review of the consents, and it included presentation of Risk vs. Risk and less intrusive alternatives to the medications. Those discussions had improved, compared to the previous visit. For example, for Individual #542 (for sleep medication, Temazepam) the discussion on lesser intrusive alternatives tried stated: (The Individual) had a PBSP targeting sleep and relaxation techniques before bed and at night when awake and environmental adjustments – soft music, warm milk, quiet area. Staff also uses verbal redirection to encourage him to try to sleep and to address refusals to attend activities. The nursing staff and primary care physician have seen (the individual) to rule out possible medical causes. " Another example for Individual #314 stated that "The individual has a current PBSP in place. Staff uses communication skills and de-escalation techniques to attempt to manage self-injury and physical aggression and encourage the use of replacement behavior which include the use of appropriate communication to request attention." Overall, individualized statements on less intrusive techniques were present in six of ten (60%) HRC reviews. For risk vs. risk, individualized presentations were made for three of ten (30%) of individuals, but for the remainder of the cases the risk vs. risk statement contained only the following standardized language"	

		"The effects of (the individual's) targeted behaviors are more harmful than the possible negative side effect of psychoactive medication. The use of psychoactive medication is and will be closely monitored by (the individual's) psychiatrist, behavioral analyst, IDT and pharmacist." As discussed under provision J10 individuals assessments in PBMC cited specifics about both the risk of treatment and risks of no treatment. Those should be summarized in the consent form. <u>Annual Renewal of Ongoing Medications</u> Ten of the individuals in Sample J1 received ongoing medications for which annual review/renewals of consent were needed. In five of 10 (50%) individuals, outdated forms for consent were used. In two of those cases (Individuals #764 and #588) multiple medications were entered on the same form. That was an additional problem, since individualized information was not possible. <u>Monitoring Team's Compliance Rating</u> Some progress was evident, but there were many remaining deficiencies, cited above. 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.	RSSLC Psychiatry Policy I.00d addressed the topic of integrated care between psychiatry and neurology in the Integrated Care section, as follows: *"The neurologist and psychiatrist must coordinate the use of the medications, through the PDT process, when medications are prescribed to treat both seizures and a mental health disorder."* <u>Steps Taken to Promote Neurology and Psychiatry Integration</u> Steps taken by the Facility to facilitate integration of neurological and psychiatric care have 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. • Psychiatrists attended neurology clinics for individuals supported by 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.	Substantial Compliance

		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: • Individual #379 was treated with Vimpat and Keppra for his seizures. Moses and Discus scores were reviewed in the clinic; discussion of the neurology status was discussed in the PBMC note of 06/04/13. The psychiatrist noted the effects of Zyprexa, a psychotropic medication, on the seizure threshold, the frequency of seizures (1-2 per month), and commented on the improvement in seizure frequency. There was discussion about the risks of prolactinemia, in an individual who already had gynecomastia, a discussion about pertinent dosing, and an overall discussion of risk and benefits of the treatment with Zyprexa in this situation and the risk and benefit of changing the dose. • For Individual #17, in the neurology clinic note from 3/27/13 there was a discussion about the use of Lamictal and Vimpat, both anticonvulsants. In the psychiatry clinic note from 06/11/13 there was a discussion of the interaction of his neurological (and neurosurgical) difficulties and in the assessment a discussion about possible effects of Zyprexa on his seizure threshold and a discussion of risk and benefits. Of some note, in the documentation prepared by psychology Lamictal was listed as a psychotropic medication along with behavioral target/symptoms although in the psychiatry section of the same clinic note the psychiatrist explicitly lists the medication only as an anticonvulsant. • Individual #712 had difficult to control epilepsy and was treated with three anticonvulsants and also with a vagal nerve stimulator. The neurologist commented on an episode of the individual's eyes rolling back that occurred after starting on Abilify, a psychotropic. The possibility of drug-drug interactions was discussed, as her Dilantin levels were also noted to be elevated. In PBMC on 04/18/13 the psychiatrist discussed the neurological issues that were presented by the nurse case manager. The psychiatrist also noted that the IDT would also meet to discuss the overall treatment plan and PBSP with the psychiatric issues in mind. The psychiatrist also commented that he would discuss a change in diagnosis from paranoid to disorganized type of schizophrenia. Those steps showed good integrated care. • Individual #346 was treated with Vimpat for epilepsy and Depakote for seizures. Management of his epilepsy was reviewed in the neurology clinic on 05/14/13. His psychiatric diagnosis was intermittent explosive disorder and he was treated for that with Zyprexa and Prozac. The PBMC clinic on 05/01/13 contained a good review of both his neurological and psychiatric care. There was detailed review of possible side effects of medication and abnormal lab values, including a very low blood sugar. The psychiatrist noted the lab abnormalities and arranged for appropriate follow-up. The psychiatrist also noted the need to monitor any myelosuppressant effects of medications, in particular Depakote.	

		• Individual #483 was treated with four anticonvulsants for difficult to manage epilepsy. She was also treated for intermittent explosive disorder and Cyclothymia with Buspar, Paxil and Invega. The overall care was discussed in the most recent PBMC clinic on 05/29/13. There was discussion about lowering the dose of Invega, to minimize any possible adverse effects on seizure threshold, along with comments about the needs for continued data collection about sleeping and eating habits. 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 (see comment under provision J3). <u>Monitoring Team's Compliance Rating</u> Until now this provision had been in noncompliance since psychiatrists had not been able to participate in relevant neurology clinics or communicate effectively with the neurologist. Psychiatrists now attend neurology clinic for clients treated with anticonvulsants for both seizures and a mental health disorder (and also other individuals treated by both psychiatry and neurology) There was good communication between the neurologist and psychiatrist. Overall, both the process and the results were good. The Monitoring Team found the Facility in Substantial Compliance with the requirements of the provision.	

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 – 8/9/2013 2. RSSLC Action Plans – 8/7/2013 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 - 1/14/2013 through 6/24/2013 6. Behavior Service departmental meetings minutes – 12/20/2012, 2/8/2013, 2/26/2013, 5/29/2013, and 6/6/2013 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, tracking spreadsheets for SFAs and PBSPs, 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 #302, #404, and #576 Data Monitoring: Individual ##27, #32, #142, #180, #260, #302, #314, #379, #576, #630, and #714 Psychologicals: Individual ##27, #32, #142, #180, #260, #302, #314, #379, #576, #630, and #714 PBSPs and SFAs: Individual ##27, #32, #142, #180, #260, #302, #314, #379, #576, #630, and #714 Observations: Individual #203, #471, and #719 **People Interviewed:** 1. Lloyd Robert Buckner, MS, BCBA – Behavior Services director 2. Roxanne Wolf, MA, BCBA – Behavior Analyst 3. Billie Dejean, MA, BCBA – Behavior Analyst 4. Benjamin Giraldo, MEd, BCBA – Behavior Analyst 5. Candice Mays, MS – Associate Psychologist 1. Approximately 25 direct care staff in the following residences and day treatment areas: Guadalupe, Lavaca, Leon, Sabine, San Antonio, and Trinity residences, as well as multiple employment areas. **Meeting Attended/Observations:** 2. Behavior Support Committee 3. Behavior Service departmental meeting 4. Human Rights Committee meeting 5. Observations were conducted in the following residences and day treatment areas: Guadalupe, Lavaca, Leon, Sabine, San Antonio, and Trinity residences, as well as multiple employment areas.
	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.

At the time of the site visit, RSSLC reported in the Self-Assessment that Provisions K.2, K.5, and K.13 were in substantial compliance with the Settlement Agreement. The Monitoring Team was in agreement with the Facility concerning Provision K.2. Regarding Provisions K.5 and K.13, the Monitoring Team did not concur with the findings of the Facility.

- Provision K.5 required psychological assessment procedures to identify medical, psychiatric, environmental and other reasons for target behaviors, as well as other psychological needs. Although Psychological Evaluation reports were developed at the Facility, RSSLC indicated that no routine assessment of intelligence or adaptive skill was expected or required for those reports. In addition, based upon tracking data provided by the Facility, approximately 39% of all behavior assessments were more than one year old.
- Provision K.13 required that the Facility maintain a ratio of one BCBA for every 30 people living at the Facility. In the Self-Assessment, RSSLC indicated that the Facility was in compliance because a ratio of one BCBA for every 24 people with a PBSP was maintained. Although laudable, the Facility's claim did not conform to the expectations of the Settlement Agreement.

For Section K, in conducting its self-assessment, the Facility:

- Did not consistently use monitoring/auditing tools. In Provision K.3, the Self-Assessment indicated that quality assurance (QA) audits had been used to determine the quality of PBSPs. Provision K.11 reflected that Treatment Integrity forms were used to assess PBSP implementation. In other Provisions, although the Self-Assessment indicated that reviews were conducted, it generally was not specifically stated what procedures were used in conducting the reviews or what criteria were implemented.
  - In Provision K.4, the Facility indicated that part of the review of PBSPs was to determine if changes were made promptly to individuals' PBSPs based on lack of progress and that changes were discussed and proposed. The Facility then stated that changes when needed were made promptly. No descriptions were included of a monitoring tool or template, and no criteria for "timely" were presented.
- Did not consistently use other relevant data sources and/or key indicators/outcome measures. Furthermore, when listed, it was not clear how the data sources were used to determine the outcomes described.
  - In Provision K.10, the Facility stated that a sample of monitoring results of interobserver agreement (IOA) data observations was used to determine the accuracy of the data while treatment integrity data were used to assess treatment fidelity. The Self-Assessment then described how no IOA or treatment integrity data were presented on progress notes. Based upon this, the Facility determined that improvements were needed in development of IOA data and the documentation of treatment integrity. It was not clear how the monitoring results lead to the conclusions presented when only progress notes were described.
- The Facility consistently did not present data in a meaningful/useful way. Specifically, the

Facility's Self-Assessment:

- Did not present findings consistently based on specific, measurable indicators. In most cases, the Facility offered general statements about quality without offering supporting data.
  - The Facility reported that 100% of full psychological assessments contained the essential elements, such as intellectual assessment and adaptive assessment. No criteria were presented to support the offered conclusion. This was particularly concerning, as the Facility elsewhere reported that intellectual and adaptive skill assessments were not routinely conducted.
- Although the Facility often reported on the quality as well as presence of items, qualitative statements frequently lacked specificity or corroboration.
- Distinguished data collected by the QA Department versus the program/discipline.

Summary of Monitor's Assessment:

Observations, interviews, and record reviews were conducted on-site at RSSLC from 8/26/2013 through 8/30/2013. 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 made some good faith attempts to improve the quality of services related to Section K. In some instances, these efforts produced positive outcomes. In other areas, however, the Facility appeared to focus too narrowly when targeting areas for improvement. Of greatest concern, however, were the circumstances in which the Facility did not follow the specific requirements of the Settlement Agreement.

Examples in which the Facility had achieved some positive outcomes included the following.

- The Facility continued to strive toward all qualified staff becoming certified as behavior analysts. At the time of the site visit, 100% of eligible staff were either board certified or actively pursuing board certification.
- The Facility had greatly expanded the use of rating scales in determining the quality of SFAs and PBSPs. Although the Facility indicated the rating scales required further revision, it was positive that RSSLC was expanding efforts in this area.
- Previous progress regarding behavior data graphs was maintained, with several areas rated at 100%.

As mentioned previously in the section, there were areas in which the efforts of the Facility appeared to lack the necessary focus or did not address all pertinent issues.

- Even though efforts were underway to improve the quality of SFAs and PBSPs, at the time of the site visit, 39% of SFAs and PBSPs had not been reviewed within one year according to the Facility's tracking data.
- At the same time that the Facility had attempted to ensure that 100% of individuals were provided Psychological Evaluation reports, the Facility was not routinely assessing intelligence or adaptive skills. Furthermore, for at least half of individuals admitted to the Facility since the beginning of 2013, Psychological Evaluations were not provided within the required 30 days following

	admission. • Although SFAs frequently mentioned symptoms of mental illness, there were few examples of empirical attempts to determine the relationship between environmentally based behaviors and the symptoms of mental illness. • Despite having identified several people in need of counseling services and developing treatment plans for those individuals, those treatment plans consistently lacked the evidence-based approach to intervention required for substantial compliance. Based upon the information obtained during the site visit, it did not appear that RSSLC had achieved consistent and comprehensive progress in relation to most Provisions of the Settlement Agreement.

<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 the 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. In November 2012, the Facility had increased the number of BCBAs to seven, with 50% 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 nine staff with the BCBA credential. This was two 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 was on sabbatical.

<table>
<tr><td></td><td>5/2010</td><td>11/2012</td><td>8/2013</td></tr>
<tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>42%</td><td>50%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>0%</td><td>100%</td><td>89%</td></tr>
<tr><td>Percent of staff who were BCBAs or were</td><td>0%</td><td>100%</td><td>94%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		pursuing board certification | | | | Documentation obtained during the site visit reflected that the Behavior Services department was aggressively pursuing Board Certification for all eligible staff. The Facility had demonstrated consistent effort to increase the number of staff possessing Board Certification, and all staff currently either possessed or were engaged in obtaining Board Certification.	
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. <u>Historical Perspective</u> 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. In November 2012, a review of 33 records reflected that although the Facility had adequate policy regarding peer review and had demonstrated progress concerning internal peer review, substantial limitations existed. <u>Current Site Visit</u> At the time of the current site visit, the Facility reported that the checklist previously used for peer review was no longer implemented. In its place, the Facility reported that two checklists were being used. • The Behavior Support Committee Review Checklist, which was to be used by each member of the Behavior Support Committee (BSC) to review submitted SFAs and PBSPs prior to the BSC meeting. The ratings provided on this form were intended to guide the decision of whether to approve the SFA and PBSP. • The Positive Behavior Support Plan Quality Assurance Checklist to evaluate the conceptual and technical soundness of the assessment and/or proposed plan, the correctness of the procedures; and the degree the assessment or plan conforms to professional standards. Although the Facility reported that both checklists were being used at the time of the site visit, it was also indicated that checklists were under revision. Both checklists and the related procedures reflected a well-balanced approach to the review of assessments and interventions. If the revisions to the checklists continue to reflect the same approach, it is likely that they will be of benefit. During the site visit, observations were conducted during the BSC meeting. The meeting was attended by all members, all of whom contributed to the review process by asking questions and offering comments. Overall, the actions of the committee members reflected a careful review of assessments according to behavior analytic principles. Although the BSC performed adequately during the meeting, concern was raised by the actions of some of the BCBAs who presented at the meeting. In one presentation, the BCBA was resistant to recommendations offered by the BSC involving limitations in both the current assessments and interventions. In a second presentation, the BCBA repeatedly used mentalistic language and non-behavioral concepts to describe both an individual's behavior and proposed interventions. The development of thorough review	

#	Provision	Assessment of Status	Compliance
		procedures is critical to ensuring that clinically sound interventions are developed. If staff, however, are ill prepared or resistant to the use of necessary skills, the review procedures will not fulfill their goals. At the time of the current site visit, the Facility provided a copy of minutes from all BRC meetings conducted between 1/14/2013 and 6/24/2013. Of the 24 weeks covered by that period, BSC meetings were conducted during 19 weeks (79%). In total, 63 PBSPs were reviewed during the 19 meetings, for an average of 3.3 PBSP reviews per meeting. At that rate, it would not be possible for the BRC to review the PBSPs for the 190 individuals identified as in need of behavior intervention within the required one year. Additionally, in a review of 10 records (presented in Provision K.5 of this report), four active PBSPs (40%) were found to have not been subject to a BRC review for at least a year. For one of these individuals, Individual #525, no BRC review had been documented since September 2010. Regarding external peer review, the Facility reported that Deborah Grossett, PhD, BCBA-D continued to be employed by the Facility for that purpose. The Facility indicated that Dr. Grossett rated a selection of PBSPs each month using the Positive Behavior Support Plan Quality Assurance Checklists, and provided a single Positive Behavior Support Plan Quality Assurance Checklist that Dr. Grossett had completed. No other information regarding external peer review was presented. During the current site visit, RSSLC demonstrated insightful and clinically sound approaches to the review of SFAs and PBSPs. When fully implemented, these procedures held the potential for an effective review process. Unless the Facility takes steps to ensure that BSC meetings are held with sufficient frequency, however, the review procedures alone would not be sufficient for substantial compliance. In addition, the Facility must ensure that the staff responsible for the development and implementation of PBSPs demonstrate the necessary skills and are receptive to the guidance and recommendations of the BSC.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected	<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.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>Current Site Visit</u>
During the current site visit, a sample of 10 individuals was selected for the review of data collection and treatment monitoring. This sample included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #32, #142, #180, #260, #302, #314, #379, #576, #630, and #714.

The table below reflects the results from the current site visit review regarding the collection and presentation of data.

<table>
<tr><th></th><th>5/2010</th><th>11/2012</th><th>8/2013</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>0%</td><td>80%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>0%</td><td>80%</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>30%</td><td>60%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making</td><td>0%</td><td>0%</td><td>30%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making</td><td>0%</td><td>0%</td><td>30%</td></tr>
</table>

Information gained from the record sample reflected that RSSLC had achieved improvement in five of the six areas (83%). In two of the six areas, The Facility had met criteria for eight out of 10 records (80%). In the remaining areas reflecting modest improvement, there was a general lack of consistency in the procedures used for data collection and presentation.

Some of the limitations noted in the documentation and presentation of treatment data included the following.

In four of the 10 records reviewed (40%), progress notes did not reflect a narrative interpretation of individual target data every month. In some cases, narrative interpretations were provided, but those narratives referred to aggregate “challenging behaviors” rather than individual targets.
In six of the 10 records reviewed (60%), data graphs lacked the features necessary for determining progress, such as baseline data, indications of changes in treatment modality, and markers reflecting when treatment targets changed.

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#	Provision	Assessment of Status	Compliance
		• For one individual (Individual #32), progress notes from each month between February 2013 and May 2013 reflected a different psychotropic drug history. The availability and presentation of treatment data are only one aspect of the process of monitoring the benefit of intervention plans and psychotropic medications. It is also necessary to conduct thorough reviews of the available data and to introduce changes in the treatment process when data indicate changes are necessary. The information submitted during the current site visit to RSSLC reflected that the Facility had improved modestly in some areas, but had not built upon earlier progress and even regressed in other areas.	

	5/2010	11/2012	8/2013
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	0%	100%	60%
Review is conducted by a BCBA	0%	50%	50%
Input from direct care staff is solicited and documented	0%	0%	0%
Modifications to the PBSP reflect data-based decisions	0%	0%	30%
Criteria for revision are included in the PBSP	0%	0%	0%
Progress evident, or program modified in timely manner (3 Months)	0%	0%	60%

The most notable aspect of treatment review procedures at RSSLC was the lack of consistency. Whether viewed across individuals or within one individual's record, evidence did not reflect that the Facility policies ensured reliable practices.

Data review Documentation obtained during the current site visit revealed that monthly treatment monitoring was conducted for each of the past six months for six out of 10 individuals (60%). This was a substantial decrease from the previous site visit, during which records revealed monthly review for 100% of the records sampled. For the remaining four records, each reflected at least two months for which no review was documented.

In all 10 reviewed records, regardless of whether treatment review was documented each month, only five records (50%) reflected review by a BCBA.

In addition, as documented in Provision C.7 of this report, the Facility had not conducted the necessary "as needed" reviews of behavior interventions associated with individuals

#	Provision	Assessment of Status	Compliance
		for whom restraint had been applied more than three times in a rolling 30 day period. Documentation provided by the Facility reflected that adequate reviews of PBSPs had not been conducted for any individual restrained more than three times in a 30-day period. Furthermore, documentation illustrated that for six of the nine people meeting the restraint frequency criteria presented above (67%), no PBSP had been implemented despite multiple applications of restraint. Input from direct support staff. Nowhere in the available records was it presented that direct support staff were offered the opportunity or participated in the review of treatment data for any of the 10 PBSPs. PBSPs reflect data-based decisions. For seven of the 10 records reviewed (70%), the development of data based decision regarding treatment would have been substantially inhibited by limitations in data presentation. • Seven of 10 records (70%) included progress notes that did not reflect baseline or pre-treatment measures for the identified treatment targets. • Six of 10 records (60%) included progress notes that lacked clear demarcation of changes in treatment modalities or treatment targets. Without reference points from which outcome measures can be compared, it is very difficult to determine whether an intervention has provided meaningful benefit for the individual. The lack of pre-treatment or baseline data would have prevented easy determination of whether the targets had improved following the onset of treatment. Similarly, due to the lack of markers for behavior or psychiatric treatment changes, it would not have been evident whether changes in targets were due to treatment changes or in response to other variables. There were also indications that data graphs, regardless of limitations, were not used to formulate sound treatment decisions. • For Individual #32, physical aggression was added as a target for behavioral intervention in an existing PBSP. Progress notes had not reflected that physical aggression had been displayed frequently by the individual up to that point, and data following the addition of the physical aggression target reflected no displays of the behavior. • For Individual #630, data collection procedures were changed in March 2013. Although not described in the progress note, graphs suggested data collection was changed from percentage of intervals to frequency. Although the percentage data had been near zero for all targets, frequency data revealed multiple displays of leaving without informing staff, threatening staff, self-injury, threats to harm self, and physical aggression each month. As there had been no overlap of the	

#	Provision	Assessment of Status	Compliance
		two data collection procedures, it was not possible to determine whether the frequency data reflected new trends in behavior or underestimates by the previous percentage data. Nevertheless, reductions in frequency were cited as progress in the progress notes and no recommendations for a review of the PBSP or data were offered. <u>PBSPs include criteria for revision</u>. Of the 10 PBSPs reviewed, all included a section to identify criteria for PBSP revision. Of those, however, none included specific criteria to identify a lack of success or other circumstances that would require the review and/or revision of the PBSP. Instead, all PBSPs reflected the following statement. *Challenging behaviors will be reviewed by the associate psychologist/ behavior analyst via progress note on at least, a monthly basis. If reported data indicate continued regression or failure, the associate psychologist/behavior analyst will review the current supports to determine if additional assessment is necessary. If additional assessment or changes are determined to be necessary, the associate psychologist/behavior analyst will meet with the IDT to discuss these recommendations.* Although the statement reflects a general process for reviewing PBSP efficacy, it does not include actual criteria for determining "continued regression or failure." In order to meet the criteria, it would be necessary at least to indicate a timeframe within which the data revealed an inadequate response to treatment. Furthermore, it would be necessary for the criteria and timeframe to be determined by the characteristics of the behavior, as well as the needs of the individual. For some individuals, a lack of decrease in the target behavior for one month might be sufficient to prompt a review of the PBSP. For other individuals, however, 60 to 90 days with no response to treatment would be required. <u>Timely revision of PBSPs.</u> As mentioned previously, the data graphs and progress notes reflected several weaknesses limiting their utility in determining adequate response to treatment. As a result, it was difficult to determine when or if PBSPs were revised in a timely manner. If those limitations are ignored, however, then data reflected that procedures for six of the 10 PBSPs (60%) were adequate, as data reflected progress and no revisions to the PBSP were implemented. Of the remaining four individuals, data suggested a substantial increase in one or more targets without any consideration of the need to review or revise the PBSP. • For Individual #576, physical aggression demonstrated an increasing trend beginning in January 2013. Although the frequency of physical aggression dropped in April, it peaked in July. During the brief ebb in physical aggression, inappropriate sexual behavior had increased. In addition, in May 2013 the	

#	Provision	Assessment of Status	Compliance
		individual had made statements of wanting to commit suicide and claimed to have a handgun for that purpose. At various times during this period, the individual was placed on increased supervision to prevent self-harm and sexual contact. At no point did the progress note reflect a recommendation that the PBSP should be reviewed or revised. Based upon information obtained during the site visit, it was evident that some improvement in the collection and presentation of treatment, as well as the use of those data in monitoring treatment outcomes, had been achieved. Overall, however, documentation did not reflect that the Facility had developed the ability to effectively monitor treatment outcomes or use an evidence-based approach to formulate treatment plans.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	<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 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 visit, documentation reflected that 309 of the 340 individuals living at the Facility (91%) had been provided a Psychological Evaluation Report or a Psychological Evaluation Update Report within the year prior to the site visit. This was a modest decrease from the previous year. The Facility also reported, however, that no testing of adaptive skills or intellectual ability had been conducted as part of those 309	Noncompliance

#	Provision	Assessment of Status	Compliance
		reports.	

	5/2010	11/2012	8/2013
A Psychological Assessment had been completed.	0%	99%	91%
The Psychological Assessment was less than one year old	0%	95%	91%
The Psychological Assessments contained findings from an intellectual test administered within the previous five years.	0%	4%	0%
The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.	0%	4%	0%

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, a sample of 11 individuals was selected in order to review the assessment of behavior and associated mental illness. This sample included individuals with recent ISPs, behavior assessments, behavior interventions, or

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>psychotropic medication reviews. The specific individuals included in the sample were Individuals #27, #32, #142, #180, #260, #302, #314, #379, #576, #630, and #714. The table below reflects the ratings associated with this sample regarding the assessment of behavior.

<table>
<tr><th></th><th>5/2010</th><th>11/2012</th><th>8/2013</th></tr>
<tr><td>Assessment or review of biological, physical, and medical status</td><td>0%</td><td>0%</td><td>64%</td></tr>
<tr><td>Review of personal history</td><td>0%</td><td>0%</td><td>64%</td></tr>
<tr><td>A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis</td><td>0%</td><td>0%</td><td>27%</td></tr>
<tr><td>The process or tool utilizes both direct and indirect measures</td><td>0%</td><td>0%</td><td>64%</td></tr>
<tr><td>Identification of setting events and motivating operations relevant to the undesired behavior</td><td>0%</td><td>0%</td><td>36%</td></tr>
<tr><td>Identification of antecedents relevant to the undesired behavior</td><td>0%</td><td>0%</td><td>9%</td></tr>
<tr><td>Identification of consequences relevant to the undesired behavior</td><td>0%</td><td>0%</td><td>36%</td></tr>
<tr><td>Identification of functions relevant to the undesired behavior</td><td>0%</td><td>0%</td><td>45%</td></tr>
<tr><td>Summary statement identifying the variable or variables maintaining the target behavior</td><td>0%</td><td>0%</td><td>27%</td></tr>
<tr><td>Identification of functionally equivalent replacement behaviors relevant to the undesired behavior</td><td>0%</td><td>0%</td><td>27%</td></tr>
<tr><td>Identification of preferences and reinforcers</td><td>0%</td><td>0%</td><td>64%</td></tr>
</table>

Although the ratings suggest improvement, it should be noted that four of the 11 individuals in the sample (36%) reflected substantial lapses regarding the SFA. RSSLC Policy J.6 required that each PBSP and the associated SFA be reviewed by the Behavior Review Committee (BRC) on an annual basis. No SFA was included in the material submitted to the Monitoring Team for these for individuals. A review of Facility tracking documentation revealed that more than a year had passed since a BRC review of these four SFAs, with the most recent review for one SFA having occurred 35 months prior to the site visit.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		As the 11 records in the sample were selected and submitted by the Facility, it was unlikely that chance or bias had resulted in the selection of four particularly weak records. It was therefore reasonable to presume that 36% of all SFAs at the Facility had similarly fallen out of compliance. To verify this hypothesis, the BRC tracking information maintained by the Facility was reviewed for all PBSPs at the Facility. This review revealed that for 74 of 190 behavior interventions (39%), the most recent BRC review had been conducted more than one year prior to the current site visit. Furthermore, 32 of 190 behavior interventions (17%) had not been reviewed by the BRC for more than 18 months prior to the current site visit. Based upon Facility documentation, therefore, it was possible to determine that 39% of SFAs were too old to include more recent format and content changes intended to meet the requirements of the Settlement Agreement. When the lack of compliance with Facility policy was combined with the resulting smaller sample size, the ability to draw conclusions from the current site visit review concerning the quality of SFAs was limited. Presented below are some relative strengths based upon the seven SFAs that were submitted and had been reviewed within the past year. • Seven of seven (100%) included personal history of the individual, as well as a summary of medical and health issues. • Seven of seven (100%) reflected the use of a functional assessment process that included direct and indirect assessment procedures. • Seven of seven (100%) included findings of preference and reinforcer assessments. The submitted seven SFAs that had been reviewed within the past year also reflected several limitations. • Four of seven (57%) reflected the application of an accepted functional assessment process. • Five of seven (71%) included the identification of setting events, consequences, and potential functions. • Two of seven (29%) identified specific antecedents for target behaviors. • Four of seven (57%) included a statement summarizing potential functions and maintaining variables. • Three of seven (43%) identified functionally equivalent replacement behaviors. As indicated immediately above, some of the SFAs included many of the components of an adequate and accepted functional assessment process. An adequate functional assessment, however, requires more than the application of observation and	

#	Provision	Assessment of Status	Compliance
		measurement procedures. In order to identify interventions that are likely to produce meaningful behavior change, a functional assessment must also integrate the findings from observations and measurements into a coherent and evidence-based hypothesis about the causes for the targeted behaviors. In several of the SFAs that were submitted, the application of a coherent assessment and integration process included several weaknesses. • In an SFA dated 12/17/2012 for Individual #32, the following limitations were noted. o Indirect assessments for physical aggression and inappropriate sexual behavior were reported to occur from August through November, although the year of the assessments were not reported. The Facility tracking spreadsheet for SFAs and PBSPs reflected that the assessment and intervention were not approved by the BSC until 2/14/2013. Six months to conduct a behavior assessment and implement an intervention is too long. After six months, the original findings may no longer be accurate, the data might no longer be representative of behavior patterns, and interventions based upon such assessments could be less likely of providing benefit to the individual. o Targets were not provided specific definitions and the definitions that were provided were not consistently followed during the assessment process. For example, inappropriate sexual behavior was defined as, "Talking or acting sexually suggestive. Touching others in an inappropriate and/or unwanted manner. Engaging in sexual acts with another individual." The narrative of the SFA indicated at one point that behavior meeting this definition had occurred once during the past year. Based upon interviews with staff reported in the SFA, however, the individual often approached staff too closely, and attempted to touch and hug staff in a manner that required redirection. This suggested that the behavior occurred with greater frequency than once per year, but the issue of frequency was not resolved in the SFA. o The SFA did include one-sentence descriptions for the conditions during which each target behavior was least and most likely to be displayed. These circumstances, which could be considered setting events although there was little to indicate the sources of the information, were not integrated into the hypothesis of maintaining factors for each target behavior. o The hypotheses presented for each target behavior lacked specificity regarding maintaining functions. Functions proposed for inappropriate sexual behavior included non-social sexual gratification and attention. Functions proposed for physical aggression included escape from a non-specified social factor or attention. In addition, hallucinations were	

#	Provision	Assessment of Status	Compliance
		identified as a potential cause for physical aggression; hallucinations were more likely to represent a setting event rather than a function, although this was not presented as such in the SFA. o Social skills, defined as standing at least an arm's length from another person when talking, was the only identified behavior for increase and was presented in conjunction with issues involving hallucinations. It was unclear how this skill would serve to address hallucinations. Furthermore, there was no indication of how this skill would serve as a functionally equivalent replacement behavior for any of the potential functions suggested by the SFA. Based upon available information, it was noted that RSSLC had begun to use several of the appropriate tools and procedures in assessing the function and maintaining contingencies of undesired behavior. In several cases, however, assessments were not comprehensive and did not integrate the findings of various procedures into a specific hypothesis regarding the undesired behavior. Furthermore, documentation reflected that the Facility had not acted to ensure that a large portion of the individuals identified as requiring behavior intervention had been provided the necessary reviews on at least an annual basis. Therefore, it was suggested that the Facility had achieved, at best, limited progress toward satisfying the Settlement Agreement. <u>Assessment of Mental Illness</u> The diagnosis and treatment of mental illness in people with concomitant intellectual or developmental disabilities requires a carefully coordinated approach. In many cases, symptoms of mental illness can be masked by limited expressive communication skills or other aspects of the developmental or intellectual disability. In addition, undesired behaviors may reflect the symptoms of mental illness as well as learned responses to environmental stimuli. It is therefore essential that the psychiatrist and behavior analyst work toward a common goal in a manner that allows their areas of expertise to complement each other. <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 administration of the Reiss Screen. Rather, it could have reflected the failure to report or otherwise integrate an existing assessment	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>into the SFA.

<u>Current Site Visit:</u>
During the current site visit, the sample used to review the assessment of mental illness included 10 of the 11 individuals listed for the review of behavior assessment. The 11th person, Individual #260, was not included in this sample, as she was not diagnosed with a mental illness. As noted previously in this section, records submitted for four individuals in this sample did not include an SFA. In addition, documentation reflected that more than a year had passed since a BRC review of these four SFAs, with the most recent review for one SFA having occurred 35 months prior to the site visit. Therefore, four of the 10 SFAs (40%) were too old to include more recent format and content changes intended to meet the requirements of the Settlement Agreement.

The table below reflects the ratings associated with this sample regarding the assessment of mental illness.
<table>
<tr><th></th><th>5/2010</th><th>11/2012</th><th>8/2013</th></tr>
<tr><td>The assessment process included screening for psychopathology, emotional, and behavioral issues.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>The assessment process included differentiation between learned and biologically based behaviors.</td><td>0%</td><td>0%</td><td>10%</td></tr>
<tr><td>Identification of behavioral indices of psychopathology</td><td>0%</td><td>0%</td><td>20%</td></tr>
<tr><td>Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities</td><td>0%</td><td>0%</td><td>27%</td></tr>
</table>
As pointed out in this Provision, as well as in Section J of this report, RSSLC had demonstrated only slight progress in relation to the integration of behavioral and mental health assessment.
• None of the six records that included an SFA (0%) reported the findings of the Reiss Screen or other screening procedures for mental illness.
• One of the six records that included an SFA (17%) reflected the differentiation between operantly maintained behaviors and those that were primarily reflective of mental illness.
• Two of six records that included an SFA (33%) included specifically identified behavioral indices of psychopathology.
• Three of six records that included an SFA (33%) adequately demonstrated the use of tools or procedures valid for use in people with intellectual disabilities.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		With almost half of the sample lacking the necessary records, the ability to identify trends in Facility practices was substantially limited. The following issues comprise some of the issues noted in the available assessments. • For Individual #32, only brief statements were offered suggesting a relationship between hallucinations and physical aggression. At the same time, however, the SFA suggested that physical aggression was associated with staff requests. No formal assessment was conducted to identify the relationship between environmental stimuli, reported hallucinations and physical aggression. • Individual #142 was diagnosed with a mood disorder. Although no defined treatment targets were presented for mood disorder, the Differentiation of Behavior section of the SFA identified self-injury as being an indicator of mood disorder. The results of the SFA, however, described how self-injury was maintained by obtaining tangible objects and attention. There was no indication in the hypothesis section of the SFA that self-injury was related to mental illness. • Individual #576 was diagnosed with Bipolar I Disorder with psychotic features. Hallucinations were tracked as an indicator of psychosis. The SFA, however, did not include any assessment of hallucinations or potential environmental factors associated with hallucinations. Information obtained during the site visit reflected that minimal progress had been achieved by RSSLC in relation to the assessment of mental illness and the relationship between mental illness and environmental variables that affect and maintain behaviors. Although the appropriate sections were often included in the SFA, the data and narrative provided in those sections lacked the rigor required to address the relevant issues. As a result, it was not evident that the Facility had developed and implemented the procedures stipulated in the Settlement Agreement. This is an area for improved assessment and greater collaboration on case formulation among psychologists/behavior analysts and psychiatrists. Based upon the available information, the efforts of RSSLC to address the issues in Provision K.5 were inadequate and inconsistent. A small number of assessments contained both the appropriate sections and the necessary information. A sizable portion of the individuals residing at the Facility, however, had not been provided the essential reviews and updates. Many of the records that included current assessment reports and SFAs did not reflect the necessary rigor and attention to detail required to specifically identify pertinent issues. As a result, it was evident that the Facility had not satisfied the requirements of the Settlement Agreement in relation to this Provision.	
K6	Commencing within six months of	Based upon the information presented in Provision K5, the Facility had maintained	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>previous progress in ensuring that individuals were provided with a current Psychological Evaluation report. Little progress had been achieved by the Facility, however, in providing the necessary intellectual and adaptive skill assessments required for a complete Psychological Assessment. In fact, the Facility indicated that intellectual and adaptive skill assessments were not routinely conducted at RSSLC. Therefore, it was evident that Provision K.6 was not in substantial compliance.</td><td></td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.</td><td>At the time of the current site visit, 309 out of 340 individuals (91%) had a Psychological Evaluation report or Psychological Update that was completed within the previous 12 months. The Facility did not provide tracking data for intellectual and adaptive skill assessments, but reported that intellectual and adaptive skill assessments were not routinely conducted.

Since the beginning of 2013, 16 individuals had been admitted to RSSLC. Of those 16 individuals, seven (44%) were provided with a Psychological evaluation report within 30 days of admission. Three individuals (19%) were not reflected in Facility tracking information as having been provided with a Psychological Evaluation report. The average span between admission and Psychological Evaluation for those newly admitted to RSSLC was 47 days. As with other Psychological Evaluations at RSSLC, there was no indication that newly admitted individuals were provided with intellectual or adaptive skill assessments.

<table><tr><th></th><th>5/2010</th><th>11/2012</th><th>8/2013</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>95%</td><td>91%</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>100%</td><td>44%</td></tr></table>
Based upon available information, it was indicated that individuals other than new admissions were provided assessment reports. Without current testing however, these assessment reports were of questionable benefit to developing skill acquisition programs for these individuals.</td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services.</td><td>During the current site visit, the Facility reported that 18 individuals had been identified as requiring counseling services. Of those 18 individuals, RSSLC provided initial counseling treatment plans for 10 individuals (56%). Although the initial counseling plans were dated from January 2013 and forward, no progress notes or treatment data were provided for any treatment plans.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Based solely upon the 10 initial treatment plans provided, the following ratings were determined.	

	1/2010	11/2012	8/2013
Needed services identified in the psychological assessment are implemented within 6 weeks of the assessment	0%	0%	0%
Service/treatment plan includes initial analysis of problem or intervention target, and a plan of service (e.g., curriculum or approach, frequency or planned number of sessions, statement of skill or intervention target)	0%	0%	0%
Services are goal directed with measurable objectives and treatment expectations	0%	0%	0%
Services reflect evidence-based practices	0%	0%	0%
Services include documentation and review of progress. If service includes individual or group sessions, progress review includes note in record, or specific data for each session	0%	0%	0%
Service plan includes "fail criteria"—criteria, such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention	0%	0%	0%
Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate	0%	0%	0%
Service identified in ISP and, if applicable, PBSP	0%	0%	0%

#	Provision	Assessment of Status	Compliance

Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	0%	0%	100%
Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists	0%	0%	0%

Although the treatment plans included sections for assessments, goals, and therapeutic procedures, zero of 10 treatment plans (0%) demonstrated indication of an evidence-based approach to intervention. The examples presented below reflect commonly noted weaknesses in the 10 treatment plans.

- For Individual #151, the following statement comprised the only indication of an assessment of the treatment target, "Impulse control issues, cognitive distortions acquired in childhood in response to trauma, Issues with relationship boundaries, self-care and weight management issues, concerns about estranged family relationships, often fails to take responsibility for her own actions." There were no definitions for any of listed treatment targets, no current or pre-treatment measures, and no indications of how progress toward treatment goals would be assessed. It would therefore be difficult to determine the salient issues that would be addressed in counseling, how treatment would be monitored, or how success or failure would be determined.
- For Individual #779, the description of treatment methodology consisted of the following statements.
    - *Initial Phase Goals: Build rapport, psychoeducation, begin to discuss difficulties in childhood, the death of loved ones, safety vs danger, and his issues with arousal, dating, body image, etc.*
    - *Medial Phase Goals: begin to identify faulty cognitions and maladaptive emotions related to Initial Phase Goals- psychoeducation and correction of these will begin take place.*
    - *Final Phase Goals: work on role playing related to anger and affect management. Practicing skills independently in the form of homework. assignments, journal entries, behavioral assignments, assessing progress.*

  Although these statements provided a general description of how treatment would be approached, there was no indication of the specific manner in which any of the included strategies would be implemented. Without specific and detailed plans for implementation, the risk of drift in counseling methods was substantially increased, thereby reducing the probability that counseling would

#	Provision	Assessment of Status	Compliance
		provide benefits to the individual. • For Individual #278, the only discussion of generalization consisted of the following statement, "[The individual] is able to generalize information from session successfully with minimal assistance to other settings. We begin the process of termination." The statement included no specific plans for how generalization would be conducted. Without specific generalization plans, it was less likely that skills acquired during counseling would be used outside of counseling sessions. That RSSLC had developed counseling treatment plans was a step forward for the Facility. Without taking the necessary steps to ensure an evidence-based approach to treatment, however, there was little to suggest that efforts by the Facility to provide counseling services would prove to be beneficial. As a result, it was not possible to determine that the Facility had achieved substantial progress toward satisfying the Settlement Agreement regarding Provision K.8.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	<u>PBSP Approval and Consent</u> Facility tracking documentation reflected that 116 PBSPs had been approved since 8/26/2012. Of those, documentation indicated that 16 PBSPs (14%) had not been approved by the BRC prior to being submitted for Human Rights Committee (HRC) review. In each of these 16 cases (100%), tracking documentation did not reflect that the PBSP had ever been approved by the BSC. During the current site visit, documentation submitted by the Facility for tracking PBSPs was used to determine if behavior interventions were implemented in a timely manner and if the necessary approvals were obtained for those behavior interventions. Although the tracking spreadsheet was designed to record PBSP implementation dates, this information was not recorded on the PBSP. Additional problems included no space for recording HRC approval dates and no HRC review dates for several PBSPs. As a result, it was not possible to determine the actual elapsed days between submission of a PBSP to the BRC and the implementation of that PBSP. It was possible to determine that of the 116 approved PBSPs, the average duration from BSC submission to BSC approval was 10 days. <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 documentation did not consistently reflect that the review and consent process offered adequate protections for the individuals living at RSSLC.	Noncompliance

#	Provision	Assessment of Status	Compliance
		During the May 2012 site visit, documentation for several PBSPs in the sample did not include a consent form or was missing portions of the consent form. Furthermore, no Human Rights Committee reviews were included for many of the submitted PBSPs. The Facility indicated 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> During the current site visit, a sample of 11 individuals was selected in order to review the assessment of behavior and associated mental illness. This sample included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #27, #32, #142, #180, #260, #302, #314, #379, #576, #630, and #714. The table below reflects the ratings associated with this sample regarding the assessment of behavior.	

PBSP Element	Baseline	11/2012	8/2013
Rationale for selection of the proposed intervention	0%	0%	55%
History of prior intervention strategies and outcomes	0%	0%	64%
Consideration of medical, psychiatric and healthcare issues	0%	0%	64%
Operational definitions of target behaviors	0%	0%	64%
Operational definitions of replacement behaviors	0%	0%	64%
Description of potential function(s) of behavior	0%	0%	55%
Use of positive reinforcement sufficient for strengthening desired behavior	0%	0%	36%
Strategies addressing setting event and motivating operation issues	0%	0%	55%
Strategies addressing antecedent issues	0%	0%	27%
Strategies that include the teaching of desired replacement behaviors	0%	0%	36%
Strategies to weaken undesired behavior	0%	0%	45%
Description of data collection procedures	0%	0%	64%
Baseline or comparison data	0%	0%	0%
Treatment expectations and timeframes written in objective, observable, and	0%	0%	0%

#	Provision	Assessment of Status	Compliance

measureable terms			
Clear, simple, precise interventions for responding to the behavior when it occurs	0%	0%	36%
Plan, or considerations, to reduce intensity of intervention, if applicable	0%	0%	0%
Signature of individual responsible for developing the PBSP	0%	0%	0%

Although the ratings suggest improvement, it should be noted that four of the 11 individuals in the sample (36%) reflected substantial lapses regarding the PBSP. RSSLC Policy J.6 required that each PBSP be reviewed by the Behavior Review Committee (BRC) on an annual basis. No PBSP was included in the material submitted to the Monitoring Team for these four individuals. A review of Facility tracking documentation revealed that more than a year had passed since a BRC review of these four PBSPs, with the most recent review for one PBSP having occurred 35 months prior to the site visit.

As noted in Provision K.5, the percentage of PBSPs in the sample not having the required BRC review was not due to chance. An examination of all PBSPs revealed that 39% of active PBSPs lacked the required BRC review. Due to this inability by the Facility to ensure that all PBSPs met Facility, DADS, and Settlement Agreement requirements, it was not possible to establish trends concerning compliance.

Concerning the seven PBSPs that were submitted and had been provided the necessary BRC review, the following relative strengths were noted.

- Seven of seven PBSPs (100%) included a history of prior interventions, operational definitions of target and replacement behaviors, and a description of data collection procedures.
- Six of seven PBSPs (86%) included a rationale for the selection of the treatment methodology, a description of potential functions, and strategies for addressing setting events and motivating operations.
- Five of seven PBSPs (71%) included strategies to weaken undesired behavior.

There were also several areas in which the seven PBSPs reflected relative weaknesses.

- None of seven PBSPs (0%) included baseline or pre-treatment data, treatment expectations that included failure criteria, methods to reduce the intensity of intervention strategies, and the signature of the PBSP author.
- One of seven PBSPs (14%) included adequate consideration of psychiatric issues.

Based upon the information obtained during the site visit, there were some indications

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>that the Facility had improved practices relating to PBSPs. Overall, however, the inability to ensure that all PBSPs were provided the necessary reviews and approvals, as well as the lack of consistency in uniformly implemented new practices, indicated that the Facility had not progressed closer to establishing compliance with the Settlement Agreement.</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>
At the time of the current site visit, a sample of 11 records was selected for review using the process previously described. The table below reflects a review of those 11 records.

<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>100%</td><td>100%</td></tr>
<tr><td>Horizontal axis and label</td><td>8%</td><td>100%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>8%</td><td>100%</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>100%</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>
Although the Facility had maintained the commendable improvements in graphing noted during the previous site visit, no progress had been achieved concerning previous weaknesses. As a result, the limitations noted during the previous site visit continued.
• The Facility lacked a mechanism for presenting the reliability of treatment data on treatment graphs and progress notes.
• Graphs did not include condition change lines for psychotropic drug changes, PBSP changes, or events that held the potential to influence behavior, such as illness, community-transition trips, or visits home. Furthermore, graphs did not reflect psychotropic drug changes across all targets. As drugs prescribed for a single symptom may influence a broad array of behaviors, it is important graphs be structured to assess the effect of psychotropic drugs on all targeted behaviors.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Based upon the information obtained during the site visit, despite sound graphing practices in some areas, the Facility had not achieved substantial compliance.	
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.	RSSLC reported that readability scores were not routinely monitored for staff instructions in PBSPs. A sample of six PBSPs was selected to assess readability of the PBSPs. According to Microsoft Word 2013, the average readability score from the six PBSPs was Grade 9.4 with a range from 8.0 to 11.7. A grade level of 8.0 is generally considered the upper range of easily accessible writing. As the sample reflected that a score of 8.0 was the lowest score achieved in the RSSLC PBSPs, it was suggested that the Facility should further refine attempts to improve the readability of behavior interventions.	Noncompliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	<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> At the time of the current site visit, the Facility reported that a new process for providing competency-based training had just commenced at RSSLC. Consistent implementation had not been achieved throughout the Facility, and there was currently no mechanism for tracking training or staff performance. Based upon this information, it was determined that the Facility had yet to achieve substantial compliance with the Settlement Agreement regarding Provision K.12.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such	At the time of the site visit, RSSLC employed nine staff members who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 38 individuals residing at the Facility and fell 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 16 individuals residing at the facility. RSSLC currently employed 12 Psychological Assistants. This would be sufficient to meet	Noncompliance

#	Provision	Assessment of Status	Compliance
	professionals.	the ratio of one assistant for every two BCBAs even if all qualifying positions were staffed by a BCBA.	

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment DATE 8/9/2013 2. RSSLC Action Plans DATE 3. Presentation Book for Section L 4. DADS Policy: Internal, and external medical audits, no number (undated) 5. RSSLC Policy: Individuals Immunization Policy, dated 2/26/2013, unnumbered 6. RSSLC Policy: Providing Health Care Services; Designating Out-of-Hospital DNR; 09/17/2010 7. RSSLC Policy: Clinical performance audit policy, 6/21/2013 (no number) 8. RSSLC Policy I.31: Chronic Clinical Indicators Policy, revised 8/20/2013 9. RSSLC Policy: Policy for Medical Services; 1.00a, dated 2/21/2011 10. RSSLC Policy I.44 : Morning Report Policy, dated 6/28/2013 11. RSSLC Policy: Clinical Pathway for Standard of Care and Documentation Policy, Dated 4/15/2013 (no number) 12. RSSLC Healthcare Trend Report to QA/QI Council Policy dated 8/27/13 (no number List of all medical providers, including number of hours worked, case load, and employment status 13. Grand rounds, dated 5/1/2013, 3/20/2013, 5/29/2013, 7/3/2013, and 7/31/2013 14. For each medical provider a. Curriculum vita for all licensed medical providers b. Copy of current medical license for all medical providers c. List of all CME obtained during the past 12 months for all medical providers 15. Copy of morning medical meeting minutes for the first week of March 2013 and 7/16/13-8/13/13 16. Annual medical summaries, medical provider's IPNs, and annual ISP for individuals #389, #718, #275, #796, #296, #661, #402x2, #614, #377, #785, #130, #235, #16, #161, #243, and #773 17. Vaccination records, and serology verification of immunization for Individuals #678, #596, #51, #470, #792, #266, #212, and #511 18. List of all individuals who were prescribed a DNR order 19. Individuals #649, #149, and #538: a. Most recent annual medical assessment b. Most recent ISP, or other relevant documentation indicating an interdisciplinary team (IDT) review c. Copy of ethics review for the DNR d. Copy of the consent for DNR e. Copy of the completed DNR form f. Copy of specific instructions to direct care, and other staff, regarding the DNR g. Copy of the medical providers interdisciplinary progress notes (IPN) documenting the clinical rationale for the DNR 20. CLDP report for Individuals #119 and #165 21. Post move monitoring assessments for Individual #119 22. Alpha list of all individuals hospitalized during the reporting period 23. For individuals #796, #296, #661, and #402 (x2):

	a. Hospital admission and discharge report b. Documentation of the medical provider's communication with the hospital medical staff c. Hospital liaison reports d. Pre and post hospital transfer report e. Post hospital IDT minutes, with sign-in sheet 24. Alpha list of all individuals with a diagnosis of osteoporosis 25. For individuals #614, #377, #785, #130, and #235: a. Most recent medical assessment b. Quarterly physician assessments for past six months c. All documentation indicating assessment for the etiology of low bone density d. Most recent IRRF e. Current medication list f. Labs for past 12 months g. Consultation reports specific for the evaluation, and/or treatment of osteoporosis h. All diagnostic studies to assess for bone density, for the past three years 26. List of all individuals with diagnosis of malignancy, and history of malignancy 27. For individuals 389, #718, and #275: a. Annual medical summary b. Most recent two physician quarterly reviews c. Most recent IRRF d. All IDT related minutes specific for diagnosis of malignancy e. Last six months IPNs by the medical provider that specifically documented assessment of malignancy f. All consultation reports specific for the diagnosis of malignancy 28. Alpha list of all individuals with diagnosed seizure disorder 29. Alpha list of all individuals who experienced an episode of status epilepticus during the reporting period 30. List of all individuals with diagnosis of intractable seizure disorder 31. List of all individuals with implantable VNS 32. For individuals #712, #440, #597, #780, and #133, copy of the most recent VNS interrogation report 33. For individuals #475, #712, #130, #402, and #133: a. Annual medical summary b. Most recent two quarterly physician summaries c. Most recent two neurology consultation reports d. Current medication list e. Most recent EEG f. Most recent brain imaging report g. Current six months medical provider's IPNs, specific for management of seizure disorder h. IDT meeting minutes documenting supports and services necessary for the management of seizure disorder i. Seizure log 34. List of all individuals 40 years old and older

	35. List of all individuals who were current and not current with their annual mammogram screen 36. Documentation by the Facility indicating the rationale why individuals were not current with their annual mammogram screen 37. List of all individuals 50 years old and older 38. List of all individuals who were current with their screening colonoscopy 39. List of all individuals who were not current with their screening colonoscopy 40. Documented rationale for each individual not current with screening colonoscopy 41. List of all men age 50 and older, and for the last ten individuals on the list: a. Copy of their PSA test results b. Documentation that the legally authorized representative (LAR) was informed of the risks, benefits, and alternatives to PSA testing c. Rationale why annual PSA testing was not completed 42. Alpha list of all individuals who were diagnosed with pneumonia during the reporting period 43. For all individuals who experienced five or more episodes of pneumonia within the past five years: a. Most recent annual medical summary b. All quarterly physician reviews for the reporting period c. Most recent IRRF d. Most recent PT/OT assessment e. Medical diagnostic and consultation reports, specific to the management of pneumonia 44. Alpha list of all individuals who sustained a fracture during the reporting period 45. Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures 46. For individuals #614, #16, #161, #243, and #773: a. Most recent annual medical assessment b. Past six months quarterly medical assessments c. PT/OT assessments, and IPNs specific for the management of fracture d. Medical provider's IPNs specific for the assessment and management of fracture e. Medical provider's IPN documenting the possible etiology of the fracture f. Most recent two IRRFs g. IDT minutes, ISP, or other documentation indicating an IDT review of the fracture h. Most recent bone density i. Most recent medication list 47. For individuals #475, #663, #493, #564, #502, and #621 a. Copy of all medical provider's IPNs, specific to the initial evaluation, and all subsequent follow-up IPNs through full resolution of the acute medical condition b. Copy of all related diagnostics specific to the evaluation and follow-up of the acute medical condition c. All related consultation reports specific to the management of the acute medical condition 48. List of all individuals who were diagnosed with bowel obstruction during the reporting period 49. For individuals #676 and #661: a. Most recent annual medical summary b. Current medication list

	c. Medical quarterly reviews for past six months d. Dates of all diagnosed bowel obstructions in the past three years e. IPNs, diagnostics reports, medical consultation reports, and discharge summary from hospital, for the management of the most recent bowel obstruction f. Most recent two IRFFs (integrated risk assessment) g. Copy of ISP, addendum to ISP, and/or IDT meeting minutes 50. List of all individuals with diagnosis of Cerebral Palsy (CP) 51. List of all individuals who had a baclofen pump implanted 52. For individuals #426, #594, #309, #402, and #267: a. Current medical assessment b. Quarterly review c. Current medication list d. Most recent QDRR e. All consultation specific to the management of CP and Baclofen Pump, for past three years f. Most recent six months physical therapy/occupational therapy (PT/OT) treatment IPNs g. Most recent PT/OT assessment h. Most recent IRRF, and specific IDT minutes addressing the use of Baclofen Pump, and CP 53. All assessments, graphs, summaries, action plans, and quality assurance (QA) reports for internal and external medical audits for round 7 54. Clinical pathway tools 55. Clinical pathway audits for round 7 56. All QA/QI follow-up to action plans for the clinical performance audits and the medical audits for round 7 57. Database elements for diabetes, osteoporosis, neuromotor, and musculoskeletal conditions, UTIs, and pneumonia 58. Data analysis reports for diabetes and UTIs 59. Healthcare trend report to QA/QI Council and minutes June 2013 and 8/27/2013 60. PCP Hypoglycemic Protocol 4/24/13 **People Interviewed:** 1. Tran Quan, DO Medical Director 2. Valarie Kipfer, MS, RN, State Office Nursing Coordinator 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. Morning medical report meeting 2. Medical grand rounds meeting 3. Observation of remodeled medical clinics 4. CLDP meeting for Individual #264 5. CLDP follow-up meeting to discuss CLDP process 6. Meeting with the above staff to review Clinical and Administrative Death Reviews, 8/29/13

	Facility Self-Assessment: The Facility is relying more on data collection and analysis, when assessing compliance for all sections of Provision L. It was evident that the Facility analyzed data, such as timeliness of completing clinical assessments and reports, and if specific assessments were completed or not. The sample size used for the self-assessment was adequate, and the items assessed were appropriate. The Monitoring Team concurred with the majority of the self assessment, as there was strong correlation with the self assessment and Monitoring Team's assessment. For example, the self assessment correlated with findings of the Monitoring Team for the assessment of osteoporosis, hospitalizations, diabetes, completion of the annual medical summaries, and clinical documentation. There were a few examples, however, that correlation did not exist. For example, the Facility rated itself as providing consistent and appropriate risk reduction for pneumonia, but the Monitoring Team determined that the Facility had not adequately addressed risk reduction strategies for pneumonia. Also, the self assessment reported that immunizations were up to date, but the Monitoring Team noted that immunization status was not documented in many cases for polio and other childhood vaccinations.. In general, the Facility indicated that it was not in compliance with Provisions L.1 and L.2, and the Monitoring Team concurred with the self assessment for both. The Facility determined that it was in compliance with Provisions L.2 and L3; although the Facility has made great strides in working towards compliance, the Facility needed to enhance its mortality review process for Provision L.2, and improve developing corrective action plans and follow up on actions plans for its medical quality assurance process and when assessing the clinical performance of its medical providers. Therefore, the Monitoring Team determined that Provisions L2, and L.3 remained not in compliance.
	Summary of Monitor's Assessment: The Facility had developed many new policies to help improve clinical practice at the Facility. The Policy for documentation has resulted in the Facility meeting acceptable practice standards for clinical documentation. Substantial compliance with Provision L.4 will require that the Facility ensures that its policies clearly delineate its practices, and that the Facility has substantially implemented its policies. Provision L.1: The Facility, including the medical director, medical providers, and medical support staff had made significant progress towards substantial compliance for Provision L.1, of the Settlement Agreement. The Facility had enhanced practice in the management of acute care conditions; maintained high standard for clinical documentation of annual medical summaries, and IPNs; maintained efficient and effective process for interdisciplinary meetings to help ensure continuity of care, and improved clinical outcomes; maintained a robust medical, and support staff; and was in the process of re-modernizing its clinical examination rooms. The Monitoring Team is complimentary to the Facility, and it's staff for the exceptional improvements noted. Further improvements are required for substantial compliance, and include the following, such as ensuring that action plans are developed for all relevant clinical issues delineated at the morning medical meeting, and grand rounds; ensure that medical providers develop clinically appropriate action plans that include specific monitoring parameters, and necessary services required to support the individual; ensure that individuals are regularly physically assessed for chronic

	care conditions; ensure that the underlying etiology for medical conditions have been well evaluated, and all potential treatments to prevent further exacerbation of the condition have been discussed by the IDT; ensure that all medical conditions are clearly delineated at the CLDP meeting, and on the CLDP plan, and ensure that relevant monitoring parameters are developed to assess individuals through the post move monitoring period; and medical providers must enhance their involvement in the IDT process. Provision L.2: The Monitoring Team continues to be concerned over the DADS medical performance audit process, and substantial compliance will require that the process include the development of medical management topics that will address significant, and common medical conditions that occur in people with developmental disabilities, and ensure that the clinical issues being reviewed assesses the clinical performance related to the actual treatment of the medical conditions being audited. The Facility is complimentary to the Facility for its development of a clinical performance audit process. The Monitoring Team is hopeful that further enhancement of this new process, by ensuring that an external physician completes a full review, and by developing a standardized way of selecting the number and specific clinical issues that will be assessed for each audit, and by ensuring the development of specific action plans, and necessary follow-up, will lead to substantial compliance. Furthermore, it is essential that the mortality review process provide a comprehensive understanding of the cause of death, to determine if alternate medical treatments, or enhanced support services could improve the overall care of individuals at the Facility. Provision L.3: The Monitoring Team is complimentary to the Facility for developing a comprehensive, and clinically relevant process to assess clinical services, at the level of a systems review. The database, process, and data analysis was determined to be clinically sound; however, there was no evidence to support that action plans, and follow-up to the action plans were developed for necessary corrective actions, as delineated in the data analysis report. The settlement agreement specifically calls for all actions plans be identified, and "monitored to ensure that remedies are achieved". This will require that the Facility track all corrective action plans, and demonstrate efficacy of the action plan. Provision L.4: The Facility had developed many new policies to help improve clinical practice at the Facility. The Policy for documentation has resulted in the Facility meeting acceptable practice standards for clinical documentation. Substantial compliance with Provision L.4 will require that the Facility ensures that its policies clearly delineate its practices, and that the Facility has substantially implemented its policies.

#	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	Provision L.1 comprehensively assesses the Facility's ability to provide medical care, at the level of generally acceptable standard of care practice. To assess the Facility's effort towards substantial compliance for Provision L.1, the Monitoring Team discussed medical compliance issues with the medical director; met with members of the Facility's medical staff; observed the Facility's clinics; and attended medical meetings, and a	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	community living discharge planning meeting. Through document review, the Monitoring Team assessed the Facility's medical administration; immunization and vaccination; cancer screening; practice for do not resuscitate orders; clinical management of acute medical conditions; management of seizure disorder, cerebral palsy, use of Baclofen Pumps, Vagal Nerve Stimulators, pneumonia, continuity of care of hospitalized individuals; osteoporosis, and bowel obstruction. <u>Medical administration</u> The Monitoring Team assessed licensure status of the Facility's medical staff, clinical documentation practice, and the Facility's regularly scheduled interdisciplinary meetings. To help with the assessment the Monitoring Team reviewed the following documentation: • List of all medical providers, including number of hours worked, case load, and employment status • For each medical provider o Curriculum vita for all licensed medical providers o Copy of current medical license for all medical providers o Copy of current CPR certificate for all medical providers o List of all CME obtained during the past 12 months for all medical providers • Copy of morning medical meeting minutes for the first week of March 2013 • Annual medical summaries, and medical provider's IPNs for individuals #389, #718, #275, #796, #296, #661, #402x2, #614, #377, #785, #130, #235, #16, #161, #243, and #773 Medical Providers: The Facility maintained one full time medical director, three full time support staff, and six full time medical providers who provided medical care. Medical licenses were reviewed, and noted to be current for all licensed medical providers and the medical director. Of the six medical providers, two were nurse practitioners that were directly supervised by the medical director, and co-supervised by staff physicians. While on-site, the Monitoring Team reviewed the practice agreements for the nurse practitioners, and there were no issues of concern. All medical providers and the medical director were current with continuing medical education for general practice. There were no examples of CME addressing specific issues that occur more commonly in individuals with developmental disabilities, such as the management of seizures, neuromotor or musculoskeletal conditions, or constipation. Although requested, CPR certificates were not included in the documents received by the Monitoring Team.	

#	Provision	Assessment of Status	Compliance
		Medical Meetings The Facility conducted three medical meetings. Morning report: Morning report is chaired by the medical director, and conducted twice per week. It is an integrated, multidisciplinary meeting that consists of medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, quality assurance, dental, and pharmacy services. The purpose of the meeting is to triage, and discuss urgent clinical issues to ensure continuity of care, and to enhance clinical management of individuals. Issues discussed include, but are not limited to: Medical on call report; hospital report; infirmary report; psychiatric; behavioral health related issues; pending medical consultations; wound care, and infectious disease issues; and significant medical conditions. Review of the meeting minutes for the morning medical meetings that occurred from 7/16/2013 through 8/13/2113 indicated summary documentation of the events discussed at the meeting, and in some instances there were comments indicating that a particular team member would follow through with an action; however, there was no consistent process to ensure that action plans would be developed for all relevant clinical issues discussed, and there was no indication that follow-up, to ensure implementation of the action plan, was completed. The Monitoring Team attended the August 27, 2013 meeting, and was impressed of the comprehensiveness, and efficiency of the meeting. The meeting enabled all members to gain greater insight into the clinical management of individuals reviewed during the meeting. Meeting minutes should be enhanced to ensure a standardized process for developing action plans for all relevant clinical issues, and a process to ensure that the action plans were completed, and implemented. Grand rounds: Medical grand rounds occur once per week, and is chaired by the medical director. Grand rounds is an integrated, multidisciplinary meeting that consists of medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, quality assurance, dental, and pharmacy services. The purpose of the meeting is to review the case of one or more individuals who are experiencing a significant medical issue. Review of the meeting minutes for the grand rounds, dated 5/1/2013, 3/20/20135/29/2013, 7/3/2013, and 7/31/2013, indicated a comprehensive review of	

#	Provision	Assessment of Status	Compliance
		the individuals discussed; however, although clinical recommendations were made, there was no action plan or mechanism for follow-up to ensure that the recommendations were carried through to implementation. The Monitoring Team attended the grand rounds on August 28, 2013, and is complimentary to the Facility for developing, and implementing this multidisciplinary process. The meeting enabled an integrated discussion of the supports, and services provided to several individuals, and resulted in a better understanding of the individual's clinical condition, by the participants. Clinical staff was also better equipped to ensure appropriate clinical follow-up. The Facility should develop a mechanism to ensure that recommendations are followed through to implementation. Medical staffing meeting: Medical staff meetings occur twice per week, and were reported by the medical director to include discussion regarding continuity of care, and systems issues related to medical services. The Monitoring Team did not observe this meeting, and meeting minutes were not available for review. <u>Physician documentation</u> The Monitoring Team reviewed the most recent annual medical summary, and the medical provider's IPNs, that were requested for other components assessed for Provision L.1, of this report for Individuals #389, #718, #275, #796, #296, #661, #402x2, #614, #377, #785, #130, #235, #16, #161, #243, and #773. The Monitoring Team compliments the medical staff for their improvement with documentation practice. Of the 18 annual medical assessments reviewed: • Eighteen out of 18 examples (100%) included a comprehensive summary of the Individual's health care issues, that included demographics; development history; social history; use of tobacco, alcohol and other habits; past diagnostics, surgeries, and consultations; physical examination and current medication review; active problem list; and an action plan developed for each active problem. • Eighteen out of 18 annual medical summaries (100%) were completed at least ten days prior to the annual ISP meeting. Review of a total of 35 IPNs, that were requested by the Monitoring Team for other components of Provision L.1 (Individuals #389, #718, #275, #796, #296, #661, #402x2, #614, #377, #785, #130, #235, #16, #161, #243, and #773) indicated that the medical provider dictated all IPNs in SOAP format in 35 out of 35 examples (100%). <u>Observation of medical examination rooms</u>	

#	Provision	Assessment of Status	Compliance
		Unless a mitigating factor, such as an individuals manifesting a behavioral issue or significant debility, medical providers at the Facility perform routine and follow-up care within the context of a clinic based system. The Facility had completed renovation of two examination rooms, which included adequate lighting, hydraulic examination tables that can accommodate individuals with physical disabilities, and functional equipment. Three additional examinations rooms are under developed, and scheduled to be functional within the next six months. <u>Summary of medical administration</u> Medical leadership, medical providers, and support staff had continued to enhance the Facility's ability to provide high quality medical care. The Facility had improved its clinical operations by modernizing two of the five examination rooms; significantly improved clinical documentation practice; annual medical summaries were comprehensive, and all active diagnoses were accompanied by an action plan; and the medical director conducted efficient and efficacious interdisciplinary meetings to enhance continuity of care and improve clinical services. The Monitoring Team recommends that clinical meetings include action plans for all relevant clinical issues, and ensure there is follow-up to the action plan through full implementation. <u>Review of Immunizations</u> To assess the Facility's compliance with CDC guidelines for immunization, the Monitoring Team reviewed the following documents: • RSSLC Individuals Immunization Policy, dated 2/26/2013, unnumbered • Complete vaccination records, and serology verification of immunization for the first individual on the current name key, as of this review, and than every fifth individual, for a total of ten examples (Individuals #678, #596, #51, #470, #792, #266, #212, #511). The Facility only provided documentation for eight individuals, as two had been transferred out of the Facility. The following is a summary of the Monitoring Team review of vaccination, and immunization records: • The Facility did not consistently document lot numbers of vaccines, expiration dates, and site of administration. Three out of eight examples (38%) demonstrated evidence of not documenting lot numbers, and expiration dates • The vaccination and immunization records were not clearly documented. • Three out of eight examples (38%) did not have documented evidence of vaccination or immunization for measles, mumps and rubella. • Three out of eight examples (38%) did not have documented evidence of vaccination or immunization for polio. • Eight out of eight examples (100%) had influenza vaccine in 2012.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team determined that the Facility did not maintain an effective immunization and vaccination program because documentation of clinically relevant information, such as lot numbers, expiration dates, and site of administration were not routinely documented, immunization records were not clearly and easily readable, and childhood immunization status was not consistently documented. As reported in Provision M1, individuals' influenza vaccinations were reported as 100% complete. The Facility entered immunization data into the AVATAR system for reporting and tracking immunizations, as well as placed immunizations in individuals' Immunization Records. No immunization data was provided for review. All individuals' immunizations were reported as current. As noted above, however, the lack of documented evidence of vaccination leads to question of whether the Facility accurately determines immunization status. <u>Review of do not resuscitate (DNR) process</u> To assess the Facility's DNR process, the Monitoring Team requested the following information: • List of all individuals who were prescribed a DNR order • RSSL Policy Providing Health Care Services; Designating Out-of-Hospital DNR; 09/17/2010 • For all individuals of the list of DNRs (Individuals #649, #149, and #538): o Most recent annual medical assessment o Most recent ISP, or other relevant documentation indicating and interdisciplinary team (IDT) review o Copy of ethics review for the DNR o Copy of the consent for DNR o Copy of the completed DNR form o Copy of specific instructions to direct care, and other staff, regarding the DNR o Copy of the medical providers interdisciplinary progress notes (IPN) documenting the clinical rational for the DNR Review of the requested documents indicated the following: • The annual medical summary clearly delineated the qualifying condition for the DNR in zero out of three examples (0%). • In zero out of three examples (0%), the ISP clearly delineated the qualifying condition for the DNR, and all supports necessary to support the individual	

#	Provision	Assessment of Status	Compliance
		during an end of life event. • In zero out of three examples (0%) the was evidence of a comprehensive review for the DNR, that included an complete understanding of the qualifying condition, potential alternatives to DNR, and periodic review for the continued need of the DNR order. • In zero out of three examples (0%) there was a comprehensive IPN by the medical provider documenting the qualifying condition, possible alternatives to the DNR. • The DNR form was fully completed in two out of three examples (67%). Provision B was not fully completed for Individual #538. • The DNR form did not allow for specific levels of do not resuscitate. For example: o No chest compression o Chemical resuscitation only o No intubation o Full DNR • There was no evidence to indicate that the Facility ensures that necessary supports and services were in place to address a terminal event. For example, if an individual had a DNR order in place because of congestive heart failure, the IDT should develop a treatment plan to address acute cardiac decompensation, and treatments for discomfort and pain during the final moments of life The following are specific examples from the Monitoring Team review of the DNR process: • The ISP (individual support plan) addendum, dated 4/4/2013, for Individual #649 commented that the Individual was provided a DNR for "debility" but did not discuss the cause of debility, if the condition was reversible, how the condition affected the Individual, and the most appropriate level of DNR required. • Review of the clinical records for Individual #149 clearly suggested a possible need for a DNR; however, there was no documentation that specifically addressed the qualifying condition, potential alternatives to DNR, a comprehensive review by human rights. • In all examples, there was no evidence to suggest that DNR orders were reviewed annually for continued appropriateness. The Monitoring Team determined that the Facility did not have a functional DNR process that enabled a meaningful ethics review, periodic assessment for the continued need for DNR, planning for end of life events for individuals with DNRs, a process to assess for possible alternatives to, and specific level of DNRs.	

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		Community living discharge planning (CLDP) To assess the medical providers' participation in the Facility's CLDP process, the Monitoring Team participated at the CLDP meeting, and reviewed the CLDP final draft report for Individual #165, and reviewed the clinical records, CLDP report, and post move monitoring assessments for Individual #119. For both individuals, the Monitoring Team noted significant concerns with multiple examples of clinical issues not being adequately represented at the CLDP meeting, and not expressed within the context of the CLDP report. Also, the post move monitoring assessment for Individual #119 was devoid of specific monitoring parameters for the individual's clinical issues. The Monitoring Team meet with leadership, including the medical director, to discuss specific concerns with the CLDP process. The medical director concurred with the Monitoring Team's concern, and made assurances that the process would be enhanced. The Monitoring Team also met with the Facility's medical staff, to review concerns with the medical providers' participation in the CLDP process. Substantial compliance will require that the medical providers ensure that all clinical issues are fully explored at the CLDP meeting, and clearly delineated within the context of the CLDP report. The risks associated with each medical condition, specific monitoring parameters for each condition, and all necessary supports and services must be clearly delineated on the CLDP, and expressed at the CLDP meeting. All clinical professionals and clinical services must be obtained prior to discharge from the Facility. Furthermore, the Facility's medical provider must ensure continuity of care by directly contacting the community based primary care provider who agreed to accept the Individual as a new patient. In addition, the post move monitoring assessment process must be significantly improved by ensuring that specific clinical monitoring parameters are in place for each clinical condition, and ensure that relevant clinical staff review monitoring parameters, and when necessary make direct observations at the community home. Continuity of care for hospitalizations To assess the Facility's ability to ensure continuity of care for hospitalized individuals, the Monitoring Team reviewed the following documentation: • Alpha list of all individuals hospitalized during the reporting period • For the first two, and last three individuals on the list of hospitalized individuals (Individuals #796, #296, #661, #402x2): o Hospital admission and discharge report o Documentation of the medical provider's communication with the	

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		hospital medical staff o Hospital liaison reports o Pre and post hospital transfer report o Post hospital IDT minutes, with sign-in sheet Between 1/4/2013, and 7/15/2013, the Facility realized a total of 81 transfers to an acute hospital. Fifteen individuals were acutely hospitalized on two occasions, and three individuals were hospitalized on three occasions. During this time period, the five most common discharge diagnoses were: • Pneumonia: 19 individuals • Urosepsis: 9 individuals • GI bleeding: 7 individuals • Seizure related conditions: 4 individuals • Non-urinary tract related sepsis: 5 individuals The following are the Monitoring Team's findings following review of the documents related to the continuity of care of hospitalized individuals: • Five out of five examples (100%)included a copy of the hospital admission and discharge summary. • Five out of five examples (100%) included a pre-hospital transfer report by the nurse, which included all relevant information necessary to understand the rationale for hospital admission. • Five out of five examples (100%) included a post-hospital evaluation report by the nurse, which included a comprehensive nursing assessment. • Four out of five examples (80%) included a completed pre-hospital transfer note documented by the medical provider. • Five out of five examples (100%) included a detailed post-hospital transfer note, dated within 24 hours of readmission to the Facility. • Two out of five examples (40%) included documentation of a Facility medical provider's communication with a hospital medical provider. The exampled noted for Individual #402, for hospital admission of 1/4/2013, was exemplary. • In zero out of five examples (0%), a clinically relevant post hospital IDT meeting was completed, that included participation by the Facility's medical provider. The IDT had met to review the hospitalization of three out of the four examples; however, there was no medical provider in attendance, and the IDT did not adequately document relevant clinical information, for example: o Individual #661 was discharged with a diagnosis of significant GI bleed, and extensive, grade iv esophagitis. The IDT documented that the Individual was hospitalized for possible GI bleed, and did not discuss the severe esophagitis.	

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		o The IDT reported that Individual #796 was hospitalized for cellulitis, but did not comment that the individual had severe herpes zoster, that involved the face and eye. Also, there was no physician in attendance at the IDT meeting. • Five out of five examples (100%) included documented evidence indicating that the hospital transfers were clinically appropriate, and individuals were triaged to the hospital in a clinically appropriate period of time. The Facility ensured prompt and appropriate triage of acute medical conditions. The Monitoring Team compliments the nursing staff for ensuring continuing of care by providing clinically relevant pre-hospital and post-hospital assessments, and consistent acute hospital follow-up via the hospital liaison process. Medical providers were consistent in providing efficacious pre and post hospital clinical assessments. The Facility must continue to improve continuity of care for hospitalized individuals by ensuring that the medical provider conducts a pre-discharge telephone discussion with the hospital medical provider, prior to the individual's discharge from the acute hospital. Also, the medical provider must participate in a meaningful IDT meeting to help ensure that the Facility is prepared for the individual's return to the Facility. <u>Clinical management of osteoporosis</u> To assess the Facility's ability to clinically assess and treat osteoporosis, the following documents were requested, and reviewed: • Alpha list of all individuals with a diagnosis of osteoporosis • For the first two and last three individuals on the list (Individuals #614, #377, #785, #130, and #235): o Most recent medical assessment o Quarterly physician assessments for past six months o All documentation indicating assessment for the etiology of low bone density o Most recent IRRF o Current medication list o Labs for past 12 months o Consultation reports specific for the evaluation, and/or treatment of osteoporosis o All diagnostic studies to assess for bone density, for the past three years The following are the Monitoring Team's findings from review of the documents related to the management of the assessment and treatment of osteoporosis: • Five out of five examples (100%) included annual medical summaries that indicated a clinically appropriate diagnosis for osteoporosis on the active	

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		problem list • In five out of five examples (100%) the annual medical summaries indicated a clinically appropriate action plan for osteoporosis. • Five out of five examples (100%) indicated a clinical evaluation for the etiology of low bone density. • Five out of five examples (100%) included evidence that a clinically appropriate diagnostic was obtained to assess bone density, and treatment efficacy, when clinically indicated. • Five out of five examples (100%) included evidence that a clinically appropriate pharmacological therapy was provided, as clinically necessary, to treat low bone density. • Five out of five examples (100%) included osteoporosis as a risk factor on the most recent IRRF. Based on the document review, the Facility, including the medical providers, provided appropriate management of low bone density at the Facility. <u>Clinical management of malignancy</u> To assess the Facility's ability to provide necessary clinical supports and services for individuals with diagnosed malignancy, the Monitoring Team reviewed the following documents: • List of all individuals with diagnosis of malignancy, and history of malignancy • For the three individuals with diagnosis of malignancy (Individuals #389, #718, and #275): o Annual medical summary o Most recent two physician quarterly reviews o Most recent IRRF o All IDT related minutes specific for diagnosis of malignancy o Last six months IPNs by the medical provider that specifically documented assessment of malignancy o All consultation reports specific for the diagnosis of malignancy The Following is a summary of the Monitoring Team's review of the documents provided: • Three out of three examples (100%) indicated appropriate clinical assessment, and follow-up by the medical provider, for the diagnosis of malignancy. • Three out of three examples (100%) indicated that clinically appropriate consultations were provided for the diagnosis of malignancy. • For the two examples that indicated diagnosis of malignancy prior to the completion of the most recent annual medical summary:	

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		o Two out of two examples (100%) included the appropriate diagnosis of malignancy on the active problem list. o Two out of two examples (100%) included a clinically appropriate medical plan for the management of malignancy. • For the one example that was diagnosed subsequent to the annual medical summary, there ware well documented clinical assessments, in SOAP format, indicating a clinically appropriate diagnosis and medical plan. • Two out of three examples (67%) included the diagnosis of malignancy on the IRRF; however, the IRRFs did not include a clinically rational action plan for malignancy. For example: o Individual #389 was diagnosed with a form of leukemia, and the individual had an elevated platelet count. The IRRF only reported the need for follow-up with the consultant, and labs every six months, and there was no comment on the need for close monitoring for potential bleeding abnormalities, thrombosis, stroke, and infections. o Individual #275 was diagnosed with skin cancer, and the only recommendation made on the IRRF was to follow-up with the consultant, and there was no comment about the need to ensure appropriate protection against exposure to the sun, or need for regular skin assessments during the interim period until follow-up with the dermatologist. • IDT minutes were provided for only one (Individual #718) out of the three examples; in this example, the IDT minutes did not address necessary supports and services necessary for the diagnosis of skin cancer. The Monitoring Team noted that the medical providers appropriately assessed, and triaged individuals for the diagnosis of malignancy. The Facility must, however, enhance the IDTs' involvement in such cases, by ensuring that the risks of malignancy are well explored, and that all necessary supports and services are identified, and provided. <u>Management of seizure disorder</u> To assess the Facility's ability to clinically manage seizure disorder, the Monitoring Team reviewed the following documentation: • Alpha list of all individuals with diagnosed seizure disorder • Alpha list of all individuals who experienced an episode of status epilepticus during the reporting period • List of all individuals with diagnosis of intractable seizure disorder • List of all individuals with implantable VNS • For the first five individuals on the list of individuals with VNS (Individuals #712, #440, #597, #780, and #133), copy of the most recent VNS interrogation	

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		report • For all individuals diagnosed with intractable seizures (Individuals #475, #712, #130, #402, abd #133): o Annual medical summary o Most recent two quarterly physician summaries o Most recent two neurology consultation reports o Current medication list o Most recent EEG o Most recent brain imaging report o Current six months medical provider's IPNs, specific for management of seizure disorder o IDT meeting minutes documenting supports and services necessary for the management of seizure disorder o Seizure log The following is the Monitoring Team's summary of its document review of seizure management: • One out of five examples (20%) included an accurate diagnosis for the seizure disorder. For example, the active problem list diagnosed Individual #133 with partial complex epilepsy; however, in the four other examples, the diagnosis of "seizures" was listed. The Facility should document the actual type of seizure activity. • One out of five examples (20%) included a clinically appropriate medical action plan on the annual medical summary. An exemplary example of a clinically appropriate action plan can be found on the annual medical summary for Individual #133. In the other examples, complete review of the seizure records, efficacy of treatment, and management strategies were not well delineated. • Four out of the five examples (80%) indicated that the Individual was regularly followed by neurology. It was evident to the Monitoring Team that the Facility maintained an efficacious neurology consultation process, and individuals were evaluated routinely, and as necessary. • Review of the first five examples from the list of individuals who had a VNS device indicated that in five out of five examples (100%), the VNS device was regularly interrogated by the neurologist. • For five out of five example cases (100%), IPNs by the medical providers indicated clinically appropriate medical follow-up, following reported seizure activity. The medical providers promptly address all reported seizure activity, and complete a comprehensive SOAP note that included relevant subjective information, an assessment of the individual, a clinical assessment, and a clinically appropriate medical action plan.	

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		The following are specific concerns regarding the management of seizure disorder: • Individual #712 was noted to have significant increase in seizure activity, and the medical provider referred the case for an IDT meeting. The IDT minutes reflected that no addition safeguards, or change in status, would be done until follow-up with the neurologist. There was no additional documentation that indicated follow-up by the IDT. Seizure can be life-threatening, and cause bodily injury, and for this reason, a recent increase in seizure activity warrants assertive action by the IDT to enhance necessary supports and services to help prevent against adverse outcome from seizures; therefore, in this case increased supervision, and perhaps staff training to alert them of worsening seizure disorder, should have been considered by the IDT. • Individual #475 was known to have pseudoseizures, and possible epilepsy. During the reporting period the Individual experienced an increased in possible seizures; however, staff were not able to distinguish neurological seizures versus pseudoseizures, and there was no documented evidence to indicate that the IDT met to develop possible ways differentiating between the two types of seizures. The Facility should have considered various possible approaches to help in assessing, and diagnosing seizure activity. For example considerations for an ambulatory EEG device, video monitoring the seizure activity, and enhanced staff training for identification of seizure activity, should have been considered within the context of the IDT meeting. Also, the medical staff reported that the individual was talking during reported seizure activity, indicating a probable pseudoseizure; the Monitoring Team would like to point out that some individuals with partial seizure are able to talk quite normally during such a seizure. • Review of seizure records indicated that all seizures were not being recorded on the seizure logs. Also, the seizure log did not include specific details about each seizure. For example, potential antecedents, specific manifestation of the seizure, and postictal events should be well documented, and reviewed by the medical provider. The Monitoring Team noted that the medical providers promptly assessed and developed meaningful medical action plans for reported acute seizure activity. The Facility must further enhance its overall management of seizure disorder by ensuring appropriate diagnosis; establish clinically appropriate action plans, that include review of the seizure record, and treatment efficacy; and ensure that seizure records are regularly maintained, and that antecedents, concise description of the seizure, and postictal manifestation, are clearly recorded.	

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		<u>Cancer screening</u> The Monitoring Team assessed the Facility's ability to provide screening procedures for cancer by reviewing the Facility's screening process for mammography, colonoscopy, and PSA screening. Mammography: To assess the Facility's breast cancer screening process, the Monitoring Team reviewed: • List of all individuals 40 years old, and older • List of all individuals who were current and not current with their annual mammogram screen • Documentation by the Facility indicating the rational why individuals were not current with their annual mammogram screen The Facility reported a total of 121 female individuals who were 40 years old and older. Of the 121 individuals, 63 were current (52%), and 58 (48%) were not current, with their annual screening mammogram. For the 58 individuals not current: o Scheduling issue (pending mammograms) 30 (25%) o Refusal/maladaptive behavior: 15 (12%) o Appropriate clinical rationale: 8 (7%) o Guardian refusal: 3 (2%) o No reason: 2 (2%) Scheduling issues resulted in 25% of the individuals not being provided timely mammogram screening. The Facility must enhance its scheduling practice to ensure timely completion of mammograms. Colonoscopy: To assess the Facility's colon cancer screening process by means of colonoscopy, the Monitoring Team was provided the following documentation: • List of all individuals 50 years old and older • List of all individuals who were current with their screening colonoscopy • List of all individuals who were not current with their screening colonoscopy • Documented rationale for each individual not current with screening colonoscopy The Facility reported a total of 173 individuals who were 50 years old or older. Of the 173 individuals, 144 were current with screening colonoscopy (83%). For the 29 individuals not current with screening colonoscopy: Scheduling issue	

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		(pending mammograms) 4 (2.5 %) Refusal/maladaptive behavior: 2 (1.0 %) Appropriate clinical rationale: 19 (11.0 %) Guardian refusal: 4 (2.0 %) No reason: 0 (0.0 %) The Facility ensured appropriate screening for colon cancer by means of colonoscopy, or alternative acceptable screening diagnostics, such as flexible sigmoidoscopy, and hemoccult testing. Prostate cancer screening by PSA blood test: The Monitoring Team reviewed the following documents to assess the Facility's prostate cancer screening program, by means of PSA blood testing: • List of all men age 50 and older • For the last ten individuals on the list: o Copy of their PSA test results o Documentation that the legally authorized representative (LAR) was informed of the risks, benefits, and alternatives to PSA testing o Rationale why annual PSA testing was not completed Of the ten examples reviewed, nine out of ten (90%) indicated that annual PSA testing was completed, and for the one example not completed, there was documentation that the LAR did not concur with PSA screening. There was no evidence provided demonstrating the Facility's discussion with the LAR about the potential risks, benefits, and alternative to PSA testing. Acceptable standard of care practice dictates that the LAR be informed of the risks, benefits, and alternatives to PSA testing. The Monitoring Team compliments the Facility for ensuring PSA screening; however, the Facility must ensure that prostate cancer screening be discussed with the LAR, and that potential risks, benefits, and alternative to PSA screening were discussed. <u>Review of the Facility's clinical management of pneumonia</u> To assess the Facility's management of pneumonia, the Monitoring Team requested the following information: • Alpha list of all individuals who were diagnosed with pneumonia during the reporting period • For all individuals who experienced five or more cases of pneumonia with in the past five years: o Most recent annual medical summary o All quarterly physician reviews for the reporting period	

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		o Most recent IRRF o Most recent PT/OT assessment o Medical diagnostic, and consultation reports, specific to the management of pneumonia The following is a summary of the Monitoring Team's findings from review of the documents related to the management of recurrent pneumonia: • Five out of five examples (100%) indicated prompt initial triage of acute pneumonia. • Five out of five examples (100%) indicated that the medical provider closely monitored the individuals through full resolution of the acute episode of pneumonia. • One out of five examples (20%) indicated that a comprehensive assessment, and consideration for treatment to help mitigate recurrent pneumonia was completed, such as fundoplication, or tracheal diversion. The annual medical summary for Individual #84 documented that the Individual had undergone a fundoplication in the past, but it was not successful in preventing reflux. The fundoplication surgery, however, was not listed on the list of past surgeries. • One out five examples (20%) indicated a specific, and clinically appropriate action plan for recurrent pneumonia. The medical action plan for Individual #523 clearly delineated recurrent pneumonia. • One out of five examples (20%) included a PNMP specific for recurrent pneumonia, which included a clinically appropriate review for the potential underlying etiology of recurrent pneumonia, and specific strategies to help mitigate future episodes of pneumonia. The PNMP for Individual #84 is an example of a comprehensive, and clinically appropriate, review. • In zero out of five examples (0%), the annual medical summary and quarterly physician reviews documented the medical provider's assessment of the efficacy and appropriateness of prescribed supports, and services to help mitigate episodes of pneumonia. Within the context of a developmental disability setting, it is incumbent for the medical provider to regularly assess the efficacy of all prescribed supports and services. Medical providers should periodically observe tube feedings, and other supports for feeding, physical transfers, and positioning of individuals on their caseload. The Facility provided clinically appropriate triage and management of acute pneumonia; however, the Facility must improve its ability to address clinical issues related to the prevention of recurrent pneumonia. For example medical providers must regularly assess all prescribed supports and services for efficacy and appropriateness, and ensure that the etiology of recurrent pneumonia has been clearly defined, and that potential	

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		treatments to help mitigate recurrent pneumonia are considered by the IDT. <u>Clinical management of fractures</u> The Facility reported ten individuals as having a fracture during the reporting period. To assess the Facility's clinical ability to manage fractures, the Monitoring Team requested the following information: • Alpha list of all individuals who sustained a fracture during the reporting period • Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures • For the first two and last three individuals on the list of fractures (Individuals #614, #16, #161, #243, and #773): o Most recent annual medical assessment o Past six months quarterly medical assessments o PT/OT assessments, and IPNs specific for the management of fracture o Medical provider's IPNs specific for the assessment and management of fracture o Medical provider's IPN documenting the possible etiology of the fracture o Most recent two IRRFs o IDT minutes, ISP, or other documentation indicating an IDT review of the fracture o Most recent bone density o Most recent medication list The following is a summary of the Monitoring Team's findings for the document review related to the management of fractures: • The Facility did not provide committee meeting minutes, or other relevant documentation indicating that it conducts regular meetings to address fractures, and mechanisms to reduce fractures, as part of a system review at the Facility. • In five out of five examples (100%) the medical provider conducted a prompt initial triage for reported fractures. • In five out of five examples (100%) the medical provider regularly followed the Individual through full resolution of the fracture. • In five out of five examples (100%) the medical provider obtained necessary diagnostics, and prompt consultation for the assessment and treatment of fracture. • In five out of five cases (100%), the medical provider assessed the individuals for osteoporosis, and prescribed pharmacological treatment, as necessary. • In zero out of five cases (0%), the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture.	

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		• In zero out of five cases (0%), PT/OT document a comprehensive assessment of all risk factors for fall, and fracture. • In zero out of five cases (0%), the IRFF document a comprehensive assessment of all risk factors for fall, and fracture. • In zero out of five cases (0%), there was documentation on the annual medical summary, quarterly physician reviews, PT/OT assessments, and ISPs, indicating that prescribed supports and services to help prevent falls and fractures, were routinely assessed for efficacy. The following are specific concerns of the Monitoring Teams review of the management of fractures: • Individual #614: The Individual was reported to have fallen, and was evaluated by the medical provider, who provided medication for pain, and referral to PT/OT. PT/OT assessment noted changes with the Individual's gait, and two weeks later the Individual was referred back to the medical provider for assessment of worsening gait issues. The medical provider obtained an MRI of the spine, and radiographs of the hips and knees, and referred the Individual to orthopedics. Multiple compression fractures of the spine were diagnosed, some in variable stages of healing. By review of the Individual's clinical records, it was noted by the Monitoring Team that the Individual had significant fall and fracture risk factors, including polypharmacy, seizure disorder, severe osteoporosis, a history of a previous serious fracture, and functional changes secondary to Alzheimer's disease. The following are some concerns, and comments, specific to the medical management of the Individual's fracture: o The annual medical summary did not include an assessment specific for fall and fracture risks, such as previous history of fracture, polypharmacy, functional decline, seizure disorder, and Alzheimer's disease o The annual medical summary did not include an action plan to help mitigate the potential for falls and fractures, in this high-risk individual. o The PT/OT summary did not provide clinically appropriate assessment of fall and fracture risk, and functional decline. The assessment should have clearly delineated all risks associated with potential falls and fracture. Furthermore, the assessment did not clearly delineate all necessary supports and services for fracture prevention, other than stating, "use of mobility device will reduce the risk of fractures." o The medical provider and PT/OT did not further assess the Individual for approximately two weeks following initial assessment, despite progressive worsening of gait.	

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		o The medical provider did not clearly document the potential etiology of the fall, and fracture. o Once identified, the medical provider documented clinically appropriate follow-up management, and followed the individual through resolution of the acute fracture; however, there was no documentation to address the potential complications of multiple compression fractures, and associated risks, such as cardiopulmonary, and bowel complications, progressive functional decline, and on-going pain related issues. o The Monitoring Team is complimentary of the comprehensive discussion documented on the ISP addendum reports for 5/9/2013 and 5/10/2013. The IDT did an exceptional job in raising clinically appropriate issues; however, there was no follow-up documenting possible enhanced fracture prevention strategies. o Despite the Monitoring Teams identification of multiple risk factors for fall, and fracture, the IRRF list both fall and fracture risk as a medium risk. • Individual #16 The document review for this Individual indicated significant, and multiple, risk factors for falls and fractures, including history of multiple fractures, severe osteoporosis, use of gait belt, difficulty maintaining balance, and prescribed sedating medication o The annual medical summary did include a comment in the action plan for osteoporosis stating indicating a need for fall precautions, and proper transferring technique. o The annual medical summary did not delineate fall and fracture risk as a specific clinical consideration. For example, in this case, the Individual had multiple risk factors, and each of those risk factors should have been evaluated. Also, the medical provider should document an assessment of the efficacy of prescribed supports and services, such as the use of gait belt, to better ensure their clinical appropriateness, and functionality. o The PT/OT assessment did not clearly document all of the relevant risk factors for falls and fractures, nor comment on the implementation and efficacy of PT/OT supports and services to help mitigate falls and fractures. It is essential for PT/OT to regularly assess if related services are being performed by staff properly. o The ISP addendum, dated 11/07/2012, documented the acute fracture, but there was no discussion about the etiology of the fracture. Furthermore, the IDT did not document the need to assess the efficacy, and appropriateness of current supports and services for fall and fracture prevention.	

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		• Individual #161 The Monitoring Team noted significant risk for fall, and fracture that included a history of multiple fractures, polypharmacy, and unsteady gait. o The annual medical summary documented a partial differential diagnosis for unsteady gait, but did not include the need for on-going assessment to identify potential occult causes of unsteady gait, such as myelopathy, occult orthopedic conditions, and polypharmacy. o The annual medical assessment commented that seizures, imbalanced gait, and osteoporosis place the Individual at risk for fall and fractures; however, there was no comment about significant polypharmacy, degenerative spine disease, and prior history of fractures as additional factors o The PT/OT assessment documented epilepsy and osteoporosis as factors that could manifest fall and fracture; however, it did not comment on other important clinical factors, such as polypharmacy, degenerative spine disease, and prior history of fractures as additional risk factors. o The physician quarterly reviews did not indicate polypharmacy as a potential risk factor for the Individual's fall and fracture risk; this issue was especially noteworthy because the PT/OT assessment documented that the Individual appeared lethargic secondary to his medications. Also, there was no focused exam documenting the status of the Individuals imbalance, and gait problems. o The ISP addendum that addressed the Individual's fracture did not assess the efficacy of supports and services to prevent fractures. o The annual medical assessment did not comment on the Individual's function decline with gait that necessitates physical assist and use of wheel chair and gait belt; and there was no evidence to indicate that an on-going clinical assessment to evaluate the possible cause of the Individual's progress functional decline. o It was most concerning to the Monitoring Team that the Individual sustained two fractures, including a fracture of the hip, and fracture of the toe, within a 30 day period of each other, with no documented evidence to indicate that the Facility assessed the efficacy and appropriateness of supports and services to help prevent falls and fractures. o Behavioral changes, that resulted in the Individual being combative, hyperactive, and aggressive. The Facility indicated that these behavioral changes were a manifestation secondary to changes made to the Individual's anticonvulsant medication; however, there was no differential diagnosis considering other possible etiologies, such as	

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		underlying pain, and discomfort, despite the Individual having significant degenerative joint disease and osteoporosis. o The ISP addendum, dated 11/6/2012, for the hip fracture indicated a substantial review; however, clinical staff, including the medical provider and PT/OT, did not delineate all potential causes of the fracture, and despite the IDT's recommendation to enhance staff training, there was no recommendation to conduct periodic assessment of the implementation and efficacy of prescribed supports and services. The medical provider, PT/OT, and the IDT must conduct periodic assessments to ensure that all prescribed supports, and services are being provided appropriately by staff, and are efficacious • Individual #773 o The PT/OT assessment indicated that the Individual used a gait belt because of balance issues, had cervical spondylosis, and was hypotonic. None of these issues were addressed on the annual medical summary, or listed on the active medical summary. In addition, the Individual was diagnosed with bilateral cataracts, and this condition was not considered as a risk factor for fall and fracture. o The IDT met on four occasions to discuss the Individual's fracture, and the only comment documented on the ISP addendum, dated 11/5/2012, was that the Individual "had a seizure on 11/3/2012 @ 5:15am that lasted one second. During the seizure she may have bumped the foot into something causing the fracture." There was no discussion about other important risk factors, including behavioral exacerbation, cervical spondylosis, cataracts, and hypotonicity. o The IRFF did not list all known risk factors for fracture. By ensuring prompt clinical assessment, appropriate diagnostic evaluations, prompt referral to orthopedics, and close follow-up through resolution, the Facility provided acceptable acute medical treatment for fractures. The Monitoring Team is concerned over the medical provider's, and PT/OT's clinical assessment of risk factors for fracture. Also, known medical conditions, such as problems with balance, and degenerative musculoskeletal conditions, were not fully assessed. Furthermore, there was no evidence to indicate that the medical providers, PT/OT services, or the IDT conducted a comprehensive review for the primary cause of the fracture, and ensured that appropriate supports and services were in place and efficacious. The Facility did not provide documentation to indicate a process improvement mechanism to assess, and help mitigate fracture risk, at a systems level. <u>Follow-up to acute medical conditions</u> To assess the Facility's ability to manage acute medical conditions, for the first reported	

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		acute medical condition that occurred during the week of June 3, 2013, for each medical provider the Monitoring Team reviewed the following documents: • Copy of all medical provider's IPNs, specific to the initial evaluation, and all subsequent follow-up IPNs through full resolution of the acute medical condition • Copy of all related diagnostics specific to the evaluation, and follow-up of the acute medical condition • All related consultation reports specific to the management of the acute medical condition Of the six acute medical conditions assessed for individuals #475, #663, #493, #564, #502, and #621, the Monitoring Team noted the following: • Six out of six examples (100%) included a comprehensive initial medical provider IPN that clearly delineated a comprehensive assessment, and action plan in SOAP (subjective, objective, assessment, and plan) format. • Six out of six examples (100%) included clinically appropriate diagnostics, when clinically necessary. • Six out of six examples (100%) included follow-up IPNs through full resolution of the acute medical conditions. • Of the six examples, two required medical follow-up by a consultant, and in both cases the Facility appropriately referred the cases for consultation. The Monitoring Team was impressed by the comprehensiveness of the initial and follow-up IPNs, and the continued assessment through full resolution of the acute medical condition. For example: • Individual #663 was noted to have skin breakdown secondary to contractures, and the medical provider initially treated the wound, and then referred the individual to wound care, and for specific therapeutic intervention for the contracture. Also, the IDT was notified of the clinical issues and plan. • Individual #493 complained of chest pain, and the Individual was clinically assessed by the medical provider, triaged for appropriate diagnostics to rule out potential life threatening conditions, and then referred for outpatient consultations. • Individual #564 was provided extensive follow up for multiple acute medical etiologies, and for all conditions was provided the necessary diagnostic evaluation, and referral to the appropriate medical consultant. By the findings of this review, it was evident to the Monitoring Team that the Facility provided an exceptional level of management of acute medical conditions. <u>Bowel obstruction</u>	

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		Bowel obstruction is a common, and serious, medical condition that affects many Individuals with intellectual, and physical disabilities. There were two reported bowel obstructions that occurred during the reporting period, and the Monitoring Team reviewed the following documents for Individuals #676 and #661: • Most recent annual medical summary • Current medication list • Medical quarterly reviews for past six months • Dates of all diagnosed bowel obstructions in the past three years • IPNs, diagnostics reports, medical consultation reports, and discharge summary from hospital, for the management of the most recent bowel obstruction • Most recent two IRFFs (integrated risk assessment) • Copy of ISP, addendum to ISP, and/or IDT meeting minutes Individual #676 had a prior history of bowel obstruction, which required surgical intervention in the remote past. On November 2013, the individual developed an acute bowel obstruction that required emergency surgery, with removal of part of the colon, and placement of a colostomy. The initial assessment of the acute bowel obstruction was clinically appropriate, and the Individual was appropriately triaged to the hospital, and received clinically appropriate post hospital follow-up care at the Facility. The Monitoring Team had concerns with the chronic care management of the Individual's chronic constipation, with a previous history of bowel obstruction: • Only one IRRF was provided for review (8/13/12), and the Individual was indicated to have a "medium risk" for bowel obstruction and constipation, and the rationale for this rating was because "on Lactulose". There was no mention about the previous bowel obstruction, history of constipation, previous laparoscopic intervention, or list of necessary supports to help minimize future risk of bowel obstruction. • There was no evidence to support that the Facility provided regular assessment of the individual's chronic constipation and risk for bowel obstruction, such as a focused physical examination by the medical provider. The medical provider should regularly assess all chronic conditions through a focused physical exam. The Facility required the medical provider was to conduct quarterly reviews, but quarterly physician reviews do not require a physical assessment. In this particular case, the physician quarterly review, dated 1/25/2013, indicated that constipation and colostomy care were reviewed; however, there was no documentation of a physical assessment being completed. • As of 12/13/2012, the general surgeon indicated that the Individual's colostomy could be removed within three months following the surgery; however, there was no documentation indicating that the colostomy was removed, and as of 7/24/2013, the annual medical summary indicated that the colostomy bag was	

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		still in place, and no mention of having the colostomy removed. • The active problem list documented on the annual medical summary, dated 7/24/2013, did not list a diagnosis of hemicolectomy, or colostomy. • The action plan listed on the annual medical summary did not delineate a specific treatment plan for monitoring, and prevention of constipation and bowel obstruction. For example, the action plan did not indicate the minimum amount of fluid the Individual should ingest, only to "increase fluids"; also, the plan did not indicate specific monitoring parameters to monitor for abdominal distention, only to "monitor for abdominal distention". Individual #661 • There was appropriate clinical follow-up by the medical provider on 11/23/2012, for possible ileus. • The Individual was referred to gastroenterology to assist in the management of ileus. • On the medical provider's quarterly review, dated 1/24/2013, there was no indication of a focused examination to assess for constipation, or worsening ileus. • The most recent IRRF, dated 9/5/2013, did not indicate ileus as a risk, and there was no additional evidence to indicate an IDT (interdisciplinary team) review of chronic ileus. • Unrelated to bowel obstruction, but noteworthy, was the medical provider's assessment listed on the annual medical summary, indicating a significant low testosterone level on 02/28/2012, and that there were no "testicular diminution"; however, as previously noted on the annual medical summary, the Individual was noted to have the right testicle entrapped in the inguinal canal, and the left testicle could not be identified. Furthermore, there was no diagnosis listed for hypogonadism, and the IRRF did not indicate the risks associated with hypogonadism and cryptorchidism (undescended testicles), such as the potential risk for testicular cancer. In general, the medical providers addressed acute conditions related to constipation, and bowel obstruction. Clinically appropriate diagnostics and consultations were obtained, as necessary. Clinical documentation of assessment for acute episodes of bowel obstruction and ileus was in appropriate SOAP format. The Monitoring Team was concerned over the lack of regular clinical assessment, by the medical provider, for constipation, history of bowel obstruction, and ileus. Also, the IRRF did not delineate important risk factors and monitoring parameters for constipation, bowel obstruction, and ileus.	

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		Management of Cerebral Palsy, and Baclofen Pump use: To assess the Facility's management of spasticity with Baclofen Pumps, the Monitoring Team reviewed the following documents: • List of all individuals with diagnosis of Cerebral Palsy (CP) • List of all individuals who had a baclofen pump implanted • For five Individuals, selected by the Monitoring Team (Individuals #426, #594, #309, #402, and #267): o Current medical assessment o Quarterly review o Current medication list o Most recent QDRR o All consultation specific to the management of CP and Baclofen Pump, for past three years o Most recent six months physical therapy/occupational therapy (PT/OT) treatment IPNs o Most recent PT/OT assessment o Most recent IRRF, and specific IDT minutes addressing the use of Baclofen Pump, and CP The Facility indicated that only one individual had a Baclofen Pump implanted (#594), and a total of 109 individuals were diagnosed with CP. Review of the documents for individuals #426, #594, #309, #402, and #267 noted the following: • The medical provider listed the appropriate clinical diagnosis on the active problem list in five out of five examples (100%). • Three out of five examples (60%) were provided pharmacological treatment for noted spasticity. • There was documentation that four out of five examples (80%) were either assessed for, or had a Baclofen Pump implanted. • The medical provider documented the functional range of the individual in zero out of five examples (0%). • Of the three individuals who were provided pharmacological therapy for spasticity, the medical provider commented on the efficacy of treatment in zero out of three examples (0%). • There was documentation that the medical provider conducted periodic physical assessments for potential functional decline, and treatment efficacy, as a part of chronic health care management in zero out of five examples (0%). • The IRRF documented the risks associated with CP and spasticity in zero out of five examples (0%).	

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		• For the one Individual who had a Baclofen Pump, the IRRF did not address the risks associated with pump failure. It is critical that staff be well aware of the signs of pump failure, and acute withdrawal signs of Baclofen. Based on the number of individuals that were diagnosed, and evaluated for CP, and by ensuring that the clinically appropriate medical diagnosis and plan was developed for CP, the Facility had significantly improved on the identification of CP. There was also noted improvement with referring individuals with CP to necessary specialists to assist in the management of care for CP. The Facility must continue to improve on the overall management of CP by ensuring that treatment efficacy is regularly assessed; ensure that the medical provider routinely physically assesses the individual for potential worsening of complications of CP; and ensure that the IDT is fully aware of the potential on-going complications of CP, all necessary supports and services, monitoring parameters, and potential complications of treatment. It is especially important that the IDT be made aware of the risks associated with Baclofen pump failure, and what to monitor for potential pump failure. In the one example of an individual with a Baclofen Pump (Individual #594), the current medication list did not list Baclofen as a currently prescribed medication. <u>Conclusion</u> The Facility, including the medical director, medical providers, and medical support staff had made significant progress towards substantial compliance for Provision L.1. The Facility had enhanced practice in the management of acute care conditions; maintained high standard for clinical documentation of annual medical summaries and IPNs; maintained efficient and effective process for interdisciplinary meetings to help ensure continuity of care, and improved clinical outcomes; maintained a robust medical and support staff; and was in the process of re-modernizing its clinical examination rooms. The Monitoring Team is complimentary to the Facility, and its staff, for the exceptional improvements noted. Further improvements are required for substantial compliance, and include the following: ensuring that action plans are developed for all relevant clinical issues delineated at the morning medical meeting and grand rounds; ensuring that medical providers develop clinically appropriate action plans that include specific monitoring parameters, and necessary services required to support the individual; ensuring that individuals are regularly physically assessed for chronic care conditions; ensuring that the underlying etiology for medical conditions have been well evaluated, and all potential treatments to prevent further exacerbation of the condition have been discussed by the IDT; ensuring that all medical conditions are clearly delineated at the CLDP meeting, and on the CLDP plan, and ensuring that relevant monitoring parameters are developed to assess individuals through the post move monitoring period; and medical providers must enhance their involvement in the IDT process.	

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L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	Provision L.2 requires the Facility to develop and implement a process to assess the clinical performance of medical providers. To comply with Provision L.2, the Facility conducted an external audit semiannually. The Monitoring Team also reviewed the Facility's mortality review process by reviewing death review summaries, and met with the mortality review committee members, including Dr. Quan. To assess the Facility's ability to conduct clinical performance audits, the Monitoring Team reviewed the following documentation: • All assessments, graphs, summaries, action plans, and quality assurance (QA) reports for Internal and external medical audits for round 7 • DADS Internal and external medical audit policy, undated, no number • RSSLC Clinical performance audit policy, 6/23/2013 • Clinical pathway tools • Clinical pathway audits for round 7 • All QA/QI follow-up to action plans for the clinical performance audits, and the medical audits for round 7 <u>External medical review</u> A physician that was external to the Facility conducted round seven of the external medical reviews on 3/21/2013 through 3/22/2013. Specific clinical indicators assessed for this review included diabetes, osteoporosis, and pneumonia. The clinical records of 27 individuals were randomly selected by a computer software program, and used for the review process. For round 7, there were only five practicing medical providers at the Facility, and all five medical providers were assessed through the external medical review process. External medical reviews were divided into three components: • Essential elements, which required a Facility determined score of 100% compliance, as a passing score • Medical elements, which required a Facility determined score of 100% compliance, as a passing score • Non-essential elements, which required a Facility determined score of 80% compliance, as a passing score The outcome of the external medical reviews for round seven was as follows: • One out of five medical providers (20%) received a score of 100% for essential elements. • Five out of five medical providers (100%) received a score of 80% or greater for non-essential elements. • Zero out of five medical providers (0%) received a score of 100% for medical management reviews. • For the three medical management reviews	Noncompliance

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		o Diabetes had a cumulative score of 94% for all five medical providers. o Osteoporosis had a cumulative score of 76% for all five medical providers. o Pneumonia had a cumulative score of 67% for all five medical providers. To rectify noncompliance issues discovered through the external medical review process, action plans were developed for each medical provider. The Facility's QA department assessed the action plans for completion: • A total of 55 essential and non-essential action plans were developed for the five medical providers, and, at the time of the Monitoring Teams on-site review, 51 out of 55 action plans (94%) were completed • A total of 22 medical management action plans were developed for the five medical providers and at the time of the Monitoring Teams on-site review, 15 out of 22 action plans (68%) were completed. The summary report developed by the external physician who conducted round 7 of the external reviews was noted to be undated, and not signed by the reviewing physician. The report was based solely on the findings of the medical review process, and indicated that the medical providers adhered to standard of care guidelines for residents with multiple medical problems, behavioral issues, and functional dependent activities. Deficiencies noted by the reviewing physician included the need for more frequent physical assessments for chronic conditions; improved assessments for chronic conditions such as osteoporosis, aspiration and diabetes; better identification of risks for falls, contractures, and pressure sores; closer follow-up to clinical concerns raised by nursing staff, such as weight loss, constipation, and other conditions; and the need to improve continuity of care with consulting medical specialists. The Monitoring Team concurs with the deficiencies noted by the reviewing physician. Following review of the 27 medical management review questions assessed for round 7, as per previous reports, the Monitoring Team continues to note significant limitations with the medical management component of the external medical review process. The medical management component included only a total of six medical management topics, including constipation, osteoporosis, UTI, pneumonia, diabetes, and seizures, and three of the six are used for each round of the medical reviews. The Monitoring Team does not disagree with assessing only three medical topics for a medical review round; however, the medical review process must ensure that the availability of additional medical topics are developed, so that that all significant clinical issues that are known to commonly occur in individuals with disabilities, are eventually assessed. Furthermore, the Monitoring Team noted that the questions used to assess clinical performance, did not specifically assess clinical performance issues. For example:	

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		• Question number 1 asked, "is osteoporosis listed on the active problem list?" Although ensuring that accurate diagnoses are listed on the active problem list, this type of question is more representative for an essential review question, and not a medical review question. • Question number 3 asked, "is there a diagnosis of a pathological fracture?" Pathological fractures are adverse outcome secondary to osteoporosis; however, they can occur regardless of maximum therapy, and may occur as a result of bisphosphonate therapy, therefore a spontaneous fracture should not be considered as a negative outcome for the provider. Conversely, all fractures must be assessed as to their possible etiology, and the provider must ensure that steps are taken to mitigate fractures, and regularly assess supports and services to ensure that they are efficacious • Question number 4 asked, "did the provider order or document findings of a dental exam before initiating a bisphosphonate?" The risk of osteonecrosis of the jaw is more likely when there is periodontal, or dental disease; and when disease is present, consultation with the dentist is obligatory before initiating a bisphosphonate. Furthermore, osteonecrosis of the jaw can occur when prescribed a bisphosphonate, despite normal oral health; therefore, the IDT, which includes the legally responsible person (LAT), must always be provided the risks, benefits, and alternative treatments to bisphosphonate treatment. • Question number 6 asked "Did the PCP document why a DEXA scan can not be completed if one has not been obtained?" Many individuals with developmental disability cannot undergo traditional DEXA evaluation, and in such cases, alternative diagnostic to DEXA, such as quantitative computed tomography, single photon absorptiometry, and ultrasonography should all be considered; not just documenting the rationale for not obtaining a DEXA scan. Review of the 27 medical management questions assessed indicated there were no examples of questions to determine if the provider assessed for the underlying etiology of a medical condition, or the efficacy of supports, and services prescribed to help mitigate exacerbation. There were no questions to determine if specific treatment modalities employed by the provider were the most current acceptable professional standard treatment for the medical condition. During the on-site review, the Monitoring Team was informed by the medical director that the results of the external medical reviews, and medical management reviews, are discussed with each medical staff, and the information gained by the review process is used to develop systems issues to enhance practice performance. For example, when the medical director determined that medical providers were not appropriately documenting and following up on acute medical conditions, per round five and six of the	

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		medical reviews process, the medical director developed guidelines to address both of these issues. During the current Monitoring Team's review, it was noted that the both documentation practice and follow-up to acute medical conditions had significantly improved. The Facility must enhance the medical review process by ensuring that medical management elements are developed for the most common and most serious medical conditions that occur in people with intellectual disability, and that the process helps to determine if the medical provider is providing medical care at the level of generally acceptable standards of clinical practice. <u>Mortality reviews</u> Since the last compliance review, eight deaths had occurred at the Facility. At the time of the Monitoring Team's compliance review seven of the eight deaths had Clinical and Administrative Death Reviews completed. The Facility was the process of completing the Clinical and Administrative Death Review for the most recent death. The Monitoring Team will review the Clinical and Administrative Death Review for this death at the next compliance review. On 8/29/13, the Monitoring Team met with the Medical Director, CNE, QA Nurses, Medical Records Director, and State Office Nursing Coordinator and reviewed and discussed the documentation supplied for review on the seven completed death reviews. The review demonstrated that the Facility conducted Clinical and Administrative Death Reviews according to their Policy A.7, Administration, Actions Following Death of Individual Served. It was positive to find, as was recommended on previous compliance review, that the Facility had begun including an external physician as part of the Clinical Death Review Committee as required by policy. The Facility continued to maintain and improve their comprehensive tracking systems for recommendations resulting from the Clinical and Administrative Death Review Committees. The recommendations stemming from these committees' recommendations were tracked, completed, and followed through to resolution as specified in the established timelines for each relevant discipline, with the exception of two decedents' recommendations that were not due for completion at the time of the compliance review. In addition, the QA Nurses continued to conduct follow-up reviews 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 Clinical and Administrative Death Review Recommendation Tracking data indicated that the recommendations were appropriate in relation to the findings in the documents supplied for review.	

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		General findings for the seven deaths reviewed included: • Of the seven deaths reviewed, the average age was 55.7 years (ages varied from 40 to 76 years of age). • Four of the decedents were residents in the Trinity Unit, two decedents were residents in the San Antonio Unit, and one decedent was a resident in Infirmary 2. These were Units and Infirmary 2 where individuals resided that were identified as the most medically complex with multiple high-risk ratings. • One of seven (14%) deaths had an autopsy completed. • Seven of seven (100%) deaths had Unusual Incident Investigations completed. • Seven of seven (100%) decedents had Do Not Resuscitate (DNR) orders signed prior to illness and at the time of death. • Six of seven (86%) of the deaths occurred in a local hospital. One death occurred at the Facility's in-patient hospice services. • The cause of individuals' deaths, as determined by the Texas Department of Health Services, Vital Statistics Unit Certificates of Death, are listed in the chart below:	

1.	Primary Cause of Death: Respiratory Failure Significant Conditions Contributing to Death: Severe Protein Caloric Malnutrition and Cerebral Palsy
2.	Primary Cause of Death: Sepsis Shock
3.	Primary Cause of Death: Sepsis Shock Secondary Cause of Death: Diabetes Underlying cause contributing to death: Colitis
4.	Primary Cause of Death: Pneumonia Secondary Cause of Death: Sepsis Shock Underlying cause contributing to death: Respiratory Failure
5.	Primary Cause of Death: Sepsis Shock Secondary Cause of Death: Respiratory Failure
6.	Primary Cause of Death: Sepsis Shock Secondary Cause of Death: Respiratory Failure
7.	Primary Cause of Death: Hypertensive Cardiovascular Disease Contributing Cause of Death: Diabetes Mellitus and Cerebral Atrophy (According to Autopsy Report – No Certificate of Death available)

Review of the clinical death summary for all seven cases, indicated that the clinical reviews were significantly limited, and did not assess the management of clinical conditions, and potential contributing factors , that led to the death. It is essential that the mortality review process provide a comprehensive understanding of the cause of death, to determine if alternate medical treatments, or enhanced support services could improve the overall care of individuals at the Facility. As was recommended in past compliance reviews, the Medical and Nursing Departments, as well as the Quality

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		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. <u>Conclusion</u> The Monitoring Team continues to be concerned over the DADS medical performance review process, and substantial compliance will require that the process include the development of medical management topics that will address significant and common medical conditions that occur in people with developmental disabilities, and ensure that the clinical issues being reviewed assesses the clinical performance related to the actual treatment of the medical conditions being audited. It is essential that the mortality review process provide a comprehensive understanding of the cause of death, to determine if alternate medical treatments, or enhanced support services could improve the overall care of individuals at the Facility.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	Provision L3 requires the Facility to implement a quality assurance (QA) process for medical services. This process included the following components: • An Internal Medical Provider quality assurance audit process • Clinical performance audits • Medical quality assurance data-based process <u>Internal medical reviews</u> Round seven of the internal medical reviews was conducted on 6/11/2013 through 3/22/2013 by a physician who was external to the Facility. To assist the Facility to conduct its own internal medical reviews, the Facility contracted with a local physician, who does not regularly practice at the Facility, to conduct the review process, in the same format as the external medical reviews are completed. Specific clinical indicators assessed for this review included diabetes, osteoporosis, and pneumonia. The clinical records of 28 individuals were randomly selected by a computer software program, and used for the review process. All seven of the practicing medical providers at the Facility were assessed through the internal medical review process. Internal medical reviews were divided into three components: • Essential elements, which required a Facility determined score of 100%	Noncompliance

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		compliance, as a passing score • Medical elements, which required a Facility determined score of 100% compliance, as a passing score • Non-essential elements, which required a Facility determined score of 80% compliance, as a passing score The outcome of the external medical reviews for round seven was as follows: • Two out of seven medical providers (29%) received a score of 100% for essential elements. • Seven out of seven medical providers (100%) received a score of 80% or greater for non-essential elements. • Two out of seven medical providers (29%) received a score of 100% for medical management reviews. • For the three medical management reviews o Diabetes had a cumulative score of 100% for all seven medical providers. o Osteoporosis had a cumulative score of 95% for all five medical providers. o Pneumonia had a cumulative score of 70% for all five medical providers. To rectify noncompliance issues discovered through the internal medical review process, action plans were developed for each medical provider. The Facility's QA department assessed the action plans for completion: • A total of 8 medical management action plans were developed for the seven medical providers and at the time of the Monitoring Teams on-site review, 8 out of 8 action plans (100%) were completed. • The Facility did not provide an analysis for action plans, for internal essential and non-essential elements. During the on-site review, the Monitoring Team was informed by the medical director that, as done for the external medical reviews, the results of the internal medical reviews and medical management reviews are discussed with each medical staff, and the information gained by the review process is used to develop systems issues to enhance practice performance. Because the Facility utilized the same format, and same audit tools, as used by for the external medical reviews, the Monitoring Team has the same concerns, and recommendations. The reader is referred to external medical reviews, above, for details. <u>Clinical performance audits</u> To enhance the Facility's assessment of medical providers' clinical performance, the	

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		Facility developed an additional assessment measure, called clinical performance audits; which is a different, and independent, process from the DADs internal reviews. This process included the uses of an extensive electronic database; use of standardized clinical pathway audit tools, that were developed to address significant conditions that commonly occur in individuals with developmental disabilities; and a computer generated random generator, which was used to select samples for the audit of each medical provider. Completed audit tools for each provider were then assigned a score, which enabled comparison of providers among each other. The medical director generated a written report, and reviewed the findings with each provider and the medical staff at large. The report included action items for issues noted to be deficient; the Facility was piloting a process to follow-up on action items. The policy for the clinical performance audit process indicated that action plans are be developed for each deficiency, and the provider's corrective action will be followed through to completion by the medical compliance coordinator, and reviewed by the medical director. The Monitoring Team reviewed the Facility's clinical performance audits in detail, while on-site at the Facility. The electronic database was functional, and effective. The Facility had completed a total of 13 clinical pathway audit tools and the clinical performance audit policy, dated June 21, 2013, indicated that the Medical Director would continue to develop additional audit tools and revise current audit tools to reflect changes in accepted community standards of care. The following 13 audit tools were made available through document request: • Aspiration syndrome • Degenerative spine disease • Cerebral palsy • Down syndrome • Gastroesophageal reflux disease (GERD) • Chronic obstructive pulmonary disease (COPD) • Chronic kidney disease • Hypertension • Constipation • Seizure disorder • Dyslipidemia • Diabetes mellitus • Osteoporosis This process, although internal in nature, was actually conducted by a physician auditor contracted by the Facility but who did not perform clinical duties at the Facility. This physician also conducted the external reviews reported in Provision L2; these internal	

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		audits were an expansion for the purpose of assessing clinical performance of medical providers. The Facility conducted an internal clinical performance audit, for each medical provider at the Facility. This audit assessed two or three clinical conditions per provider. Based on the results of each audit tool, a standardized score was generated, and the medical director completed a comprehensive summary of the findings, and listed many corrective actions that were necessary to develop; also, completed audit tools included a comment field for corrective actions. The Monitoring Team was not provided evidence that included a list of all action plans, and summary of action plans, that were completed or not completed for the internal audit. <u>Data-based Quality Assurance Process</u> Provision L3 requires the Facility to implement a medical quality assurance (QA) process that collects data; assess data for trends; initiate corrective action plans, when necessary; and monitors to ensure that remedies are achieved. . To assess the Facility's effort towards compliance for Provision L3, the Monitoring Team reviewed the following documentation: • Chronic Clinical Indicators Policy, revised 8/20/2013 • Healthcare Trend Report to QA/QI Council Policy, undated • Database elements for diabetes, osteoporosis, neuromotor, and musculoskeletal conditions, neuromotor conditions, UTIs, and pneumonia • Data analysis reports for diabetes and UTIs • Healthcare trend report to QA/QI, dated 8/27/2013 • Observation of electronic medical QA database functionality The Facility has developed a robust, and comprehensive medical quality assurance process that incorporates data from a series of Facility developed clinical indicators, and also incorporates data collected from its clinical performance audit, and internal medical audit processes. The medical director, in collaboration with the Facility's quality assurance department, trends data and develops necessary corrective action plans, and monitors the plans for completion and efficacy reviews data elements. A trends analysis is documented in the monthly QA/QI healthcare reports, and is also presented to members of the medical staff, during medical staff meetings. The medical director documents regular updates on outcomes from action plans on the healthcare trend report, which is reviewed by the QA/QI department. Clinical Indicators: The Monitoring Team noted that the Facility had significantly increased the number of clinical indicators that were used its medical QA process, and included specific indicators	

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		for osteoporosis, preventive health care, neuromotor, musculoskeletal, infections, pneumonia, urinary tract infections, and medical consultation follow-up. All nine clinical indicators were reviewed by the Monitoring Team, and determined to be clinically relevant. Further more, the Facility's policy, Chronic Clinical Indicators, revised 8/20/2013, indicated that the medical director would continue to develop additional clinical indicators in the future. Clinical indicators identify specific outcome data relevant to each medical issue; for example, the clinical indicator for diabetes mellitus assesses: • Type of diabetes • Prescribed medications, included antidiabetogenic agents, ACE inhibitors, aspirin therapy • Surveillance examinations, such as physical examination, and eye examinations • Screening labs, including A1C, LDL, microalbuminuria, and creatinine • Complications, such as neuropathy, retinopathy, nephropathy, and hypoglycemic events • PCP Hypoglycemic Protocol, 4/24/2013 Medical QA database for clinical indicators: The Facility-developed medical QA electronic database, is utilized to store clinical database elements, and automatically develops trends analysis reports, which are used by the medical director and the Facility's QA/QI department. The electronic database was was noted to be efficient and effective in helping the Facility analyze outcome data collected by the utilization of the clinical indicators. The database is kept current by each medical provider entering required data, at the time of completing annual medical and quarterly medical assessments. The Facility demonstrated the medical QA electronic database at the time of the on-site review at the Facility. The database was fully functional, and maintained current data for each of the nine clinical indicator conditions and processes. Clinical indicator trends analysis: The medical director reviews trends data for medical indicators monthly, and develops a report that is shared with the medical staff, at regularly scheduled medical staff meetings and provides a healthcare trends report for review by the Facility's QA/QI department. During the reporting period, database elements, and trends data were reviewed for three of the nine clinical indicators; diabetes, urinary track infections, and medical follow-up. The following is a summary of two trends analyses completed by the medical director, and reported on the healthcare trends report: • Review of data, and trends analysis for diabetes: Data and trends analysis for	

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		diabetes included assessment of glycosylated hemoglobin, and diagnosed complications of diabetes, such as hypertension, retinopathy, neuropathy, nephropathy, and proteinuria. In addition, the use of pharmacological treatment was also assessed, including treatment with statins, ACE-I, aspirin, and antidiabetic agents. The Trends analysis report, dated 8/15/2013, was comprehensive and discussed overall trends of the management of diabetes. The trends analysis indicated that the overall management of diabetes and complications of diabetes was effective. For example, the data analysis was able to ensure that the overall treatment for diabetes was efficacious, as the average glycosylated hemoglobin was 6.4 for the 21 individuals diagnosed with diabetes; one out of the 21 individuals was noted to have an LDL level greater than 100; and only one individual had an elevated microalbuminuria. • Review of data, and trends analysis for UTI: The data and trends analysis included assessment of the incidence of UTIs at the Facility, with breakdown by living area; the presence and type of urinary catheters used, and a specific breakdown of all UTIs at the level of the individuals, with analysis of recurrent UTIs, identified organism, comorbidities, initial presenting symptoms, use of incontinent pads, antibiotic use, and culture results. The trends analysis was noted to be comprehensive and efficacious. For example the data analysis was able to determine that there were kidney stones identified in six out the ten cases of recurrent UTIs, and consequently, these individuals were referred to urologists for further evaluation, and medical providers had been instructed to assess for the presence of kidney stones when evaluating recurrent UTIs. In addition, the data analysis indicated that UTIs were more common in the summer months, which in turn resulted in the Facility developing recommendations to enhance hydration during the summer months; the Monitoring Team verified implementation of recommendations, for example by observing water stations placed throughout campus to make water readily accessible as individuals moved from place to place. Medical QA action plans: As evident by review of the Facility's QA/QI meeting minutes, dated 3/19/2013, and 8/15/2013, the Monitoring Team determined that following review of database elements and trends analysis, the medical director, in collaboration with the Facility's QA/QI department, develops specific action plans for specific clinical issues and system issues, when necessary. During this reporting period, action plans, and follow-up of action plans, were developed for the three medical indicators assessed (urinary tract infections, diabetes, and medical follow-up). The following is a summary of three action plans developed by the medical director and medical QA/QI department, during the review period:	

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		• Action plan for urinary tract infections (UTIs): The healthcare trends report to the Facility's QA/QI report, dated August. 2013, documented comprehensive review of database elements for UTIs, and identified three specific systems issues that required the development of corrective action plans: o Medical factors: As reported in the August 2013 healthcare trends report, physicians were instructed at the August 2013 medical staff meeting to obtain specific management instructions from urology specialist, for all individuals known to have renal lithiasis; o Hygiene factors: During the August medical staff meeting, medical providers were instructed to write specific orders for high risk individuals for mandatory changing of disposable briefs, at specific time intervals. o Hydration factors: As reported in the August 2013 healthcare trends report, the medical providers were instructed at the August medical staffing meeting to review enteral tube hydration for all individuals who receive hydration by means of enteral tube, and residential managers were instructed to encourage hydration of individuals who are hydrated orally. The action plans were documented in the 8/15/2013 medical QA/QI minutes, and will be followed by the medical QA/QI department to ensure implementation. Efficacy of the action plans will be assessed by follow-up trends analysis in the future. Action plan for medical follow-up: The Facility's QA/QI department reviewed the healthcare trends report, dated 6/18/2013. The trends analysis identified that from January, 2013 to June, 2013, there were 1,153 medical consultations, and 217 diagnostic studies ordered. Only 1 out of the 217 diagnostic studies were missed, and there were 90 out of the 1,153 medical consultations that were missed. The medical director, in collaboration with the Facility's QA/QI department, determined the need for the following corrective action plans, which will be monitored for implementation and efficacy: • Interdisciplinary Team (IDT) meetings will review missed appointments and diagnostics and identify strategies to ensure completion of scheduled consultations and diagnostics. • The Facility's QA/QI department will monitor and ensure that medical follow-up reports are sent to each unity monthly, and unit directors will be required to review, and develop strategies to help reduce missed appointments at their unit • To enhance timeliness of medical appointments, medical providers were instructed by the medical director to collaborate directly with the medical scheduler when a medical appointment is considered urgent.	

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		• Case managers were instructed by the Facility's QA/QI department to ensure that they update missed appointment data into the database, monthly. Action plan for diabetes: As reflected in the 8/15/2013 healthcare trends analysis for diabetes, dated 8/15/2013, the medical director, in collaboration with the Facility's QA/QI department reviewed database elements and trends data for its medical QA process for the management of diabetes. Specific action plans were developed. The Monitoring Team noted in the 8/15/2013 healthcare trends analysis report that the Facility's QA/QI department reviewed and assessed a previously developed action plan to enhance diabetic education at the Facility, and results of their findings are as follows: • QA monitors had reviewed the past six months clinical records of all diabetics to ensure that nurses had provided individuals and their families/guardians diabetic education for off campus events. This action plan was developed because the Facility's medical QA data indicated that the diabetic management of individuals was not as effective, by evidence of abnormal glucose monitoring, when attending off campus events, other than with staff. Result of the QA data analysis suggested that diabetic education was not documented, as required, for individuals attending off campus events and home visits. Subsequently, additional action plans had been developed to, and will be monitored for efficacy by the Facility's QA/QI department. The updated corrective action plans are as follows: o The QA/QI department will develop an enhanced method to identify and track diabetic education. o The medical director will establish a new program to better educate all relevant staff of the importance, and procedure for providing diabetic education for individuals going on off campus events, such as home visits. o An additional query was be added to the existing database to include a field indicating hypoglycemic events for diabetics (these actions were the result of the medical director's assessment of the diabetic education follow-up, and were developed prior to the development of the 8/15/2013 healthcare report of diabetes). o At the time of this review, the Monitoring Team reviewed a new protocol that had been developed, PCP Hypoglycemic Protocol, and the database had been updated to include hypoglycemic events. In addition to the Facility's development of a robust, comprehensive medical QA database, development of nine medical QA indicators, monthly review of healthcare trends analysis with the Facility's QA/QI department; and process to develop, implement and determine efficacy of medical QA corrective action plans, the Facility also conducts internal medical audits, and clinical performance audits, as delineated in section L.2, of	

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		this report. <u>Conclusion</u> The Monitoring Team compliments the Facility for developing a comprehensive, and clinically relevant process, which involves three components to assess clinical processes and outcomes at the Facility. The internal medical review supplements the external medical review described in Provision L2 but has the same issues of concern expressed in Provision L2 for the external medical review. The development of a clinical performance audit process addresses clinical performance across a broad range of conditions; this was implemented recently, and the Facility was, at the time of the compliance visit, still in the pilot stage of implementing a process to develop and follow through on action items. There will need to be experience to demonstrate that it is maintained and that it produces effects on PCP performance and on health status of individuals. The Monitoring Team wishes to commend the Facility on development of a comprehensive data-based system that identifies clinical indicators of care that are to be tracked for individuals, with the ability of this system also to aggregate the data from these indicators for systemic review of the efficacy of health care and integrated clinical services at the Facility. This system includes a database, clinical indicators, development of trends analysis, review by the medical director and Facility's QA/QI department, development of meaningful corrective action plans, and had early indications of follow-up on action plans to determine efficacy. The Monitoring Team understands that this system will continue to grow and be refined with experience. For a finding of substantial compliance, the Facility must demonstrate that it continues to identify issues needing attention and that follow-through for both chronic care of individuals and actions to improve health status in the aggregate occur and demonstrate effectiveness or additional action.	
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	Provision L.4 requires that the Facility maintain appropriate policies and procedures to ensure quality medical services at the Facility. To assess compliance for Provision L.4, the Monitoring Team reviewed the Facility's self-assessment, and discussed efforts with the Facility's medical director. In addition, the following documents were reviewed: • Policy for Medical Services; 1.00a, dated 5/15/2013 • Morning Report Policy, dated 6/28/2013 • Clinical Pathway for Standard of Care and Documentation Policy, Dated 4/15/2013 • Chronic Clinical Indicator Policy, revised 8/20/2013	Noncompliance

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	compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Monitoring Team recognized that the Facility had developed and implemented many new policies, and practices since the last Monitoring Teams on-site review. The Monitoring Team noted continued improvement in developing meaningful policies to ensure acceptable practice standards at the Facility, and is complimentary to the Facility for further developing process improvements with medical services. <u>Policy for Medical Services</u> The general policy for medical services was reviewed. The Policy requires that "all active and chronic problems will be reviewed every quarter", and that "a medical summary form or narrative note will be used to document the review". As per the Monitoring Team's review for Provision L.1 of this report, and per recommendations by the external physician who conducted round 7, of the medical audits, the Facility's medical providers did not regularly physically assess individuals to evaluate chronic health care conditions. It is paramount that medical providers physically assess individuals at the level of community standard of care practice, or more frequently if clinically necessary. The Policy should reflect that medical providers must complete physical assessments, on a regular basis, for all chronic care conditions. The Policy indicated that the Facility will conduct a "medical debriefing" meeting on each business day, to enhance continuity of care. The Monitoring Team is aware of two medical meetings. The Wednesday grand rounds meeting is a multidisciplinary meeting that provides a focus case review, unlike the morning report, that occurs on Tuesdays, and Thursdays, which functions more as a medical debriefing meeting. <u>Morning Report Policy, dated 6/28/2013</u> The Morning Report Policy clearly delineated the practice as observed by the Monitoring Team. The policy requires that the medical compliance coordinator to track agenda items for completion. Upon review of morning report minutes for Provision L.1 of this report, the Monitoring Team noted that there was no consistent process to ensure that action plans be developed for all relevant clinical issues discussed, and there was no indication that follow-up, to ensure implementation of the action plan was completed. <u>Clinical Pathway for Standard of Care and Documentation Policy, Dated 4/15/2013</u> The policy required that specific standards were to be followed, by medical providers, when completing the annual medical summary. The Monitoring Team reviewed the required format with the medical director, and following it's review for Provision L.1, noted that the medical providers had appropriately completed the annual medical summary for individuals #389, #718, #275, #796, #296, #661, #402x2, #614, #377, #785, #130, #235, #16, #161, #243, and #773. As noted in Provision L.1 of this report,	

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		the Monitoring Team is complementary to the Facility for its significant improvements with the annual medical summary process. <u>Chronic Clinical Indicator Policy, revised 8/20/2013</u> The policy for chronic clinical indicators indicated that corrective action plans would be developed, and tracked by the medical compliance coordinator and the QA monitors. As noted in Provision L.3 of this report, specific action plans were not developed for all identified issues that required corrective action, and there was no evidence to indicate that action plans were followed through implementation. <u>Conclusion</u> The Facility had developed many new policies to help improve clinical practice at the Facility. The Policy for documentation has resulted in the Facility meeting acceptable practice standards for clinical documentation. Substantial compliance with Provision L.4 will require that the Facility ensures that its policies clearly delineate its practices, and that the Facility has substantially implemented it's policies.	

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: 8/9/13 2. RSSLC Section M Action Plan, Updated: 8/7/13 3. RSSLC Section M Presentation Book 4. Texas Department of Aging and Disability (DADS), Medication Variance Policy, Number 053, Effective: 9/23/11 5. DADS Procedure: Medication Administration Guidelines, Dated: June 2013 6. DADS Procedure: Medication Administration Observation Guidelines, Dated: June 2013 7. DADS Policy: Nursing Services, Policy Number: 010.2, Effective: 9/20/12, Replaced: 010.1 8. DADS Nursing Procedure: Gastrostomy Tube: Insertion by a Nurse: Dated: June 2013 9. DADS Nursing Protocol: Enteral Nutrition, Dated: May 2011, Revised: May 2013 10. DADS Nursing Protocol: Hospitalizations, Transfers, and Discharges, Dated: March 2013 11. DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, April 2013 12. DADS Policy: Medical Care, Policy Number: 009.2, Effective: 5/15/13, Replaced: 009.1 13. RSSLC Policy I.42 PCP Hypoglycemia Protocol, Dated: 4/24/13 14. RSSLC Policy I.43 The Vest Policy, Dated: 6/21/13 15. RSSLC Nursing Services: Pain Assessment Using the Wong-Baker Faces Pain Rating Scale, E_24, Revised: 4/11/13 16. RSSLC Nursing Services: Emergency Response Policy, Reviewed: 4/11/13 17. RSSLC Policy: Nursing Services, 100b, Revised: 6/17/13 18. RSSLC Nursing Services: Physician Quarterly Orders, B2, Revised 7/17/13 19. RSSLC Policy, I.34 Providing Health Care Services, Medication Variances, Effective: 9/11/11, Revised: 2/27/12 20. RSSLC Pharmacy Policy and Procedure Manual, Medication Variances, 01.05.20, Revised: 11/2/11 21. RSSLC Pharmacy Policy and Procedure Manual, Adverse Drug Reactions, 01.05.25, Revised: 7/15/11 22. RSSLC Providing Health Care Services, Actions During and Following a Medical Emergency (444), Revised: 9/7/11 23. RSSLC Nursing Services, Protocol – Training Pulled Nurse, Effective: 5/7/13 24. RSSLC Nursing Organizational Chart 25. RSSLC Nursing Department Staffing Schedules and Staffing Patterns for last six months 26. RSSLC Nursing Education and Training Reports July 2012 through July 2013 27. RSSLC Nursing Department Meeting Schedule for Week of 8/26/13 28. RSSLC Nursing Department Administration and Nurse Managers Meeting Minutes, January 2013 through June 2013 29. RSSLC Nursing Plan of Improvement (POI) Meeting Minutes, November 2012 through July 2013 30. RSSLC Quarterly Pharmacy and Therapeutics Committee Meeting Minutes, 11/14/12, 1/8/13, 4/17/13, and 7/18/13 31. RSSLC Monthly Medication Variance Committee Meeting Minutes, 11/14/12, 12/20/12, 1/31/13, 2/21/13, 3/29/13, 4/25/13, 5/30/13

	32. RSSLC Medication Administration Observation Reports, for the last six months 33. RSSLC Monthly Skin Integrity Committee Meeting Minutes, January 2013 through July 2013 34. RSSLC Nursing Department Policy and Procedure Committee Meeting Minutes, 4/11/13, 5/2/13, and 5/20/13 35. RSSLC Monthly Emergency Response Committee Meeting Minutes, 1/9/13, 2/20/13, 3/20/13 4/17/13 and Quarterly Meeting Minutes, 7/17/13 36. RSSLC Summary of Emergency Equipment and Automated External Defibrillator (AED) Checklist Reports January 2013 through June 2013 37. RSSLC List of Location of Emergency Equipment and AEDs Campus-wide 38. RSSLC List of Staff Responsible for Conducting Mock Medical Emergency Drills 39. RSSLC Monthly Mock Medical Emergency Drill Trend Analysis for last six months 40. RSSLC Curriculum for Implementation of Emergency Procedures and Training Materials 41. RSSLC Emergency Response Committee Membership and Mission Statement 42. RSSLC Emergency Response Debriefing Meeting Minutes, 2/28/13, 5/22/13, and 7/30/13 43. RSSLC Quarterly Infection Control Committee Meeting Minutes, January 2013 and April 2013 44. RSSLC Infection Control Policy and Procedure Meeting Minutes, January 2013 through April 2013 45. RSSLC Summary of Infections Report for last six month 46. RSSLC Monthly Antibiograms and Epidemiology Reports, January 2013 through June 2013 47. RSSLC Competency Training and Development (CTD) Infection Control Due/Delinquent List, Printed: 7/30/13 48. RSSLC Percentage of Individuals Current with Tuberculosis Screening 49. RSSLC Percentage of Employees Current with Tuberculosis Screening 50. RSSLC Percentage of Individuals Current with Influenza Vaccinations 51. RSSLC Percentage of Employees Current with Influenza Vaccinations 52. RSSLC Percentage of Employees Current with Hepatitis B Vaccinations 53. RSSLC List of Nursing Monitoring Tools and Procedures for Monitoring 54. RSSLC Nursing Monitoring Tools Analyses and Corrective Action Reports, January 2013 through June 2013 55. RSSLC Clinical Morning Report Minutes, 8/20/13 through 8/29/13 56. Sample Review of Comprehensive Records for 13 Individuals #243, #66, #366, #594, #106, #468, #296, #379, #25, #177, #524, #43, and #569 57. Sample Review of Community Placement Nursing Summaries and Discharge Packets for Five Individuals #685, #728, #81, #480, and #267 58. Sample Review of Recently or Currently Active Skin Integrity Issuers for Eight Individuals #623, #30, #384, #724, #619, #77, #99, and #538 59. Sample Review of Ten Most Recent Reported Medication Variance Reports for Individuals #503, #151, #264, #579 (had two medication variances), #592, #564, #588, #618, and #743 60. Sample Review of Records of Five Active Reportable Infectious/Communicable Diseases for Individuals #209, #108, #471, #223, and #1 61. Sample Review of Twelve Hospital Liaison Nurse Records for Recently and/or Currently Hospitalized Individuals #500, #351, #477, #388, #489, #99, #17, #40, #689, #239, #77, and #538 **People Interviewed:**

	1. Valerie Kepfer, RN, State Office Nursing Coordinator 2. Charlene McCurry, RN, Chief Nurse Executive 3. Genniffer Moore, RN, Program Compliance Nurse 4. Emma Purvey, RN, Infirmary/Campus Director 5. Adriano Soria, Jr., RN, Hospital Liaison Nurse 6. Ugo Nweke, RN, Nurse Educator 7. Alice Bruner, RN, Assistant Nurse Educator 8. Wickiff Fawibe, RN, Skin Integrity Coordinator 9. Reneda Simmons, RN, Infection Control Nurse 10. Antonio Crescini, RN, Assistant Infection Control Nurse 11. Deloris Milligan, RN Nurse Manager, Trinity 12. Irma Bernas, RN, Nurse Manager, San Antonio 13. Deborah Brewer, RN, Nurse Manager, Leon 14. Franca Uzuegbu, RN, Nurse Manager, Three Rivers 15. Amanda Hogan, RN, Nurse Manager, Four Rivers 16. Wilma Parker, RN, Quality Assurance Nurse 17. Robyn Partridge, RN, Quality Assurance Nurse 18. Numerous RN Case Managers, Staff RNs and LVNs 19. Wayne Webb, Director of Food Services 20. Mark Wyman, Director of Support Services 21. Gabriel Herrera, Risk Manager 22. Donald Pavliski, Competency, Training, and Development Director **Meeting Attended/Observations:** 1. Nursing POI Meeting, 8/26/13 2. Review of Section M with Nursing Administration and Management Staff, 8/26/13 3. Review of Restraint Checklists/Records with Nursing Administration and Management Staff, 8/26/13 4. Clinical Morning Report, 8/27/13 5. Nursing Morning Report, 8/27/13 6. Incident Management Meeting, 8/27/13 7. ISP Prep for Individual #324, 8/27/13 8. QA/QI Council Meeting, 8/27/13 9. Medication Administration Observation in San Antonio, 8/27/13 10. Infection Control Quarterly Committee Meeting, 8/27/13 11. Grand Rounds Meeting, 8/28/13 12. Medication Administration Observation in Leon C, 8/28/13 13. Skin Integrity Committee Meeting, 8/28/13 14. Meeting Regarding Section I Monitoring, 8/28/13 15. Tour of Central Kitchen, 8/29/13 16. Tour of Three Rivers (TJ7), 8/29/13 17. Nursing Morning Report, 8/29/13 18. Tour of Trinity Unit, 8/29/13 19. Medication Variance Committee Meeting, 8/29/13

	Facility Self-Assessment: For Section M, in conducting its Self-Assessment, the Facility: ▪ Used the statewide Facility Self-Assessment Monitoring Tools. The monitoring/audit tools the Facility used to conduct its Self-Assessment included: Data analyses of nursing vacancies and staffing levels for nursing over time and agency nursing hours, infection control, skin integrity, emergency response, nursing monitoring tools, medication variances, and narrative explanations for items assessed for each Provision. These data provided sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. ▪ The data reported included sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. ▪ The Self-Assessment identified the sample(s) sizes. ▪ The monitoring/audit data used in the Self-Assessment had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The following staff/positions were responsible for completing the audit tools: The Chief Nurse Executive, Compliance Nurse, Nurse Educators, Specialty Nurses, Nurse Managers, and Quality Assurance Nurses. ▪ The staff responsible for conducting the audits/monitoring were considered competent in the use of the tools and were programmatically competent in their relevant area(s). ▪ Sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the Nursing Care Monitoring/Audit Tools and Medication Administration Observation Tools. ▪ The Facility used other relevant data sources and/or key indicators and/or outcome measures. For example, these included databases that showed the percentage of compliance with assessments, percent of nurses who had completed training classes, and number of pressure ulcers. ▪ The Facility consistently presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific and measurable indicators. The data provided an indication of the areas of strength, weakness, or the status of progress. The indicators clearly identified what was being measured or the criteria used for measurement. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the Nursing Department. The Facility's Self-Assessment stated they were not in compliance with Provisions M.2, M.3 and M.5 and were in substantial compliance with Provisions M.1, M.4, and M.6; the Monitoring Team concurs with their findings for Provisions M.4 and M.6. While the entire Provision M.1 was not found in substantial compliance, most of the various requirements were either close to substantial compliance, or very close. For the provisions that were not found in substantial compliance, the Facility's Action Plans addressed plans for each provision that should assist them in moving forward toward substantial compliance in the near future.
	Summary of Monitor's Assessment: Based on the Monitoring Team's review, Provisions M.4 and M.6 were found in substantial compliance. Provisions M1, M2, M.3 and M.5 were not found in substantial compliance. The Nursing Department

	showed significant progress in Section M Provisions, more so in some than others. For Provision M.2, the guidelines for admission, annual, and quarterly nursing assessments were recently revised and continuing to evolve toward compliance. The same was true for Provisions M.3 and M.5 due to recent revisions to the ISP, Integrated Risk Rating, and Integrated Heath Care Plan processes and forms. There were no provisions found to regress. The RN Case Manager Supervisor, which is essential for providing oversight and direction to the RN Case Managers, was vacant. The lack of this position impacts the Nursing Department's ability to move forward toward substantial compliance with Provisions M.2, M.3, and M.5. Provision M.1 contained multiple requirements. If the requirements for staffing, Hospital Liaison Nurses, Infection Control, and skin integrity activities were standalone activities they would be considered in substantial compliance. Other requirements for documentation and assessment of acute change of status and emergency response showed progress but continue to need improvements in order to be considered in substantial compliance. The Quality Assurance processes are well established, including inter-rater reliability processes. Provision M.2 showed that the Nursing Department recently revised the guidelines and forms for conducting annual and quarterly nursing assessments. The RN Case Managers were adapting to and implementing the new guidelines and forms, which were too recently changed to adequately assess the nursing assessments for quality and compliance. The RN Case Manager Supervisor position was vacant. This position urgently needs to be filled because it is essential to moving the provision forward toward substantial compliance. The RN Case Managers need oversight, mentoring, training and monitoring. Provisions M.3 and M.5 showed the Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. However, these processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance. The RN Case Manager Supervisor is essential to assisting the RN Case Managers in moving these provisions forward toward substantial compliance. Provision M.4 showed a robust competency based educational program that tracked all required training to ensure the training was completed. There was evidence through interviews with nursing administration and management staff, and individuals' records reviewed that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed sufficient to meet individuals' health care needs. Provision M.6 showed significant progress in all aspects of medication administration practice according to current generally accepted standards of practice. The Facility had a robust system for identifying, reporting, tracking and analyzing nursing medication variances, as well as for taking corrective actions to mitigate medication variances.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Monitoring Team's Findings: The Facility's Provision M.1 Self-Assessment stated they were in compliance with this Provision but the Monitoring Team did not concur. However, most of the requirements for this provision were very close, if not in compliance with this provision. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, observations, and review of documents, there was evidence that the Nursing Department had continued to make significant progress toward achieving compliance in all of the various requirements contained in this Provision. 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 compliance. This Provision of the Settlement Agreement includes a number of requirements that address various areas of compliance. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions M.2 and M.3 reports. Information and recommendations regarding nursing documentation on restraint usage is included above in Provision C.5 of the report. Information and recommendations regarding nursing stemming from the death review process are reported above in Provision L.2. Staffing: At the time of the compliance review there were 340 individuals residing at the Facility. This represented a reduction of seven individuals since the last compliance review when the Facility census was reported as 347. The Nursing Department reported there was a total of 170 budgeted nursing positions, of which 107 were Registered Nurses (RNs) and 64 were Licensed Vocational Nurses (LVNs). There were 17 open positions, two LVN and 15 RN open positions. Of the 17 open positions, 15 were on hold for deletion. Although the census had been reduced due individuals' deaths and discharges to the community, the Facility continued to admit new individuals. Coupled with the aging population and individuals with increasing acuity, it is essential that the Facility continuously evaluate the need for nursing assets based on census and acuity levels to ensure that sufficient nursing services are available to meet individuals' complex health and high risk care needs. The number of Infirmary beds was reduced from 10 beds to four. The nursing staff longer needed as a result of the reduction in bed capacity were redistributed across campus. The Monitoring Team found that the Nursing Department's Administrative and Management Nursing staff had continued to remain relatively stable, highly motivated, and dedicated to providing high quality nursing services. The Nursing Department was fortunate to continue to have experienced and competent specialty nurses, e.g., Program Compliance Nurse, Certified Wound Care Nurse, Nurse Educators, Hospital Liaison Nurse, Infection Control Nurse, Infection	Noncompliance

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		Control Nurse Assistant, and Clinic Coordinator. This was demonstrated through observations, nursing 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 CNE provided information regarding staffing changes since the last compliance review. The Nursing Department's two essential administrative and management nursing positions were vacant for the Nursing Operations Officer and RN Case Manager Supervisor. The Nursing Operation Officer resigned, the RN Case Manager Supervisor moved to the Nurse Manager position for Three Rivers Unit, a Nurse Manager elevated to become the Nurse Educator Assistant, and a new Nurse Manager was hired for Four Rivers Unit. The Nursing Operations Officer and RN Case Manager Supervisor positions urgently need to be filled because of the overall impact they have on the delivery of nursing services. While both positions are essential, the RN Case Manager Supervisor is particularly essential because of the impact it has on moving the Facility forward toward compliance with Provisions M.2, M.3, and M.5. Interviews with RN Case Managers showed their dedication to ensuring quality nursing assessments and care planning but they need a supervisor to provide oversight, direction, mentoring, training, and monitoring in their area of responsibilities to ensure continuity of care, as well as coordination, collaboration, and integration of services with other relevant disciplines. Having a RN Case Manager Supervisor frees up the Unit/Infirmary Nurse Managers to provide more oversight and direction to the direct care nursing staff. The Nursing Department was in the process of recruiting and reviewing applications for qualified nurses to fill these positions. However, in the field of Intellectual and Developmental Disability (IDD) Nursing it is exceedingly difficult to find qualified and experienced nurses to hire for this special population. It is positive to find facilities that develop and promote qualified incumbent nursing staff to higher levels of responsibility. The Facility should give consideration to promoting qualified incumbents to the Nursing Operations Officer and RN Case Manager Supervisor positions. Promoting incumbent nursing staff has significant benefits because they know the individuals, have received investment of training in the Facility's policies, procedures, Intermediate Care Facility Regulations, as well as the Settlement Agreement requirements. This prevents down time in the nurses' abilities to assume their new roles and responsibilities, which results when nurses are hired externally without IDD experience. The Nursing Department continued to track and analyze staffing patterns/ratios for each Unit/Infirmary by shift daily, monthly and longitudinally. 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. A Nursing Services, Protocol – Training Pulled Nurse, was implemented on 5/7/13. When there was a shortage in coverage, the "pulling system" was used to pull nurses from other units that	

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		had staffing over the required ratios, to cover the shortage. According to the Nurse Educator and review of nursing training records, nurses were cross-training to work on units they were pulled to cover. The Nursing Department continued not to use agency nurses to supplement nursing staffing. They continued to track and analyze hours of nursing overtime monthly. <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 January 2013 through June 2013. She was knowledgeable of activities and was able to answer questions and provide supporting documentation as requested. Since the last compliance review, the POI Committee had continued to make significant improvements with regard to quality assurance efforts. The Nursing POI Committee continued to meet weekly or as needed to review completed Nursing Care Monitoring Tools and Protocol Card Audit Tools. 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 was comprised of CNE, NOO, QA Nurses, Nurse Educators, Hospital Liaison Nurse, Infection Control Nurses, Skin Integrity Coordinator Infirmary Director, Nurse Managers, Nursing Secretary, and Nursing Data Entry Clerk. The Committee reviewed the monitoring/audit tools to ensure they were completed according to schedule, and identified and, when necessary, clarified technical problems and/or questions found on the monitoring/audit tools. When tools or items within the tools fell below 80% compliance, local corrective action was taken. For systemic trends identified CAPs were developed, implemented, and sent to the QA/QI Council for further review and disposition. The POI Committee ensured consistency between the internal (Nursing Department) and external auditors (QA Nurses). Both sets of auditors were monitoring the same records for the same time periods to ensure the accuracy of the data. They reviewed and discussed the completed monitoring/audit tools, identified the tools and/or items within the tools that fell below the established threshold of 80% compliance, and made recommendations for corrective action plans (CAPs) to meet compliance. This information was sent to the QA Department. The progress of the implementation of the CAPs was tracked by the QA Department through to resolution. The POI committee continued to monitor the progress of the CAPs and provided the QA Department updates. The Monitoring Team validated recommendations made for CAPs through review of the POI Committee Meeting Minutes, November 2012 through July 2013. The Monitoring Team attended the POI Committee Meeting on 8/26/13. During this meeting the results of the internal and external findings for the July 2013 Nursing Care Monitoring Tools and Protocol Card Audit Tools were reviewed, discussed, and tools or items within the tools that fell below 80% compliance were identified. The CAP for Urgent Care/ER/Hospitalization was continued for three months. Three new Protocol Card Audits were added to the August	

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		schedule, which included Pre-treatment and Post-sedation, Constipation, and Antibiotic Therapy, along with Head Injury. The Monitoring Team attended the QI/QA Council Meeting on 8/27/13 where nursing monitoring data were presented and reviewed for: Infection Control, Medication Variance, and Skin Integrity. Nursing Quality Assurance Audit Process: Since the last compliance review, the Nursing Quality Assurance Audit Process had changed in April 2013. The Monitoring Team was provided with the new process: • Sample size: The rule was to monthly complete 10%, or five, whichever was greater of tools audited, for a total sample size of 44 records. The only exception was if the Nursing Department chose to do more when there were areas of concern. Monthly the QA Nurses audited four Nursing Care Monitoring Tools and four Protocol Card Audit Tools for inter-rater reliability. • New Protocol Card Audits: o Five Vomiting o Five Urinary Tract Infection o Five Head Injury o Five Post Anesthesia The Protocol Card Audit tools, which were audits of documentation, will be interchanged with other tools every three months as compliance is reached in the documentation process. • Nursing Care Monitoring Tools: o Five Pain Management o Five Urgent Care/ER Visits/Hospitalizations o Nine Medication Observation and Documentation o Nine Care Plans – This tool, related to the Integrated Health Care Plan for nursing services, was put on hold for approximately the next six months to allow them to gain more experience in its use. • Monthly Meetings: The CNE, NOO, QA Nurses, and Program Nurse began meeting on the second Monday of the month, starting on 5/13/13, during the regularly scheduled POI meeting for the purpose of identifying systemic issues and to develop CAPs as necessary. • Quarterly Meetings: The purpose of the meetings was to review the previous quarter's monitoring/auditing results, to identify trends, evaluate the need for further review of items, and identify need for additional monitoring/education. The Nursing QA meeting was scheduled prior to the QA/QI Council meetings in which the Nursing Department was scheduled to present their Quarterly Nursing Data Analysis Report. The Monitoring Team was provided and reviewed monthly Monitoring Schedules, January 2013	

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through July 2013, that identified the tools and sample size, individuals' records to monitor, and the nurses assigned to conduct the monitoring. 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 provisions of the report.

The Monitoring Team's review of the Longitudinal Trend Report for Monthly Monitor Tool Audits (Internal), January 2013 through July 2013, showed most of the tools monitored over the last seven months remained stable, as demonstrated in the chart below:

Nursing Care Monitoring Tools	January	February	March	April	May	June	July	Overall
Urgent Care/ER/Hospitalizations	89%	89%	90%	89%	79%	92%	92%	89%
Medication Observations and Documentation	99%	100%	98%	99%	99%	99%	100%	99%
Pain Management	94%	89%	89%	93%	100%	100%	100%	99%
Skin Integrity	89%	99%	96%	None*	None*	98%	79%	92%
Annual Nursing Assessment*	97%	97%	99%	none	none	none	none	98%

* Skin Integrity audits were not conducted in April and May because the previous months' audits for internal was 98.70%, for external 100%, with 100% inter-rater reliability. Audits were deferred until June. ** Annual Nursing Assessments were deferred because the revised Annual and Quarterly Nursing Assessment procedure was implemented in April 2013.

Since the last compliance review, Corrective Action Plans (CAPs) were implemented for trends identified in the Urgent Care/ER/Hospitalizations and Pain Management Nursing Care Monitoring Tools and followed according the Quality Assurance Department's procedure for CAPs. CAPs were continued and/or repeated until compliance was achieved.

The results of four randomly selected, recently implemented Protocol Card Audits, April 2013 through June 2013, showed:

Nursing Protocol Card Audit Tools	April	May	June	Overall
Vomiting	100%	94%	96%	97
Post Anesthesia	95%	95%	83%	97%
Urinary Tract Infections	100%	100%	90%	96%
Head Injury	96%	87%	92%	92%

No CAPs were required for the above audits.

The Monitoring Team's review of the Nursing Department auditors' and QA Nurse auditors' reports showed the percentage of agreement between the inter-rater reliability checks on the following audits, which all reflected adequate agreement levels:

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		Nursing Care Monitoring Tools, January 2013 through June 2013: • Pain Management had 94% agreement. • Skin Integrity had 94% agreement. • Urgent Care/ER/Hospitalizations had 89% agreement. • Medication Observation and Documentation 99% agreement. Protocol Tools, April 2013 through June 2013: • Vomiting, Urinary Tract Infections, Post Anesthesia Sedation, and Head Injury had an overall agreement of greater than 90%. • Pre-treatment and Post-sedation Protocol Card Tool Audits began in August 2013. Summary of data 8/1/13 through 8/26/13 showed: 88% internal compliance and 88% external compliance with 100% agreement for inter-rater reliability. The Nursing Care Monitoring Tools and Protocol Card Audit Tools were completed according to the Monitoring Schedule, entered into the Quality Assurance Database timely, and were presented at the QA/QI Council Meetings according to schedule. The monitoring data more consistently achieved 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 QA monitoring/auditing procedures and processes were found well established. Based on this compliance review, if the Quality Assurance Efforts were a standalone requirement, it would be considered in substantial compliance. Assessment and Documentation of Individuals with Acute Changes in Status: Since the last compliance review the Facility had continued to expand the Clinical meeting to include more disciplines and had formalized a template and agenda for conducting and reporting issues reviewed and discussed during the meetings. The Monitoring Team attended the Morning Report meeting on 8/27/13. The following disciplines in attendances included: Nursing, Behavioral, Habilitation, Residential, Hospital Liaison Nurse, Quality Assurance, /dental, Pharmacy, QIDP, and Dietitian. All of the psychiatry and medical providers were in attendance. The meeting format was followed and minutes were taken by the Data Analyst. The on-call physician gave a report on individuals for which he was called while on duty. The Infirmary Nurse and Hospital Liaison Nurses provided comprehensive reports on individuals they were following in the Infirmary and hospital respectively. Minutes of the Integrated Morning Meetings were reviewed and found substantive and productive in ensuring communication and continuity of the individuals review and other relevant clinical issues. The Monitoring Team attended the Nursing Morning Meeting on 8/27/13, following the Morning Report meeting. The Nursing Administrative, Management, Specialty Nurse, and Nurse Managers gave reports on pertinent information regarding the individuals and/or issues they were following up on. Following this meeting, the Monitoring Team attended the Incident Management Meeting. It was positive to find that pertinent information discussed in the two	

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		previous meetings was presented at this meeting. This enhances communication across all disciplines and fostered continuity of care. The Monitoring Team attended the Grand Rounds Meeting on 8/28/13, which was also attended by interdisciplinary members. The focus of the meeting centered on a thorough review of Individual #140's clinical course for her psychiatric condition, current management plan, and elicited further strategies for management and treatment. The Grand Rounds Meetings served as an excellent method for focusing on individuals who have complex behavior and medical problems for the interdisciplinary teams to identify issues and explore treatment strategies. The Monitoring Team reviewed a sample of records selected from the Facility's At Risk List for individuals identified at high/medium risk health conditions from each unit for 13 Individuals #243, #66, #366, #594, #106, #468, #296, #379, #25, #177, #524, #43, and #569, and found significant improvement in the implementation of nursing protocols for assessing, documenting, and following through to resolution for acute illness and injuries that did not necessarily require the initiation of acute Care Plans but did require Medical Monitoring for 24 to 48 hours. Numerous examples demonstrating the implementation of Nursing Protocol were found throughout the records reviewed. A few examples of more frequently implemented nursing protocols included, but was not limited to, the following: • Individual #25: On 5/31/13 at 0730, Individual #25 engaged in an episode of mild head banging. The Nursing Protocols for Head Injury and Pain were promptly initiated and followed through according to the protocol for 24 hours with a resolution note documented in the Integrated Progress Notes. The resolution note was documented on 6/1/13 at 0900. No complications were sustained. The Neurological Checklist and Client Injury Report were completed according to protocol/policy. • Individual #243: On 5/26/13 Individual #43 was seen in sick call for abdominal pain and was ordered Zantac 150 mg orally for three days and 24 hour Medical Monitoring. On 5/26/13 at 1930, Medical Monitoring was initiated according to the Nursing Protocol for Abdominal/Pain. The protocol was followed through to resolution on 5/30/13 at 0830. No further abdominal pain was assessed. Individual #243 stated, "My stomach do not hurt and it didn't hurt last night." • Individual #106: On 8/20/13 at 0500, the DSP reported that Individual #106 had a small amount of vomiting. The nurse promptly notified the primary care provider (PCP) according to the Nursing Protocol "When contacting the PCP"; the PCP ordered Medical Monitoring for 48 hours. The nurse also implemented the Nursing Protocols for Vomiting and Pain. Individual #106 was followed according to the protocol through to resolution on 8/23/13 at 0500. There were no complications documented resulting from the vomiting episode. • Individual #66: On 8/19/13 at 1645, Individual #66 complained of right ear pain. He was	

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		assessed for pain according to the Wong-Baker Face Pain Scale. A per necessary (PRN) dose of Tylenol 650 mg was administered. At 1745, he was reassessed for pain. The pain medication was documented as effective with no further complaints of pain. This demonstrated that the Pain Protocol was implemented and followed through to resolution. • Individual #524: On 7/3/13, Individual #524 complained of a headache. He was assessed per the Wong-Baker Face Pain Scale. The PCP was promptly notified of the complaint and assessment of headache. A one-time dose of Tylenol 650 mg was ordered and administered at 1430. He was reassessed for relief of headache approximately two hours later, which was found effective. This demonstrated that the Pain and When contacting the PCP Protocols were implemented and followed through to resolution. The Monitoring Team reviewed a sample of records selected from the Facility's At Risk List for individuals identified at high/medium risk health conditions from each unit for 13 Individuals #243, #66, #366, #594, #106, #468, #296, #379, #25, #177, #524, #43, and #569, and found in general significant improvement since the last compliance review across all records reviewed in the following areas: • There was consistent use of the SOAP format for documentation. • The nursing entries were more consistently timed using military time. • The nursing staff more consistently notified the medical providers promptly when there were significant acute changes in individuals' physical and/or mental health status. • There was significant improvement in consistently following the 23 nursing protocols, as indicated for specific problems. • Individuals placed on 24 and/or 48 hour Nurse Watch Monitoring were more consistently followed through to resolution. • The follow-up documentation of assessments on individuals with acute change in status more consistently stated what would be followed up on, but did not consistently state the frequency of the follow-up activities. • Individuals' response to per necessary (PRN) medications were more consistently documented on the back of the Medication Administration Record (MAR) and/or in the Integrated Progress Notes. There was significant improvement in the assessment and documentation of the effectiveness of the PRN medications. The Pain Protocol was more consistently followed for assessment of pain and followed through to resolution. Pain was assessed using the Wong-Baker Face Pain Scale. • Individuals' level of comfort or discomfort and mental status were more consistently included in the assessments completed related to the illnesses or injuries. • The Pre and Post Hospital and Emergency Room Visit Records were more consistently completed according to the Nursing Protocol: Hospitalizations, Transfers, and Discharges. • Documentation in the Integrated Progress Notes was beginning to show more collaboration/integration with other disciplines.	

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		Areas found it the records reviewed above that needed continued improvement included: • Late entries documented in the Integrated Progress Notes were not consistently documented correctly. • When entries in the Integrated Progress Notes were carried over to the next page, the time was not consistently included with the date of the entries. • Occasionally entries in the Integrated Progress Notes were not documented in chronological order. • Occasionally there were blanks found in the Integrated Progress Notes without a line drawn through as required. • Occasionally entries were written below the last line of the Integrated Progress Notes. • The legibility of the nurses' handwriting had somewhat improved but the signatures and titles for some nurses continued to be illegible. • There was improvement in the assessment and documentation of injuries related to individuals' maladaptive behaviors but there was a continued need to report such injuries to the behavioral staff. Although improvements were noted through interviews, record reviews, and observations, the Nursing Department needs to ensure that the positive practices are maintained and strengthened to meet substantial compliance with this requirement. For the next six months the Nursing Department should consider focusing on the areas identified that need continuous improvement. Availability of Pertinent Medical Records: At the time of the last compliance review, the original Health Management Plans were maintained in individuals' unified records with working copies in the Care Plan Books on the Units/Homes for ready access. Currently, the IHCP was located in the Active Record, and the Monitoring Team was informed that the DSP Instruction Sheet is also placed in the Active Record. Review of the table of contents of the active record and individual notebook confirm that IHCP is to be filed in the Active Record, but it was not listed as being filed in the Individual Notebook. Furthermore, the DSP Instruction Sheet is not listed in either record, nor was there a separate binder in the home for these sheets. Although this reduces the potential for error when plans or instructions are updated, it also reduces the usability of the record for ensuring staff providing direct support are familiar with the supports they are to provide to individuals with healthcare needs. Hospital Nurse Liaison Nurse Activities: 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 and documents supplied and record reviewed validated that these activities were performed. The Hospital	

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		Liaison was readily knowledgeable of hospitalization activities and was able to answer questions and provided additional supporting documentation when requested. The Monitoring Team found that 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 (except for weekend/holidays) onsite visits or by phone. The Campus nurses maintained contact with the hospitals and/or LTAC facilities over the weekends and on holidays. The Skin Integrity Coordinator served as backup for the Hospital Liaison Nurse in his absences. • The Hospital Liaison Nurse's hospital visits included visual assessments, chart reviews, and interviews with nurses and physicians providing care to individuals to ascertain individual health status and response to treatment, in accordance with the Nursing Protocol for Hospitalizations, Transfers, and Discharges. Hospitalized individuals' skin integrity status was assessed at each visit. If skin integrity issues were identified the Skin Integrity Coordinator 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. • Attended Pre and Post Hospital Discharge ISP meetings; and provided IDTs with reports on hospitalized individuals. The IDT members were notified as soon as pending discharges were known in order to discuss any necessary training or equipment needed upon discharge to ensure a smooth transition back to home. • Reported and submitted preliminary reviews of circumstances surrounding the deaths of hospitalized individuals. Reported and submitted reports for an Unusual Incident Investigation of individuals hospitalized. Prepared and submitted three preliminary reviews on three deaths reported from May 2012 through July 2013. Attended Clinical and Administrative Death Review Committee Meetings. One Clinical Death Review Committee was attended in May 2013 and one Administrative Death Review Committee Meeting was attended in August 2013. The Monitoring Team validated the above activities through review of Integrated Progress Notes for seven individuals who were recently hospitalized and discharged that included Individuals #99, #17, #40, #689, #239, #77, and #538. In addition to the activities above, the Hospital Liaison Nurse performed other activities, which included: • Attending daily Integrated Morning Meetings and Grand Rounds Meetings on Thursdays and Thursdays. • Conducting orientation classes for newly hired nurses on the Protocol for Hospitalization,	

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		Transfers, and Discharges for a total of 17 nurses. • Performing chart audits in participation with the Infirmary nurses for individuals discharged from the hospital and admitted to the Infirmary. Sixty charts were reviewed, which met an overall of 98% compliance based on the Post Hospitalization Admission Tool for individuals admitted to the Infirmary. • Serving as backup to the Physical and Nutritional Management Team (PNMT) Nurse. Assessed five individuals' Post Hospital Assessments and Evaluations in June 2013. The Monitoring Team reviewed records of five of the currently hospitalized individuals--Individuals #500, #351, #477, #388, and #489--and found: • The Individuals' records were reviewed through 8/24/13 for documentation leading up to the necessity for hospital admission and during the hospitalization. They showed documentation in the Integrated Progress Notes that the Hospital Liaison Nurse made daily visits or phone call contact with hospital personnel on weekdays and the Campus Nurses on weekends regarding Individuals' health status. All Integrated Progress Notes were consistently dated, timed, and signed with handwritten signatures and titles. This showed significant improvement since the last compliance review. • Previous to the March 2013, revised Nursing Protocol: Hospitalization, Transfers, and Discharges, the protocol stated, "The Hospital Liaison Nurse may place the Hospital Liaison Report in the IPN section of the record, or may document directly on the IPN form." The revised protocol states, "The Hospital Liaison/designee will place the Hospital Liaison Report in the IPN section of the record." The Monitoring Team was not aware of this change when the document request was submitted. Therefore, the Hospital Liaison Reports were not requested. The Hospital Liaison Report Forms were not included in the documents reviewed; therefore, it could not be discerned if the Hospital Liaison Reports were not included because it was not requested or it was not completed and filed in the Integrated Progress Note section of the record. According to the revised Nursing Protocol: Hospitalization, Transfers, and Discharges, the Hospital Liaison should ensure that the Hospital Liaison Reports are completed and filed in the Integrated Progress Notes section of the record. • It was positive to find that the Skin Integrity Coordinator accompanied the Hospital Liaison Nurse on 8/23/13 to visit Individual #351 to assess his peristomial irritation. No skin breakdown was noted and the individual was continued on present hospital wound care treatment for the irritation. On 8/23/13, the Skin Integrity Coordinator accompanied the Hospital Liaison Nurse and visited Individuals #477, who had developed a blister on his left hand due to peripheral IV infiltrated 8/22/13. The hand was wrapped with a Kerlix dressing and was not unwrapped to assess. The hospital wound care team was managing the treatment of the blister on the left hand. There were no other skin integrity issues noted. On 8/23/13, the Skin Integrity Coordinator accompanied by the Hospital Liaison Nurse visited Individual #489. Individual #489 was admitted on 8/22/13 for worsening of	

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		cellulitis of the right lower leg. He was receiving IV antibiotic therapy for the cellulitis. The right leg continued to have erythema, and was warm to touch with edema. The hospital was providing wound care. The neurodermatitis on his back showed no areas of redness or irritation. There were no other skin integrity issues noted. • The Monitoring Team reviewed five records against Nursing Protocol for Hospitalizations, Transfers, and Discharges and found an overall 95.4% compliance with the tool, which was consistent with the Facility's audit findings. • The Monitoring Team reviewed one record using Nursing Protocol Card Monitoring Tool for vomiting and found 100% compliance with the protocol card. • The Monitoring Team reviewed one record using Nursing Protocol Card Monitoring Tool for vomiting and found 100% compliances with the protocol card. • The Monitoring Team reviewed one record using Nursing Protocol Card Monitoring Tool for Antibiotic Therapy and found 100% compliance with the protocol. Additionally, the Acute Care Plan for Cellulitis incorporated items from the Antibiotic Therapy Protocol. The baseline data was sufficient to identify what lead to the need for the care plan. The goal was appropriate. The care plan was individualized sufficient to meet the individual's health care need. • The Monitoring Team reviewed three records using the Nursing Protocol Card Monitoring Tool for When Contacting the PCP and found 100% compliance with the protocol card. Two of the individuals' records reviewed were direct admissions due to the results of diagnostic and/or laboratory testing results. Based on this compliance review, if Hospital Liaison Activities were a standalone requirement, it would be considered in substantial compliance. <u>Skin Integrity Activities:</u> It was impressive to find that Skin Integrity Coordinator had continued to prepare 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 Skin Integrity Coordinator continued to consistently conduct weekly Skin Integrity Committee Meetings. The Skin Integrity Committee membership included: Skin Integrity Coordinator, chair, Medical Director, Physicians, Dietitians, Habilitation Therapist, Behavior Analyst, Clinical Pharmacist, Chief Nurse Executive, Program Compliance Nurse, Nurse Educator, Quality Assurance Nurse, Nurse Managers, Infirmary Director Infection Control Nurse, RN Case Managers, and Data Analyst. The Monitoring Team's review of the Skin Integrity Committee meeting minutes showed that relevant disciplines consistently attended the meetings.	

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		The Monitoring Team attended the Skin Integrity Committee Meeting on 8/28/13, which demonstrated that the meeting was integrated with relevant disciplines. It was impressive to find, since the last compliance review, that the Skin Integrity Coordinator had worked with the Data Analyst and developed a comprehensive Wound Tracking Database in July 2013. All wounds were tracked over time for each individual. The tracking system presented photographs and clinical data describing the date of discovery; type of wound location, size (length, height, and depth) of the original wound and status wound healing overtime, treatment regimen, and supplements if prescribed. The Wound Tracking Database also tracked wound by unit and/or departments. The Skin Integrity Coordinator reviewed and discussed the status of 10 individuals identified with a combination of 13 active wounds, of which two were stage II pressure, with the Committee and elicited input regarding treatment and care interventions. There was active participation by the members in offering recommendations to enhance individuals' wound care. The Wound Tracking Sheets for each individual was placed in their active records to monitor wound healing progress over time. The Monitoring Team reviewed a Summary of the Skin Integrity Committee Reports from February 2013 through July 2013 showed: • In the last six months the Committee reviewed and discussed the care and treatment of five individuals with seven pressure ulcers. • Three of these pressure ulcers were hospital acquired in the months of February, May and June 2013, i.e., in February there was one stage I pressure ulcer, in May there was one unstageable, and in June one unstageable. Four of the pressure ulcers were Facility acquired in May and June 2013, i.e., one stage I in May and three stage I in June. • There were no pressure ulcers in March, April, and July 2013. • Currently for the month of August 2013, there were two active pressure ulcers. One was hospital acquired and the other was Facility acquired. Both were stage II pressure ulcers. Since the last compliance review, the Skin Integrity Coordinator had enhanced the longitudinal data reporting of pressure ulcer/decubitus in a chart format. The chart below represents the Decubitus Report for Fiscal Year 2013:	

	Data Collection	Sept	Oct	Nov	1st QRT	Dec	Jan	Feb	2nd QRT	Mar	Apr	May	3rd QRT	Jun	Jul
	Number of Individuals with Pressure Ulcers	0	1	0	1	2	0	1	3	0	0	2	2	2	0
	Number of pressure ulcers acquired at the Facility	0	0	0	0	1	0	0	1	0	0	1	1	3*	0
	Number pressure ulcers	0	1	0	1	1	0	1	2	0	0	1	1	1	0

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	acquired outside the Facility															
	Stage I:	0	0	0	0	0	0	1	1	0	0	1	1	0	0
	Stage II:	0	0	0	0	2	0	0	2	0	0	0	0	3	0
	Stage III:	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Stage IV:	0	1	0	1	0	0	0	0	0	0	0	0	0	0
	Unstageable:	0	0	0	0	0	0	0	0	0	0	1	1	1	0
	Suspected Deep Tissue Injury:	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Pressure	0	1	0	1	2	0	1	3	0	0	2	2	4	0

* One individual had more than one pressure ulcer.

It is important to point out that the number of monthly pressure ulcers/decubitus reported were a duplicated count. Individuals who had pressure ulcers/decubitus were carried over from month to month until they were healed. Therefore, by reporting them from month to month it makes the data appear to artificially report more individuals than there actually were. The Facility should only report monthly new cases of pressure ulcers/decubitus.

It was positive to find the system for tracking, analyzing, trending, and representing pressure data had significantly improved since the last compliance review. It is essential that this data is accurately tracked, analyzed, and trended. Considering the number of medically fragile individuals with multiple high and medium risks rating, it is essential that pressure data are accurately tracked, analyzed, and trended. The Skin Integrity Coordinator appeared to have enhanced the collaboration and coordination with the Hospital Liaison Nurse, IDT, as well as with outside facilities. In the next six months the Skin Integrity Coordinator in collaboration with the Skin Integrity Committee should continue to focus on more in-depth analyses and trending for underlying causes that contribute to pressure ulcers acquired in facility in residential homes/units, systemically campus-wide, as well as those acquired in outside facilities. The accompanying analyses/trends of the data findings should continue to be interpreted for decision-making purposes and to evaluate progress or lack of progress toward preventing or reducing the Facility's incidence of pressure ulcers. The Facility's goal should be zero tolerance for the development of pressure ulcers, unless an individual had a terminal Kennedy ulcer that was not expected to heal.

The Monitoring Team was provided a detailed summary of activities performed since January 2013, with supporting documentation. These activities were validated through interview with the Skin Integrity Coordinator, review of supporting documentation, and record reviews. These activities included:

- Thirteen Skin Integrity Committee Meetings were conducted. The main issue discussed was an individual with multiple pressure ulcers in Trinity Unit. It was determined that the individual had multiple systemic problems that contributed to the skin breakdown despite an aggressive plan to prevent pressure ulcers.

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		• Twenty two Skin Integrity Monitoring Tool audits were conducted. Overall the compliance score was 94% for the months of January through March and June 2013. • Twenty five wound care consults were received from RN Case Managers and RNs by e-mail for timely response to treatment. While e-mail communications were expedient and effective methods of communication, the RN Case Managers and RNs should document the referrals for wound care consultation and pertinent related information in individuals' Integrated Progress Notes to ensure continuity of care and integration of services. • Attended eight pre-hospital discharge ISP meetings. The main point of discussion was on two individuals that developed unstageable pressure ulcers in the hospital between Friday and evening and Monday morning. Recommendations were made for wound care treatment. • Ten Acute Care Plans (ACPs) for Skin Integrity Issues and two Health Management Plans were reviewed. Four of the ACPs required revision of the wound care treatments. • Eight hospital visits were made with the Hospital Liaison Nurse. The Skin Integrity Coordinator expressed his concern with the hospital's wound care team on the need to increase the hospital's nursing assessments time frames for individuals admitted for care from the Facility and provided wound care consultation and recommendations for treatment with the hospital wound care team. Consultations and recommendations for treatment included Individuals: #551, #477, #489, #77, #99, and #538. The Monitoring Team's review of documentation in these Individuals' Integrated Progress Notes validated the Skin Integrity Coordinator's and Hospital Liaison Nurse's integration and collaboration with the hospital personnel. • Nineteen new hired nurses were trained on wound care assessments, management, and documentation. The necessity to assess and document wound size, drainage, location and healing process in the Integrated Progress Notes. • Attended Grand Rounds meetings every Tuesday and Thursday and gave updates to the IDT on the status of individuals with skin integrity problems. Based on this compliance review, if Skin Integrity Activities were a standalone requirement, it would be considered in substantial compliance. Refer to Provision M.3 for information regarding ACPs and documentation for a sample of individuals with active skin integrity problems. <u>Infection Control Activities:</u> It was impressive to find that the Infection Control 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 Nurses and review of documents showed that they were readily knowledgeable of infection control activities and were able to answer questions and provided additional supporting documentation when	

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		requested. Infection Control Policies and Procedures Reviewed: The Infection Control Manual was reviewed/revised for 2013. The hard copies of the Infection Control Manual were no longer kept on the Units/Infirmary. The manuals were placed on the Share drive for all relevant disciplines to use. The Pandemic Respiratory Infectious Readiness Plan was not part of the manual. The Monitoring Team's review of the Infection Control Policy and Procedure Committee meeting minutes validated that they were reviewed/revised since last compliance review. Infection Control Training Activities: The Infection Control Nurses • Taught Infection Control Measures at New Employee Orientation and at annual refresher training in collaboration with CTD. The CTD Course Delinquency List indicated there were three delinquent employees for Infection Control annual refresher training. The Facility should ensure that all employees are current in infection Control annual refresher training. • Provided additional in-service training on infection control issues identified that need further reinforcement of training to prevent the spread of infections. The Monitoring Team was provided with the topics taught, with training materials used, and training sign-in sheets for training that occurred since the last compliance review. Training topics included: o Infection Control Concerns from Video Surveillance Observations Report was provided to the Campus Nurses. o Multi-Drug Resistant Organisms (MDRO) was provided the Infirmary and Campus Nurses. o Methicillin Resistant Staphylococcus Aureus (MRSA) was provided to Three Rivers (TJ9) Direct Support Professionals (DSPs). o Infection Prevention to Individual and Others was provided to the TJ9 Nurses and DSPs. o Procedure for monitoring the condition and cleanliness of medical equipment (IV Poles, Stethoscopes, Feeding Poles and Pump, Dina Maps and Poles) on the homes and environmental cleanliness to avoid transmission of infections was provided to Unit Nurse Managers. o New Pneumonia Tracking Form Instructions for AVATAR was provide to Nurse Managers, RNs and CNE. o General Infection Control Items were provided to all nurses. o Conjunctivitis training (Signs and Symptoms – Preventing the Spread of Conjunctivitis) was provided to the Nueces Direct Support Professionals. o Disposal of trash in medication room; Set up a specific time for housekeeping to pick up the trash; and RNs' entering infections in AVATAR was provided to Unit Nurse Managers. • Attended Essentials in Infection Prevention, sponsored by DSHS, July 8 and 9, 2013, earning	

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		15.5 contact hour of continuing education through the Texas Nurses Association. Infection Control Committee Meetings: Infection Control Committee Meetings continued to be consistently conducted quarterly. The Committee was integrated with other Facility disciplines participating. The standing membership included: Infection Control Nurse, chair, 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 meeting minutes showed that relevant disciplines consistently attended the meetings. The Monitoring Team reviewed the Infection Control Committee meeting minutes for 1/15/13, 4/9/13, and 7/16/13. A review of the quarterly Infection Control Committee Meeting sign in sheets showed that not all members consistently attended the meetings. The Infection Control Program encompasses aspects related to all areas of the campus, all departments, and programs. It is essential that all core members attend and participate at the committee meetings to ensure that all aspects of infection control are addressed. As was found in previous meeting minutes, there was much emphasis on monitoring and improving environmental issues. Since the last compliance review it was positive to find that several environmental improvements had been made, which included but were not limited to: • The use of environmental safe cleaning products. • Shower mats were removed from all areas and Tub-Safe was applied to directly on the bathroom and pool areas surfaces to prevent slipping and falling. • The Infection Control Nurse summarized and reported quarterly infection data derived from the Infection Database, by type, number and type of infections occurring with high frequency, by units/homes, and corrective measures taken to reduce the incidences of those infections. At the April 2013, meeting it was reported that the terminal clean-up in Trinity, due to the regular aggressing clean, steaming, air scrubbers, new mattresses UV lighting and cleaning chemicals, the amount of sick individuals had dropped dramatically. However, there was no data presented to substantiate this claim. At the meeting the Medical Director requested to see the trends, to analyze and draw conclusion before the next meeting. At the meeting in July 2013, the high incidence of urinary tract infections in the male population in Trinity was discussed along with probable causes and corrective actions needed to be taken. The data was to be further reviewed, analyzed, and discussed at the August 2013 meeting. The Monitoring Team attended the Infection Control Committee on 8/27/13. The meeting was well integrated with relevant disciplines. Of the standing membership, 82% were in attendance. Due to the Monitoring Team's visits, some of the members were otherwise	

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		occupied with other activities and could not attend. The meeting was substantive, productive, with active participation of the members. The Infection Control Nurse Assistant presented a summary of infections for the quarter of April 2012 through June 2013. • A summary of the urinary tract infections (UTIs) showed there was a total of 27 individuals diagnosed with UTIs; 11 of these had two or more infections within the quarter. It was positive to find that the Infection Control Nurses, in collaboration with the Medical Director, had conducted a comprehensive and in depth trend analysis of UTI data. They included individuals who had had two or more UTIs that included: Individuals names, home, date of UTIs, initial symptoms, urine analysis lab and culture and sensitivities, number of UTIs during the past 12 months, comorbidities, whether acquired inpatient or outpatient, diaper usage, and antibiotics given. • A summary of the pneumonias data showed an increase in pneumonia cases. In Trinity, 37 of 44 cases were in this unit. The homes in Trinity most affected were Trinity A and B. Considerable discussion was focused on identifying the underlying causes and problem solving measures to mitigate the incidents of reoccurrence. The aspiration pneumonia/pneumonia trend analysis data for 4/1/13 through 6/30/13 was also discussed at length for underlying causes and possible measures to take to mitigate the incidence of aspiration pneumonia/pneumonia. The Committee will continue to analyze and trend these data seeking to identify the underlying causes and explore preventative measures to reduce the incidences of both infections. During the discussion it was mentioned that infections were entered into AVATAR Infection Database when antibiotics were prescribed; then later if cultures and sensitivities studies were ordered and the results did not identify growth of organisms (indicating there was no infection present), there was no way to eliminate the reported infection from the AVATAR Infection Database. This was of concern to the Monitoring Team because reporting unconfirmed infections has the potential to skew the data. In addition, treating infections presumptively with antibiotics without confirmation may increase the potential risk for developing multi-drug resistant organisms. The Monitoring Team will follow-up at the next compliance review on the final outcome of decisions made to reduce the incidences of UTIs and aspiration pneumonias/pneumonias. Refer to Sections L and O for additional information regarding the incidence of aspiration pneumonias/pneumonias and actions taken to reduce the incidences. In addition to the reports on infections, the Support Services Director reported on the purpose of the Environmental Readiness Team (ERT) and reviewed the changes made since the last compliance review. It was thought the measures taken to improve air quality and the physical environment had aided in reducing the incidence of infections. The list of environmental improvements was impressive, which included:	

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		• Stationary air scrubbers were permanently mounted in the Infirmary. • Portable air scrubbers were controlled by the Infection Control Nurses who sends them to the units as needed. They remained operational and ready to deploy at any time. • UVC lighting was on the last phase to complete all of the home buildings, i.e., two more cottages, and one programing area (Neches). • For the floor program, new type of sealant was laid down on the floors after stripping, which had hydrogen inside. It is activated by light to let off hydrogen that kills bacteria. • Fabreeze air freshener was removed for the Facility's chemical inventory. They have gone "green" with new chemicals. • A new policy was developed and implemented for Mattress Cleaning and Replacement Program. This reduced the number of individuals being exposed to sleeping on soiled mattresses. In conclusion, the Support Services Director stated that the mattress cleaning/replacing, floor stripping, Tub-Safe in shower areas, air-scrubbers, UVC light on Trinity A and C, and weekly mass cleaning on Trinity had greatly reduced the problems with air and the environment in Trinity. The Monitoring Team toured the Central Kitchen on 8/29/13, accompanied by the Infection Control Nurse and Data Entry Clerk. The Food Service Director provided a tour throughout all areas of the kitchen, showed and explained how various food products were stored and used. The kitchen was clean and well organized. The quality of the food products observed appeared of good quality and in date. Observation was done of food preparation for lunch; lunch appeared and smelled appetizing. Unused/unopened formulas returned from the units and those with short shelf life were stored on separate selves away from the general stock to prevent formula from expiring. It was positive to find that the Food Service Director was a chef for 29 years before assuming this position. Having such an experienced Director, no doubt, contributed to the well organized and managed kitchen, as well as the quality of food served to individuals. Infectious and/or Communicable Disease Data Reports: The Monitoring Team was provided a summary of infections from 1/1/13 through 6/30/13, which showed a high rate of UTIs, conjunctivitis infections, and cellulitis infections. There were a total of 47 UTIs, 16 conjunctivitis infections, and 17 cellulitis infections. All other infections had 10 or fewer episodes campus-wide, as the quarterly Summary of Infections Report for the first and second quarter of 2013 shows in the chart below:	

Infections by Type	January – March 2013	April – June 2013	Total Number
Urinary Tract	20	27	47
Soft Tissue/Cellulitis	7	10	17
Conjunctivitis	9	7	16

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Otitis Media	3	7	10
Upper Respiratory Tract	1	4	5
Lower Respiratory Tract	3	1	4
Total Number	43	56	99

The Infection Control Nurses' recommendation was to continue auditing with the hand washing tool for the residential units to ensure competency and compliance to reduce the spread of infections. While good hand washing practices are essential to prevent the spread of infections, the Infection Control Nurses, in collaboration with the Infection Control Committee, should consider using a nationally accepted method to analyze and trend infectious and communicable disease data and ensure that all potential underlying causes for contracting infections and/or the spread of infections are identified and appropriate preventative measures are put in place to mitigate all forms of infections. Copies for Reportable Infectious and/or Communicable Disease Reports were not provided for review as requested. Therefore, it was not possible to determine the incidences of these diseases, such as Multi-Drug Resistant Organisms (MDRO).

Other Infection Control Activities:

- Handwashing/Glove Use audits were completed from 1/1/13 through 6/30/13, and showed that five random samples out of 14 areas for a total of 70 samples were at 100% compliance in demonstrating hand washing and standard precautions to prevent infection by all employees audited in the departments.
- Environmental Surveillance Reports conducted by the Environmental Review Team for all infection control issues in the months of January 2013, May 2013, and June 2012, found on the 12 areas audited on the Environmental Surveillance Tools, four areas had sanitary issues that could lead to infections. The identified issues were corrected with an overall compliance of approximately 95%.
- Prepared monthly Antibiograms and provided the information to the medical staff and to the Pharmacy and Therapeutics Committee.
- Conducted the monthly assigned Protocol Tool for Urinary Tract Infections, Monitoring Tool for Hand washing, and Environmental Surveillance Checklist.
- Entered immunization data into the AVATAR system for reporting and tracking immunizations, as well as placed immunizations in individuals' Immunization Records. No immunization data was provided for review. All individuals' immunizations were reported as current. In May 2013, the Infection Control Nurses collaborated with the Clinic Nurse to begin the use of the new employee immunization database. The Clinic Nurse maintained an updated account of employee immunizations with assistance from the Infection Control Nurses.
- There were no trends reported for employee infections or plans of corrective actions.
- Reviewed and reported Individuals' and employees' tuberculosis skin testing and influenza vaccination status:

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		o Individuals' were reported to be 100% current with tuberculosis skin testing. There were seven individuals with previously converted tuberculosis skin tests, all of whom were current with their follow-up screening. o Individuals' influenza vaccinations were reported as 100% complete. o Employees' tuberculosis skin testing and/or chest x-ray/screenings were reported at 99.45% completed. o Employees' who received influenza vaccinations were reported at 34% complete. Employees' who received Hepatitis B vaccination series were reported at 52%. • Continued to conduct monthly audits on assigned Nursing Protocol Cards for Urinary Tract Infections. • Continued implementing the Protocol for "Real Time Data Monitoring using an Individual Infection Control Report" Form for the nursing staff to complete and send or fax to the Infection Control 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. From 1/1/13 through 6/30/13: o 204 of 204 (100%) Infection Control Forms were completed and submitted. o 200 of 204 (98%) Infection Control Forms had an ACP completed. o 178 of 200 (87%) ACPs included interventions for infection control. o All interventions were corrected as they were identified; therefore, Infection Control Forms were found 100% compliant. Nurses failed to complete four ACPs in January 2013 when infections were diagnosed. Corrective action was taken: In-service the Unit Nurse Managers to retrain their nurses on initiating infection control ACPs and to include interventions for all infections. Refer to Provision M.3 information on ACPs related to infections. Summary of Infection Control Nurses Integration with other disciplines/departments included: • Attended the Integrated Morning Meetings on Tuesdays and Thursdays. • Attended the Grand Rounds Meetings. • Attended the Wound Care Committee Meetings weekly. • Taught Infection Control Measures at New Employee Orientation in collaboration with CTD. • Attended IDT meeting when there were infection control issues that needed addressed. • Attended the Safety Committee Meeting monthly. • Attended Pharmacy and Therapeutics Committee Meetings Quarterly. • Attended the Environmental Readiness Team monthly meeting rounds on campus. • Attended Pre-hospital Discharge ISP meetings on individuals with infectious issues. Based on this compliance review, the Infection Control Program was well organized, managed and met the generally accepted standards of infection control for long term care facilities. If Infection Control Activities for this provision was a standalone requirement it would be considered in substantial compliance.	

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		Mock Medical Emergency Drills and Emergency Response Activities: 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; with the exception of fully implementing a variety of scenarios that might require emergency response. Improvements were verified through review of documents, staff interviews, and observations. 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, Competency Training and Development Director, Director for Residential Services, Quality Assurance Nurses, Risk Management Clerk, and Nursing Administrative Assistant. The Respiratory Therapist will be added to the membership. The Emergency Medical Response Committee met monthly, January 2013 through April 2013. In July 2013, the meetings were changed to quarterly because it was report there was now little work that needs to be done on a monthly basis. The Committee's Mission Statement stated, "The mission was to establish guidance for training and management of real life medical emergencies and emergency response…" The Monitoring Team reviewed Emergency Medical Response Committee Meeting minutes for 1/9/13, 2/20/13, 3/20/13, 4/17/13, and 7/17/13. The minutes reviewed found meetings were substantive and issues identified in previous meetings that needed follow-up were addressed in following meetings. It was positive to find that the Facility had procured carts that held the entire required emergency equipment and was easily maneuvered. The carts were stored under the AED cabinets on the units, thus locating all the equipment in one location for ready access. The Committee discussed a proposal for all administrative staff to undergo CPR training just as the DSPs are required since many of them are not trained or have never been trained. The final disposition of this proposal was not included in the minutes. As the last compliance review recommended the Facility should conduct a variety of scenarios that might require emergency response, the Committee stated, "These scenarios would be staged in different areas, and would require staff to adapt to changes in environment and resource availability. The issue is that conducting a drill on this magnitude places undue burdens on facility staff, resources, and systems. Committee chose to adhere to current protocol of calling 911 and making person as comfortable as possible." It was positive to find that the Emergency Medical Response Committee had continued to conduct Emergency Medical Response Debriefing for code events. For example, the Committee conducted a debriefing on a code event that occurred in February 2013, where an individual was found unresponsive in a wheelchair where the staff attempted CPR in the wheelchair, and then in the bed without a back board underneath, in addition to other response measures that	

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		did not go well. Corrective actions were recommended and implemented as validated through signed training records. However, the Monitoring Team found it unfortunate that the Emergency Medical Response Committee did not understand the merit in conducting a variety of realistic scenarios for emergency response. Individuals experiencing a code event typically do not lie conveniently day down in the floor and wait for the staff to respond with CPR. Code events occur in many locations and under numerous environmental circumstances for which the staff should have the emergency response skills to deal with to save lives. This was particularly true in light of this code event that actually occurred. The Monitoring Team's asked to have the Risk Manager and CTD Director conduct an impromptu mock emergency drill using the scenario of "man down" in bed with side rails up to determine how staff would respond to such a scenario that had not been practiced. However, the drill was not possible due to the lack of a bed with side rails to use that did not already belong to someone. The Monitoring Team met with the Risk Manager, CTD Director, and CNE and discussed the importance of conducting a variety of realistic mock emergency drill scenarios. To simply follow the basic drill protocol with "man down" in the floor, call 911, and keep the individual as comfortable as possible does not meet the requirement for effective CPR. The CTD Director agreed to develop and implement a variety of realistic mock emergency drills. This is in keeping the Mission Statement to establish guidance for training and management of real life medical emergencies and emergency response. The Monitoring Team's review of the monthly Mock Medical Emergency Drill Reports, January 2013 through June 2013 found, that 100% of the scheduled drills were completed, and data were analyzed and trended. Data were represented in tabular and graphic form with narrative explanations of any identified deficiencies. One deficiency was identified in February 2013 where the staff did not respond to the drill in in Pacos home; it was immediately reported to the Unit Director for a positive performance plan. Otherwise, 100% of the drills completed were reported as passed. 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 reported. It was reported that copies of the completed Mock Medical Emergency Drill Reports were sent to the Incident Management Meeting (IMM). However, there were no copies of the IMM minutes provided to review to validate the reports were sent. The Monitoring Team's observations of the AEDs and emergency equipment in Trinity, San Antonio, and Leon Units found them readily accessible, with the equipment in good working order. A review of the monthly AED and Emergency Equipment Checklists and the Monthly Walkthrough Checklists provided evidence they were reviewed and completed as required by policy. The Facility's List showed the location of AEDs and Emergency Equipment throughout the campus. A list was provided for the qualified instructors trained in basic CPR, as well as a list of CPR faculty and CPR Instructors.	

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		The Competency Training and Development (CTD) Due/Delinquency Training Lists indicated one employee was delinquent in Basic Life Support (BLS) for Health Care Providers. The CTD Course Delinquency List indicated three employees were delinquent in Cardiopulmonary Resuscitation (CPR) Basic. These employees had been delinquent since July 2011. The Facility should ensure that all required employees are current with Basic Life Support and/or Basic CPR training. In order to meet substantial compliance with this requirement of this provision the Facility must be able to demonstrate that they are able to successfully perform drills in variety of locations and under numerous environmental circumstances. The Monitoring Team will follow-up at the next compliance review on the development and implementation of realistic drill scenarios.	
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.	<u>Monitoring Team Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.2's Presentation Book; review of documents requested; meetings/interviews with Chief Nurse Executive, Compliance Nurse, and Nurse Educator; and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.2 and the Monitoring Team concurs with their findings. <u>New/Revised Policies, Procedures, and Processes:</u> • RSSLC At Risk Individuals, I.08, Revised: 8/15/13 • DADS Quarterly Nursing Physical Assessment form and a Quarterly Nursing Record Review form Procedure, April 2013. Refer to Provision M.4 for other new/revised policies, procedures, protocols, and processes <u>RN Case Manager Training Activities:</u> According to Nursing Administration, training activities were provided to the RN Case Managers to: • Ensure that nursing problems/diagnoses were analyzed and summarized concisely. • Adequately and accurately represent individuals' health status. • Measure the effectiveness of their respective health maintenance plans (HMPs). • Review/revise Comprehensive Nursing Assessments for significant changes in health status. • Ensure that nursing problems/diagnoses and accompanying HMPs were developed and implemented for all individuals with medium and high risk ratings. • Ensure the HMPs were transitioned to Integrated Health Care Plans in February, and initiated with each annual planning meeting.	Noncompliance

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		The Following in-service trainings were provided to the RN Case Managers: • 1/3/13: RN Case Managers were trained on: o Assuring routinely ordered laboratory studies were filed in the record. o Ensuring follow-up occurred with each consultant's recommendations, i.e., order laboratory studies and diagnostic tests. o Number trained = 23, with 100% trained. • 1/17/13: RN Case Managers were trained on: o Entering immunization in to AVATAR o IHCPs, starting in February 2013. o ISP Nursing Assessment filing in QIDP folder/information to be filled 10 days prior to the meetings. o Ensuring cover sheet was done when Acute Care Plans were implemented o Number trained = 17, with 89% trained. • 1/23/13: RN Case Managers were trained on: o Revised IRRF/IHCP/CoS IRRF processes. o Number trained = 20, with 100% trained. • 1/31/13: RN Case Managers were trained on: o Bedrail/Weight Databases and entering data into AVATAR. o Number trained = 15, with 79% trained. • 2/7/13: RN Case Managers were trained on: o Quality Audit Peer Review o Bedrail Database o Number trained = 12, with 60% trained. • 2/28/13: RN Case Managers were trained on: o Bedrail Database: trained by Habilitation Director and Data Analyst o Revised restraint check list. o D6 Fire Alarm Alert Vibrating Devises. o MOSES/DISCUS o Number trained = 13, with 65% trained. • 3/7/13: RN Case Managers were trained on: o RN Case Managers responsibilities and job descriptions. o Audit Peer Review. o Adverse Drug Reaction trained by the Pharmacist o Number trained = 14, with 70% trained. • 3/27/13: RN Case Managers were trained on: o AVATAR – MOSES/DISCUS o Number trained = 14, with 70% trained. • 4/18/13: RN Case Managers were trained on: o Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly	

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		Physical Assessment o 100% trained Since the last compliance review, It was of concern to the Monitoring Team that the Nursing Department had lost the RN Case Manager Supervisor. The RN Case Manager Supervisor position urgently needs to be filled because of the overall impact it has on the delivery of nursing services. The RN Case Manager Supervisor is particularly essential because of the impact it has on moving the Facility forward toward compliance with Provisions M.2, M.3, and M.5. Interviews with RN Case Managers showed their dedication to ensuring quality nursing assessments and care planning, however; they need a supervisor to provide oversight, direction, mentoring, training, and monitoring in their area of responsibilities to ensure continuity of care; as well as coordination, collaboration, and integration of services with other relevant disciplines. It was positive to find that the Nurse Educator was filling in until a RN Case Manager Supervisor position was filled and providing oversight, mentoring, training and monitoring. The reporting form for the Comprehensive Nurse Assessment was revised and implemented in April 2013. The form's name was changed to Comprehensive Nursing Review. The physical assessment section was replaced with a Quarterly Nursing Physical Assessment form and a Quarterly Nursing Record Review form. The procedure for completing the Comprehensive Nursing Review included: • Within 30 days of the date of admission. • Annually, at least ten working days prior to the annual ISP. • Upon return to the center, if the individual was absent from the facility for more than 30 days. • The Nursing Physical Assessment form will be completed along with the annual or admission Comprehensive Nursing Review, at least quarterly along with the Quarterly Nursing Record Review form. These forms must be completed by the last day of the month in which the quarterly was due. Although the procedure and forms for the nursing assessments were changed, the Monitoring Team found that the actual content and requirements for compliance did not change significantly. Since the last compliance review, the Nursing Department had trained the RN Case Managers and implemented the revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment Procedure and Forms in April 2013. Training records indicated 100% of the RN Case Managers were trained on the procedure and forms. Because of recently revised nursing assessment procedure and forms, the records reviewed below were documented on a combination of the previous used Annual/Quarterly Comprehensive Nursing	

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		Assessment and the revised forms. The Monitoring Team reviewed the most recently completed Admission, Annual and/or Quarterly Nursing Assessments for a sample selected from the Facility's At Risk List for individuals identified at high/medium risk health conditions from each unit for 13 Individuals #243, #66, #366, #594, #106, #468, #296, #379, #25, #177, #524, #43, and #569, and found: • Twelve of 13 (92%) most recently completed Admission, Annual, and/or Quarterly Nursing Assessments requested were available for offsite review. The Annual Comprehensive Nursing Assessment for Individual #177 was not provided for review as requested.. • Four of four (100%) Admission Comprehensive Nursing Assessments were completed within 30 days of admission. • Six of six (100%) Annual Comprehensive Nursing Assessments were completed at least 10 working days prior to the ISP meetings. • Two of two (100%) of the Quarterly Nursing Physical Assessment Records were completed by last day of the month in which the quarterly was due. One of two (50%) included a completed Quarterly Nursing Record Review. The Monitoring Team's review of the 12 most recently completed Admission Annual and/or Quarterly Nursing Assessments using a monitoring tool comparable to the tool previously used by the Facility found an overall compliance of 96%. This was a significant improvement from previous compliance reviews. This was relatively consistent with the Facility's Quality Assurance data reported in Provision M.1. The RN Case Manager who completed the recent Annual Comprehensive Nursing for Individual #468 was exemplary in the completeness and accuracy of the assessment. Required items on the tool that fell significantly below 90% compliance, and which need continued improvement included: o Current active medical diagnoses were not consistently updated. o Immunization data was not consistently completed with all current and required immunization and Tuberculosis (TB) Screening. For example: Individual #43's Purified Protein Derivative (PPD) skin test was dated 10/12/11. The Annual Medical Assessment documented that the PPD was completed on 10/1/12 and was negative. o End of Life Planning issues were not consistently completed. o Nursing Diagnoses/Problems related to all high and/or medium risk rating on individuals' Integrated Risk Rating Forms were not always included with accompanying Integrated Health Care Plans. However, for the Nursing Diagnoses/Problems that were listed and their accompanying overall Nursing Summaries in Section XI there was significant improvement in concisely summarizing raw clinical data to reflect the health status for each Nursing	

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		Diagnosis/Problem in terms of improving, maintaining and/or regressing, as well as the effectiveness of their care plans. o The recently revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment Procedure and Forms was still evolving. The RN Case Managers need the oversight and direction of the RN Case Manager Supervisor to ensure that all required assessment and report forms are completed per procedures. The Facility's Self-Assessment, interviews with the Compliance Nurse and RN Case Manager, and review of documentation provided, showed that although the revised Nursing Assessment Monitoring Tool was not yet implemented, Nursing Administration was reviewing completed nursing assessment using the new procedure and forms, as well as providing feedback to the RN Care Managers. For the next six months the Nursing Department should consider focusing on improvements for the issues identified above in order to move toward compliance with this Provision. Refer to Provision M.5 and Section I, Provision I.1 and I.2 for additional information regarding the risk rating process and IRRFs and IHCPs.	
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.	<u>Monitoring Team's Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.3's Presentation Book; review of documents requested; meetings/interviews with Chief Nurse Executive, Compliance Nurse, Nurse Educators, Nurse Managers; and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.3 and the Monitoring Team concurs with their findings. <u>New/Revised Policies, Procedures, and Processes:</u> • RSSLC At Risk Individuals, I.08, Revised: 8/15/13 <u>Training Activities:</u> • 1/23/13: Revised Integrated Risk Rating Form (IRRF), Integrated Health Care Plan (IHCP), and Change of Status IRRF training was provided by the QIDP Director to RN Case Managers. • 3/1/13: Aspiration Training provided by RSSLC staff to all Nueces 2-10 and 6-10 shifts staff. • 4/29/13: Risk Follow-up was presented by the State Office Coordinator of Specialized Therapies. Training records were not provided for review. • 6/17/13: ISP Process, including IRRF and IHCP provided by State Office staff to RN Case	Noncompliance

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		Managers and QIDPs. As mentioned in Provision M.2, it was of concern that the Nursing Department had lost the RN Case Manager Supervisor. The RN Case Manager Supervisor position urgently needs to be filled because of the overall impact it has on the delivery of nursing services. The RN Case Manager Supervisor is particularly essential because of the impact it has on moving the Facility forward toward compliance with Provisions M.2, M.3, and M.5. The Monitoring Team reviewed a sample of five individuals with recent or current Active Skin Integrity Issues (Individuals: #623, #30, #384, #724, and #619), and found: • Five of five (100%) plans had baseline data sufficient to identify the skin integrity issue that led up to the necessity for care plans. • Five of five (100%) plans had goals sufficient to identify the desired outcomes of the skin integrity issues for which the care plans were design to resolve. • Five of five (100%) plans were reviewed and revised when indicated by the Skin Integrity Coordinator. • Four of five (80%) plans were individualized care plans sufficient to meet the individuals' specific skin integrity issues. • Five of five (100%) plans incorporated relevant protocols in the plan, such as., What to tell the PCP, Antibiotic Therapy, and Pain. • Five of five (100%) plans included integration of care with other relevant disciplines. • Four of five (80%) plans that required antibiotic therapy included notification to the Infection Control Nurse. • Five of five (100%) plans included how frequently interventions were to be completed, by whom, and where documented. • Five of five (100%) plans included relevant preventative measures. • Five of five (100%) included that DSPs were trained on the DSP Instruction Sheets. The DSP Instructions Sheets were individualized sufficient to meet individuals' health care needs that were applicable to individuals' specific skin integrity issues. However, from the signature sheets it was not possible to discern whether all DSPs were trained on each shift, including whether newly assigned and/or pulled staff were trained on the plans. Overall the quality and completeness of the ACPs for skin integrity issues showed significant improvement including the incorporation of respective nursing protocols into the plans and in the Integrated Progress Notes. While the Integrated Progress Notes related to the ACPs showed improvement, the shift entries did not consistently include a full set of vital signs and oxygen saturations level, address adverse drug reactions, the effectiveness of the treatments, and size, description of wound, or status of wound healing. From a review of the DSP Instruction Signature Sheets it was not possible to discern whether all DSPs were trained on each shift, including whether newly assigned and/or	

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		pulled staff were trained on the plans. • Example of findings from review of Integrated Progress Notes: o Individual #30: The Monitoring Team reviewed Individual #30's Integrated Progress Notes from 8/1/13 through 8/27/13. He was discharged from the hospital on 8/1/13 where he was diagnosed and treated for aspiration pneumonia and UTI. He was admitted to the Infirmary. Upon return from the hospital 8/1/13, the physician ordered a consult for wound management of a coccyx pressure wound. The pressure ulcer was evaluated and treatment regimen ordered on 8/1/13 by the Skin Integrity Coordinator. This was a hospital acquired pressure ulcer. Upon admission to the Infirmary, the Integration Progress Notes documented the initiation of ACPs for pneumonia and UTI but there was no ACP for the coccyx pressure wound. From 8/1/13 through 8/5/13, there was one entry on 8/3/13 that documented the assessment of the coccyx pressure wound. The Acute Care Plan for Impaired Skin Integrity Stage II Pressure Ulcer of the Coccyx was not initiated until 8/5/13 when Individual #30 returned to his home. According to the ACP the status of pressure ulcer was to be assessed and documented every shift until healed. The Integrated Progress Notes 8/5/13 through 8/27/13 indicated that the ACPs/ relevant protocols for pneumonia and UTI were consistently followed. However, The Integrated Progress Notes for the pneumonia, UTI, and the pressure wound were combined into one entry making it difficult to discern the status on any one single problem. The notes did not consistently include assessment and documentation regarding the status of the coccyx pressure wound. When there were wound assessments, the notes did not consistently describe the size and appearance of the wound healing. Most often the notes stated, "Wound slowly healing." For individuals who have skin integrity issues, particularly pressure wounds, the Skin Integrity Coordinator should, in addition to reviewing the ACPs, review the Integrated Progress Notes regarding documentation of wound care assessments and management to ensure that individualized plans for care and treatments are consistently followed through to resolution and in accordance with nursing services wound care procedures/protocols. The Monitoring Team reviewed a sample of five individuals with recent and/or current active infections Acute Care Plans and supporting documentation for Individuals #209, #108, #471, #223, and #1, and found: • Five of five (100%) plans had baseline data sufficient to identify the skin integrity issues that led up to the necessity for care plans. • Five of five (100%) plans had goals sufficient to identify the desired outcomes of the skin integrity issues for which the care plans were design to resolve.	

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		• Five of five (100%) had Individual Infection Control Forms completed and sent to the Infection Control Nurses. • Five of five (100%) plans were reviewed and revised when indicated by the Infection Control Nurses. • Five of five (100%) plans were individualized care plans sufficient to meet the individuals' specific skin integrity issues. • Five of five (100%) plans incorporated relevant protocols in the plan, i.e., What to tell the PCP, Antibiotic Therapy, and Pain. • Five of five (100%) plans included integration of care with other relevant disciplines. • Four of four (100%) plans that required antibiotic therapy included notification to the Infection Control Nurse. • Five of five (100%) plans included how frequently interventions were to be completed, by whom, and where documented. • Five of five (100%) plans included relevant preventative measures. • Five of five (100%) included that DSPs were trained on the DSP Instruction Sheets. The DSP Instructions Sheets were individualized sufficient to meet individuals' health care needs that were applicable to individuals' specific skin integrity issues. However, from the signature sheets it was not possible to discern whether all DSPs were trained on each shift, including whether newly assigned and/or pulled staff were trained on the plans. • Four of Four (100%) plans that were resolved were followed through to resolution with an accompanying resolution note in the Integrated Progress Notes. One plan was still in process. Since the last compliance review and from a review of the above ACPs for infections, it was evident the Nursing Administration and the Infection Control Nurses had worked aggressively to improve the quality and completeness of the ACPs. Overall the quality and completeness of the ACPs for infections showed significant improvement including the incorporation of respective nursing protocols into the plans and in the Integrated Progress Notes. While the Integrated Progress Notes related to the ACPs showed improvement, the shift entries did not consistently include a full set of vital signs and oxygen saturations levels, address adverse drug reactions, or the effectiveness of the treatments in curing the infections. The Monitoring Team reviewed five Nursing Discharge Summaries and Community Living Discharge Planning (CLCP)Packets for Individuals #685, #728, #81, #480, and #267, and found: • Zero of five (0%) individuals' CLDP packets provided to the Monitoring Team contained a Comprehensive Nursing Assessment within 45 days of discharge. It could not be discerned whether the assessments were not included in the discharge packets for review or were not completed. • Five of five (100%) Nursing Discharge Summaries were completed for the individuals prior to discharge/transferring to the community.	

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		• Five of five (100%) Nursing Discharge Summaries listed nursing diagnoses/problems for all high/medium risk ratings or other problems that required interventions. • Two of five (40%) Nursing Discharge Summaries thoroughly summarized health status of each nursing diagnosis/problem such that the receiving agency could understand their present health status in order to respond to their health care needs. The health status in relation to high/medium risk ratings and or other nursing diagnoses/problems were not completed on the summaries for Individuals #480, #267, and #81. • Four of five (80%) Nursing Discharge Summaries completed included the required, "Special Instructions: for Medication techniques (likes/dislikes, crushed, etc.), triggers/signs/symptoms of illness/behaviors (how I communicate when I don't feel well or what makes me angry, etc.,), and special techniques to have them be cooperative. Other pertinent information (i.e.: special behaviors and what they mean, how I communicate, signs and symptoms of pain, etc.)." • Four of five (80%) CLDP Packets contained Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs). • Five of five (100%) provided training on health care plans sufficient to meet individuals' health care needs for identified high and/or medium risk rating and/or nursing diagnoses/problems, and recommendations for future health care needs. As was found in previous compliance reviews, the Facility did not have instructions for completing the Nursing Discharge Summary form beyond the few instructions printed on the last page of the form related to special instructions. Therefore, it was not surprising to find the deficiencies identified above. The Most Integrated Setting Practices Policy contained no instructions that identified the RN Case Managers' role and responsibilities for completing the Nursing Discharge Summary form. While onsite, the Monitoring Team discussed the lack of explicit instructions regarding nursing's role and responsibilities for CLDP with the State Office Nursing Coordinator, who stated she was working on including more instructions on the Nursing Discharge Summary forms. Further, for compliance purposes it would be useful to consider developing a monitoring tool for Nursing Discharge Summaries. The Monitoring Team concurs with the Facility's Self-Assessment that they were not in substantial compliance with this provision based on the lack of consistent documentation for each shift entry in the Integrated Progress Notes for some of the required ACP interventions. In addition, there needs to be more specific instructions for nursing's role and responsibility related to Community Living Discharge Planning. Refer to Provision M.5 and Section I, Provision I.1 and I.2 for additional information regarding the risk rating process and IRRFs and IHCPs.	
M4	Within twelve months of the	<u>Monitoring Team's Findings:</u>	Substantial

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	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 Monitoring Team validated the Nursing Education information presented in the Facility's Self-Assessment through: Review of the Nursing Education information presented in the Section M Presentation Book; and meetings/interviews with Chief Nurse Executive, and Nurse Educators, and Compliance Nurse. Ample supporting documentation was provided in the Presentation Book's Provision M.4 section that further validated training and monitoring activities that demonstrated compliance with this provision. Other related Self-Assessment data were updated while onsite. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.4 and the Monitoring Team concurs with their findings. It was impressive to find that the Nurse Educators 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 Educators demonstrated that they were readily knowledgeable of education activities and were able to answer questions and provide supporting documentation when requested. The Nurse Educators also provided competency-based training materials used and training records for the training reported. <u>New/Revised Policies, Procedures, and Protocols:</u> The following State Policies and RSSLC Protocols and Guidelines were new and/or revised since the last compliance review: • Nursing Services Policy • Medication Administration Guidelines • Medication Administration Observation Guidelines • Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment • Gastrostomy Tube Insertion • Enteral Nutrition • Hospitalization, Transfers, and Discharge Protocol • Medication Administration for Individuals with Dysphagia • Five New Nursing Protocols: Pain, Emergency/Hospital Transfers, Falls or Suspected Falls, Suspected Fracture/Dislocation, and Hypoglycemia • Medical Care Policy RSSLC Local Policies: • Quarterly Physician Orders (revised) • The Vest Policy • Insulin Administration • Diabetic Teaching to Individuals and Family Members There was training record documentation that validated that 100% of the nursing staff had been trained on the new/revised state and RSSLC policies, procedures, guidelines, and	Compliance

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		protocols listed above. See training activities listed below. Nursing Training Activities: The Nursing Training Database was used to track all nursing trainings, nurse training by role, by dates of training, training topics, names of nurses trained, percentage of nurses trained per course, and delinquency reports indicating who was delinquent on an given course. The training was ongoing for those trainings that had not achieved 100% completion. The projected completion date for all missed training was within two weeks following the return to duty for those nurses who were either off on vacation or Family Medical Leave Act (FMLA) leave. The Nurse Educators worked with the Data Analyst to make improvements to the Nursing Training Database. • New Nurse Orientation: o The Nurse Educators continued to use the state standardized Nursing Education Hand Boole for all new nursing trainings and annual refresher competencies. There were no changes made to the new nurse trainings other than the state mandated Physical Assessment Class and Examination was added to the training components. All incumbent RN Case Managers and RNs had previously received this training. Another training that was added included the state mandated Medication Administration for Individuals with Dysphasia, which was jointly taught by the Habilitation Therapy, PNMT Nurse and the Nurse Educators. o A total of six New Nurse Orientation trainings had been provided. The dates are as follows: 12/3/12, 1/7/13, 1/29/13, 4/29/13, 5/24/13, and 6/27/13. The trainings were competency-based using the formalized lesson plans from the state Nurse Educator Hand Book. o 100% of the new nurses were trained on the following policies, procedures, guidelines, and protocols: ▪ Nursing Services Policy ▪ Nursing Documentation Guidelines ▪ 24 Hour Clock ▪ Nursing Standardized Abbreviation List ▪ Medication Administration Guidelines ▪ Medication Administration Observation Guidelines ▪ Self-Administration of Medication ▪ Medication Variances Policy ▪ Medication Administration for Individuals with Dysphagia Procedures ▪ Management of Acute Illness and Injury Policy ▪ Nursing Protocol Cards (23 cards) ▪ Care Plan Development Policy ▪ Skin Management and Wound Prevention Guidelines ▪ Neurological Assessment Protocol ▪ Seizure Management Nursing Protocol	

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		▪ Vagal Nerve Stimulator Nursing Protocol ▪ Pre-treatment and Post-sedation Protocol ▪ Post Anesthesia Care Nursing Protocol ▪ Weight Management Procedure ▪ PICA Protocol ▪ Nursing Competency-based Training Curriculum that included the state mandated Physical Assessments Class and Examination Listed below are the in-service trainings provided to the incumbent nursing staff since the last compliance review: • 1/22/13: Individualized Acute Care Plan Development using Nurse Protocol Cards for RNs only: 100% trained. • 3/7/13: Medication Administration for Individuals with Intellectual and Developmental Disabilities: 100% of all nursing staff were trained on the new state mandated Medication Administration for Individuals with Dysphagia, which was jointly taught by Habilitation Therapy, Physical Nutritional Management Team (PNMT) Nurse, and the Nurse Educators. This training was an ongoing training as part of the New Nurse Orientation training. • 4/4/13: Communicating Effectively/Dealing with Difficult People, for RN Case Managers only: 100% of the RN Case Managers received this training. • 4/18/13: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment: 100% of the RN Case Managers were trained. • 4/22/13: Retrained on Documentation of Wounds, Hospitalizations, Transfers, and Discharges, Wong-Baker Faces Pain Rating Scale, and Emergency Response: 97% of all nursing staff were trained. • 4/24/13: Diabetic Teaching for Individuals, Direct Support Professionals, and Family Members, PCP Hypoglycemia Protocol, and Competency-based Skill Check-off on Insulin Administration: 100% of the nurses were trained. • 5/14/13: Mosby's Physical Examination Training: 99% of the RNs were trained on chapters 21 and 22, Musculoskeletal and Neurological systems respectively. • 5/24/13: Medical Care Policy from the state office: 99% of the nurses were trained on this policy and it will be ongoing. • 6/24/13: Vest Policy: 100% of all nurses received this training and it will be ongoing. • 7/1/13: Gastrostomy Tube Reinsertion, Enteral Nutrition, Nursing Services including changes to MOSES and DISCUS, Medication Administration Guidelines, and Medication Administration Observation Guidelines: 99% of all nurses were trained. • 7/9/13: Mosby's Physical Examination Training, on chapter 14, heart: 99% of the RNs were trained. • 7/9/13: Plan Of Improvement: Campus wide training was conducted on Assessment and Documentation of Acute Changes in Health Status, which included but was not limited to: Documentation of Wounds, Nursing Protocols, Seizure Management Protocol including use	

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		of Post-sedation Protocol when Diastat was administered, Medical Monitoring including frequencies and responsible parties, Antibiotic Therapy Protocol, Focused Assessments, Acute Care Plans and Guidelines for Using Non-Re-breathers for Emergency Oxygenation: 99% of the nurses were trained. • 7/18/13: Physical Quarterly Orders Policy: 97% of the nurses were trained. • 8/15/13: RN Case Managers were retrained on the importance of tracking individuals' unplanned weight loss/gain and notification of the physician and IDT when they have such changes. • CPR for Healthcare Providers training: 100% of the nursing staff were current with this training. • The Nursing Education Department continued to provide training at the New Employees Orientation on the state mandated Observing and Reporting Clinical Indicators of Health Status Changes of Individuals. In the absence of an RN Case Manager Supervisor the Nurse Educator continued to assist in conducting the RN Case Manager Meetings, in-service trainings, and conducting quality peer review of Integrated Health Care Plans (IHCPs), Annual, Quarterly and Physical Nursing Assessments. The results of four randomly selected, recently implemented Protocol Card Audits, April 2013 through June 2013, showed: Nursing Protocol Card Audit Tools: April 100%, May 94%, June 96%, Overall 97 Post Anesthesia: April 95%, May 95%, June 83%, Overall 97% Urinary Tract Infections: April 100%, May 100%, June 90%, Overall 96% Head Injury: April 96%, May 87%, June 92%, Overall 92% No CAPs were required for the above audits. <u>Nursing Education Integration with Other Disciplines:</u> • Habilitation Therapy Department: The new state mandated Medication Administration for Individuals with Dysphagia was taught jointly by the Nurse Educators, Habilitation Therapy and Physical and Nutritional Management Team Nurse. • QA/QI Council: The Nurse Educators participated in the QA/QI interdisciplinary team meetings. • Bedrail Committee: The Assistant Nurse Educator participated in the Bedrail Committee meeting, which oversaw the planning, training, implementation, and monitoring of the program, as well as collaborated with the Quality Assurance Department on the program's quality assurance plan for improvement. The committee addresses the safe and appropriate use of bedrails and other alternatives, as well as ensures professional oversight and ongoing review of the equipment. The QIDP submits the assessment report to the	

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		Committee for quality assurance review. • Competency Training and Development: The Nurse Educators continued to train the newly hired employees on the state mandated Observation and Reporting Clinical Indicators of Individuals Served Class. The degree of adherence to the nursing protocols was reported in the other appropriately related Provisions. As reported in Provision M1, care was consistent with nursing protocols for antibiotic therapy, urinary tract infections, pain, head injury, vomiting, pain, and other conditions, assessment and documentation followed the protocols, and the requirements in various protocols for reporting to the medical practitioner were followed. Quality Assurance audits found high compliance with the requirements of the protocols. The Monitoring Team's observations and interview with nurses on the units showed that they carried the protocol cards with them and used them when documenting care in the Integrated Progress Notes. In addition, laminated charts with all of the protocol cards were posted in the nursing offices for ready reference. Furthermore, the review of individuals' care did not reveal any significant inconsistencies with the protocols. The Facility's Self-Assessment stated they were in compliance with this provision. The Monitoring Team concurs that this Provision was in substantial compliance. As reported above, substantial compliance was demonstrated through the Monitoring Team's independent review of the Section M Presentation Book, staff interviews, direct onsite observations of nursing care, and review of documents to verify that the Nursing Department had continued to maintain positive practices toward the development and implementation of nursing policies, procedures, processes, protocols and training.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	<u>Monitoring Team's Findings:</u> The Facility's Section M Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. The Facility reported there was not enough data to self-assess. Through the Monitoring Team's review of Section M Self-Assessment, Section M Presentation Book, interviews with the Chief Nurse Executive, Program Compliance Nurse, QA Nurses and Nurse Educators, and Nurse Managers; and review of documents and individuals'' records, there was evidence that the State Office, Facility, and 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 status of noncompliance. The Nursing Department reported that they put the Monitoring Tool for the Integrated Health Care Plan on hold until they had more experience with its use. <u>Revised Policy and Procedures:</u> The following RSSLC Policy and Procedures were revised since the last compliance review:	Noncompliance

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		• RSSLC At Risk Individuals Policy, I.08, Revised: 8/15/13 There was training record documentation that validated that 100% of the nursing staff had been trained on revised RSSLC At Risk Individuals Policy listed above. See training activities listed below. <u>Training Activities:</u> • 1/23/13: Revised Integrated Risk Rating Form (IRRF), Integrated Health Care Plan (IHCP, and Change of Status IRRF training provided by RRLS staff to RN Case Managers • 3/1/13: Aspiration Training provided by RSSLC staff to all Nueces 2-10 and 6-10 shifts staff • 4/29/13: The state office Coordinator of Specialized Therapies presented Risk Follow-up. Training records were not provided for review. • 6/17/13: ISP Process, including IRRF and IHCP provided by state office staff to RN Case Managers and QIDPs. <u>Quality Assurance Efforts for ISP, IRRF, and IHCP:</u> It was positive to find that the QIDPs were responsible for conducting monitoring on the IRRFs and IHCP. The QIDPs are in the best position to review the IRRFs and IHCP because of their overall responsibility for ensuring individuals receive the necessary supports and services from all disciplines. Because the monitoring tools were still in process, there was no data available to review for a monitoring tool regarding the status of compliance with the IRRF and IHCP process. The Nursing Department had started to develop and implement a monitoring tool but their efforts to finalize and implement their monitoring tool was put on hold until the IDT had more experience with the IRRF and IHCP processes. Since the last compliance review, the Facility had continued to implement and improve/refine the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes. The Facility's Self-Assessment stated that they continued to provide training on the revised IRRF and IHCP Processes. The Monitoring Team reviewed six of the most recently completed Integrated Risk Rating Forms and Risk Action Plans for Individuals #106, #468, #379, #177, #43, and #569. All were completed using Integrated Risk Rating Forms and Integrated Health Care Plan Forms. The findings included: • Four of six (67%) identified significant changes in some of the risk rating categories since the last review. • Three of six (50%) had comprehensive interdisciplinary assessment completed. • Three of six (50%) risk assessments provided clinical data sufficient to accurately determine risk levels. • Three of six (50%) risk assessments sufficiently provided information that helped to	

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		develop a plan to address risk ratings. • Four of six (67%) IHCPs indicated they were approved and implemented by the IDTs within 14 days. However, from reviewing documents in individuals' active record it was difficult to determine the dates the plans for all identified risk ratings were actually implemented. • Two of six (33%) IHCPs were clinically sufficient to meet the needs for all identified risk ratings. • One of six (17%) IHCPs included preventative interventions to minimize all of the identified risk ratings. • Two of six (33%) IHCPs were sufficiently integrated among all appropriate disciplines. • Zero of six (0%) changes were made in individuals' services and supports for all identified risk ratings. • Four of six (67%) IHCPs contained functional and measurable objectives in the ISPs to measure efficacy of the plans. However, most were generic and should have been more specific to the risk ratings and individuals. • Three of six (50%) IHCPs identified appropriate clinical indicators to be monitored and the frequency of monitoring. • Six of six (100%) IRRFs and IHCPs were attached to the ISPs. Examples of IRRFs and/or IHCPs reviewed showed: o Individual # 468's risk rating for weight was changed from low to medium risk due to a gradual weight loss of up to one-half pound per month during 2013. According to physician's order she was to be weighed weekly. The IHCP did not include a plan for this clinical indicator to be weighed weekly. According to the clinical data Individual #468 had three short-term treatments for GERD during 2013, with the last treatment in May 2013. There was no clinical data included that considered or that correlated the possibility the weight loss may have been, and possibly continued to be, be related to GERD symptoms. There were no other plausible causes for the weight loss considered. The Aspiration risk rating clinical data documented that Individual #468 had abdominal and pelvic pain but was unable to determine the cause. According to the Annual Medical Examination, the physician noted that a Computerized Tomography (CT) was completed that showed a small ovarian cyst. This showed that the physician did not review all of the pertinent information before or during the IRRF review. This information would have more appropriately documented in the gastrointestinal section of the IRRF with an explanation of the CT results. The ISP attendance sheet did not indicate that the Dietitian attended the ISP meeting. o Individual #569's Osteoporosis/Fall/Fracture risk rating clinical data failed to include that she was post-menopausal and visually impaired, which could also be contributing risks factors. Individual #569 was receiving Prolia injections for the osteoporosis, which along with other side effects had the potential to cause high cholesterol and osteonecrosis. These potential side effects of the Prolia were not	

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		document in the clinical data or interventions to monitor for these side effects were not included in the IHCP. In addition, Individual #569 had a diagnosis of Degenerative Joint Disease (DJD). There was no documentation regarding the risk of pain. Individual #569 was rated at high risk for Dental. There was no clinical data document in the Dental risk rating section regarding the potential side effects of the Prolia for jaw rotting disease. Neither was intervention to monitor for these side effects included in the Dental section of the IHCP. The ISP attendance sheet did not indicate that the Dietitian or Pharmacist attended the ISP meeting. o Individual #177 was rated at medium risk. The IHCP did not include the Hypoglycemia Protocol, for which the interventions would be important to implement in the event he experienced hypoglycemic episodes. The ISP attendance sheet did not indicate that the Dietitian attended the ISP meeting. o Individual #379's risk rating for Seizures was changed from low to high because he had been seizure free from 2001 until he began having seizure medication tapered in January 2013. During the past year he had experience 23 episodes of seizures. He was being seen by a Neurologist who had made numerous adjustments to his seizure medications. The ISP attendance sheet did not indicate that the physician and Pharmacist attended the ISP meeting. Because of the high risk rating related to increased seizure activity and accompanying adjustment to his seizure medication it would have been important for the physician and Pharmacist to attend the meeting. • Four of six (67%) of the IHCPs had the Integrated DSP Instruction Sheets attached. The Individuals who did not have the DSP Instruction Sheets attached were Individuals: #379 and #177. • Three of four (75%) of the records reviewed had accompanying IHCPs had Integrated DSP Instruction Sheets that were individualized and sufficient to meet individuals' needs. The Integrated DSP Instruction Sheets contained signatures of the Home Managers and DSP staff trained. However, from the limited signatures on the sheets it was not possible to discern whether all DSPs were trained on all shifts, or if new or pulled staff were trained. Individual #106's DSP Instruction Sheet was not sufficiently individualized to meet the needs for the identified high and medium risk rating groups, At the time of the last compliance review, the original Health Management Plans were maintained in individuals' unified records with working copies in the Care Plan Books on the Units/Homes for ready access. Currently, the IHCP was located in the Active Record, and the Monitoring Team was informed that the DSP Instruction Sheet is also placed in the Active Record. Review of the table of contents of the active record and individual notebook confirmed that IHCP is to be filed in the Active Record, but it was not listed as being filed in the Individual Notebook. Furthermore, the DSP Instruction Sheet is not listed in either record, nor was there a separate binder in the home for these sheets. Although this reduces the potential for error when plans or instructions are updated, it also reduces the usability of the record for ensuring	

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		staff providing direct support are familiar with the supports they are to provide to individuals with healthcare needs. Although the RN Case Managers were responsible for developing the draft IRRF and IHCP to bring to the ISP meetings, it is essential that the other disciplines provide them with their assessment data timely in order completely and accurately conduct risk ratings for all risk categories and group. The IRRF and IHCP must be integrated with all disciplines and cannot be the sole responsibility for the RN Case Managers. All disciplines should attend the ISP/IRRF/IHCP meetings, particularly for individuals who have high risk ratings within their particular areas of expertise. In general, as was found in past reviews, there was wide variation from unit to unit, and across the IDTs, in the formats used for ISPs, IRRFs, and IHCPs, as well as the quality of the clinical data used to support the risk ratings. While the risk guidelines serve some useful purpose in assisting with risk level determination, the sole reliance on the guideline prohibits the IDT from independent/critical thinking. The Facility needs to ensure consistency across all IDTs, as well as among disciplines, if compliance is to be achieved regarding the IRRFs and IHCPs processes. For the next six months, the IDT should consider enhancing skills in critical thinking regarding the interrelationship between the various risk conditions within a particular group of risk conditions, as well as the interrelationship between the various risk rating groups in order to accurately determine risk ratings. While the risk guidelines serve some useful purpose in assisting with risk level determination, the sole reliance on the guideline prohibits the IDT from independent/critical thinking. The changes to IRRF and IHCP 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.	
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	<u>Monitoring Team's Findings:</u> The Monitoring Team validated the Medication Administration information presented in the Facility's Self-Assessment through: Review of the Medication Administration information presented in the Provision M.6 section of the Presentation Book; review of documents requested; meetings/interviews with the Chief Nurse Executive, Nursing Operations Officer, Pharmacy Director, Clinical Pharmacist, Medical Director, QA Director, QA Nurse, Program Compliance Nurse, and Nurse Managers; attendance at the Pharmacy and Therapeutics Committee Meeting; inspections/observations of units' Medication Rooms; Review of Units' Medication Administration Notebooks; and conducted Medication Administration Observations. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6 and the	Substantial Compliance

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	provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Monitoring Team concurs with their findings. <u>New/Revised/Reviewed Medication Administration Policies, Procedures, and Guidelines:</u> • DADS Policy: Medication Variances, Policy Number: 053, Effective: 9/23/11 • DADS Procedure: Medication Administration Guidelines, Dated: June 2013 • DADS Procedure: Medication Administration Observation Guidelines, Dated: June 2013 • RSSLC Pharmacy Policy and Procedure Manual, Medication Variances, 01.05.20, Revised: 11/2/11 • RSSLC Pharmacy Policy and Procedure Manual, Adverse Drug Reactions, 01.05.25, Revised: 7/15/11 • RSSLC Nursing Services: Medication Variance Guidelines, A-#, Dated: 1/24/12 • RSSLC Providing Health Care Services: Medication Variances, I.34 Effective: 9/23/12, Revised: 2/27/12 <u>Medication Administration Training Activities:</u> o 100% of the new nurses were trained on the following policies, procedures, guidelines, and protocols: o Medication Administration Guidelines o Medication Administration Observation Guidelines o Self-Administration of Medication o Medication Variances Policy o Medication Administration for Individuals with Dysphagia Procedures • 3/7/13, Medication Administration for Individuals with Intellectual and Developmental Disabilities: 100% of all incumbent nursing staff were trained on the new state mandated Medication Administration for Individuals with Dysphagia, which was jointly taught by Habilitation Therapy, Physical Nutritional Management Team (PNMT) Nurse, and the Nurse Educators. This training was an ongoing training as part of the New Nurse Orientation training. • 7/1/13, Gastrostomy Tube Reinsertion, Enteral Nutrition, Nursing Services including changes to MOSES and DISCUS, Medication Administration Guidelines, Medication Administration Observation Guidelines: 99% of all incumbent nurses were trained. The training placed special emphasis on: Correctly rating the medication errors/variances category; discovery, reporting, and timely notification of the primary care providers of medication error/variance; timely implementation of corrective action; documenting corrective action taken; and documentation of the location where the medication errors/variances occurred. <u>Medication Variance Committee Meetings:</u> A review of the monthly Medication Variance Committee meeting minutes November 2012 through June 2013 showed 100% of the meetings were conducted. The Committee was chaired by the CNE. All medication variances are to be reviewed, trended, and assessed by the director	

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		of the responsible department on a monthly basis, i.e., Chief Nurse Executive, Pharmacy Director, Medical Director, and Dentist. Prior to the meeting the responsible disciplines reviewed and analyzed their medication variance data for the number and type of medication variances, as well as for systemic variances, developed strategies, and recommendations to mitigate medication variances. The QA Nurse reviewed the findings from the previous month's data derived from the Medication Variance Database and reviewed the status of any outstanding issues from the previous month's Committee minutes to ensure all issue were followed through to resolution. The disciplines' current data were presented at the Committee meetings for review, discussion and disposition. The information was reviewed, discussed and when indicated systemic recommendations were made for improvement in mitigating the incidences of medication variances. Nursing also reported on the results of Medication Administration Observation Audits, Medication Room Survey Audits and Medication Administration Record Audits and any corrective action taken to correct deficiencies found on these audits. The recommendations and findings from the Medication Variance Committee were presented at the quarterly Pharmacy and Therapeutics Committee Meeting for further review, discussion, and disposition. The Monitoring Team attended the Medication Variance Committee meeting on 8/29/13. The meeting was attended by 100% of relevant members. The meeting was substantive and informative. The Unit Nurse Managers reported the findings for medication variances, Medication Administration Observations, Medication Room Survey Audits, Medication Administration Record Audits, medication refusals, adverse drug reactions, and irreconcilable medication excess/shortages. Trinity was the only unit that reported medication variances. They reported five medication variances. One individual received the wrong medication (patch), two individuals had a dose omission, and one medication variance was for faxing an order to the pharmacy late. The order was written on 5/14/13 and faxed on 7/12/13 for Ferrous sulfate. Ferrous sulfate is a floor stock medication and the individual did not miss a dose of medication because it was available in the home. Another medication variance was because of a shortage found for four antibiotic tablets. A shortage form was completed and sent to the pharmacy to replace four antibiotic tablets for an individual. The reason for the shortage of the antibiotic tablets was not included in the report. In-service sheet was provided to show corrective action was implemented for nurses committing these variances. The Pharmacy Director reported that the state office had directed facilities to split pills for medications that could not be found when lower doses were ordered. Per the discussion the rationale for splitting these pills was because, if the pills were split in the pharmacy they would deteriorated before they pills dispensed were administered. Pills that are not scored would not be split. This should be the last resort. The physicians were working to eliminate the need for prescribing pills that would require splitting. The committee discussed the need to order pill cutters. The nurses would dispose of the unused portion of the pills in the sharps containers. If	

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		the medication requiring splitting is a controlled substance, two nurses would witness the wastage. SSLC pharmacy policy requires two signatures to document that the wasted portion of the pills was verified and signed by the two nurses. The Pharmacy Director presented copies of signs to be posted for the DSPs and nursed regarding the Potential Signs of an Adverse Drug Reactions and If you See/Suspect these Symptoms Please Contact Nursing Right Away! The Committee approved the use of these signs. <u>Pharmacy and Therapeutics Committee Meetings:</u> The Monitoring Team's review of the quarterly Pharmacy and Therapeutic Committee meeting minutes showed the committee conducted 100% of the meetings. The minutes showed that the CNE or designee consistently reported monthly medication variance data at the meetings for review, discussion, and disposition, according to the state and local Medication Variance Policies. The Infection Control Nurse consistently presented for review, discussion, and disposition the monthly Antimicrobial Susceptibility Reports, Epidemiology Reports, and the resulting Antibiograms for the antibiotic therapies used to treat infections. At the Medical Directors request, trend data for aspiration pneumonias and UTI's were presented for review, discussion, and disposition. Refer to Provision N.8 for information regarding the Pharmacy and Therapeutics Committee meetings. <u>Medication Variance Data Reports:</u> The Facility continued to have a robust comprehensive Medication Variance Database using a root cause analysis approach. Medication Variance data was included for Nursing, Medical, Pharmacy, and Dental Department. The database contained aggregated, analyzed and trended data by: Month and quarter, Unit/Infirmary, home, campus-wide, shift, number of variances type and node, severity index by Categories A though I, nurses who committed the variances, individuals for which the variances were committed, contributing factors, and medications associated with the variance. The database also included Inspection and Storage data. The data were represented by bar graphs, linear graphs, pie charts, and tabular charts, including the number of variances represented, with a color coded legend explaining the graphs. The data also provided a narrative explanation of the medication variances. This data provided the Facility with detailed medication variance information from which to make decisions for local and systemic corrective action to mitigate the incidents of variances. The Monitoring Team was provided with medication variance data January 2013 through June 2013 that had been aggregated, analyzed, trended, along with remedial actions taken to mitigate medication variances and storage issues. The Monitoring Team reviewed the total number of medication variances by severity index, reported past rolling 12 months, which showed: Severity | A | B | C | D | E | F | G | H | I | Monthly	

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Index										Total
August 2012	15	1	8	0	0	0	0	0	0	24
September 2012	1	10	3	3	0	0	0	0	0	17
October 2012	4	10	2	0	0	0	0	0	0	16
November 2012	6	5	30	0	0	0	0	0	0	41
December 2012	0	10	2	0	0	0	0	0	0	12
January 2013	3	10	3	0	0	0	0	0	0	13
February 2013	1	7	3	0	0	0	0	0	0	8
March 2013	28	0	3	0	0	0	0	0	0	31
April 2013	8	1	16	0	0	0	0	0	0	25
May 2013	12	0	3	0	0	0	0	0	0	15
June 2013	5	0	2	0	0	0	0	0	0	7
July 2013	7	0	2	1	0	0	0	0	0	8
Total	90	54	77	4	0	0	0	0	0	225

The Monitoring Team reviewed the total number of medication variances by department, reported past rolling 12 months, which showed:

Month	Medical	Nursing	Pharmacy	Dental	Total *
August 2012	4	12	13	0	29
September 2012	0	10	7	0	17
October 2012	1	10	7	0	18
November 2012	2	38	2	0	42
December 2012	0	5	9	0	14

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January 2013	1	10	8	0	19
February 2013	3	5	3	0	11
March 2013	2	22	9	0	33
April 2013	0	19	7	0	26
May 2013	1	4	10	0	15
June 2013	0	6	4	1	11
July 13	0	5	6	0	11
Total	14	146	85	1	246

*As variances are discovered, the database will credit the month in which the variance occurred. Therefore, the above referenced numbers may not match the committee minutes, as variances were discovered after the monthly meetings. These numbers are based on the discovery date, not the date of the incident.

It was evident to the Monitoring Team, since the last compliance review; the Facility had made significant improvements in reporting, analyzing, trending, and corrective actions taken to mitigate medication variances. As the data above showed, all departments were reporting their medication variances, as required by policy. There was an increase in the number of medication variances as improvements were made in reporting all types of medication variances. However, as systems were put in place to identify, report all medication variances, and corrective actions implemented, there was a steady decrease in the number of medication variances. The improvements made included, but were not limited to, the Pharmacy, Medical, and Dental Departments reporting medication variances, as well as when unreconciled excesses/shortages in medications were found they were reported as medication variances. It was positive to find that the Pharmacy, Medical, and Dental Departments were reporting, tracking, analyzing, trending, and taking local and systemic corrective action on identified medication variances.

<u>Ten Most Recent Medication Variance Reports:</u>
The Monitoring Team's review 10 of the recent Medication Variance Reports and supporting documentation for Individuals: #503, #151, #264, #579 (had two medication variances), #592, #564, #588, #618, and #743, and found significant improvement in the completeness and accuracy of the reports completed by all respective disciplines, i.e., nursing, pharmacy, medical, and dental departments:

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		• Ten of 10 (100%) reports were fully completed, and indicated the type of variance, severity index, and were reviewed by the respective supervisors. • Ten of 10 (100%) reports showed that the respective supervisors documented appropriate corrective actions. • Eight of 10 (80%) reports documented notification to the physician of the medication variances. The two Medication Variances did not contain documentation of the physician(s), which was pointed out at the Medication Variance Committee meeting on 8/29/13, and was reviewed and discussed for corrective action. • Ten of 10 (100%) reports were incorporated into the Medication Variance Database, and after an analysis was presented to the Medication Variance Committee for further review and disposition. This showed that the corrective actions reported since the last compliance review was effective in improving the completeness and accuracy found in the above Medication Variance Reports. The Monitoring Team noted that when multiple variances were discovered at one time, they were reported as one single event/variance, i.e., Individual #151 missed five doses of medication on 6/7/13, which was reported as one variance. According to state and local Medication Policies, "When multiple doses are involved in the variance, such as a transcription variance that leads to multiple missed or extra or an individual receives another individual's medications, these are considered a single event/variance rather than multiple variances." Although the Facility followed their policies, reporting multiple variances discovered at one time as a single event/variance has the potential to skew the medication variance data and represent artificially underreporting of medication variances. <u>Facility Medication Administration Observations and Documentation, and Medication Room, Audits:</u> It was positive to find that the Nursing Department and the QA Nurses were completing inter-rater reliability checks on Medication Administration Observations and Documentation, Medication Room Survey, and Medication Administration Record Audits. The inter-rater reliability checks by QA Nurses on the Medication Room Surveys and Medication Administration Record Audits started in April 2013. The Monitoring Team's review of these audits and supporting documentation found: • Nursing Department was using the state Medication Administration Observation Form implemented on 10/31/12 and revised on 3/5/13. The form contained "Essential Elements" that must be complied with 100%. Failure to comply with these elements required immediate retraining and follow-up observations. The Monitoring Team reviewed Medication Administration Observation data completed by the Nurse Managers and the inter-rater reliability checks performed by the QA Nurse, January 2013 through July 2013. A total of 222 Medication Administration Observations were conducted during the reporting period. The data below shows the overall monthly percentage of compliance	

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with the observation tool and level of agreement between the Nurse Managers and the QA Nurse, January 2013 through July 2013:

Month	January	February	March	April	May	June	July
Internal Percentage of Compliance	99%	100%	98%	100%	99%	100%	100%
External Percentage of Inter-rater reliability	98%	100%	95%	99%	97%	100%	100%

Because of the overall percentage of compliance of the Medication Administration Observations and Documentation audits, no systemic corrective action plans were necessary. Any deficiencies identified by nurses observed, was corrected at the time of the observation, with follow-up actions when needed.

- The Monitoring Team reviewed Medication Room Survey data completed by the Nurse Managers and the inter-rater reliability checks performed by the QA Nurse, April 2013 through July 2013. A total of 603 Medication Room Surveys were conducted during the reporting period. The data below shows the overall monthly percentage of compliance with the observation tools and level of agreement between the Nurse Managers and the QA Nurse, April 2013 through July 2013:

Month	April	May	June	July
Internal Percentage of Compliance	96.36%	95.24%	94.83%	98.25%
External Percentage of Inter-rater reliability	100%	92.86%	96.55%	98.25%

A CAP was implemented as a result of being cited by ICF/DD surveyors on medication maintenance and storage. The CAP was submitted to the QA Department with a start date of 3/27/13. The Nurse Managers aggressively audited all of their respective medication rooms using the state/facility standardized Medication Room Audit Tools, during April 2013 and June 2013 and corrected the identified deficiencies. A review of the 7/16/13, Quality Assurance Summary of actions taken through to resolution, showed the CAP was resolved.

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		The Monitoring Team's Medication Room Survey Audits: The Monitoring Team conducted random Medication Room Survey Audits in the medication rooms in Trinity A, Leon C, and San Antonio using the state's standardized Medication Room Audit Tool. The findings were consistent with the Facility's findings reported above: • The Monitoring Team's independent audit results found the Trinity A Medication Room at 100% compliance. • The audit results found the Leon C Medication Room at 96.7% compliance. There was a bottle of liquid calcium purchased by an individual's family that was opened and not dated. The medication was immediately discarded by the Nurse Manager. An open and not dated container of pudding was found on medication cart. The Nurse Manager disposed of the pudding. The battery for the soap dispenser needed replaced, but an additional dispenser was available in the room. Housekeeping was called and immediately replaced the battery. Medication Room shelves were dusty. Housekeeping was notified and immediately dusted the shelves. • The Monitoring Team's independent audit results found the San Antonio Medication Room at 96.7% compliance. One of three medication carts were found unlocked. The nurses explained that the electronic lock did not work and had to be locked with a key. The nurse was present in the room, so no problem with security had occurred. To ensure the cart would lock electronically, the QA Nurse instructed the Nurse Manager to turn in a work order for repair, to which she agreed to do immediately. If the automatic lock cannot be repaired the Facility should consider replacing the medication cart because of the safety risk of possibly leaving the cart unlocked. There were some tubes of stock topical medications found that were used on multiple individuals. The QA Nurses instructed the Nurse Manager to dispose of these medications, and to order the medications specifically for each individual when need. The stock topical medications were immediately discarded. • The Monitoring Team reviewed all of the Units/Infirmary, and Campus Nurses' Universal Signature Sheets. They were found current for nurses that administer medications with their printed names, signatures, and titles. • The Nursing Department's internal process for checking the Medication Administration Records for accuracy and completeness required the oncoming and off going nurses on each shift to check the Medication Administration records. If there were any medication variances they were required to complete Medication Variance Reports. This included completing Excess/Shortage Reports submitted to the Pharmacy. The Medication Administration Record Notebooks contained a master Medication Administration Record Check Sheet form for the nurses' signatures to verify that both nurses had completed the checks. The Monitoring Team reviewed the Medication Administration Record Check Sheets, August 1 through August 27, 2013 in Trinity A, Leon C, and San Antonio and found all Medication Administration Record Sheets were consistently signed by both nurses for each shift as required to verify they had checked their Medication Administration Notebooks. The Medication Administration Records reviewed for this time period found no	

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		blank boxes that would indicated that medication variances had occurred. This process has no doubt contributed to identifying and reducing the instances of medication variances. • The Monitoring Team's independent audit of Medication Administration Records and Integrated Progress Notes for the past three months (June 2012 through August 27, 2013 for Individuals: #243, #66, #366, #594, #106, #468, #296, #379, #25, #177, #524, #43, and #569) found: o Thirteen of 13 (100%) of individuals' Medication Administration Records had allergies listed. o Thirteen of 13 (100%) of individuals' Medication Administration Records had no blank blocks where medications were not given. If individuals were in the hospital or otherwise away from of the Facility for some reason, the medication blocks were consistently circled with accompanying notes of explanation documented on the back of the Medication Administration Records. o Thirteen of 13 (100%) of individuals' Medication Administration Records contained start and/or stop dates for all medications ordered. o Thirteen of 13 (100%) of individuals' records showed, when indicated, per necessary (PRN) medications were consistently documented as administered on both the Medication Records and in the Integrated Progress Notes. This included the documentation times the medications were administered and times assessed for their effectiveness. o Thirteen of 13 (100%) of individuals' records showed, when indicated, medications ordered that required assessments for certain parameters prior to administration, i.e., blood pressure and/or pulse, the Medication Administration Records consistently contained the results of these assessments prior to administration of the medications. <u>The Monitoring Team's Medication Administration Observations:</u> • The Monitoring Team conducted Medication Administration Observation in San Antonio on 8/27/13 at the 4:00 p.m., med pass: o Individuals were administered medication in a room to ensure privacy. o The nurse administering medications followed the generally accepted professional standards of safe medication administration. o The nurse referred to individuals' PNMPs before administering medications. Individuals PNMPs were up to date and included strategies to ensure safe oral intake and/or adaptive equipment. It was positive to find that the nurse had benefited from the Medication Administration for Individuals with Dysphagia training. Medications were administered at eye level and she ensured that individuals did not hyperextend their heads/necks when taking medications, provided adequate liquids to drink after taking medications, and ensured that the medications were swallow. The nurse followed any other special strategies and the	

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		use of adapted equipment contained on individuals' PNMPs. o The nurse talked to individuals during the medication pass telling them what medications they were receiving and their purpose. Self-Administration of Medication Programs were reinforced during the med pass. o The DSPs assisted the nurse during the med pass by bringing one individual at a time to receive medications. o It was positive to find that the medication cart was stocked with maroon spoons for medication administration. o The medications administered were check against Physician's Orders by the Monitoring Team and were found to be administered as ordered. • The Monitoring Team conducted Medication Administration Observation at Leon on 8/28/13 at the noon med pass: o Individuals were administered medication in a room to ensure privacy. o The nurse administering medications followed the generally accepted professional standards of safe medication administration. o The nurse referred to individuals' PNMP before administering medications. Individuals PNMPs were up to date and included strategies to ensure safe oral intake and/or adaptive equipment. It was positive to find that the nurse had benefited from the Medication Administration for Individuals with Dysphagia training. Medications were administered at eye level and she ensured that individuals did not hyperextend their heads/necks when taking medications, provided adequate liquids to drink after taking medications, and ensured that the medications were swallow. The nurse followed any other special strategies and the use of adapted equipment contained on individuals' PNMPs. o The nurse talked to individuals during the medication pass telling them what medications they were receiving and their purpose. Self-Administration of Medication Programs were reinforced during the med pass. o The DSPs assisted the nurse during the med pass by bringing one individual at a time to receive medications. o It was positive to find that the medication cart was stocked with maroon spoons for medication administration. o One individual was a brittle diabetic who required blood glucose finger sticks before administering the 11:30 a.m. (before meal). The nurse followed his insulin administration physician orders and nursing protocol before administering the insulin. Two nurses checked the dose of insulin drawn up in the syringe and signed the Medication Administration Records after administration. After his oral medications were administered, the individual grabbed a bottle of water and rapidly chugged it down with his head/neck hyperextended before the nursing staff could stop him. Then, he had a slight cough with clearing. He was immediately taken to another nurse who assessed him according to the Aspiration	

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		Protocol. Later it was reported to the Monitoring Team that his assessment and monitoring was within normal limits. These observations showed significant improvement from previous medication administration observations. Refer to Section O for additional information regarding the Monitoring Team's medication administration observations. The Monitoring Team found significant improvement is all aspects of this provision. All recommendations suggested at the last compliance review were followed. Based on the findings of this compliance review, this provision was found in substantial compliance.	

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 Action plan, 8/7/2013 2. RSSLC Self Assessment, 8/9/2013 3. RSSLC Presentation Book, 8/2013 4. RSSLC Pharmacy Policy and Procedure Manual, Adverse Drug Reactions, revised on 8/28/2013 5. RSSLC medication variance committee meeting minutes, for 2/2013 through 7/2013 6. RSSLC Pharmacy and Therapeutics Committee (P&TC) meeting minutes for 1/8/2013, 4/17/2013, and 7/18/2013 7. RSSLC monthly polypharmacy meeting minutes for 1/2013 through 7/2013 8. For Individuals #130, #729, #410, #515, #558, #785, #220, #140, #456, and #10: • Copy of new medication orders with documentation of pharmacists review • Past six months laboratory data • Current medication list • EKG for past three years • Most recent ophthalmology consultation 9. Quarterly Drug Regimen Review (QDRR) schedule for past six months, and pending six months 10. List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date 11. Alpha list of individuals who are prescribed a neuroleptic, and have diabetes 12. Alpha list of individuals who are prescribed a neuroleptic, and have diagnosis of hypertension 13. Alpha list of individuals who are prescribed a benzodiazepine 14. Alpha list of all individuals with diagnosis of osteoporosis 15. Alpha list of all individuals with diagnosis of seizure disorder 16. For Individuals 239, #641, #424, #787, #354, #137, #142, #109, #302, #220, and #614): • Most recent two QDRRs • Past six months MOSES and DISCUS assessments • Most recent 12 months lab results • Most recent two EKG reports • Most recent annual physician summary • Most recent psychiatric assessment • Most recent IRRF • Evidence that the medical providers reviewed the pharmacists' recommendations; indication if they agreed or disagreed with the recommendations and if disagreed, documentation of their clinical rationale 17. Alpha list of all individuals on benzodiazepine 18. Data analysis, and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use 19. For the following individuals #155, #475, #513, #555, #714, #354, #412, #483, #161, and #386:

	• Most recent two QDRRs • Most recent IRRF • Current medication list • Most recent psychiatric assessment • Most recent annual medical assessment 20. Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties 21. Alpha list of individuals who are prescribed anticholinergic drugs 22. For Individuals 239, #523, #112, #442, #529, #372, #630, #524, #600, and #641: • Most recent two QDRRs • Current medical list • Most recent medical, and psychiatric annual reviews • Most recent MOSES and DISCUS assessments 23. Monthly polypharmacy meeting minutes for 1/2013 through 7/2013 24. List of all individuals on polypharmacy 25. For Individuals #787, #140, #555, #711, #155, #238, #66, #19, #626, and #487: • Most recent two QDRRs • Most recent psychiatric assessment • Current medication list 26. Most recent ISP, or related IDT document that reviews the IDTs understanding of side effects of the of use of polypharmacy 27. List of all stat chemical restraint 28. Chemical restraint data, data analysis, summaries of chemical restraint 29. Emergency (stat) Medication Monitoring Report to P&TC, document dated 7/18/2013 30. Copy of past 12-month stat medication database 31. For Individuals #160x2, #48 #625, #463, #368, #475, #346, and #593: • Single patient drug intervention (SPDI)report • Copy of associated medication order • Documentation of pharmacist's review of the order • Clinical evidence for the medical provider following up on the recommendation, or alternative rationale 32. First, and than every second completed adverse drug reaction (ADR) form, for a total of ten ADRs from a list of all ADRs that occurred during the reporting period 33. Data, graphs, data analysis used for the ADR process 34. Staff training materials used to train staff on the ADR process 35. Drug Utilization Evaluation (DUE) schedule for 2012 and 2013 36. DUE materials for: • Clobazam • Phenobarbital • Anticholinergic review • Benzodiazepine review

	37. All graphs, data tables, and data analysis for medication variances used by the Facility for a systems review of medication variances 38. List of all medication variances that occurred during the reporting period 39. Copy of completed medication variance report forms for the first, and than every second individual listed on the medication variance list, for a total of ten examples **People Interviewed:** 1. Anto Parambil,Pharmacy Director 2. Valerie Kipfer, RN, State Office Nursing Coordinator 3. Charlene McCurry, RN, Chief Nurse Executive 4. Genniffer Moore, RN, Program Compliance Nurse **Meeting Attended/Observations:** 1. Medication Variance Committee Meeting
	Facility Self-Assessment: The Facility's self-assessment for Section N indicated substantial compliance for all provisions, N.1 through N.8. The Monitoring Team concurred with the Facility's self-assessment of substantial compliance for section N.1, N.4, and N.7; however, the Monitoring Team determined noncompliance for section N.2, N.3, and N.5, N.6 and N.8. The Self-assessment used data collection when assessing all provisions; however, the self-assessment did not assess data elements specific to required components for each provision, and they did not assess the clinical efficacy for activities assessed. For example, when assessing Provision N.2, the Facility determined, by reviewing 10% of QDRRs, that the provision was substantially compliant because for 100% of the examples the QDRRs were completed as scheduled. The Monitoring Team concurred with this assessment, and the sample size; however, the Facility rated itself as being 100% compliant with regards to the QDRR addressing medical conditions such as diabetes, metabolic syndrome and all polypharmacy issues. While although those specific issues were discussed by the QDRRs that were reviewed by the Monitoring Team, the Monitoring Team determined that QDRRs were not efficacious. For example, when addressing polypharmacy, the QDRRs did not specifically address many issues that were necessary for medical providers and other members of the IDT to be aware of, such as potential risks, drug-drug interactions, and recommendations to mitigate polypharmacy, when clinically appropriate. Another example is the assessment of Provision N.7, which indicated that the Facility was in substantial compliance because the Facility conducted DUEs for FDA drugs used at RSSLC. The Monitoring Team noted that the FDA issued several relevant FDA advisories, such as for azithromycin, ketoconazole, zolpidem, and Olanzapine Pamoate, among others. These drugs are commonly used in mental health and primary care, and although the Facility may or may not have individuals currently one such medications, it is important that the medical providers, and pharmacists are provided information on these important advisories, to keep providers current on such medications, as that information may influence their prescribing practice in the future. For Provision N.8, the Facility determined substantial compliance because 100% the six medication

	variance committee meeting minutes reflected analysis, and corrective plans for medication variances. The Monitoring Team, however, determined noncompliance because in zero out of ten examples, there was indication that there was an analysis or summary for medical provider and pharmacy variances. The Facility should consider enhancing its self-assessment process for Provision N, by developing assessment tools to assess the clinical efficacy for each activity assessed.
	Summary of Monitor's Assessment: The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with Provisions N.1, N.4, and N.7. The Monitoring Team has significant concern over the Facility's lack of further compliance. Review of the quarterly drug regimen (QDRR) reviews did not include important clinical information; the adverse drug reaction (ADR) reviews did not provide pharmacists' comments or recommendations; the medication variance process did not include an analysis, or summary, of medication variances by medical providers and pharmacists; and the drug utilization evaluation (DUE) processes were not developed for all clinically relevant FDA warnings. Significant enhancements in these areas are needed. The following are additional comments, and concerns specific to each provision: Provision N.1: The Facility continued to provide necessary review of new medication orders, and the Monitoring Team determined that the Facility maintained substantial compliance with Provision N.1. Provision N.2: The Monitoring Team noted several concerns with the QDRR process, that included: The medical provider's agreement with the physician recommendations, but not following through with the recommendations; delay in the medical providers, and psychiatrists, review of the QDRRs; the IRRFs not accurately reflecting risks associated with side effects; and polypharmacy issues reflected by the QDRR review. Also, as part of the QDRR process, the Facility should comment on appropriateness and efficacy of pharmacological treatment. The Monitoring Team experienced significant challenges when reviewing the QDRRs, as formal recommendations were buried within the pharmacist's narrative, and not easily discoverable. For these reasons, the Monitoring Team determined noncompliance for Provision N.2. Provision N.3: The Monitoring Team determined noncompliance for Provision N.3. The Monitoring Team found it extremely challenging to extract relevant clinical information from the QDRRs, and could not efficiently, or effectively determine if necessary clinical information was present, and in no examples could the Monitoring Team easily determine the recommendations made by the pharmacists. The Monitoring Team strongly encourage the Facility to have the QDRR process reviewed by the medical director and lead psychiatrists, to ensure that the medical providers and psychiatrist can efficaciously utilize the QDRRs as a clinical resource. The Monitoring Team has concern that because recommendations are not specifically listed as recommendations, so the reviewing medical providers and psychiatrists may overlook recommendations, and not follow-up on them when agreeing with the recommendations made on the QDRR. The Monitoring Team will assess the medical providers' and psychiatrists' follow-up to recommendations issues on the QDRRs, at the next review. The Monitoring Team also suggests that the QDRR be divided into specific components--for example, a specific component for the review of stat medications, benzodiazepines, polypharmacy, anticholinergic usage, and other necessary reviews. The

	systems review for polypharmacy, benzodiazepines, anticholinergics, and stat medication review must be significantly enhanced, as the examples provided included graphical data that were not adequately labeled, and detailed analysis of the medications usage was not presented. Provision N.4: The Monitoring Team noted that medical providers at the Facility appropriately respond to physician recommendations, and for the single patient drug interventions reviewed, there was evidence to support that the medical provider documented either agreement with the recommendations, or documented a clinically appropriate alternate action. For these reasons, the Monitoring Team will continue substantial compliance for Provision N.4. Provision N.5: The Facility had a good system in place to monitor side effects of psychotropic medications. Administration of the DISCUS and MOSES screens was done by nurses who received good training on the tools and who received annual retraining to assure continued competence. The pharmacy supported DISCUS and MOSES administrations and QDDR reports that included good discussion of matters that were rated on the MOSES and DISCUS. Because adequate physician reviews are not yet in place due to the lack of timely review and the cited difficulties with the physician review section on the MOSES and DISCUS forms, the Facility is not yet in compliance with this provision. Provision N.6: The Monitoring Team noted significant issues with the Facility's ADR process. Although there were excellent training materials developed for the identification of ADRs for medical providers, there was no evidence of the specific training initiatives for other health care professionals, such as nurses and pharmacist. Nineteen nurse case managers were documented as having training on the ADR process. To ensure that all possible ADRs are reported, it is important to train the remainder of the nurses, who observe individuals daily, and other staff who may observe changes in an individual that should be reported as possible ADRs. The lack of meaningful, on-going training may contribute to the continued low number of ADRs reported, and the majority of ADRs, 70%, being reported by pharmacists, after reviewing labs There was no severity level documented for the ADR. The ADR reporting forms were not being completed timely, or fully completed. Clinical actions for reported ADRs was significantly delayed, and the providers did not assertively address the ADR in 40% of the examples reviewed. The Monitoring Team was especially concerned that the ADR reporting form, and ADR form, did not include sections for pharmacist comments and clinical recommendations. For these reasons, the Monitoring Team determined that the Facility is noncompliant with Provision N.6. Provision N.7: Because of the high quality DUEs that were developed, and provide to the medical, and pharmacy staff, the Monitoring Team will continue substantial compliance. Provision N.8: the Monitoring Team has determined noncompliance for Provision N.8. The Facility must ensure that the medication variance committee reports not only on nursing variances, but also summarizes medication variances for medical providers and pharmacists, and documents corrective actions, follow-up to corrective actions, and remediation steps.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	Provision N.1 requires that a pharmacist reviews all new medication orders to ensure that the medication is for a clinically appropriate indication; evaluate all diagnostics necessary for safe administration of the medication; evaluate efficacy of the drug; ensure that the dose is clinically appropriate; and ensure that there were no contraindications, such as allergies, and drug-drug interactions. The pharmacist also utilizes the WorX, drug safety computer program, when reviewing all medication orders. The WorX program is an automated process that assesses for possible drug-drug interactions, known allergies, and prompts the pharmacist to review necessary diagnostics. To document the pharmacist's review of new medication orders, the pharmacist completes a checklist, which is stamped on each new medication order. The stamp includes notation for appropriate indication, evaluation of labs, assessment for allergies, and dose. To assess continued compliance with Provision N.1, the Monitoring Team reviewed copies of the last two medication orders of each month, for 2/2013 through 6/2013, for a total of ten new medications orders. In addition, the following information was reviewed for each example provided (Individuals #130, #729, #410, #515, #558, #785, #220, #140, #456, and #10): • Pharmacy documentation that a review for allergies, interactions, required diagnostics, appropriate indication, and dose • Past six months laboratory data • Current medication list • EKG for past three years • Most recent ophthalmology consultation The following is a summary of the Monitoring Team's review: • The pharmacist reviewed all new medication orders for potential allergies, interactions, appropriate doses, necessary diagnostics, and indications in ten out of ten examples (100%). • The Monitoring Team reviewed the medication order for potential drug interactions with the medication listed on the current medication list, and in ten, out of ten examples (100%), the Monitoring Team identified no evidence of drug-drug interactions. • There were no examples requiring the initiation of a single patient drug intervention report (SPDI). • By review of the current medical list, and last 12 months of laboratory data, and EKG reports, there was evidence that appropriate diagnostics, including labs, DEXA, and EKG monitoring, were obtained as necessary in ten out of ten examples (100%).	Substantial Compliance

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		Summary: The Facility continued to provide necessary review of new medication orders, and the Monitoring Team determined that the Facility maintained substantial compliance with Provision N.1, of the Settlement Agreement.	
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.	To assess that the Facility conducts quarterly drug regimen reviews (QDRRs), that are consistent with generally acceptable standard of care practice, and that the QDRRs are completed within the Facility's 14 day window for scheduled completion of QDRRs, the Monitoring Team reviewed the following documents: • QDRR schedule for past six months, and pending six months • List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date • Average daily census • Alpha list of individuals who were prescribed a neuroleptic, and have diabetes • Alpha list of individuals who were prescribed a neuroleptic, and have diagnosis of hypertension • Alpha list of individuals who were prescribed a benzodiazepine • Alpha list of all individuals with diagnosis of osteoporosis • Alpha list of all individuals with diagnosis of seizure disorder • The Monitoring Team selected the following examples from the alpha lists above (Individuals #239, #641, #424, #787, #354, #137, #142, #109, #302, #220, and #614): o Most recent two QDRRs o Past six months MOSES and DISCUS assessments o Most recent 12 months of lab results o Most recent two EKG reports o Most recent annual physician summary o Most recent psychiatric assessment o Most recent IRRF o Evidence that the medical providers reviewed the pharmacists recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale <u>Timely Completion of QDRRs</u> During the six-month reporting period, the Facility reported an average census of 360 individuals. During the same period, a total of 720 QDRRs were required to be completed. Based on review of the QDRR schedule, and list of QDRRs completed outside of the Facility's 14 days window for scheduled completion of the QDRR, a total 692 out of	Noncompliance

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		720 (96%) QDRRs were completed timely during the reporting period. <u>Review of completed QDRRs</u> The following is a summary of the Monitoring Team's findings of the document review for the selected sample (Individuals #239, #641, #424, #787, #354, #137, #142, #109, #302, #220, and #614): • Polypharmacy was addressed by the pharmacists in nine out of nine examples (100%) of the cases when polypharmacy was present. • For the four individuals treated with benzodiazepines, four out of four (100%) examples indicated a specific assessment for the use of benzodiazepine by the pharmacist. • The pharmacist assessed Laboratory tests in 11 out of 11 examples (100%). • An EKG was commented on, when clinically necessary, in 11 out of 11 examples (100%). • Metabolic syndrome was appropriately assessed in four out of the five examples (80%) that required a review for metabolic syndrome. Individual #641 had risk factors, including the diagnosis of diabetes, hypertension, and was treated for dyslipidemia, but was determined not to be at risk for metabolic syndrome. Conditions known to be risk factors for metabolic syndrome, are to be considered risk factors, even when treated. • The QDRR indicated review by the medical provider in nine out of 11 examples (81%). The Monitoring Team noted that although the QDRR was signed by the medical provider, the date that the medical provider signed the QDRR was, for some, more than two months after the completion of the QDRRs; examples of significantly delayed review by the medical provider are Individuals #137 and #641. • The QDRR indicated review by the psychiatrist in three out of the five examples (60%) of the QDRRs that required review by the psychiatrist. The Monitoring Team noted that although the QDRRs were signed by the psychiatrist, the date that the psychiatrist signed the QDRR was more than two months after the completion of the QDRRs. • The MOSES and DISCUS were included as part of the assessments for the QDRRs in 11 out of 11 (100%) examples; however, the Monitoring Team noted that both assessment tools did not include a physician signature, and the physician did not complete the physician component of the assessment tool. It is important for the pharmacist to take into consideration the physician's interpretation of the assessments, so possible discrepancies can be addressed. • The IRRFs reflected side effects in three out of the 11 examples (27%). • The medical provider documented agreement with the pharmacist's recommendation in ten out of 11 examples (91%); in two cases, although the	

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		medical provider indicate agreement, there was evidence to indicate that the recommendation was not followed: o Individual #461: Recommendation to discontinue ferrous sulfate was agreed upon, but the medication was not discontinued. o Individual #137: Recommendation to discontinue lorazepam was agreed upon by the provider; however, there was no evidence to indicated that the medication was discontinued, as the most recent medication list indicated lorazepam as a prescribed medication. • For the five individuals reviewed by Monitoring Team who had a diagnosis of osteoporosis, the pharmacist: o Commented specifically on the appropriateness of treatment in three out of five examples (60%): Individuals #302, and #220 were exemplary examples of assessing the use of specific treatment for osteoporosis. o Commented specifically on the efficacy of treatment for osteoporosis in zero out of five examples (0%). • The QDRR clearly delineated the appropriateness for all drugs prescribed in zero out of 11 examples (0%). • The QDRR clearly delineated effectiveness of all drugs prescribed in zero out of 11 examples (0%). • Clinically rational recommendations were clearly delineated on the QDRR in zero out of 11 examples (0%). The following are the Monitoring Team's comments and concerns, upon review of the documents associated with the QDRR process: Individual #641 • The medical provider did not indicate agreement or disagreement with the pharmacist's recommendation for the QDRR dated 8/15/2013, and the psychiatrist did not indicate agreement or disagreement for the QDRR dated 4/30/2013. Furthermore, the medical provider's and Psychiatrist's signature dates for the 4/30/2013 QDRR were 7/31/2013 and 7/15/2013 respectively, which was over three months following completion of the QDRR. • The individual is diagnosed and treated for diabetes, hypertension, and dyslipidemia, and is on a neuroleptic. Metabolic assessment noted on the 8/15/2013 QDRR indicated that the individual was not at risk for metabolic syndrome. If an Individual is being administered treatment for dyslipidemia, hypertension, and diabetes, all three conditions should be considered as risk factors, thus in this example the Individual meets criteria for metabolic syndrome.	

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		• The 4/30/2013 QDRR included a recommendation to consider discontinuation of ferrous sulfate, and the primary provider agreed with the recommendation; however, the Individual continued on ferrous sulfate, and the 8/15/2013 QDRR recommended to continue ferrous sulfate, because of noted labs on 11/14/2012. The 11/14/2012 labs were labs reviewed for the 4/30/2013 QDRR that indicated a need to discontinue the ferrous sulfate, and there was no documentation on the QDRR reconciling the pharmacist's differing recommendations • The 4/30/2013 QDRR recommended discontinuing enalapril because it could worsen renal failure, and the primary provider agreed with the recommendation; however, the Individual continued on enalapril, and the 8/30/2013 QDRR again commented on the potential danger of continuing this medication. The Monitoring Team is concerned this Individual continued on enalapril, without documented clinical rationale for continuing the enalapril, or discontinuing the medication. Individual #424 • The pharmacist completed an exemplary review for the use of psychotropic polypharmacy, including a review for the continued need to provide benzodiazepine. Individual #354 • The pharmacist's review and assessment of for erythropenia, and hyponatremia was exemplary. • The most recent IRRF was not completed for polypharmacy. Individual #137 • The pharmacist recommend tapering of lorazepam because "lorazepam is not indicated for schizoaffective disorder and may actually precipitate aggressive and hyperactivity in psychiatric patients". The Monitoring Team compliments the pharmacist for the comprehensive assessment of polypharmacy. • The 5/31/2013 QDRR was signed by the pharmacist on 6/14/2013; however, it was not signed by the medical provider until 8/8/2013, and the psychiatrist on 8/25/2013, which was a significant period following completion of the QDRR. The Monitoring Team noted several concerns with the QDRR process, that included: • The medical provider's agreement with the physician recommendations, but not following through with the recommendations; • Delay in the medical providers' and psychiatrists' review of the QDRRs; • The IRRFs not accurately reflecting risks associated with side effects and polypharmacy issues reflected by the QDRR review. The Monitoring Team experienced significant challenges when reviewing the QDRRs, as	

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		formal recommendations were buried within the pharmacist's narrative, and not easily discoverable for decision-making by the PCP and psychiatrist. For these reasons, the Monitoring Team determined non-compliance for Provision N.2.	
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 requires that the Facility evaluate its process and usage of stat emergency medications, polypharmacy, benzodiazepines, anticholinergics, and metabolic syndrome. The following is the Monitoring Team's review of Facility's processes for monitoring these medication related issues: <u>Benzodiazepine usage:</u> The Monitoring Team requested the following documents to review the Facility's review of benzodiazepine use: • Alpha list of all individuals on benzodiazepine • Data analysis, and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use • For the first five individuals on a list of benzodiazepines used for psychiatric indication, and first five individuals on a list of benzodiazepines used for neurological indication: o Most recent two QDRRs o Most recent IRRF o Current medication list o Most recent psychiatric assessment o Most recent annual medical assessment The Facility provide a document by the clinical pharmacists that was entitled "A Comparative Review of Benzodiazepine Usage at RSSLC 5/30/2013". This document was intended to document a review of benzodiazepines for the period 5/17/2012 thru 5/30/2013. The document indicated that the number of individuals receiving benzodiazepines decreased from 43 to 41 individuals during the 12-month period reviewed, and a reported 0.02% reduction from 11.90% to 11.88%. Further review of the document indicated that the Facility described the indication for each specific type of benzodiazepine used at the Facility. For example, the Facility reported that for diazepam, the dose range was "2 mg BID" to "10 mg QPM", and that one individual was prescribed diazepam for seizure control, eight for spasticity, and one for anxiety. Although the document indicated that the review period was from 5/17/2012 thru 5/30/2013, much of what was reported included data that predated 5/17/2012. For example, when describing changes associated with the use of clonazepam, the data	Noncompliance

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		presented was from March 2010, and indicated a net reduction in usage of clonazepam of 38.09% over the three-year period, between 3/2013 and 5/2012. The document concluded by stating that the Facility's use of benzodiazepines was appropriate, and medically justifiable, and that the Facility was able to reduce the overall usage of benzodiazepines. The Monitoring Team was conflicted with this statement because in the body of the document, it was stated that the 0.02% reduction was not statistically significant. There was also no evidence documented in this report indicating that the clinical pharmacist determined if the use of the drug was appropriate, other then reviewing the diagnosis. The clinical pharmacist should sample the population and determine if there were actual clinical indications warranting the use of the drug. The document stated that the information would be submitted for review and discussion by the P&TC at the third quarter. There was no additional documentation, such as committee meeting minutes, indicating that the use of benzodiazepines was regularly evaluated by the Facility; thus, the information provided indicated that the Facility only conducted one systems review for its review of benzodiazepines, within a 12 month period. Based on review of the clinical documents, per the document request, the Monitoring Team made the following determination, for Individuals #155, #475, #513, #555, #714, #354, #412, #483, #161, and #386: • In ten out of ten cases (100%), the QDRR documented the use and indication for the use of the benzodiazepine. • In seven out of ten cases (70%), the QDRR documented risks associated with the use of the benzodiazepine. Review of associated IRRFs indicated that in zero out of ten examples (0%), specific risks associated with the use of benzodiazepines was listed, such as potential fall risk, cognitive changes, and behavioral exacerbation. • In eight out of ten cases (80%), the QDRR documented efficacy or lack of efficacy of the benzodiazepine. It should be noted, however, that the Monitoring Team was required to interpret the pharmacist's determination of efficacy for each drug reviewed, because there were no specific comments about efficacy. For example, the QDRR for Individual #354 documented "I suggest we continue to downward taper the Tegretol per (the neurologist's recommendation) and if breakthrough seizures continue to occur consider continuing an upward taper of dose for Clobazam to 10mg BID". The Monitoring Team strongly recommends that the pharmacist clearly delineate if the dosage is appropriate. • In eight out of ten cases (80%), the QDRR documented whether the dose of the benzodiazepine was clinically justifiable. Again, the Monitoring Team was	

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		required to interpret the pharmacist's determination of appropriate dose, as there were no specific comments addressing appropriateness of dose. For example, the QDRR for Individual #714, the pharmacist documented that the psychiatrist "did reduce the patient's lorazepam dosage to 0.5 mg BID from the previous 1 mg BID dosage to lessen the total polypharmacy burden and the patient appears to have remained stable. Based upon the stability of the patient when seen by (physician) no medication changes were made and the patient will RTC in 3 months for follow up with (the psychiatrist)". In this example, the Monitoring Team determined that the pharmacist concurred with the benzodiazepine dose, as there was no specific statement indicating that the pharmacist disagreed with the recommended dose. • In eight out of ten cases (80%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. The following are some comments, and concerns noted by the Monitoring Team, following review of benzodiazepines reviews by the pharmacist: documents: Individual #161: This is an example of exemplary pharmacist's review of side effects and a potential drug-drug interaction, as the pharmacist documented on the QDRR "continue to monitor for gait imbalance, movements, and weakness noted on 5/7/13 MOSES assessment possibly linked to phenytoin use as patient is at an increased risk of toxicity despite dosage reduction due to a potential interaction between clobazam and phenytoin". This example also demonstrates an effective review of drug-drug interaction among anticonvulsants. Individual #386: Although the pharmacist did not specifically indicate the efficacy of benzodiazepine, the pharmacists recommended to follow up with the neurologist to determine efficacy. In this example, the clinical pharmacist did not assess, or determine efficacy, but did indicate that the neurologist should determine efficacy; hence, the Monitoring Team determined that efficacy was addressed by the pharmacist in this example. Individual #714: As with the other QDRRs reviewed, there was an extensive narrative describing various details of the psychiatric treatment regimen, which made it difficult to interpret the specifics of the QDRR review for benzodiazepine and other medications. In this particular case, the Monitoring Team could not determine if the pharmacist concurred with the use of benzodiazepine or not, could not determine if efficacy was assessed, and could not identify specific determination of risk versus benefit. Summary	

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		The Monitoring Team noted extensive narrative regarding treatment for neurologic and psychiatric use of benzodiazepines, and in some occasions, as listed above, exemplary review of drug-drug interaction was noted. Overall, it was challenging for the Monitoring Team to determine if the pharmacist concurred with the use of benzodiazepine, appropriateness of dose, and efficacy of the benzodiazepine; for these reasons, the Monitoring Team strongly recommends that for future reviews the pharmacist specifically indicate the following: • Agrees or disagrees with the indication and use of benzodiazepine • Agrees or disagrees with the dose of benzodiazepine • By review of clinical data, reports, and if necessary by direct observation of the individual, determine if the medication is efficacious or not efficacious • Document associated risks, and benefits for benzodiazepine use • Provide clinically rational alternatives to benzodiazepines, when appropriate <u>Anticholinergic usage:</u> To assess the Pharmacists' participation in the monitoring of anticholinergic drug usage at the Facility, the Monitoring Team requested the following documents: • Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties • Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties • Alpha list of individuals who are prescribed anticholinergic drugs • For the first ten individuals on the list of individuals prescribed anticholinergic drugs (Individuals #239, #523, #112, #442, #529, #372, #630, #524, #600, and #641): o Most recent two QDRRs o Current medical list o Most recent medical, and psychiatric annual reviews o Most recent MOSES and DISCUS assessments Systems review of anticholinergics drug utilization: as evidence that the Facility conducted systems review of anticholinergic medication usage at the Facility, the Facility provided a document entitled A Comparative Review of Anticholinergic Usage at RSSLC", dated 5/31/2013. The document indicated that a previous review was completed on 7/2012. The document indicated that the Facility assessed the usage of benztropine, Solifenacin, and diphenhydramine, but did not document psychotropic medications, such as antipsychotics, and antidepressants that have anticholinergic properties. The review did, however, indicate an excellent overview of benztropine usage, by identifying	

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		inappropriate use of the drug, and providing clinically relevant information to providers, about appropriate indications for the use of benztropine. The Facility did not provide committee meeting minutes, or otherwise indicate regular systems review for the Facility's usage of anticholinergic drugs; hence the previous systems review would have been ten months prior to the 5/31/2013 review of benzodiazepines. Individual reviews for anticholinergic usage: Based on the documents for the pharmacists review of individuals prescribed anticholinergics, the Monitoring Team made the following determinations for Individuals #239, #523, #42, #442, #529, #372, #630, #524, #600, and #641: • In six out of ten cases (60%) the QDRR documented the indication for the use of all anticholinergics prescribed. • In four out of ten cases (40%), the QDRR documented risks associated with the use of anticholinergics. • In two out of ten cases (20%), the QDRR documented whether the dose of the anticholinergics drugs were clinically justifiable. • In six out of ten cases (60%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. • In five out of ten cases (50%), the pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics. The following are specific examples of the Monitoring Team's findings, along with concerns and comments: • Individual #112: The only comment noted on the QDRR for the anticholinergic Solifenacin was "perhaps a dietary consultation for consideration of a high fiber diet may be an option due to Solifenacin use which can increase risk of constipation for which patient already has an active diagnosis for." There were no additional comments about other risks associated with the drug, and no recommendations for alternate or additional pharmacotherapy. • Individual #630: As with all other QDRRs reviewed, the Monitoring Team had to interpret from a narrative written by the pharmacist, that the pharmacist assessed indication, risks, efficacy, and treatment options. For example, the pharmacist documented the following review for the anticholinergic Benztropine: "Perhaps a slow taper of benztropine may be an option if the patient continues to remain free of EPS symptoms as findings reveal that EPS are usually transient and therefore resolve within one to (two) weeks. Furthermore discontinuation of this agent will decrease the risk of confusion and	

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		hallucinations associated with use of this agent and lessen the anticholinergic burden as haloperidol also has anticholinergic properties." This was an exemplary review for potential side effects; however, the pharmacist did not specifically indicate if the indication was appropriate or not, if the current dose was appropriate, or if the medication was efficacious or not. • Individual #600: The only comment about anticholinergics was for the medication benztropine, in which the pharmacist documented, "Perhaps slow taper of benztropine may be an option in order to determine need since patient has been EPS free for a while and findings which indicate the transient nature of EPS symptoms and subsequent lack of need for benztropine use after a 1-2 week period". The Monitoring Team compliments the Facility for its assertive assessment of the continued need for benztropine; however, the QDRR should also specifically delineate potential risks associated with the medication, and appropriateness of dose, so that the provider and other IDT members can understand the risk and benefits of the medication, and if the prescribed dose is efficacious. <u>Review of polypharmacy usage</u>: To review the pharmacists' participation with assessing the appropriateness of polypharmacy, the Monitoring Team reviewed the following documents: • P&TC meeting minutes for 1/8/2013, 4/17/2013, and 7/18/2013 • Monthly polypharmacy meeting minutes for 1/2013 through 7/2013 • List of all individuals on polypharmacy • For the first, and than every second individual on the list of polypharmacy, for a total of ten individuals (Individuals #787, #140, #555, #711, #155, #238, #66, #19, #626, #487): o Most recent two QDRRs o Most recent psychiatric assessment o Current medication list o Most recent ISP, or related document the use of polypharmacy Polypharmacy review panel meetings: The Facility assesses appropriateness of polypharmacy usage for approximately four individuals each month, at the monthly polypharmacy review panel meeting. The review consists of a pharmacist, medical provider, psychiatrist, psychologist, and nursing representatives. The committee also reviews the Facility's overall usage of polypharmacy, as part of a systems review, each quarter. The polypharmacy committee generated quarterly reports for the P&TC to review. Review of the 1/8/2013, 4/17/2013, and 7/18/2013 P&TC committee meeting minutes indicated that the committee was informed by the polypharmacy committee of the current incidence of medical, psychiatric, and mixed polypharmacy, and provided	

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		relevant information explaining changes with the incidence of polypharmacy. For example, the P&TC meeting minutes dated 7/18/2013 documented that "psych polypharmacy patient numbers did increase by 6 patients; 4 of which were new admissions and 2 patients that had addition psychotropic medications added to their regimens due to behavioral issues." A graph was included, along with a narrative for the P&TC meeting's review, that indicated the number of individuals for psychiatric, medical, and mixed psychiatric and medical polypharmacy, for the past 12 months. The Monitoring Team had no concerns with the information presented at the P&TC meeting; however, for both the polypharmacy meeting minutes and the P&TC meeting minutes reviewed, there was no section that specifically outlined action steps for the committee members, or section to assess compliance with previous action steps. The following is a summary of the documents reviewed for polypharmacy: • In ten out of ten examples (100%) the QDRR documented the indication for the use of each polypharmacy agent. • In two of ten examples (20%), the QDRR documented serious risks for the use the polypharmacy combination. Despite indication that the pharmacist reviewed the MOSES and DISCUS assessment results, The QDRR did not list specific potential side effects, and other potential consequences, such as drug-drug interactions, that should be closely monitored. The QDRR should provide other IDT members an understanding of the risks associated with the prescribed polypharmacy, and that was not clearly delineated. • In zero out of ten cases (0%), the QDRR documented whether the dose for the specific polypharmacy agents was appropriate or not appropriate. There were some examples of the pharmacist indicating drug levels were not appropriate, and dosages needed to be adjusted; however, in none of the examples reviewed, were all of the doses commented on for polypharmacy. • In four out of ten cases (40%), the QDRR documented clinically justifiable recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. The QDRR must document recommendations for each medication associated with polypharmacy. • In three out of ten cases (30%), the pharmacist documented the efficacy, or lack of efficacy for the use of polypharmacy. The QDRR should document the efficacy, or lack of efficacy for the polypharmacy. The following are specific examples of the Monitoring Team's concerns following review of the documents: • Individual #140: The QDRR indicated that an elevated prolactin level was thought to be secondary to valproic acid; however, there was no indication that	

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		the prescribed olanzapine may also contribute to elevated prolactin levels. Although not common, olanzapine has been reported to manifest in hyperprolactinemia. There was also no recommendation on how to clinically manage hyperprolactinemia. There was no evidence documented on the QDRR to indicate that the pharmacist concurred with the current polypharmacy, documented the efficacy of polypharmacy, and commented on potential risks associated with the prescribed polypharmacy. • Individual #555: Although the QDRR noted that additional MOSES and DISCUS assessments should have been obtained, and listed several of the side effects experienced by the Individual, the QDRR did not document potential associated risks for the prescribed polypharmacy, and did not indicate if the pharmacist agreed or disagreed with prescribed polypharmacy treatment. • Individual #711: As with the QDRR for Individual #555, the QDRR noted that additional MOSES and DISCUS assessments should have been obtained, and listed several of the side effects experienced by the Individual. The QDRR did not document potential associated risks for the prescribed polypharmacy, and did not indicate if the pharmacist agreed or disagreed with prescribed polypharmacy treatment. • Individual #155: The Individual was prescribed olanzapine for bipolar affective disorder, and donepezil for possible dementia. The QDRR did not comment on the black box warning for the administration of olanzapine in individuals with diagnosis of dementia. Serious and common risks associated with the polypharmacy were not documented on the QDRR. • Individual #66: The QDRR commented on possible alternative therapy for the use of valproic acid, chlorpromazine, and zolpidem; however, there was no comment regarding appropriateness of guanfacine for psychiatric indication, and the efficacy of guanfacine, was not commented on. • Individual #626: The QDRR provided recommendations for citalopram by "I suggest we consider a slow taper in citalopram it may be playing a role in the electrolyte disturbance and sinus bradycardia reported on last EKG. Furthermore we may not be deriving very much benefit from this agent due to reports of crying and withdrawal noted on 6/13/13 Moses assessment. Noted the paradoxical effects such as agitation and depression also associated with citalopram use due to increase in cortisol levels and subsequent adrenaline crash." In addition, the QDRR reported "Perhaps the addition of fish oil may be an option due to its potential mood stabilizing properties as patient recently had an upward titration in olanzapine dosage from 2.5 mg/day to 5 mg/day due to bouts of irritability. This may also allow us to reduce reliance on the Divalproex (Note: VAP level w/CBC is currently pending) which may be playing a role in the depression in sodium and chloride levels at 131 mmol/L and 94mmol/L	

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		respectively". In this example, the QDRR did not indicate appropriateness of dose for the polypharmacy agents, potential side effects of the polypharmacy, or efficacy of polypharmacy related agents, other than citalopram. Furthermore, no alternative therapy, or follow-up action was recommended for the "slow taper" of citalopram. The Monitoring Team also noted that the QDRR provided recommendations to administer "Namenda and/or donepezil", for the indication of dementia secondary to head trauma with behavioral disturbances. Because the FDA indication for Namenda is specific for mild to moderate Alzheimer's type dementia, the QDRR recommendation should state the clinical rationale for the off-label use of this drug very clear, so other members of the IDT can be aware of the off label use. • Individual #487: The Individual was diagnosed with bipolar affective disorder and the QDRR indicated that because the blood level of the mood stabilizer, carbamazepine was subtherapeutic, and if the Individual remained stable, carbamazepine would be discontinued. The QDRR did not indicate an alternative agent that should be considered for maintenance mood stabilization, or that if pharmacotherapy was not indicated, the diagnosis should have been questioned. Furthermore, the QDRR raised concern over the possibility continued use of fluoxetine could cause a "manic episode", which indicated to the Monitoring Team that the diagnosis of bipolar disorder was not in question; hence, standard of care practice would indicate a need for continued maintenance therapy. Potential side effects secondary to the polypharmacy were not elaborated on in the QDRR. <u>Stat chemical restraint usage:</u> The Monitoring Team requested a list of all stat chemical restraint data, data analysis, summaries, and committee meeting minutes for the use of stat chemical restraints that were administered during the reporting period, and for the first ten individuals who were administered a state chemical restraint during the reporting period: • Copy of the Facility's Face-to-Face debriefing report, or other documentation indicating a review of the usage of stat chemical restraint by the pharmacist, and the psychiatrist Systems review of stat chemical restraint usage: The Facility provided two graphs indicating the use of emergency, stat medication use: • Emergency (Stat) Medication Monitoring Chart dated 7/2013, was a line graph representing a rolling 12 month review of stat emergency medication use. • Emergency (Stat) Medication Monitoring 8/1/1012 – 7/18/2013 Counts by Month" included both a line graph and bar graph for the same data. This graph did not document what the stat drug indication was for; hence, the Monitoring	

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		Team could not discern if the data represented stat medications specific for chemical restraint, medical restraints, seizure control, or all stat medications. The data represented on the two charts differed from one another. For example, the Counts by Month chart indicated 12 stat psychiatric medications were administered in March 2013, and the graph representing the rolling 12-month review indicated only 11 stat psychiatric medications were administered in March 2013. Furthermore, both charts did not include data for all of the months indicated. For example, the counts by month chart was dated 8/1/2013 through 7/18/2013; however, the graph did not start until 10/1012, and there were no data fields for months 12/12, 5/13, and 7/13; hence, only severn of 12 months were actually listed. In the event that no stat medications were administered during the omitted months, the chart should have indicated the month, and that zero drugs were administered. A data table was provided for review, entitled "Emergency (Stat) Medication Monitoring", with a date range of 9/1/1012 – 8/29/2013, and listed a total of "45 reviews" that occurred during the reported time frame. The Monitoring Team could not discern what was meant by "reviews", and as with the previous examples, could not discern if the data represented stat medications specific for chemical restraint, medical restraints, seizure control, or all stat medications. A written report, entitled "Emergency (stat) Medication Monitoring Report to P&T Committee 7/18/2013" was provided for review. The report indicated that from 8/1/2012 through 7/18/2013, a total of 36 emergency (stat) medication orders were completed for psychiatric conditions. Although the title of the report stated that the report was to be presented at the 7/18/2013 P&T committee meeting, the closing statement of the report indicated that it was submitted to the 4/17/2013 P&T Committee; this would have been before all the months were entered and may have been an error. The report did not provide an analysis, or provide recommendations for the Facility's usage of stat chemical restraint. A copy of the Facility's database on "Emergency (Stat) Medication Monitoring", with a date range of 9/1/2012 – 8/30/2013, was provided for review. The database included the pharmacist's comment for each instance that a stat medication was administered, including psychiatric and general medical indications. An example of the pharmacist's comment for the first documented instance of a stat psychiatric medication, dated 10/5/2012, is as follows: The data base listed the Individual's name, stat medication used, type of stat medication, the physician who ordered the medication, and the indication. The pharmacist provided the following comment justifying the use of the stat medication: "Patient was exhibiting active hallucinations with aggressive behaviors directed at other patients and staff and was viewed by the psychiatrist to be responding to internal stimuli. Dosage and indication for use is appropriate per FDA use guidelines".	

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		The pharmacist did not document if the maintenance medication was appropriate; if there were reported, or observed, side effects to the stat chemical restraint; did not indicate if an alternative to the specific medications used should be considered; and did not comment if other drugs were possibly playing a role in in the behavioral exacerbation, such as secondary to altered drug levels from polypharmacy. The Pharmacy reported that they do not use a Face-to-Face debriefing document that other DADS Facility use, and they did not provide any other document that enabled the pharmacist's, and psychiatrist's comprehensive review of the use of stat chemical restraint. The Facility should ensure that the reviewing pharmacist documents: specific circumstances of the behavior exacerbation, or other need for the stat chemical restraint, and if the medication was justified; effectiveness of the chemical restraint; if side effects or other adverse effects occurred during the stat chemical restraint; evaluation to assess efficacy of the maintenance medication, and recommendation to adjust or change the maintenance medication if necessary. The pharmacy review should be completed by the following business day and specific recommendations should be documented, when necessary. In addition, the pharmacist should review, and concur or disagree with, the psychiatrist's review of the stat chemical restraint, that documents the following information: Description of the behavioral exacerbation, and justification for the use of the stat chemical restraint; comment on the appropriateness of the maintenance medications; review of the appropriateness of the PBSP, and relevant environmental factors associated with the behavioral exacerbation; assessment of possible side effects from the stat chemical restraint; efficacy of the stat medication; and comment about the risks of drug-drug interaction; and specific recommendations, when necessary. The pharmacist's and psychiatrist's assessment and recommendations for the stat chemical restraint usage should be reviewed by each other, and by other members of the IDT. <u>Metabolic Syndrome:</u> The Monitoring Team relied on the sample selection, and documents used for Provision N.2 of this report, when assessing the pharmacy's review for metabolic syndrome. Metabolic syndrome was appropriately assessed in four out of the five examples (80%). Individual #641 had risk factors, including the diagnosis of diabetes, hypertension, and was treated for dyslipidemia, but was determined not to be at risk for metabolic syndrome. Individuals with a diagnosis of a conditions that is known to be a risk factor for metabolic syndrome, that condition should be considered a specific risk for metabolic syndrome. The Facility conducts adequate assessment for metabolic risk associated with medication usage. Summary: The Monitoring Team determined noncompliance for Provision N.3. The Monitoring Team found it extremely challenging to extract relevant clinical information from the	

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		QDRRs, and could not efficiently determine if necessary clinical information was present, and in no examples could the Monitoring Team easily determine the recommendations made by the pharmacists. The Monitoring Team strongly encourage the Facility to have the QDRR process reviewed by the medical director and lead psychiatrists, to ensure that the medical providers and psychiatrists can efficaciously utilize the QDRRs as a clinical resource. The Monitoring Team has concern that because recommendations are not specifically listed as recommendations, the reviewing medical providers and psychiatrists may overlook recommendations, and not follow up on them when agreeing with the recommendations made on the QDRR. The Monitoring Team will assess the medical providers, and psychiatrists, follow-up to recommendations issues on the QDRRs, at the next review. The Monitoring Team also suggests that the QDRR be divided into specific components--for example, a specific component for the review of stat medications, benzodiazepines, polypharmacy, anticholinergic usage, and other necessary reviews. The systems review for polypharmacy, benzodiazepines, anticholinergics, and stat medication review must be significantly enhanced, as the examples provided included graphical data that were not adequately labeled, and detailed analysis of the medication usage was not presented.	
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.	To assess the pharmacist's clinical recommendations, and clinical appropriateness of the medical providers' response to the recommendations, the Monitoring Team assessed the QDRRs from Provision N.3, and requested the following information for the first two single patient drug intervention reports (SPDI) for 2/2013, 3/2013, 4/2013, 5/2013, and 6/2013 (Individuals #160x2, #48 #625, #463, #368, #475, #346, #593): • SPDI (single patient drug intervention) report • Copy of associated medication order • Documentation of pharmacist's review of the order • Clinical evidence for the medical provider following up on the recommendation, or alternative rationale Review of the requested documents indicated the following: • The QDRR indicated review by the medical provider in nine out of 11 examples (81%). The Monitoring Team noted that although the QDRRs were signed by the medical provider, the date that the medical provider signed the QDRR was more than two months after the completion of the QDRRs, for example for Individuals #137 and #641. • The QDRR indicated review by the psychiatrist in three out of the five examples (60%) of that required review by the psychiatrist. The Monitoring Team noted that although the QDRRs were signed by the psychiatrist, the date that the medical provider signed the QDRR was more than two months after the completion of the QDRRs, for example for Individuals #137 and #641.	Substantial Compliance

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		• Ten out of ten SPDI reports and supporting documentation (100%) indicated that the medical provider either accepted the pharmacist's recommendations or provided clinical rationale for not following the pharmacists recommendations. o For nine out of ten examples (90%) the medical provider concurred with the pharmacist's recommendation. o For one out of ten examples (10%) the medical provider documented clinical rationale for not agreeing with the pharmacist's recommendations. • There was supporting documentation that appropriate clinical action was taken for ten out of ten SPDIs (100%). • A SPDI physician notification form was provided for six out of 10 examples (60%); for the six SPDIs provided to the medical provider, two out of six (33%) were completed by the medical provider. • For the four SPDIs that did not include an SPDI physician notification form, there was indication that the medical provider was notified by telephone, and provided verbal confirmation for the recommendation in four out of four examples (100%). The Monitoring Team noted that medical providers at the Facility appropriately respond to pharmacy recommendations, and for the single patient drug interventions reviewed, there was evidence to support that the medical provider documented either agreement with the recommendations, or documented a clinically appropriate alternate action. For these reasons, the Monitoring Team will continue substantial compliance for Provision N.4.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The reader is referred to Provision J12 of this report for the Monitoring Team's assessment of the Facility's utilization of side effect scales. The Facility had a good system in place to monitor side effects of psychotropic medications. Administration of the DISCUS and MOSES screens was done by nurses who received good training on the tools and who received annual retraining to assure continued competence. The pharmacy supported DISCUS and MOSES administrations and excellent QDDR reports that included good discussion of matters that were rated on the MOSES and DISCUS. Adequate physician reviews are not yet in place due to the lack of timely review and the cited difficulties with the physician review section on the MOSES and DISCUS forms.	Noncompliance
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year,	To assess the Facility's ADR (adverse drug reaction) process, the Monitoring Team reviewed all associated clinical documentation for the first, and then every second ADR, for a total of ten ADRs, that occurred beginning 3/1/2013; updated policies and	Noncompliance

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	the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	procedures for ADRs; all data, trends analysis, summary review, and committee meeting minutes related to a system review of ADRs at the Facility; and staff training materials, specific to the ADR process. <u>Staff Training:</u> The Facility provided copies of training materials, and sign-in roster for a training venue for medical staff. Training for the ADR process was provided by the pharmacy department to the medical staff on 3/27/2013. All medical providers, and the medical director, indicated their attendance by signing the sign-in form. The training materials were robust, and provided detailed information on definition, identification, and reporting procedures. The pharmacy provided robust in-service training on the ADR process to all medical providers, including the medical director. The Facility did provide a sign in sheet of staff who were trained on the "ADR/Moses and Discus In-service for nursing staff and pharmacy staff", dated 7/25/2013. The Monitoring Team noted that 19 Nurse Case Managers and pharmacists participated with the in-service. The training material was not provided to the Monitoring Team for review. <u>Data analysis of ADRs</u> The Facility provided a bar graph entitled Adverse Drug Reactions, dated 8/1/2012 through 7/18/2013. The graph indicated that during the period 8/1/2012 through 7/18/2013, a total of 31 ADRs had been reported, and during the Monitoring Team's reporting period, 16 ADRs were reported. The Pharmacy department generated a data analysis of ADRs for the previous quarters ADR, and presented the information to the P&TC committee. The Monitoring Team assessed the pharmacy department's analysis of ADRs for its second quarter review by assessing "the adverse drug reaction reporting analysis for 2nd quarter (3/13-6/13) report to the P&TC". The report indicated that a total of 15 ADRs were reported during the second quarter; 11 out of the 15 were reported by a pharmacist; and no ADRs were serious enough to report to the FDA. The report documented specific outcome information for each of the 15 ADRs, and indicated that five medications were required to be discontinued. The report also indicated that "we will continue to prompt PCPs and nurses for more ADR reporting and in return will hopefully get more support in order to shore up the numbers in all units". There were specific recommendations to enhance the ADR process documented on this report. <u>ADR Policy</u> The Facility's Pharmacy Policy and Procedure Manual, Adverse Drug Reactions, revised on 8/28/2013 was reviewed. The policy did not document specifics about who is to	

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		participate in the ADR process. The ADR process is multidisciplinary, and physicians, nurses, direct care staff, and pharmacists must all be vigilant in identifying ADRs, and be aware of reporting requirements. <u>ADR reporting forms:</u> There were two forms provided to the Monitoring Teams for review. The form called "Medication Adverse Drug Reaction Reporting Form" appeared to be specific for staff to complete when reporting ADRs. The Monitoring Team noted the following concerns, specific to this form: • Did not include a signature line for the reviewing pharmacist • Did not include a comment section for the pharmacist's review of the ADR and recommendations • Did not include a signature line for the staff who reported the ADR • No section to indicate if the FDA was notified or not • No section to indicate if the guardian was notified of the ADR The form called "Adverse Drug Reaction" form was a typed document, that appeared to be completed following review of the Medication Adverse Drug Reaction Reporting Form. This form included the same clinical information that was reported on the Medication Adverse Drug Reaction Reporting Form. There was no information to indicate who completed this particular document, and no signature line. As with the above example, the Monitoring Team had the following concerns with the form: • Did not include a signature line for the reviewing pharmacist, or other indication who completed the document • Did not include a comment section for the pharmacist's review of the ADR and recommendations • No section to indicate if the FDA was notified or not • No section to indicate if the guardian was notified of the ADR • The MD comment did not include a section documenting the name of the medical provider who issued the comment for the ADR The following is a summary of the examples reviewed by the Monitoring Team: • An ADR reporting form was completed for each ADR reported during the review period, in ten out of ten examples (100%). • The ADR reporting form was fully completed in one out of ten examples (10%). There were multiple sections of the reporting form not completed. • The ADR form was completed for each ADR reported, in ten out of ten examples (100%) • The ADR form was fully completed in ten out of ten examples (100%)	

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		• The medical provider component of the ADR reporting form was completed in seven out of ten examples (70%); however, the medical provider's comments were documented by the pharmacist on the ADR form in ten out of ten examples (100%). In other words, the pharmacist documented the medical provider's response on the ADR report form, as the medical provider did not complete the ADR reporting form. • The medical provider signed the ADR report form in five out of ten examples (50%). • The pharmacist provided comments regarding the ADR in zero out of ten examples (0%). • The pharmacists provided clinical recommendations for the ADR in zero out of ten examples (0%). • Clinically appropriate follow-up and, or treatments for the ADR was noted in six out of ten examples (60%). • For the ten ADRs reviewed, three out of ten (30%) were reported by medical providers, zero out of ten were reported by nurses (0%), and seven out of ten (70%) were reported by pharmacists. The following are comments and concerns specific to the examples reviewed: Individual #726: Because of abnormal sodium and platelet counts on 6/6/2013, the pharmacist completed an ADR report form on 6/12/2013. The medical provider commented on the ADR report form to "repeat labs after 3 months", and there was no comment by the pharmacist questioning this action. Follow up lab for low platelets was obtained on Labs on 7/18/2013 and indicated worsening of the low platelet count. The psychiatric assessment dated 7/23/2013 indicated that "the platelet count was severely suppressed at 77. However, the patient is asymptomatic for any type of bleeding or bruising noted". In addition, the psychiatrist documented "We are mainly concerned about the platelet suppression at this point in time that is still occurring. At this time the patient will need further stabilization due to (his/her) mania. Even with the suppressed platelets and white blood cell count. We will increase (his/her) medication in hopes of stabilizing (his/her condition." The action plan for the psychiatric assessment indicated for the individual to "continue follow up with endocrinologist on an annual basis due to marrow suppression." There was no documentation provided to the Monitoring Team that the pharmacist commented, and provided clinical recommendations on, this potentially very serious issue. The Monitoring Team is concerned that the low platelet count was severe enough for a pharmacist to report an ADR; the pharmacist did not comment or provide clinical recommendations; the medical provider initially indicated that the labs would be evaluated three months, after the ADR report was initiated; and that despite worsening low platelet counts, there were no specific monitoring	

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		parameters and cautions developed to help protect the Individual; and the psychiatric assessment plan did not indicate when to evaluate the low platelet count, other than stating that "We will closely follow (his/her) marrow suppression". Individual #779: The ADR was completed by the pharmacist for elevated prolactin level. There was no comment or recommendations documented by the pharmacist for this ADR. The medical provider indicated that the Individual was evaluated on 7/9/2013, and was asymptomatic because of "no breast tenderness or galactorrhea will cont to monitor prolactin level and for side effects". The psychiatric assessment, dated 6/9/2013 indicated "The patient also has elevated prolactin levels from antipsychotic usage. (He/She) is totally asymptomatic at this point in time. No galactorrhea or breast tenderness. The action plan documented for the psychiatric assessment stated "We are also concerned about elevated prolactin level causing galactorrhea. At this point in time (he/she) is asymptomatic for both". The Monitoring Team has the following concern with this ADR report: • No comment and recommendations by the pharmacist • The medical provider indicated on the ADR report form that the examination was completed on 7/9/2013; however the ADR form was completed on 6/7/2013. • The medical provider did not comment on other potential adverse effects from elevated prolactin. • Specifics on follow-up on prolactin levels, and potential side effects were not indicated. • The psychiatric assessment documented that the individual was "totally asymptomatic"; however, there was no physical examination documented. • The psychiatric assessment plan did not document a specific plan to address the elevated prolactin; also, the assessment did not take comment on potential differential diagnosis, and other manifestations of hyperprolactemia. • The ADR reporting form was not fully completed, as sections #3, #4, and #6 were not completed. Individual #; The ADR was dated 5/14/2013, and the medical provider documented a comment on the reporting form. The ADR was completed because of of an elevated CPK level of 1,493 on 4/9/2013. An integrated progress note (ISP) was completed by the medical provider on 5/9/2013, that indicated "an elevated CPK of 1449 on 4/9/2013", and that the medication would be discontinued at that time. A follow-up IPN by the medical provider, dated 5/14/2013 indicated that the CPK was normal after discontinuing simvastatin. The Monitoring Team has the following concerns: • The Individual had labs completed on 4/9/2013; however, the medical provider did not document an action plan for the abnormal labs until 5/9/2013, and the	

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		ADR form was not completed until 5/14/2013. • The pharmacist did not provide a comment or documented recommendation on the ADR forms for this potentially lethal clinical issue. • Despite an elevated CPK, the medical provider indicated on the ADR reporting form "no adverse event", and did not completed section #2 of the form, which was meant to document the adverse outcome from the ADR. • The ADR report form was not initiated until 5/14/2013, despite abnormal labs being reported on 4/9/2013, and evaluation of the labs on 5/9/2013 Individual #391: The individual was treated for an adverse drug reaction on 3/22/2013 by the medical provider; however, the ADR form was not completed until 3/26/2013, and it was completed by the pharmacists, and not the medical provider who treated the ADR, or the nurse who noticed the signs of the ADR. The following concerns were noted by the Monitoring Team: • The ADR reporting form was not completed for sections #4, #5, and #6. • The MD comment section was not completed by the medical provider; however, the medical provider's treatment and comments were documented by the pharmacist on the electronic Adverse Drug Reaction document. Summary: The Monitoring Team noted significant issues with the Facility's ADR process. Although there were excellent training materials developed for the identification of ADRs for medical providers, the Monitoring Team was not provided examples of the training materials developed for nurses and pharmacists. Also, nineteen nurse case managers were documented as having training on the ADR process. To ensure that all possible ADRs are reported, it is important to train the remainder of the nurses, who observe individuals daily, and other staff who may observe changes in an individual that should be reported as possible ADRs.. The lack of meaningful, and on-going training may contribute to the continued low number of ADRs reported, and the majority of ADRs, 70%, being reported by pharmacists after reviewing labs. There was no severity level documented for the ADR. The ADR reporting forms were not being completed timely, or fully completed. Clinical actions for reported ADRs were significantly delayed, and the providers did not assertively address the ADR in 40% of the examples reviewed. The Monitoring Team was especially concerned that the ADR reporting form, and ADR form, did not include sections for pharmacist comments, and clinical recommendations. For these reasons, the Monitoring Team determined that the Facility is non-compliant with section N.6, of the Settlement Agreement. The Facility must significantly enhance its ADR process	
N7	Commencing within six months of	To assess the Facility's development and provision of drug utilization evaluations (DUEs)	Substantial

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	the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	the Monitoring Team requested the following information: • Complete DUE schedule for 2012 and 2013, to include all DUEs provided and pending • Copies of all DUEs provided during the reporting period <u>DUE Schedule:</u> The Monitoring Team reviewed the 2013 DUE schedule and noted that the Facility completed two of the four pending DUE scheduled for 2013. The two DUEs completed were provided as scheduled. The selected DUEs included clobazam and phenobarbital. The two remaining DUEs that are scheduled for the remainder of 2013 are aripiprazole and coumadin. The DUE schedule also indicated that a DUE was issued secondary to an FDA alert on 8/1/2013, for acetaminophen. In addition, the DUE schedule indicated a that two addition DUEs were provided, secondary to the Facility's review of anticholinergic and benzodiazepine drug usage at the Facility. <u>Review of completed DUEs:</u> The Facility provided copies of the following DUEs, that were completed during the reporting period: • Clobazam • Phenobarbital • Anticholinergic review • Benzodiazapine review The Monitoring Team noted that the DUEs provided an excellent review of drug utilization, and meaningful clinical information was well delineated in each report. The DUE developed for the FDA advisory for acetaminophen was not provided for review. <u>FDA advisories:</u> The FDA issued many advisories during the reporting period. FDA advisories relevant to the medical providers at the Facility included warning for the following drugs: • Acetaminophen – Severe skin reactions • Azithromycin – fatal arrhythmias • Ketoconazole – new black box warning • Olanzapine Pamoate – unexpected deaths	Compliance

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		• Zolpidem – worsening cognitive impairment The Facility's DUE schedule indicated that one DUE was developed for FDA advisories, and that was for acetaminophen. Because Individuals were not currently prescribed azithromycin, a DUE was not completed for that drug; however the pharmacy department issued emails to all medical providers at the Facility alerting them to the FDA's advisory. The Monitoring Team was informed by the Facility that because Zolpidem, Olanzapine Pamoate, and Ketoconazole were not on formulary, the pharmacy department did not issue notification of the FDA's advisory for these drugs. Summary: The Monitoring Team noted that the Facility maintained a DUE schedule for completed and pending DUEs, and had identified four DUEs for the 2013 calendar year; two of which were provided during the review period, as scheduled. The Facility also developed and provided DUEs for the Facility's review of its usage of benzodiazepine and anticholinergic drugs, and issued an email to all medical providers informing them of the FDA advisory for azithromycin. Because ketoconazole, zolpidem, and olanzapine pamoate, were not on formulary, the pharmacy department did not notify medical inform medical providers of FDA advisories for these drugs. These drugs are commonly used in mental health and primary care, and although the Facility may or may not have individuals currently one such medications, it is important that the medical providers, and pharmacists are provided information on these important advisories, to keep providers current on such medications, as that information may influence their prescribing practice in the future; hence, the Monitoring Team suggests that the pharmacy develop a mechanism to assist medical providers current on FDA alerts and warnings for commonly prescribed medications. Because of the high quality DUEs that were developed, and provide to the medical, and pharmacy staff, the Monitoring Team will continue substantial compliance.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The Monitoring Team assessed the Facility's medication variance process by reviewing the following documents: • Medication variance committee meeting minutes, for 2/2013 through 7/2013 • All graphs, data tables, and data analysis for medication variances used by the Facility for a systems review of medication variances • List of all medication variances that occurred during the reporting period • For the first, and than every second individual listed on the medication variance list: o Copy of completed medication variance report form o All physician IPNs associated with the medication variance	Noncompliance

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		o All nursing IPNs associated with the medication variance o All pharmacy documentation, and communication related to the mediation variance o All IDT minutes specific to the medication variance o Documentation that the guardian was notified of medication variance of category C or worse <u>Completion of Medication Variance Report Forms:</u> The Facility provided nine of the ten requested completed medication variance report forms. Review of the medication variance report forms indicated the following: • The Medication Variance forms were fully completed, and indicated the type of variance, severity index, physician notification, and review by the department supervisor, in nine out of nine (100%) examples • The department supervisor documented appropriate corrective action in nine out of nine (100%) examples • The pharmacy department reviewed, and commented on zero out of nine (0%) examples. The Facility reporting form did not include a section for pharmacy review, and did not provide additional supporting evidence of a pharmacists review, and recommendations. • Medication variances were incorporated into the medication variance database, and after analysis was presented to the medication variance committee for review in nine out of nine (100%) examples <u>Medication Variance Monitoring and Analysis</u> The Monitoring Team refers the reader to section M.6, of this report, for a comprehensive review of the Facility's data analysis of medication variances that occurred during the reporting period. <u>Medication Variance Committee</u> Review of the medication variance committee meeting minutes for 5/2013 through 9/2013, indicated data analysis; summary of the medication variances; documentation of corrective actions when necessary for nursing and pharmacy related medication variances. The pharmacy director attended all medication variances committee meetings, and reported on pharmacy related variances, and indicated corrective action steps for each variances reported. The medical director attended all medication variance committee meetings, and documented specific medication variances associated with medical providers, however, the medical provider did not indicate corrective action steps for variances reported on the 7/2013, 8/2013, and 9/2013 medication variance committee meeting minutes. The monitoring team also noted that the medication variance committee meeting minutes did not include a section indicating identified	

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		action plans, nor was there consistent documentation on follow-up to previously identified action plans.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Self Assessment-Section O and P (8-9-13) 2. RSSLC Action Plan-Section O and P (8-7-13) 3. Presentation Books for Sections O and P 4. RSSLC Policy K.05.2 Occupational Therapy/Physical Therapy (rev: 7/3/13) 5. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 6/11/13) 6. RSSLC Policy K.01 Physical and Nutritional Management (rev: 3/11/13) 7. RSSLC Policy K.08 Developing Pathways to Oral Intake 8. RSSLC Policy K.09 Wheelchair and Accessories Maintenance 9. RSSLC Policy K.0.9.1 Wheelchair Clinic and Ordering 10. RSSLC Policy K.10 Mealtime Procedure 11. Record or partial record review: • Sample O.1: Individuals #192, #228, #268, #284, #296, #378, #523, #538, and #686 • Sample O.2: Individuals #10, #77, #192, #239, #251, #254, #286, #553, and #686 • Sample O.3: Individuals #77, #107, #184, #235, #284, #286, #515, #553, #564, and #765 • Sample O.4: Individuals #8, #23, #73, #76, #84, #86, #106, #117, #125, #142, #173, and #176, #215, #235, #251, #265, #268, #286, #302, #340, #360, #384, #402, #410, #413, #426, #436, #471, #512, #515, #535, #553, #604, #623, #646, #649, #675, #701, #711, #714, #719, #724, #736, #745, #747, and #753 • Sample O.5: Individuals #585 and #787 12. Integrated Progress Notes (not dated) 13. For the past two quarters, any data or trend summaries used by the Facility related to Physical and Nutritional Management (PNM), and/or related quality assurance/enhancements reports, including subsequent corrective action plans. 14. Lists of individuals: (a) On modified diets/thickened liquids; (b) Who require mealtime assistance; (c) Who receive nutrition through non-oral methods. For individuals who, require enteral feeding. Please identify each individual by name, living unit, type of feeding, the date that the tube was placed, and if the individual is receiving pleasure foods; (d) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (e) With BMI equal to greater than 30 including the individual BMI; (f) With BMI equal to less than 20 including the individual BMI; (g) Since the last compliance visit, who have had unplanned weight loss of 10% or greater over six (6) months; (h) Since the last compliance visit, have had a fecal impaction;

	(i) With poor oral hygiene. (j) Who cannot feed himself or herself and notation of any changes since the last review; (k) Who require positioning assistance associated with swallowing activities and notation of any changes since the last review; (l) Who have difficulty swallowing and notation of any changes since the last review; (m) At high and/or medium risk for aspiration pneumonia and choking; (n) With choking incidents since the last compliance review (o) Who had a feeding tube inserted since the last compliance review (p) Who were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis (q) Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) (r) Who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last compliance visit. (include date and general findings) (s) With falls in the last 6months (date, location , type of injury)* (t) With chronic respiratory infections (u) With chronic dehydration (v) With fecal impaction (w) With pressure ulcers in the last 12 months (date, location and resolution) (x) With fractures in the last year (date, location of fracture, status) (y) Who were non-ambulatory or require assisted ambulation (z) With wheelchairs for primary mobility (aa) With wheelchairs for transport (bb) Who use Assistive Devices for ambulation (type of device) (cc) With orthotic/braces (dd) Who have received oral motor therapy since the last compliance visit 15. List of current PNMT members, including PNMT Coordinator/Lead, designated and non-designated members 16. PNMT members and PNMT back up curriculum vitas 17. PNMT members' state licenses 18. PNMT minutes since the last review; minutes should include signatures of attendees 19. Caseloads of PNMT dedicated and non-dedicated members 20. List of medical consultants to the PNMT (e.g., medical doctor, nurse practitioner, or physician's assistant) and PNMT meeting minutes and attendance sheets for presence and participation of a medical doctor, nurse practitioner or physician assistant, and other IDT members as needed or defined in Facility policy 21. Continuing Education completed by PNMT members and back ups for the past 12 months 22. QA reports/matrix since the last compliance review 23. List of referrals to the PNMT since the last compliance visit 24. List of individuals on PNM caseload since the last compliance visit 25. PNMT RN post hospitalization assessments completed since the last compliance visit. 26. PNMT assessment template

	27. PNMT Action Plan template 28. PNMP format 29. PNM NEO orientation covering the following elements: (include, agenda, handouts, curriculum and performance check offs) (only if changed from previous visit) o Lifting and Transfers; o Positioning (Alternate, wheelchair, and bathing/showering); o Adaptive Equipment; o PNMP orientation and implementation; o Safe Mealtime strategies; and o Basics of Dysphagia. 30. List of new employees since last compliance visit and evidence that they have received all PNM related trainings 31. List of staff assigned to train other staff on the PNM core competencies (i.e., foundational skills) and dates of training, including back-up training records (i.e., sign-in sheets and competency check-offs) 32. Facility documentation showing categories of staff requiring annual refresher training, numbers of staff requiring training, and numbers of staff who have successfully completed training; 33. PNM Monitoring Tool template 34. Summary of last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) **People Interviewed:** 1. Ping Law OTR Habilitation Therapies Director 2. David Taylor OTR PNM OT 3. Sally Eastwood PNMT RN 4. Brandie Rabe PNMT SLP 5. Jean Cuevo PNMT PT 6. Dana Hatter QIDP/PNMT Lead 7. Eight DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meetings Attended/Observations:** 1. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon) 2. PNMT meeting (8-28-13)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 8/9/13 and Action Plan dated 8/7/13. 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. 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 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 have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The Self Assessment did not state the staff/positions who were responsible for completing the audit tools, such as Facility therapists (i.e., OTs, PTs, and SLPs); therefore, there was no evidence staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. 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 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 Action Plan was well thought out and was felt to lead RSSLC towards a path of substantial compliance. That being said, it is recommended that RSSLC continue to review the Monitoring Team's report as well as the self assessment to ensure the action plans address the needed components.
	Summary of Monitor's Assessment: Overall, significant improvement was noted throughout all provisions. The PNMT continued to improve their process as well as their assessments. PNMPs showed significant improvement and contained the most of the components needed to mitigate risk pending staff implementation. Additionally, the PNMPs were reviewed by the IDT and/or PNMT in response to a change in status and implemented and trained in a timely manner. Staff knowledge as well as proper implementation continued to be a concern of the Monitoring Team but improvement was noted. Improvement in Provision O.3 was especially noted. The PNMPs, overall, continued to show significant

	improvement and demonstrated information to guide staff in mitigating risks associated with PNM. Missing from the PNMPs was consistent information regarding how staff should communicate with the individual as well as how the individual may express discomfort or other wants/needs but this was an area showing improvement as well. PNMPs were revised in a timely manner and there was evidence of review of the PNMP as indicated by a change in status as part of the ISPA and/or PNMT minutes as well as training and implementation of the PNMP in a timely manner. Provision O.1: This provision was determined to be not in compliance. The comprehensiveness of the PNMT evaluation continued to show improvement. Missing from the policy was a clear method in which the PNMT would participate in the analysis of trends related to PNM. Provision O.2: This provision was determined to be not in compliance. There was still not a QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed. Additionally, there was lack of threshold development by the PNMT that identified when the individual should be referred back to the PNMT. Lack of evidence regarding IDT follow-up was also noted to be a concern. Provision O.3: This provision was determined to be not in compliance. The PNMPs, overall, continued to show significant improvement and demonstrated the information needed to guide staff in mitigating risks associated with PNM. Missing from the PNMPs was consistent information regarding how staff should communicate with the individual but this was an area in which improvement was also noted. PNMPs were revised in a timely manner and there was evidence of review of the PNMP as indicated by a change in status as part of the ISPA and/or PNMT minutes as well as training and implementation of the PNMP in a timely manner. In order to RSSLC to achieve compliance in this area, the Monitoring Team recommends that improvement with the communication portion of the PNMP be noted on subsequent visits. 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 consistently provided with safe dining or positioning strategies. While implementation continues to be an issue, improvement was noted especially as it related to positioning in bed. Per interview, staff 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. RSSLC had recently implemented a core competency class related to PNM but only 36% of the employees had received the training as of this review. It should be noted that this has increased by 30% since the previous compliance visit and overall appears to be resulting in improved implementation. Provision O.6: This provision was determined to be not in compliance. Monitoring tools included adequate

	indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. As stated in previous reports, 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. Due to this scoring issue, data suggesting high compliance was potentially inaccurate. Additionally, there was not a clear process or guidelines in place that ensured those individuals who were at a risk level other than "high risk" were provided with consistent monitoring. Provision O.7: This provision was determined to be not in compliance. There was a lack of evidence of indicators being integrated as part of the Integrated Health Care Plans (IHCPs) to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy). The QDDP monthly reviews also only stated if changes were made to the PNMP and provided no information regarding status of the individual or if the individual had any issues related to PNM. 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. This area was just beginning to be implemented so the Monitoring Team looks forward to seeing how the system progresses at subsequent visits.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of nine individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of nine individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of 10 individuals at RSSLC who received enteral nutrition. Some of these individuals might have been included in one of the other samples.	Noncompliance

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	PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	Sample O.4 consisted of 47 individuals observed in homes and day programs throughout the 24-hour day. Sample O.5 consisted of two individuals who were receiving oral motor therapy. <u>PNM Policy and Role of the PNMT:</u> While the Facility did not have evidence of a comprehensive PNM Policy, many of the areas that were not addressed in policy were in practice and occurring on a consistent basis. It was recommended that the policy include the following elements: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking	

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		and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), o Identification of monitors and their roles and responsibilities, o 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, o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and o Frequency of monitoring to be provided to all levels of risk. ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The system should include: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan). o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. ▪ 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. The policy stated that the Habilitation Director will provide inter-rater reliability of assessments but did not provide the schedule or did it address reviews of the monitoring process. Examples of indicators that were absent included: ▪ Requirements for continuing education for PNMT members. Although this was not listed in policy, upon review of the continuing education received, it was determined by the Monitoring Team that continuing education was at an	

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		appropriate level of frequency and included appropriate content for the PNMT. ▪ Method for establishing triggers/thresholds and their integration into the IHCP. This was an area noted to not be in practice. ▪ Collaboration with the Dental Department to address the risk of aspiration after dental appointments. In order to move towards substantial compliance, the policy should include guidance regarding expectations regarding continuing education, the establishment of thresholds as well as integration into relevant plans of care and how positioning supports will be integrated post dental appointments. <u>Core PNMT Membership</u>: 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: • Dana Hatter QIDP/PNMT Lead • David Taylor OTR • Jean Cuevo PT • Brandie Rabe SLP • Sally Eastwood RN • Anjum Muncer RD • Sandra Wentzel RD back up • Ariono Soria RN back up • Ping Law, PNMT Lead back up • Tran Quan DO, PNMT Medical Consultant <u>Consultation with Medical Providers and IDT Members</u> For eight of nine individuals in Sample 0.2 (88%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. An example in which consultation occurred but was lacking in quality was Individual #192 who had multiple vomiting episodes post sedation. The PNMT expressed concern to the PCP regarding the need to monitor more closely post sedation. The response by the PCP was that vomiting was not related to sedation and therefore recommendation was irrelevant with no evidence of assessment.	

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		For nine of nine individuals in Sample O.2 (100%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities. The PNMT held joint meetings in which recommendations from the PNMT were shared with the IDT. Qualifications of PNMT Members Eight of eight core and back up PNMT members (100%) were licensed to practice in the state of Texas. Eight of eight PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Continuing Education Eight of eight PNMT staff (100%) had completed 12 continuing education hours directly related to physical and nutritional supports and/or topics transferrable to the population served within the past 12 months. Examples of continuing education included but were not limited to: ▪ PT attended: Issues with Evaluation and Treatment of Individuals with Developmental Disabilities ▪ SLP attended: Issues with Evaluation and Treatment of Individuals with Developmental Disabilities ▪ OT attended: Nurse Medication Administration ▪ RD attended: Which eating Pattern Works for weight Loss ▪ RN attended: Oral Care for those with Developmental Disabilities PNMT Meetings From 1/3/13 to 6/27/13, of the 25 weeks, the PNMT met 25 of 25 weeks (100%). All core members of the PNMT were present for at least 80% of the meetings with the exception of the RD who was present 61% of the meetings and the PNMT lead who was present only 76% of the meetings. Twenty-five of the 25 PNMT meeting minutes reviewed (100%) include documentation of appropriate topics: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. Outside of the pneumonia database, the Facility PNMT did not have a sustainable system fully implemented for resolution of systemic issues/concerns. Missing from the system	

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		was: ▪ How monitoring data from the QA Department as well as Habilitation Therapies and the PNMT was collected, trended, and analyzed; ▪ How Habilitation Therapies and the PNMT identified and presented systemic issues requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting). In order for the Facility to move towards substantial compliance, the PNMT should include as part of their review, systemic issues that are impacting the level of care provided to individuals. This information may be included as part of the facility QA process but should include review by the PNMT for potential trends and problem solving,	
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.	<u>Identification of PNM risk</u> Three hundred and twenty of 320 individuals (100%) who cannot feed themselves, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who were at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a PNMP. The Facility had a sustainable system to maintain and update lists of 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"). Five of nine individuals in Sample O.1 (55%) were provided with an accurate risk score related to all of the PNM risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). Examples of individuals who were not provided with accurate risk scores included: • Individual #686 had a diagnosis of aspiration pneumonia within the last year but was listed as being at low risk. • Individual # 192 had multiple episodes of vomiting due to constipation but was only listed as being at a medium risk for constipation. <u>Physical and Nutritional Management Team Referral Process</u> Nine of nine individuals from Sample O.1 were appropriately referred to the PNMT based on the criteria included in the Facility policy. The Monitoring Team noted a concern that the facility policy had been modified to reflect the revised state policy, which allows for multiple choking events or aspiration pneumonia without requiring an automatic referral to the PNMT.	Noncompliance

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		In nine of the nine individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. RSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Another method in which the PNMT was made aware of changes in status was through participation by the PNMT RN in the morning medical meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. There was still not a QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed. Two of two individuals from Sample O.1 who received a feeding tube (not on an emergency basis) since the last review (100%) had been referred to or discussed by the PNMT prior to the placement of the tube. No individuals at RSSLC received an emergency feeding tube placement since the last review. <u>PNMT Assessment</u> Nine of nine PNMT assessments/reviews for individuals in Sample O.2 (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). RSSLC's PNMT RN provides assessment upon return from the hospital in an effort to identify any concerns noted with PNM. Results of the assessment were discussed at the PNMT at the weekly meeting or sooner as indicated. Referrals that were submitted by the IDT outside of a return from hospitalization were discussed at the following PNMT weekly meeting with members of the PNMT attending the IDT as indicated Nine of nine PNMT assessments in Sample O.2 (100%) were completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances The need for full comprehensive assessments was based upon discussion of the incident and assessment of the situations surrounding the PNM event. Per interview with the Director of Habilitation Therapies, based on the findings and results of discussion, the	

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		PNMT then makes the determination of whether a comprehensive assessment was needed. When a full assessment was not warranted, all relevant assessments (i.e., Nutritional, Habilitation) were reviewed for relevance and included as part of the PNMT discussion and taken into consideration when meeting with the IDT. All of these areas in addition to the PNMT RN assessment were taken into consideration when measuring compliance with this metric. Based on review of nine individuals' records who were referred to the PNMT (Sample O.2), the comprehensiveness of the PNMT assessment components were as follows: • Nine of nine (100%) contained date of referral by the IDT. This information was contained within the ISPA, ISP and/or PNMT assessment. • Nine of nine (100%) contained date assessment was initiated. This information was contained within the PNMT assessment, PNMT minutes, or Habilitation Therapies Assessments. • Nine of nine (100%) contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment. • Nine of nine (100%) identified the individual's current risk rating(s), including the current rationale. This information was contained within the IRRF, and Habilitation Therapy Assessments and/or PNMT evaluation as indicated. The concern a stated previously was that the risk ratings were often not reflective of the individuals' level of risk. • Nine of nine (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data. This information was contained within the IRRF, ISPA, Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Nine of nine (100%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition. • Nine of nine (100%) contained assessment of current physical status. This information was contained within the PNMT minutes, the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Nine of nine (100%) contained assessment of musculoskeletal status as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Nine of nine (100%) contained evaluation of motor skills as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Nine of nine (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments	

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		(Habilitation, Nutrition, etc.). • Nine of nine (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. These were provided through the completion of Head of Bed (HOB) assessments as part of the PNMT referrals/reviews or through evidence of evaluation of general posture as part of the Habilitation Assessment, and PNMT RN Assessment. • Nine of nine (100%) contained evaluation of current adaptive equipment. This information was contained within the PNMT Assessment, Habilitation Assessment as well as the PNMT minutes. • Nine of nine (100%) contained nutritional assessment, including but not limited to history of weight and height, intake, nutritional needs, and mealtime/feeding schedule. This information was contained within the PNMT evaluation, Annual Nutritional Assessment, the PNMT RN Assessment, as well as consults. • Nine of nine (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. This information was contained within the Nutritional Assessment as well, but there was no evidence of review of this component evident if there was not a formal PNMT evaluation. • Zero of two (0%) who received enteral nutrition had identified residual thresholds, for return to the PNMT. • Nine of nine (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. • Nine of nine (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting • Nine of nine (100%) contained evidence of review/analysis of lab work. If there was not a formal PNMT evaluation then this area was not discussed as part of the IDT meeting. • Nine of nine (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. • Nine of nine (100%) contained discussion as to whether existing supports were effective or appropriate. This information was contained within the PNMT evaluation, PNMT RN Assessment, ISPA as well as in the PNMT minutes. • Nine of nine (100%) contained oral hygiene status. This information was contained within the Habilitation Assessment, and PNMT evaluation. • Nine of nine (100%) contained evidence of observation of the individuals' supports at their home and day/work programs. • Nine of nine (100%) contained evidence that the PNMT conducted hands-on assessment and/or review. • Nine of nine (100%) identified the potential causes of the individual's physical	

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		and nutritional management problems. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Nine of nine (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Nine of nine (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. • Zero of nine (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. • Nine of nine (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (e.g. revision of the individual's PNMP). • Nine of nine (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT/IDT. The primary concern noted was that only one of nine (11%) had a PNMT discharge meeting with the IDT that clearly documented parties responsible for the completion of tasks and the expected due dates. • Nine of nine (100%) contained signatures with dates. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u> For two of nine individuals (33%) in Sample O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. Examples of recommendations not integrated included: • Individual #239 had a recommendation to turn on his side when having a seizure to help prevent aspiration but this was not evident in the IHCP. • Individual #553 had a recommendation to include "rocking head back and forth" as a trigger but the trigger was not included as part of the IHCP. • Individual #286 had a recommendation to increase water flushes during medication administration to provide additional hydration and discourage constipation. This was not included as part of the IHCP. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In nine of nine individuals' plans reviewed (100%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment.	

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		• In nine of nine individuals (100%) for whom Head of Bed Elevation (HOBE) assessments were conducted or reviewed, the HOBE recommendations were integrated into individuals' plans. • In two of the nine individuals' plans reviewed (22%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. The IDT did not clearly develop action plans to address the recommendations provided by the PNMT and therefore the Monitoring Team and Facility are unable to determine if action steps were completed in a timely manner. • In nine of the nine individuals' plans reviewed (100%), the plans included the specific clinical indicators of health status to be monitored. These were noted as being primarily in the form of trigger identification. • In zero of the nine individuals' plans reviewed (0%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. Although indicators had been listed for some, objectives were not established. • In nine of nine individuals' plans reviewed (100%), the plans defined triggers. • In zero of the nine individuals' plans reviewed (0%), the frequency of monitoring was included in the plans. In order to move towards substantial compliance, The PNMT must do a better job at identifying threshold for return to the PNMT as well as identifying the frequency of monitoring the person will receive. Additionally, the IDT must begin to clearly track the outcomes of the recommendations and provide due dates for completion as well as follow up post completion. <u>PNMT Follow-up and Problem Resolution</u> With regard to plan implementation for Individuals in Sample O.2: • In zero of nine individuals' documentation reviewed (0%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days of the plan's finalization, or sooner as needed, although the PNMT utilized a PNMT-IDT discharge plan that identified the steps to be taken by the IDT post PNMT discharge. The IDT and PNMT held a joint meeting, and tasks were identified. However, there was still no evidence that the IDT met to discuss the completion of these tasks or their results or that monthly monitoring reviewed and considered completion of the action plan tasks and effectiveness. • In zero of nine individuals' plans reviewed (0%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps. The issue noted was that once the action plan was	

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		handed down to the IDT, the tracking of steps to ensure completion was not evident. In order for the Facility to move toward substantial compliance, the Monitoring Team recommends the IDT identify clear due dates for consults and meet in a timely manner upon completion of the task to review the overall plan of care and make any revisions based upon the findings of the consult. <u>Individuals Discharged from the PNMT</u> For individuals discharged by the PNMT in Sample O.2: ▪ Nine of nine individuals (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ Nine of nine individuals' (100%) discharge summaries/action plans provided objective clinical data to justify the discharge. ▪ Zero of nine individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. ▪ Zero of nine individuals' ISPA documentation and/or action plan (0%) included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. There was not a clear, consistent process that documented a collaborative discharge summary/action plan which included recommended supports and services, key clinical indicators, individualized triggers, guidelines for monitoring the individual's supports, services and triggers, objective clinical data to justify the discharge, evidence that discharge recommendations were integrated into the IHPC, and criteria for referral back to the PNMT integrated as part of the IHCP.	
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	Although Provision O.3 was found not to be in substantial compliance, the PNMPs, overall, continued to show significant improvement and demonstrated information to guide staff in mitigating risks associated with PNM. Missing from the PNMPs was consistent information regarding how staff should communicate with the individual as well as how the individual may express discomfort or other wants/needs but this was an area showing improvement as well. The PNMPs, overall, continued to show significant improvement and demonstrated information to guide staff in mitigating risks associated with PNM. Missing from the PNMPs was consistent information regarding how staff should communicate with the individual as well as how the individual may express discomfort or other wants/needs but this was an area showing improvement as well. <u>Identification of Individuals Requiring a PNMP</u> For the nine individuals in Sample O.1, nine of their annual ISPs (100%) noted that the	Noncompliance

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	mealtimes and other activities that are likely to provoke swallowing difficulties.	appropriate disciplines were present to approve and integrate the PNMP in the ISP. The SLP, OT or PT, RD, and RN were all present with greater than 80% consistency at the annual IDTs in which the PNMP was reviewed and revised. Eight of nine PNMPs (88%) were reviewed by the individual's IDT in the annual ISP meeting. The ISPs contained evidence of review, update/revision, and effectiveness, and specified the changes required to the PNMP. The ISPs contained evidence of review in addition to providing information regarding if the individual had experienced any issues related to PNM over the past year. <u>PNMP Format and Content</u> A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 18 of 18 individuals (100%) were current within the last 12 months. • PNMPs for 18 of 18 individuals (100%) included a list of high-risk levels and individual triggers as indicated. • In 18 of 18 most current PNMPs (100%), there were large and clear color photographs with instructions. • In 18 of 18 PNMPs (100%) listed the adaptive equipment required by the individual. Rationale regarding the need for the adaptive equipment was not present on the PNMP but was available as part of the Habilitation Therapy assessments. Rationales were included as part of the competency based training during new employee orientation as well as individual specific training as indicated; as reported in Provision O4, staff interviews found improvement in knowledge, including knowing reasons for thickened liquids (87%), modified food texture (100%), and specific utensil (62%). • In 14 of 14 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions, were provided. • In 18 of 18 PNMPs (100%), positioning was adequately described per the individuals' assessments. Pictures were present and instructions were clearly linked to the assessment. • In 18 of 18 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 18 of 18 PNMPs (100%), bathing instructions were provided. • In 17 of 18 (94%) PNMPs, toileting-related instructions were provided, including check and change. • In 18 of 18 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning, or the individual was described as independent. • In 18 of 18 PNMPs/dining plans (100%), instructions related to mealtime were	

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		outlined, including for those who received enteral nutrition. • Eighteen of 18 individuals' (100%) Dining Plans were current within the last 12 months. • Three individuals had feeding tubes with no oral intake. Three of three (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 18 of 18 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. • In 15 of 15 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 15 of 15 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 15 of 15 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. • In 18 of 18 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 18 of 18 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. • Six of 18 PNMPs (33%) included information related to communication (how individual communicated, how staff should communicate with individual). Missing from the communication section was detailed information on how the person communicated as well as how staff should bridge communication. While not occurring at the desired frequency, this was an area that had improved since the previous visit. In order for the facility to move towards substantial compliance, the communication component of the PNMP must include more detailed information regarding how staff should bridge any communication gaps as well as how the individual communicates. <u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u> For four individuals in Sample 0.1 for whom the IDT identified changes needed to be made to the PNMP, four ISPA meeting documentations or PNMT meeting documentation (100%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For individuals for whom the PNMP was revised, there was supporting documentation that four of four individuals' (Sample 0.1) revised PNMPs (100%) had been implemented.	

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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.	<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u> Staff did not engage in safe mealtime practices, as indicated by the following: Per observations conducted by the Monitoring Team, nine of 24 individuals' (37%) dining plans/PNMPs in sample O.4 were implemented as written. Examples of dining plans not implemented included but were not limited to: • Individual #142 was not encouraged to take sips of liquids after every 2-3 bites to help clear oral cavity resulting in an increased risk of aspiration and/or choking. • Individual #711 was overstuffing his mouth and eating at a fast rate with no cues from staff to slow down. It should be noted that there was much improvement noted regarding the implementation of plans as the majority of the implementation errors were observed on Four Rivers and may have been a result of the plates utilized for the meals. During the observation it was noted that the bite size foods were stacked high on small plates which encourage the individuals to stack their food items high on their spoons and forks. The Facility may want to consider reviewing how the food is presented on the plates and may benefit from having half servings or multiple plates to prevent the stacking of food. Based on observations by the Monitoring Team: Fifteen of 23 individuals' positioning plans (O.4) (65%) were implemented as written. Examples of non-implementation included: • Individual #623 was not elevated according to the plan of care. • Individual #484 had slid down in the bed and was leaning heavily to the right, resulting in increased pressure to the coccyx and increased abdominal compression, thus increasing the risk of skin breakdown and reflux. Transfers were improved and observations noted: • Three of three individuals' transfer plans (100%) were implemented as written. During three of three observations of medication administration (Sample O.4) (100%), the nurse followed procedures in the PNMP. <u>Knowledge of Staff Regarding PNMPs</u> Staff were not consistently knowledgeable of the individuals' PNMPs. Based upon interviews with ten staff from Three/Four Rivers, San Antonio, Trinity and Leon, knowledge of staff had continued to improve but was not yet adequate to ensure correct	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>implementation. Following are the numbers of staff who answered correctly and the number asked the question:

<table>
<tr><th></th><th># Asked</th><th># Correct</th><th>% Correct</th></tr>
<tr><td>Positioning:</td><td></td><td></td><td></td></tr>
<tr><td>How do you know the individual is in the correct position in their wheelchair/bed?</td><td>8</td><td>6</td><td>75%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Mealtimes:</td><td></td><td></td><td></td></tr>
<tr><td>For what reason does the individual have thickened liquids?</td><td>8</td><td>7</td><td>87%</td></tr>
<tr><td>For what reason does the individual eat a modified texture?</td><td>8</td><td>8</td><td>100%</td></tr>
<tr><td>What is the reason for the individual using a specific utensil?</td><td>8</td><td>5</td><td>62%</td></tr>
<tr><td>If the individual receives enteral nutrition, how do you determine if he/she is in the correct position?</td><td>8</td><td>6</td><td>75%</td></tr>
</table></td><td></td></tr>
<tr><td>O5</td><td>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.</td><td><u>New Employee Orientation (NEO)</u>
The PNM related core competencies (i.e., foundational skills) were comprehensive. NEO orientation included the following elements:
▪ Physical Management
▪ Positioning
▪ Adaptive Equipment
▪ PNMP Orientation
▪ Safe Mealtime Strategies
▪ Basics of Dysphagia

The large majority of staff successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs. Per RSSLC training records, 150 of 150 (100%) new staff had received and successfully passed all NEO trainings.

<u>PNM Core Competencies for Current Staff</u>
Twenty nine of 29 staff (100%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. These staff included those who were responsible for training the following courses:
▪ Physical Management
▪ Positioning</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		▪ Adaptive Equipment ▪ PNMP Orientation ▪ Safe Mealtime Strategies ▪ Basics of Dysphagia RSSLC continued to provide 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) The training process was as follows: • Phase 1: Training for Therapist and Physical and Nutritional Management Plan Coordinators (PNMPC). • Phase 2: Training for Residential Coordinators and Home Supervisors. • Phase 3: Training for Direct Support Professionals (DSPs). Status of the training was as follows:	

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		• Three/Four Rivers: Phase 2 to be completed by October 31, 2013 • Trinity/Leon/San Antonio: Phase 3 to be completed by September 30, 2013 As of 7/23/13, not all staff had received the PNM Core Competency Training; only 232 of 647 direct support professionals (36%) had been trained. <u>Annual Refresher Training</u> As of 8/27/13, staff that requires training had completed annual refresher competency-based training and performance check-offs within the last 12 months. ▪ Lifting People: 909 staff (99%) had completed their annual lifting class. Per PNM policy, training will be provided at least annually and as indicated by monitoring. At the time of the review, the only trainings provided annually were "Lifting People". Missing from the annual trainings were Physical Management Skills and Personal Care Services. It was unclear as to why only "Lifting People" was provided annually when the other areas are equally important in ensuring staff remain updated on latest standards of care. In order for the Facility to move in the direction of substantial compliance, the Monitoring Team recommends the Facility develop shortened versions of the classes (possibly using i-learn) covering other areas of PNM (i.e., dysphagia). <u>Individual-Specific Training</u> To determine whether the Facility had a process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team reviewed three individuals from Sample O.1 and reviewed evidence that staff working with these individuals had received all the training related to PNM. Based on that evidence and interview, the Monitoring Team determined the Facility did not have a clear process in place. The concern noted with the training process was that there was not a clear start date of the training documented; therefore it the Monitoring Team was unable to determine if the training was provided in a timely manner. In order for the Facility to move in the direction of substantial compliance, the Monitoring Team recommends the Facility clearly identify the start date of the training so that the Facility is able to determine the timeliness of the training being completed. There was no evidence that staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. While the name of the staff providing training was included on the form as the trainer, there was no evidence that staff had been trained by the clinician	

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		who recommended the strategies and/or revisions. In order for the Facility to move in the direction of substantial compliance, the Monitoring Team recommends the training forms include evidence that the individual providing the training outside of the clinician be listed as receiving the training and there is evidence of completion of all applicable competencies. One way to accomplish this would be by having the trained instructor be listed as the first person trained on the provided roster and identified as the trainer. A process did exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. Per review and interview with the HT Director, individuals who required person specific training had their names and steps for training included in a notebook in the Aide Station. Also included in this notebook was all staff that had received the person specific training and therefore could work with the individual. It was the responsibility of the Home Supervisor to ensure no staff worked with the individual who had not received the training. If the pulled staff required training then the PNMPC would be notified and would provide the needed training. The Monitoring Team reviewed Person Specific Training Notebooks and found the process was being implemented as indicated.	
06	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.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> The PNMP Training and 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 problem was that it was not clear, outside of "high risk", the frequency in which individuals would be provided with increased monitoring. 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 • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician • Inter-rater reliability schedule Monitoring tools included adequate indicators to determine whether or not "staff	Noncompliance

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		demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. As stated in previous reports, 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. Due to this scoring issue, data suggesting high compliance was potentially inaccurate. Staff members had completed all the requirements to demonstrate competence in monitoring. PNMP Coordinators (PNMPCs) were primarily responsible for the majority of monitors completed. There was evidence that the PNMPCs: • Completed the necessary core training related to PNM • Successfully completed training on the monitoring forms • Had been validated by clinicians on completion of monitoring forms Twenty-nine of 29 staff (100%) responsible for conducting the monitoring were provided with the training needed to successfully complete the forms in a consistent and comprehensive manner. It appeared that the PNM core competency training had begun to have a positive impact as implementation was noted to have improved since the last compliance visit. RSSLC did have a formal system in place in which information regarding the completion of monitoring forms and its related data could be pulled, analyzed and trended. Per Policy K.07 PNMP Training and Monitoring, the HT director: • tracks and trends the monitoring data • identifies staff who are unable to implement the PNMP • reports results to QA/QI Council • develops corrective action plan A graph showing the approximate percentage of areas monitored for PNM during the months of January 2013 to June 2013 provided information as follows:	

	Bathing	Lifting/Transfer	Meal	Med Admin	Oral Care	Positioning	Snack
1/13	7%	8.5%	32.9%	9.1%	7.4%	23%	8.8%
2/13	6.7%	7.1%	21.6%	10.3%	10.6%	26.2%	7.8%
3/13	10.6%	4.7%	31.6%	10.6%	7%	18.6%	8.6%
4/13	10.3%	11.8%	29.9%	10.9%	9%	15.9%	5.9%

#	Provision	Assessment of Status	Compliance
		5/13 | 10.9% | 12.5% | 31.6% | 11.5% | 9.5% | 16.8% | 6.3% 6/13 | 13.8% | 14.6% | 33.2% | 12.3% | 9.1% | 18.6% | 8.7% The above graph demonstrates a proportionate number of monitors being focused on all areas in which PNM difficulties are likely to be provoked. <u>Monitoring for Individuals in Samples</u> For individuals in Sample O.1, PNM compliance monitoring over the past three months for nine of nine individuals (100%), the frequency of monitoring occurred as per the individuals' assessment and/or the individuals' plans/IHCPs. For individuals in Sample O.2, PNM compliance monitoring over the past three months for nine of nine individuals (100%), the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. Frequency of monitoring primarily defaulted to the risk based monitoring schedule which was as follows: • High Risk: monitored once weekly • Lower Risk: randomly once per week if the home does not have 5 high risk individuals. Per interview with the Director of Habilitation Therapies, PNM Coordinators are required to review five individuals per week. The concern with the process was that as a result, individuals who are moderate risk may not receive any monitoring at all due to the focus being only on high risk individuals. In order to move toward substantial compliance, individuals who are at a moderate risk must have a clear schedule that ensures they receive monitoring on a consistent basis.	
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.	<u>IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans</u> Zero of the nine individuals' records in sample O.2 (0%) contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy). Three of the 18 individuals' records in Samples O.1 and O.2 (16%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QDDP monthly reviews only stated if changes were made to the PNMP and	Noncompliance

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		provided no information regarding status of the individual or if the individual had any issues related to PNM. Eighteen of 18 individuals' records (1000%) in Samples O.1 and O.2 included evidence that the IDT discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. As part of the IRRF and/or ISPA, the IDT identified if there was a need to implement a trigger sheet. Zero of 18 Trigger sheets (0%) were completed correctly. Zero of 18 Trigger sheets (0%) were reviewed at a minimum daily by the appropriate shift RN. 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 and Case Manager Review of the trigger sheet was inconsistent.	
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.	<u>Evaluation of Individuals who receive Enteral Nutrition</u> The Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Included as part of the list was the individual's home, name, type of feeding, date tube was placed, diet, and if the individual received any form of pleasure feeding. Ten of 10 individuals who receive enteral nutrition (Sample O.3) (100%) were evaluated at a minimum annually as evidenced by review of their IRRF, ISP, OT/PT Assessment and Nutritional Assessment. Ten of 10 individuals (100%) evaluated had an appropriate evaluation to determine the medical necessity of the tube. Medical necessity was identified as part of the Nutritional Assessment, Habilitation Assessment, IRRF as well as part of the Aspiration Pneumonia and Enteral Nutrition (APEN) form. One individual who received enteral nourishment was admitted since the last review; and was reviewed to determine the medical necessity of the feeding tube within 30 days. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> Three of 10 individuals (30%) from Sample O.3 who receive enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was	Noncompliance

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		appropriate. This information was contained within the OT/PT assessment. Although return to oral intake was included as part of the Habilitation Assessment template, APEN, and/or IRRF, there was not a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake but for improved saliva control. RSSLC had developed an Oral Motor Intervention Policy K.08 "Developing Pathway to Oral Intake" but there was no evidence that this had been put into practice based on the drawn sample. Per the sample, plans for increased oral intake focused primarily on pleasure feedings. Extending beyond the pleasure feedings was something RSSLC was aware of needing to accomplish. RSSLC did not consistently provide treatments or strategies to help move the individual along the pathway to oral intake. Examples included: • Individual #235 and #286 were identified as having poor oral motor ability but no plan was in place to improve oral musculature was recommended. An extended sample was drawn in an effort to review individuals who had received oral motor treatment relevant to dysphagia. At the time of the review, this consisted of only two individuals. It should be noted that although only two individuals were receiving oral motor therapy, this was a new process and one that was just beginning to be implemented. It is expected that this number will continue to increase over the next few months. Zero of two individual from Sample O.5 who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake (0%) had a comprehensive plan outlining the treatment or return to PO process. Zero of two individuals' plans to return to oral eating or improve oral eating was based on the results of the IDT's discussion (0%) and was integrated in the IHCP, ISP, and/or an ISPA. While it was based on IDT discussion, there was no evidence of integration into the IHCP. One of two individual's plans to return to oral eating in the IHCP (50%) was implemented in a timely manner. There was no evidence that Individual #787 received therapy from 6/14/13 to 8/22/13. Plans for oral therapy did not include all of the following components: • Staff training required prior to implementation;	

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		• Staff roles and responsibilities (e.g., implementation, monitoring); • Time and schedule of interventions; • Specific triggers for when the plan should be stopped; • Milestones for progressing with the plan; • Documentation requirements (method for tracking progress); and • Frequency of subsequent assessments and staff responsible. The IRRF did not provide clinical assessment data to identify an individual's potential to return to oral eating. IRRFs did not consistently provide justification for the medical necessity of the feeding tube, however this was noted as part of the OT/PT assessment.	

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. Self Assessment-Section O and P (8-9-13) 2. RSSLC Action Plan-Section O and P (8-7-13) 3. Presentation Books for Sections O and P 4. Record or Partial Record Reviews: a. Sample P.1: Individuals #192, #228, #268, #284, #296, #378, #523, #538, #686 b. Sample P.2: Individuals #17, #25, #423, #468, #614, #669, and #783 5. RSSLC Policy K.05.2 Occupational Therapy/Physical Therapy (rev: 7/3/13) 6. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 6/11/13) 7. RSSLC Policy K.01 Physical and Nutritional Management (rev: 3/11/13) 8. RSSLC Policy K.08 Developing Pathways to Oral Intake 9. RSSLC Policy K.09 Wheelchair and Accessories Maintenance 10. RSSLC Policy K.0.9.1 Wheelchair Clinic and Ordering 11. RSSLC Policy K.10 Mealtime Procedure 12. Integrated Progress Notes procedure (not dated) 13. List of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 14. Current lists of individuals: 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 (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury 15. OT/PT assessments template 16. Wheelchair seating, PNM clinic assessment templates and related documentation OT/PT-related spreadsheets 17. For the past six months, any summary reports or analyses of monitoring results related to OT/PT generated by the Facility, including but not limited to quality assurance reports, including action plans 18. List of individuals receiving direct OT and/or PT services and focus of intervention 19. Last five assessments completed by OT/PT **People Interviewed:** 1. Ping Law OTR Habilitation Therapies Director 2. David Taylor OTR, PNMT OT 3. Sally Eastwood PNMT RN 4. Jean Cuevo PNMT PT

	5. Dana Hatter QDDP/PNMT Lead 6. Eight DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meeting Attended/Observations:** 7. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon) 8. PNMT meeting (8-28-13)
	Facility Self-Assessment: For Section P in conducting its self-assessment: ▪ 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 P. o This monitoring/audit tool did primarily include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to continue reviewing the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ▪ The Facility rated itself as being in compliance with Provision P.1 and not in compliance with Provisions P.2, P.3, and P.4. This was consistent with the Monitoring Team's findings. The Actions plans developed were felt to move RSSLC in the right direction towards compliance; however, as stated previously, RSSLC should continue to review the findings of the Monitor's report and revise the Action Plan as indicated to address all identified concerns.
	Summary of Monitor's Assessment: Overall, there continued to be improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at RSSLC. Assessments continued to improve and did a respectable job in providing a comprehensive review of the individual. While Provision P.1 was considered to remain 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 remained 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 RSSLC 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 and evidence of improvement was already demonstrated. Provision P.2: This provision was determined to be not in compliance. OT/PT plans of care and PNMPs were not consistently integrated into the ISP nor was there evidence of review that focused on the

	effectiveness of the plans of care. Provision P.3: This provision was determined to be not in compliance. A large majority of staff had yet to complete the PNM Core Competency Training. Provision P.4: This provision was determined to be not in compliance. Based on review of the RSSLC PNMP Training and 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, resulting in lack of a system that ensured all individuals at an increased risk or potentially requiring increased OT/PT related supports were monitored on a regular basis.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	This provision remained in substantial compliance. The OT/PT Assessments were completed in a timely manner and addressed the majority of components needed to fully assess an individual with the exception of consistently providing ways to improve functional skills. These areas were noted to be improving with the newer assessments. Samples for this section were as follows: Sample P.1 is the same as Sample O.1 that consisted of a non-random sample of nine individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed in a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Sample P.2 consisted of seven individuals who receive direct OT/PT services chosen based on a review of a list of individuals receiving therapy, including the focus of the therapy. **Timeliness of Assessments** Sixteen of 16 individuals admitted since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. RSSLC does not do screenings upon admission but, instead, conducts a comprehensive OT/PT assessment. The Monitoring Team considers the presence of assessments as meeting and surpassing compliance with this metric.	Substantial Compliance

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		Fifteen of 16 individuals' OT/PT assessments in sample P.1 and P.2 (93.75%) were dated as having been completed at least 10 days prior to the annual ISP. Sixteen of 16 assessments or updates in Sample P.1 and P.2 (100%) were current within 12 months for individuals who are provided OT/PT supports and services. **OT/PT Assessment** Sixteen of 16 assessments (100%) (Samples P.1 and P.2) were completed consistent with the established schedule, or the individuals' need. Based on review of the sample of assessments, the OT/PT assessment substantially contained the needed components, The OT/PT assessments for Samples P.1 and P.2 were as follows: • Sixteen of 16 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. • Sixteen of 16 assessments (100%) included diagnoses and relevance to functional status. • Sixteen of 16 assessments (100%) 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. • Thirteen of 16 assessments (81%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • Thirteen of 16 individuals' OT/PT assessments (81%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • Sixteen of 16 assessments (100%) included medical history and relevance to functional status. • Sixteen of 16 assessments (100%) addressed health status over the last year • Sixteen of 16 assessments (100%) listed medications and potential side effects relevant to functional status • Sixteen of 16 assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills • Sixteen of 16 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work) • Sixteen of 16 assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings • Nine of 16 assessments (56%) included discussion of the expansion of the	

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		individual's current abilities. For example, Individual #378 requires assistance during showering but there was no plan identified to expand upon that skill. • Four of 16 assessments (25%) included discussion of the individual's potential to develop new functional skills. For example, Individuals #268 and #296 were totally dependent with grooming, bathing, and dressing yet no skill acquisition opportunities were identified through the OT/PT assessment. • Sixteen of 16 assessments (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day • Sixteen of 16 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions. • Sixteen of 16 assessments (100%) included a monitoring schedule. The monitoring schedule primarily listed was the default schedule that is based upon risk or that the measurable objectives should be monitored daily. • Sixteen of 16 assessments (100%) included a re-assessment schedule. The reassessment schedule at RSSLC was an assessment every year if receiving direct or indirect services and a comprehensive assessment every five years for everyone. • Sixteen of 16 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This information was much improved as more detailed requirements were now included as part of the overall determination. Included was the need for staff training as well as adaptive equipment. • Sixteen of 16 assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Sixteen of 16 assessments (100%) included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature. • Sixteen of 16 assessments (100%) include recommendations for services and supports in the community. This information was present as part of the "Factors for Community Placement." • Sixteen of 16 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP. The Facility has improved the comprehensiveness of the OT/PT assessment in all areas including the identification of skill acquisition programs as it relates to Activities of Daily Living (ADLs). Although improvement is needed in three components, Substantial Compliance will be retained at this time as components lacking (relating to expansion of	

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		skills and skill acquisition) were not part of the previous review. In order for the facility to maintain substantial compliance at the next compliance visit, improvements must be noted in the areas focusing on expansion of skills and skill acquisition as well as inclusion of comparative analysis of functional status.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**OT/PT Interventions** For individuals receiving OT/PT supports and services, 16 of 16 plans for Samples P.1 and P.2 (100%) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. For 16 of 16 individuals in Samples P.1 and P.2 (100%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. Primary integration was in the form of discussion and review of the PNMP. **Direct OT/PT Interventions** The records of individuals in Sample P.2 were reviewed resulting in the following findings: • Eight of nine individuals' direct intervention plans (88%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • For eight of nine individuals' records (88%) reviewed, the current OT/PT assessment/note identified the need for direct intervention with rationale. These could be annual assessments or interim assessments completed during the year in response to changes in status or identified needs. • For zero of nine individuals' records (0%) reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. Measurable outcomes were not included as part of the ISP or ISPA but were clearly included as part of the OT/PT plan of service. • For four of four individuals' records (100%), whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. **Indirect OT/PT Programs** The implementation of these plans is discussed under Section O4 for PNMPs and in Section S for skill acquisition plans. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** An OT or PT attended the ISP or ISPA meeting, unless adequate justification was	Noncompliance

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		provided in the Pre-ISP meeting documentation. Sixteen of 16 ISP annual meetings (100%) had a member from either OT or PT present to represent the disciplines. Sixteen of 16 ISPs or ISPAs from Samples P.1 and P.2 (100%) integrated the OT/PT interventions. The ISP or ISPA consistently described the supports based on the rationale provided in the therapy assessment. Integration was primarily in the form of PNMP review and acceptance. In four of four of the ISPs or ISPAs reviewed (100%), skill acquisition programs that had been recommended in the OT/PT assessment were present. The problem noted with this area was that skill acquisition programs continued to be rarely identified as part of the OT/PT Assessment. The OT/PT Assessments continued to focus primarily on supports to mitigate risk or provide support and did not identify potential areas in which skills such as ADLs could be addressed. Eight of nine individuals receiving direct OT/PT Services (Sample P.2) (88%) were provided with comprehensive progress notes (IPNs) that contained all of the indicators listed below. Progress notes included the following indicators: • Contained information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). • Reported the consistency of implementation. • Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. Progress notes did not consistently include the following indicators: • Described the benefit of the goal to the individual. Although this indicator was not present as part of every notes entry, it was observed as part of the initial note and therefore meets the intent of this indicator. For individuals with PNMPs, for 0 of 16 individuals in Samples P.1 and P.2 (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. Monthly documentation from the OT and PT and/or QDDP did not include: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as	

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		indicated in reference to the individual's progress or lack of progress. The monthly QDDP note simply stated that service was provided or that there were no changes to the PNMP. No more detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review. In order for the Facility to move towards substantial compliance, the PNMP review conducted by the QDDP should include a statement regarding the effectiveness of the plan and if there appears to be a need for modification or revision.	
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.	The requirements for this section were discussed in detail with regard to Provision O.5. Indirect plans are inclusive of the PNMPs since OT/PT is covered substantially in the PNMP. As reported in that provision, only 36% of direct support staff had received core competency training on physical and nutritional management. Furthermore, refresher training needs to be expanded to cover additional essential topics beyond lifting.	Noncompliance
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.	**Monitoring System** The Facility did not implement a system for the adequate monitoring of PNMPs. • See Provision O.6 PNMP Training and Monitoring Policy K.07 (revised 6/11/13) was reviewed and included information regarding frequency of monitoring for individuals who were at a high risk of choking/aspiration. This frequency was set at once per week. Individuals who were at a moderate risk or low risk were not provided with a set schedule that ensured review of their OT/PT related plans. This was a concern, as those individuals who are at medium risk still should receive some level of monitoring outside of the annual assessment and/or review. Per interview with the HT Director, the need for a set schedule was identified but the Facility's focus at this time was to improve the reliability of the monitors occurring for those individuals who were at a high risk and the expansion of a schedule for moderate risk will be addressed in the future. The Monitoring Team will review the maturation of this process at subsequent visits. The Monitoring Team reviewed the following policies and procedures: • Occupational Therapy/Physical Therapy-K.05.2 (rev: 7/3/13) • PNMP Training and Monitoring Policy- K.07 (revised 6/11/13) • Physical and Nutritional Management-K.01 (rev: 3/11/13) • Integrated Progress Notes procedure (not dated)	Noncompliance

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		The Facility did not have an OT/PT policy(s) that substantially included the needed components. The policy(s) included the following elements: • Define the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; • Identify monitors and their roles and responsibilities; • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Includes re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requires that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identifies the frequency of assessments; • Defines how individuals' OT/PT needs will be identified and reviewed; and • Sets forth documentation expectations for individuals receiving direct services Missing from policies/procedures reviewed were elements that: • Define a formal schedule for monitoring to occur. As stated previously in this provision, individuals who were not at high risk did not have a formal schedule that ensured they were monitored for appropriate effectiveness and compliance of support plans. In order to move towards substantial compliance, RSSLC should develop and implement a set schedule of monitoring that ensures individuals who are at a moderate risk are reviewed outside of their annuals. Additionally, the monthly review conducted by the QDDP should include a statement regarding the effectiveness of the supports provided as evidenced by health and functional status. For 16 of 16 individuals from Samples P.1 and P.2 (100%), routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Monitoring data logs provided to the Monitoring Team indicated checks of positioning devices and other adaptive equipment were included as part of the risk based PNMP monitoring or at a minimum were provided with preventative checks by the wheelchair clinic on a	

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		quarterly basis. If issues were noted outside of the scheduled checks, a work order/consult was sent to the home therapist. For 16 of 16 individuals (100%), positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Per review of the Wheelchair Repair Log, for 50 of 50 (100%) individuals for whom adaptive equipment was noted to be in disrepair or needing replacement between the dates of 5/15/13 to 6/13/13, equipment was repaired or replaced within 30 days unless justification was provided, or unless the issue impacts the individual's health or safety, in which case action was taken within 48 hours. The large majority were repaired the same day of the submission/request date.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment, 8/9/2013 2. RSSLC Action Plan, 8/7/2013 3. RSSLC Presentation Book, August 2013 4. RSSLC Policy: Dental Desensitization Policy, 8/1/2013, unnumbered 5. Untitled document indicating dental office staffing 6. Copy of last six months schedule 7. Copy of last six months database schedule 8. Dental appointment attendance sheet for past six months 9. Oral health care plans for Individuals #16, #14, #678, #273, #6 #694, #155, #551, #604, and #238 10. Oral health spot check document, dated 1/26/2012 through 8/7/2013 11. Untitled document indicating that the Facility did not track the status of dental imaging studies 12. Dental integrated progress notes, dental record, and all related medical provider, and nursing IPNs related to dental emergencies that occurred during the reporting period (Individuals #475, #555, #314, #302, and #181) 13. Current ISP, document demonstrating efficacy of suction tooth brushing, and most recent oral health care rating for Individuals #154, #781, #729, #585 and #235 14. Untitled document indicating the names of all individuals who were pending restorative dental treatments 15. TIVA anesthesia report and all associated documentation related to pre, and post anesthesia monitoring for Individuals #678, #155, #426, #470, #751, #235, #125, #130, and #114 16. Untitled document indicating the number of individuals who were provided dental services under TIVA 17. List of all individuals who were diagnosed with pneumonia during the reporting period 18. Untitled document indicating that the Facility did not have a policy or procedure for dental quality assurance 19. Dental Services, Data Analysis Report, 11/2/2012 – 8/28/2013 20. Untitled document indicating that the Facility did not have a mechanism to track and trend dental services **People Interviewed:** 1. Carol Heath, Dental Director 2. Laurena Moore DDS **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: The Monitoring Team compliments the Facility for incorporating, and reporting on, data elements in a standardized format, and concurs with the overall self-assessment of noncompliance for Provisions Q.1, and Q.2. The self-assessment demonstrated evidence that specific indicators, sample selection, and sample size were collected for many important clinical indicators. The Monitoring Team recommends, however,

	that the Facility enhance its data collection process by assessing the clinical efficacy of clinical programs, and to ensure that dental programs are appropriately completed. The following are a few specific examples offered by the Monitoring Team: • The Facility's self-assessment reported oral hygiene ratings for the period 11/1/2012 through 7/11/2013, and indicated that 19.6% of the examples indicated good oral hygiene; 32.34% indicated fair oral hygiene, and 0.3% indicated poor oral hygiene. Compared to the to the dental department's spot checks for oral hygiene at the living area, for June 2012, through August 2013, the dental office reported 44% having poor oral hygiene; 56% having fair oral hygiene; and 0% having good oral hygiene, this is a marked contrast between the two assessments. Also, the Monitoring Team determined that only 20% of the examples assessed did not have a periodontal assessment documented on the dental record. • The self-assessment indicated that individuals referred for emergency dental services had their treatment completed, as recommended by the dentist; however, the self-assessment did not comment on collecting data for significant delays in providing follow-up treatment. For example, Individual #555 had experienced significant maladaptive behaviors, and was immediately seen by the dentist, who identified the need for restorative treatment. There was a significant delay in providing the restorative treatment. Also, the self-assessment did not assess the effectiveness of the dental office's communication of meaningful information to the living area staff. • Regarding TIVA, the self assessment documented that in 100% of the examples, there was a REACT score provided, for the immediate recovery period following TIVA; however, the Monitoring Team's review of documentation indicated that only 44% of the Individuals had specific REACT scores documented. Also, the Facility did not document relevant specifics about the anesthesia monitoring, such as if all necessary vital signs were assessed. The form may be present, but the assessment did not assess for clinical efficacy. The self-assessment should also assess if the dental office provided specific post anesthesia monitoring parameters for the living area staff to assess and report on. • The self-assessment did not assess the effectiveness of the dental office's quality assurance process, to ensure that the efficacy and adverse outcomes of oral health care were regularly assessed.
	Summary of Monitor's Assessment: The Monitoring Team noted some improvements in dental services, such as ensuring robust monitoring by the living area nurse of individuals prior to and following anesthesia, and the Facility's initial stages of developing a dental QA program to assess the efficacy and adverse outcomes secondary to the provision of oral health care at the Facility. The Facility must continue to further develop dental services, and should strongly consider enhancing its process of tracking and trending oral health care services, so that relevant information about dental services can be efficiently tracked for completion, and to assess efficacy. Also, the Facility should enhance the communication of oral health care related issues, such as monitoring parameters following dental treatments, to the living area staff. Provision Q.1**:** The Monitoring Team determined that the Facility is not in substantial compliance with Provision Q.1, of the Settlement Agreement. The Facility must enhance methods to track and trend dental

	services; develop a mechanism to regularly assess the provision of oral health care treatments at the living area; ensure emergency dental evaluations and treatments are promptly provided; and ensure that living area staff are provided with clinically relevant information regarding dental visits, including the reason why the individuals was seen by the dentist, treatment provided, monitoring parameters, and follow for the dental issues. Provision Q.2: The Facility has made some improvement in the area of pre and post anesthesia assessments by the living area nurse, and provides excellent monitoring of individuals who undergo TIVA for dental services. Also, the Facility has begun initial development of a dental QA program, to assess the efficacy and potential adverse outcomes secondary to the provision of oral health care assessments and treatments. Substantial compliance will require further development of the dental QA process, development of a robust dental scheduling process that enables tracking and trending of dental services, and collaboration with the psychology department to develop and implement sound clinical processes to help reduce the need for sedation. These findings support a determination of noncompliance with Provision Q.2.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	To assess the Facility's ability to provided necessary oral health care assessments and treatments, the Monitoring Team assessed dental administration; the provision of routine, restorative, and emergency oral health care; dental hygiene; oral hygiene provided by the living area, the use of suction tooth brushing; and dental imaging. <u>Dental Administration:</u> The Monitoring Team met with the dental director and discussed issues regarding dental administration. In addition, the Monitoring Team requested the following information: • List of all staff of all dental office staff, and: o Name of staff, and title o Indicate if full time or part time o Average number of direct care hours provided each week o Caseload (number of Individuals under the direct care of each dentist) o Documentation of all DD dentistry continuing education during the past 12 months The Facility provided a document that indicated the following: • The Facility has one dentist and one dental director. The dental director provides an average of ten hours of direct care each week. • The full time staff dentist provides an average of 30 hours of direct care each week. • The Facility has one full time dental hygienist, who provides 30 hours of direct care per week, and an average of ten hours of training and monitoring.	Noncompliance

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		• The Facility is recruiting an additional full time dental hygienist. • There was no evidence to indicate the dental professionals participated in continuing education specific to special dentistry during the reporting period. • The Facility has two-full-time dental assistants. Each provide an average of 25 hours of direct care per week, and 15 hours of administrative support per week. The dental director indicated to the Monitoring Team that there are no resource issues that are limiting the provision of dental services. Summary: The Facility's dental director indicated that there were no deficient resource issues that would limit the provision of dental services at the Facility. The Monitoring Team recommends that the Facility develop a mechanism to ensure that dental professionals maintain generally acceptable practice standards, by ensuring the provision of necessary continuing education, for its dental professionals. <u>Annual Dental Examinations and Routine Dental Hygiene</u> To assess the provision of routine dental services, the Monitoring Team requested the following information: • Copy of last six months and next six months appointment schedule for annual dental examinations • As of the day prior to the Monitoring Teams visit, alpha list of all individuals who were <u>not</u> current with their annual dental examination by the dentist, and also a list of all individuals who had not fully completed their annual dental examination. Please include the following information: o Name o Date of previous years annual dental examination o Scheduled date for most recent dental examination The Monitoring Team was provided a document that indicated the following: • "Copy of the last six months appointments attached. The database does not isolate annual exams only." • "Database does not keep a list of individuals not current on annual exams. The database does not distinguish not fully completed exams." Following review of the dental appointments attendance sheet, the Monitoring Team was unable to efficiently identify when annual dental examinations and routine dental hygiene was provided, or if dental examinations and dental hygiene treatments could be fully completed. Summary: To gather the data for the Self-assessment, the Facility must audit charts; data	

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		are not routinely available for the Facility to track on an ongoing basis to determine whether individuals are receiving services, the effectiveness of those services, and needs for actions to improve status of oral health and dental services. The Facility must develop an effective mechanism to track and trend all appointments, and develop a process to efficiently assess what, and when, treatments were provided, when routine appointments are due, and when annual exams are overdue and must be prioritized. <u>Oral Health Care at the Living Area</u> To assess the Facility's mechanism to ensure that oral health care needs were provided at the living area, the Monitoring Team requested the following documentation: • Oral health care plans for the first and than every fifth individuals listed on the current name key, for a total of ten examples. • Evidence that oral health care treatments were routinely assessed at the living area, such as oral hygiene spot checks Review of the oral health care plan, and documentation of oral health care assessments (Individuals #16, #14, #678, #273, #6 #694, #155, #551, #604, and #238) indicated: • In ten out of ten examples (100%) there was evidence of a completed oral health care plan. • Zero out of ten examples (0%) included documentation that the Facility routinely assessed the provision of oral health care, such as flossing, suction tooth brushing, and tooth brushing, at the living area. It should be noted that the oral health care plans provided as examples were not from the sample requested, as they were not every fifth individual on the current name key; hence, the sample was not provided as requested. Therefore, the Monitoring Team could not determine the representativeness of the sample. The Facility provided a document called "oral hygiene spot checks", which indicated that a total of 13 spot checks had occurred at the living areas between 1/26/2012, and 8/7/2013, with only three since October 2012 (11/29/12, 7/23/13, and 8/7/13). Results of these spot checks were reported as: • Good: 4 (31%) • Fair: 3 (23%) • Poor: 6 (46%) Summary: The Monitoring Team determined that that Facility did not provide a mechanism to routinely assess the efficacy of oral health care treatments at the living areas. The Facility should ensure that all individuals are routinely assessed, to ensure that necessary oral health hygiene, such as tooth brushing, flossing, and suction tooth	

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		brushing is being provided as clinically indicated, and completed efficaciously. Dental Imaging To assess if the Facility provides dental imaging, at the level of generally acceptable standard of care, the Monitoring Team requested the following documentation: • Alpha list of all individuals who the Facility has identified as not being current with dental radiography • Alpha list of all individuals who have not had bitewing dental x-rays (or alternative to bitewings) within the past 24 months • Policy and/or procedure specific to dental radiography • For the first five and last five individuals on the list of individuals not having had bitewing radiographs, with in the past 24 months: o Reason why dental x-rays are not current o Copy of IDT minutes and/or ISP minutes, that comments on delinquent dental x-rays, and specific plan to address incomplete dental x-rays The Monitoring Team was provided a documented that stated: • The database does not keep a list of those not current with dental x-rays. The dental director informed the Monitoring Team that the only way to determine if radiographs were current was to conduct a chart audit. • The database does not keep a list of those who have not had dental x-rays within 24 months. • There are no IDT minutes addressing dental x-rays. Therefore, the Monitoring Team determined that the IDT does not address noncompliance issues related to necessary dental imaging studies. There were no clinical examples provided for review. Summary: Because requested documentation was not available for review, the Monitoring Team was unable to assess the Facility's provision of dental imaging. The Facility should have an efficient mechanism to determine if dental imaging studies are current. Dental Emergencies To assess the Facility's process for managing dental emergencies, the Monitoring Team requested the following information: 1. List of all policies/procedures specific for "dental emergencies" 2. Alpha list for all dental emergency during past six months, and include: i. Name ii. Description of dental emergency	

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		iii. Date, and time dental emergency was first identified 3. For Individuals #475, #555, #314, #302, and #181: i. Progress notes documenting initial triage of the dental emergency (medical/or dental note) ii. Dental progress notes/dental records from initial evaluation through full resolution of treatment for the dental emergency (all associated note/records specific for initial and follow-up treatment for dental emergencies) iii. All documentation of IDT review/s, and recommendations, specific for the dental emergency Review of documents indicated that a total of 13 dental emergencies were reported to the dental office for treatment. Review of the five examples requested (Individuals #475, #555, #314, #302, and #181) indicated the following: • In zero out of five cases (0%), the integrated dental progress note (IPN) documented an action plan that included further monitoring parameters, and necessary follow-up for the dental emergency. • In zero out of five cases (0%), the dental IPN reflected the dental note's assessment and treatment of the dental emergency. In all cases, the assessment was documented in language that could not easily be interpreted by non-dental professional staff. • In three out of five cases (60%), the dental emergency was provided prompt clinical attention by living area staff and the dental office staff. Because there was no documentation provided to determine when the possible dental issue was first identified at the living area for Individuals #474 and #555, the Monitoring Team could not determine if the individual was promptly assessed by the dental office. • In zero out of five cases (0%), there was evidence to support that the IDT discussed the dental emergency. The Monitoring Team is concerned that in no cases, did the IDT meet to discuss the dental emergency, even when there was a possibility of the dental issues manifesting, or contributing to severe behavioral exacerbation. Following is information from individual examples. • Individual #475: The dental integrated progress note (IPN), dated 6/26/2013, did not document the dental emergency, did not document an assessment, and did not inform the living area staff of the follow-up plan, including monitoring parameters for staff and follow-up date, in language that non-dental	

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		professionals could easily understand. • Individual #555: The dental IPN, dated 11/28/2012, did not provide specific follow-up date, or indicated monitoring parameters for staff. The Individual was seen for a second time for dental pain, on 12/7/2012, and it was determined that further evaluation under TIVA was necessary. The Individual was eventually provided a dental examination with TIVA, on 1/17/2013, and at that time the individual had a tooth extracted. Review of nursing IPNs indicated that a follow-up for medical monitoring for dental pain was completed on 2/14/2013; however, the following two nursing IPNs, for continued follow-up by the nurse, were dated 9/14/2013, and 9/15/2013 (the actual dates in the IPNs, although after the compliance visit). The Monitoring Team is concerned over possible back documentation. There were no nursing, or medical provider's IPNs documenting the 11/28/2012 dental emergency. • Individual #314: The dental IPN, dated 4/30/2013, did not provide documentation of the dental emergency, did not provide follow-up date, and did not provide monitoring parameters for staff. • Individual #302: On 11/5/2012, the nursing IPN documented that the individual had worsening behavioral issues, including head banging, and indicated that the psychiatrist referred the individual to the dental clinical for evaluation. The dental IPN on 11/5/2012 indicated that the individual had decay of tooth #30, and would obtain consent for filling of two teeth, #30, and #31. Nursing IPN on 11/6/2012, indicated continued signs of pain, and Motrin was administered. On 11/8/2012, the nursing IPN indicated significant, and worsening behavioral issues, including head banging, and indicated that an additional psychiatric medication would be added. Restorative dental treatment was not provided until 12/6/2012. The dentist indicated on the dental IPN that the identified dental decay was most likely not the source of pain. No further documentation was provided. In this case, the Individual exhibited serious behavioral issues, and definitive treatment for dental decay was delayed for four weeks. • Individual #181: Was seen by the dentist for dental emergency on 2/13/2013, and there were no nursing or medical provider IPNs documenting the initial evaluation of a dental emergency. The dentist identified the need for dental extraction, and the individual had the tooth extracted the following day. The dental IPN did not indicate monitoring parameters for staff. On 2/19/2013, the Individual was followed up by the dentist to evaluate the extraction site, and noted that an additional tooth required extraction. Nursing IPN on 2/20/2013 indicated that the Individual had a tooth infection, and that an antibiotic was started. The tooth was eventually extracted on 3/11/2013. Individuals with behavior exacerbations, and suggestions of possible oral health issues, must be	

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		readily assessed, and identified pathology treated. Summary: The Facility must enhance the management of dental emergencies. The Facility should consider improving on the dental office's documentation of dental emergencies, and ensure that specific information is provided to the living area staff regarding the type of dental emergency, monitoring parameters, treatments, and follow-up plan. The interdisciplinary team (IDT) should review dental emergencies, and ensure that prompt dental and other supports are made available to the individual. <u>Suction Tooth brushing</u> To assess the Facility's process for providing suction tooth brushing, the Facility requested the following documentation: • Alpha list of all individuals who are provided suction tooth brushing • Alpha list of all individuals identified as needing suction tooth brushing, but not currently receiving suction tooth brushing. • For the first two and last three individuals on the list of those who are provided suction tooth brushing (Individuals #154, #781, #729, #585 and #235), please provide: o Copy of the most recent assessment results used to evaluate efficacy of suction tooth brushing for the individual o Copy of most recent oral health rating scale o Copy of the most recent ISP, and/or IDT minutes specific to the use of suction tooth brushing o Documentation assessing the efficacy of the use of suction toothbrush Individuals identified as requiring suction tooth brushing, but not provided suction tooth brushing: The Facility did not provide the Monitoring Team with a list of all individuals who were currently being provided suction tooth brushing, and the dental director informed the Monitoring Team that all individuals who required suction tooth brushing were in fact currently being provided suction tooth brushing; however, it would require a document audit to determine if an individual was provided suction tooth brushing. The Facility did not have an efficient method to identify all individuals on suction tooth brushing, or if individuals were assessed as requiring suction tooth brushing but were not being provided suction tooth brushing. The Monitoring Team requested documentation that periodic assessments of the efficacy of suction tooth brushing was being completed. The Monitoring Team was provided a document called Oral Hygiene Spot Checks. This document listed a total of nine individuals, whose oral hygiene had been assessed since June 2012 through August 2013.	

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		Of the nine individuals assessed during the 14 month period: • Zero out of nine (0%) were rated as having good oral hygiene. • Five out of nine (56%) were rated as having fair oral hygiene. • Four out of nine (44%) were rated as having poor oral hygiene. The Monitoring Team review of the examples of individuals who were provided suction tooth brushing (Individuals #154, #781, #729, #585 and #235) indicated: • The individual support plans (ISPs) for five out of five examples (100%) indicated the use of suction tooth brushing. • The ISP documented the rationale and associated risks of suction tooth brushing in in zero out of five examples (0%). • Assessment of periodontal disease was documented in one out of five examples (20%). The Monitoring Team has concerns that dental assessments for individuals #154, #781, #729, and #235 did not have the periodontal section of the dental integrated progress note (IPN) completed. • Of the four assessments provided for oral health, zero out of four (0%) indicated a oral health rating of good or better. For this reason, the Monitoring Team is concerned that oral hygiene efforts at the living area are not effective. Summary: The Facility developed and implemented a suction toothbrushing program. The Facility must continue to enhance its suction toothbrushing program to ensure that all individuals are assessed for the possible need for the use of suction tooth brushing, in the event of a change in clinical status. The Facility should also ensure that the dental QA process assesses the efficacy, and potential adverse outcome from the use of suction tooth brushing. The Monitoring Team was concerned that in the five examples reviewed, only one of the dental notes documented assessment of periodontal disease. <u>Restorative dental care:</u> To assess effectiveness of the Facility's provision of restorative dental care, the Monitoring Team reviewed the following documents: • List of all pending restorative treatments • Date when the underlying condition requiring the restorative treatment was first identified • Date when the restorative treatment was completed, or date of pending treatment • Documentation why restorative treatment has not been completed • Copy of the most ISP or related document, indicating the IDTs awareness of the need for restorative treatment Review of schedule for restorative dental treatments: The Facility issued a report	

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		indicating a total of six individuals were pending restorative treatment (Individuals #238, #771, #192, #537, #337, and #165), at the time of the on-site review. The report included the date that the underlying oral health condition was initially assessed by the dentist, and reason for delay in completing restorative treatments, when the delay was greater then 14 business days. In five out of six examples (83%), delay in treatment was attributed to either scheduling failure, or not obtaining the consent for treatment. Delay in treatment ranged from a low of three months delay, to eight months delay, with an average delay in treatment of 4.8 months. The dental director informed the Monitoring Team that the dental database was unable to generate a report on the total number of restorative treatments; hence, the Monitoring Team was unable to determine the rate of delay of dental treatments at the Facility. Summary: The Facility reported a relatively low number of individuals who were delayed with their restorative dental treatments. Administrative issues, such scheduling of appointments, and obtaining necessary consent for dental treatment were the primary issues resulting in prolonged delays. Because there was no efficient means to track and trend treatment delays, the Monitoring Team was concerned that the Facility is not effectively tracking and trending delay in dental treatment. <u>Conclusion</u> The Monitoring Team determined that the Facility is not in substantial compliance with Provision Q.1. The Facility must enhance methods to track and trend dental services; develop a mechanism to regularly assess the provision of oral health care treatments at the living area; ensure emergency dental evaluations and treatments are promptly provided; and ensure that living area staff are provided specific information regarding dental visits, including the reason why the individuals was seen by the dentist, treatment provided, monitoring parameters, and follow for the dental issues.	
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	To assess compliance issues for section Q.2, the Monitoring Team reviewed the Facility's processes related to dental Quality Assurance, issues related to dental anesthesia, and dental scheduling, and programs to reduce the need for dental sedation. Review of Desensitization Policy The Facility provided a its policy, and procedure for dental, dated 8/1/2013. The policy stated the following: • If medical restraint or sedation is required for routine dental care for an individual, the health care professional should attempt to minimize or eliminate the need for their use • A desensitization plan shall be a prudent program implemented to minimize or eliminate the need for restrain or sedation.	Noncompliance

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	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.	• The IDT, in associating with the dental clinic, under the leadership of behavioral services, shall create a desensitization plan for the individual. Summary: The policy for desensitization did not delineate the Facility's process for providing desensitization, and other programs to help reduce the need for chemical restraint. <u>Total Intravenous Anesthesia (TIVA)</u> To determine the Facility's availability of providing adequate quantity of TIVA services for dental procedures, and to assess the Facility's process for ensuring safe administration of TIVA, the Monitoring Team requested the following information: • Number TIVA hours per month available at the Facility • Number of individuals who have been provided TIVA services each month, for the past six months, beginning with 1/1/ 2013 • Alpha list of all individuals who require TIVA for dental services • Alpha list of all individuals who were provided TIVA for dental services during the past 12 months • For the first five and last five individuals who were provided TIVA anesthesia were requested, but the Facility only provided documentation for nine individuals who had TIVA. One of the examples had oral sedation, and not TIVA: (Individuals #678, #155, #426, #470, #751, #235, #125, #130, and #114): o Copy of TIVA records associated with the most recent use of TIVA anesthesia o Copy of all nursing notes associated with post anesthesia monitoring of the individual, following general anesthesia, once back at the living area (or infirmary) • List all individuals who were provided TIVA anesthesia during the past six months, and who were diagnosed/treated/and or hospitalized for pneumonia (any type of pneumonia). o Date that general anesthesia was provided o Date pneumonia was diagnosed/treated/or person hospitalized • Statement by the Facility's dental director indicating that all individuals who require TIVA for their oral health care needs, are afforded TIVA services for their annual dental assessments for a minimum of two dental hygiene opportunities per year, and more if clinically indicated; and for all necessary restorative treatments, without a delay in treatment of more then 14 business days. Review of TIVA experiences that were provided during the reporting period: Documentation provided by the dental director indicated that during the time period 7/1/2012 through 8/28/2013, a total of 125 individuals received TIVA; there were a	

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		total of 158 treatments provided under TIVA, and 23 individuals were provided TIVA on two or more occasions. The dental director indicated that the Facility did not maintain a database or master list that would identify all individuals who require the use of routine TIVA for their oral health care. Based on the data provided, the Facility provided an average of 11.3 TIVA opportunities each month, and that, of the reported 125 individuals who were provided TIVA, only 23 out of 125 (18%) were provided TIVA on more than one occasion. Review of the TIVA order form: The Facility utilizes a standardized order form when ordering TIVA; however, there is a section for the ordering clinical professional to individualize each order, when necessary. Review of clinical documentation related to treatments that included administration of TIVA: The following is a summary of findings from the Monitoring Team's review of sample cases provided for review (Individuals #678, #155, #426, #470, #751, #235, #125, #130, and #114): • In nine out of nine cases (100%), anesthesiology records were complete, and documented all necessary monitoring parameters. • In four out of nine cases (44%), there was documentation of necessary post anesthesia monitoring parameters, until the individual reached a REACT score of greater than or equal to eight. REACT scores were only provided for Individuals #114, #751, #470, and #155. • In nine out of nine cases (100%), the dental office ensured that potential serious side effects of the anesthesia, and specific issues such as behavioral exacerbation, were communicated to the living area staff. Post anesthesia nursing IPNs completed at the living area indicated that the living area nursing staff were monitoring closely for potential side effects. The Monitoring Team compliments the nursing staff for the exceptional level of close monitoring, as evident by review of all post anesthesia nursing IPNs reviewed (Individuals #678, #155, #426, #470, #751, #235, #125, #130, and #114) • In nine out of nine cases (100%), the nurse performed, and documented, pre-sedation assessment. The Monitoring Team compliments the nursing staff for the comprehensiveness of the pre-anesthesia nursing IPNs. IPNs reviewed by the Monitoring Team noted that nurses assessed vital signs, including oxygen saturation levels, and documented a focused nursing assessment. • In five out of nine cases (56%), the dental office provided post-sedation orders, or other specific documentation that delineated monitoring parameters Summary: The Monitoring Team determined that the Facility provides adequate monitoring of	

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		individuals prior to, during, and following the administration of TIVA for dental procedures. The Monitoring Team compliments the nursing staff for documenting comprehensive nursing assessments following TIVA procedures. The Monitoring Team is concerned that only 18% of Individuals received TIVA for two or more dental assessments and treatments over a 14-month period. Although some individuals may not require TIVA for all of their dental assessments, and treatments, the dental director informed the Monitoring Team that individuals who require TIVA for dental treatments also require TIVA for efficacious dental hygiene, such as deep scaling, which should be done at least twice per year. As noted in Provision Q.1, of this report, the Facility noted that there was significant delay in treatment for an Individual while awaiting TIVA resources for treatment that was identified during an emergency dental assessment. Also, the Facility did not maintain a process to efficiently identify individuals who require routine TIVA resources for their oral health care, and must rely on either a chart review, or review of the dental schedule, and search for individuals who received TIVA in the past. The Facility should enhance its process of identifying, and tracking all individuals who require TIVA for oral health care assessment and treatment, and ensure that adequate TIVA services are available to ensure that all individuals are provided adequate oral health management, including dental hygiene, as clinically necessary. <u>Pre-Treatment oral sedation</u> Oral sedation for dental services is assessed as a component of Section J, and the reader is referred to Provision J.4 for specific details and the Monitoring Team's findings. The Monitoring Team did discuss some aspects of the dental office participation in providing pre-treatment oral sedation for dental services with the dental director, who informed the Monitoring Team that the Facility did not maintain a list of all individuals who regularly require oral sedation, and must relay on a record review at the time of scheduling an individual's dental appointment. In addition, the Monitoring Team reviewed the list of all individuals who were provided a pre-treatment oral sedation for oral health treatments, and compared that list to a list of all individuals who were diagnosed with pneumonia during the reporting period; there were no examples of an individual developing pneumonia within a two week period, from the date of being administered the pre-treatment oral sedation for oral health treatment. Summary: The Monitoring Team refers the reader to Provision J.4 of this report for a detailed summary of the usage of oral sedation. In addition, the Monitoring Team strongly recommends that the Facility develop a method to track and trend individuals who routinely require the use of pre-treatment oral sedation for oral health care treatment.	

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		Programs to Help Minimize Restraint To assess the Facility's ability to better enable least restrictive oral health care treatment, the Monitoring Team requested: 1. Alpha list of all individuals who were provided a process to help minimize the use of sedation for dental services 2. Alpha list of all individuals who were unable to complete their dental visits because of challenging behaviors, and who are not currently participating in a process to help minimize the use of sedation 3. RSSLC Policy: Dental Desensitization Policy, 8/1/2013, unnumbered 4. Schedule for process to help minimize the use of dental desensitization 5. For the first ten individuals, on the list of individuals whom are provided a process to help minimize the use of sedation for dental services a. Copy of program for minimizing dental sedation b. Copy of program data for past six months c. Copy of current ISP or addendum to ISP that documents the use of the program, and expected outcome During the Monitoring Team's on-site review at the Facility, the dental director informed the Monitoring Team that there was no formal collaborative process at the Facility, where psychology and dental services are providing the necessary support to help develop, implement, and assess the efficacy of specific programs to help mitigate the need for dental sedation. Furthermore, the dental director indicated that the dentists and dental hygienist work with individuals on a "case-by-case" basis, and provide training to the individuals to overcome their fear of dental procedures. It was evident to the Monitoring Team that the dental director understood behavior issues of the individuals she reported on, during the discussion with the Monitoring Team; however, there was no evidence to support meaningful tracking and analysis of the Facility's effort. In addition, there was no documentation provided to indicate that the Facility had developed an effective process to help Individuals reduce the need for dental sedation. Summary: The Facility must develop and implement clinically effective processes to help individuals reduce the need for dental sedation. The process should include identifying all individuals who require a program, program development, and routine implementation of the program, along with data collection, analysis, and assessment of efficacy of the program. The Monitoring Team suggests that the psychology department collaborate with the dental department, and help lead this effort. Dental quality assurance: To assess the Facility's process to monitor the quality of dental services, and develop	

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		strategies to enhance oral health care at the Facility, the Monitoring Team requested the following documents: • List of all dental QA indicators • All data, trends analysis, summaries, committee minutes, action plans, and follow-up to action plans for the Facility's dental QA process, for this reporting period Review of dental QA data, and data analysis: The Facility provided a document that was labeled Dental Services, Data Analysis Report, 11/1/2012 – 8/28/2013. The document indicated that the data represented a total of 119 internal audits completed during the date range listed. The Monitoring Team noted that there were a total of 40 specific questions to assess dental service related issues. Adjunct to each of the forty questions was a score. The Monitoring Team noted that all question items were clinically relevant, and would help the Facility better understand some of the strengths and deficits of dental services; however, there were no specific questions that would assess the efficacy of oral health care, or adverse outcome secondary to oral health care. Furthermore, there were no narrative summaries or reports provided for review regarding analysis of dental QA data elements. Review of dental QA action plans: The Facility did not provide corrective action plans for any items identified as deficient for dental services. Summary: The Facility provided some information that indicated the beginning steps of developing a dental QA process. More robust data collection, that includes data elements specific to treatment outcomes and adverse effects of oral health treatments should be developed, and a comprehensive data analysis, longitudinal tracking of data elements, and corrective action plans for all identified deficiencies, should be developed. The Monitoring Team is complimentary for the Facility's initial steps at developing a dental QA process. <u>Dental Schedule:</u> To assess the Facility's ability to maintain an efficient and effective dental scheduling system, and to determine if all dental services are current, the Monitoring Team requested the following documentation: • Copy of dental schedule for past six months, and pending six month period o List of all "missed" appointments and ▪ Reason for missed appointment ▪ Date appointment was missed ▪ Date follow-up appointment was scheduled ▪ Specific effort document to help mitigate future missed	

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		appointments. • Total number of missed dental appointments during that past six months • Number of missed appointment during the passed six months, from July 23, 2013 • Total number missed • Total number scheduled • Number of missed appointments because of illness of the individual • Number of missed appointments because of staffing issues at the living area • Number of missed appointments because of staffing issues at the dental office • Number of missed appointments because living area forgot to transport the individual to the dental clinic • Number of missed appointments because of the a TIVA related issue (ie, not enough TIVA days; another individual required that particular TIVA appointment for a dental urgency, etc) • Number of missed appointments because appropriate consent was not obtained • Number of missed appointments because of other, non-specified issues • Committee Meeting minutes, associated data, and data analysis used by the facility to improve compliance with dental services In response to the Monitoring Team's document request, the Facility provided a untitled documents that stated: "Please note the database will not print a simple, complete copy of the schedule without going day by day, staff person by staff person. The hand written appointment pages for the past six months show the staff person contacted by phone to confirm the appointment, the check mark indicates if the person attended, NS stand for no show, AO indicates an add-on appointment set after the appointment schedule was sent out by the medical secretary. Refusals are marked. Missed appointment BIRs go to the Q and the Behavior Analyst weekly". Also, the documented stated, "The database does not capture specific effort to mitigate future missed appointments." Summary: Because the Facility did not have an efficient or effective method for tracking dental appointments, and because there was no documentation regarding efforts to mitigate missed appointments, the Monitoring Team was unable to determine the efficacy of the Facility's dental scheduling process, or to determine if dental treatments were current. <u>Conclusion</u> The Facility has made some improvement in the area of documentation of pre and post anesthesia assessments, and provides excellent monitoring of individuals by the living	

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		area nurse, of individuals who underwent TIVA for dental services. Also, the Facility had begun initial development of a dental QA program, to help assess the efficacy and potential adverse outcomes from the provision of oral health care assessments, and treatments. Substantial compliance will require further development of the dental QA process; development of a robust dental scheduling process that enables tracking and trending of dental services; and collaboration with the psychology department to develop and implement sound clinical processes to help reduce the need for sedation. For these reasons, the Monitoring Team determined that the Facility is not in substantial compliance with Provision 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 (8-9-13) 2. RSSLC Action Plan (8-7-13) 3. RSSLC Policy K.06.2 Speech-Language Pathology Services policy (rev: 7/3/13) 4. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 6/11/13) 5. Record reviews for the following samples: a. Sample R.1: Individuals #60, #86, #154, #179, #220, #386, #410, #429, #612, #621, #646, #669, #736, #780, and #781 b. Sample R.2: Individuals #559, #630, and #651 c. Sample R.3: Individuals #410, #429, #612, #646, #736, and #760 d. Sample R.4: Individuals #179, #462, #544, and #669 e. Sample R.5: Individuals #219, #260, #508, and #716 6. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 7. A list of people with Alternative and Augmentative Communication (AAC) devices 8. AAC evaluation and Speech Language assessment template 9. Monitoring tools template for ACC and SLP programs 10. List of individuals receiving direct speech services, and focus of intervention 11. PBSPs for sample individuals 12. Communication assessments for sample individuals 13. Communication programs for sample individuals **People Interviewed:** 1. Brandie Rabe MS, CCC-SLP 2. Ping Law Director of Habilitation Therapies 3. Carol Elliot MS, CCC-SLP (SLP Lead) 4. Eight DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meeting Attended/Observations:** 1. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 8/9/13 and Action Plan dated 8/7/13. 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:

	• The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section R • 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. For example, Provision R.4 did not include information regarding the monitoring policy. • 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. • 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). • The monitoring/audit tools did have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The Facility consistently did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: • Did present findings consistently based on specific, measurable indicators. • Did not consistently measure the quality as well as presence of items. The Facility rated itself as not being in compliance with any of the sub-sections of Provision R. This was consistent with the Monitoring Team's findings of noncompliance with all sections of Provision R. The Action Plan did an admirable job in outlining the steps needed to move towards compliance but as with the self assessment. RSSLC is encouraged to review the Monitoring Teams report to ensure the actions steps are in line with the requirements identified in reports.
	Summary of Monitor's Assessment: RSSLC showed overall improvement with Provision 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 continued to be reviewed and implemented in a more functional manner but implementation continued to be severely lacking. Ms. Elliot MS, CCC-SLP has done some impressive work on the Four Rivers homes and the Monitoring Team looks forward to seeing how these homes improve and if this process spreads to other areas of the facility. It should be noted that while the presentation of the devices had improved on Four Rivers, implementation had not shown the same level of improvement. 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. RSSLC had four full time therapists that focused on communication and one Speech Therapist Assistant. Per the HT director, the current staffing was sufficient and the lack of services being provided was more related to identification versus lack of staffing; therefore, the Monitoring Team will need to review this provision in more detail at subsequent visits to determine if service standards are beginning to be met. Additionally, there was no a clear policy that outlined how individuals would be provided with the needed monitoring to ensure staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. Provision R.2: This provision was determined to be not in compliance. 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 or monitored. There was also lack of consistent integration of the communications strategies into the PBSP; however this has shown significant improvement since the previous review. Provision R.3: This provision was determined to be not in compliance. Communication strategies and programs were not consistently integrated into the ISP, and 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. Monitoring regarding the working condition of devices as well as the effectiveness of supports remained lacking and processes that were in place were not fully implemented.

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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	Samples for this section are as follows: Sample R.1: Consisted of 15 Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months. Sample R.2: Consisted of three Individuals receiving direct speech services. Sample R.3: Consisted of six Individuals with a PBSP and communication deficits. Sample R.4: Consisted of five Individuals with AAC systems Sample R.5: Consisted of four individuals who received indirect Speech	Noncompliance

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	implement programs, provide staff training, and monitor the implementation of programs.	Services/Supports. **Staffing** It was unclear at this time whether RSSLC did or did not employ enough SLPs needed to actively participate in all facets of care. At the time of the review, RSSLC had four full time Speech Language Pathologists plus one SLP who was assigned to the PNMT. In addition to the SLPs, RSSLC had a full time Speech Therapy assistant (SLPA) that assisted with modeling and the implementation of programs. The SLPA position was developed due to RSSLC having difficulty finding a SLP to fill the open position. The current ratio of therapist to client ratio was 1:84. Per interview with the HT Director, the current caseloads were able to be adequately managed by the current SLP staffing levels as outcome measures (e.g., timeliness of assessments) were able to be met. Also included as part of the staffing determination was analysis of SLPs' responsibilities, including consideration of the acuity of individuals' speech and communication needs, and assistance from speech assistants. Per the HT director, the current staffing was sufficient and the lack of services being provided was more related to identification of individuals' communication needs versus lack of staffing therefore the Monitoring Team will need to review this provision in more detail at subsequent visits to determine if services are beginning to be met. **Qualifications:** Four of four positions for SLPs (100%) for which documents were provided to the Monitoring Team were filled by licensed SLPs. • Four of four SLPs (100%) were licensed to practice in the state of Texas. • Four of four SLPs (100%) had evidence of ASHA certification. **Continuing Education:** Based on a review of continuing education completed in the last 12 months, four of four SLP staff (100%) had completed continuing education related to communication in an area that was relevant to the population served. Education included but was not limited to: • Working with Communication Partners to support language development • Evidence based Intervention for Dementia **Facility Policy** A local policy/process did not exist that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlines minimum components of communication supports and services.	

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		RSSLC had a localized Speech-Language Pathology Services policy (K.06.2-rev: 7/3/13). The policy contained the following components: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Timelines for completion of new admission assessments • Criteria for providing an update • Outlines assessment schedule • Frequency of assessments/updates • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication • Methods of tracking progress and documentation standards related to intervention plans. • Addressing a process for effectiveness monitoring by the SLP. Missing from the policy was: • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Assessment Plan:** The Facility had a reasonable plan to screen/assess all individuals and, based on priority need, assess individuals who would benefit from the use of alternative or augmentative communication systems. RSSLC provided assessments for all new admissions in lieu of providing screenings. Individuals at a minimum are provided with a Communication Assessment annually if they receive direct or indirect communication supports and all others will be provided with assessments if there was a change in status, IDT request or at a minimum will be provided with an assessment every 5 years. **Assessments Provided** Eleven of 15 individuals in Sample R.1 (73%) were provided a communication assessment per policy and/or Master Plan. Individuals who did not get a communication assessment per policy included Individuals #154 and #429 assessments were last completed in 2008 although they were identified as having severe communication deficits and were to have received a new assessment. Sixteen of 16 individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission. For eleven of 15 individuals in Sample R.1 (73%), assessments/updates were dated as	Noncompliance

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		having been completed at least 10 working days prior to the annual ISP. Thirteen of 18 individuals in Samples R.1 and R.2 (72%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. **<u>Communication Assessment:</u>** Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows: • Two of 18 individuals' Communication assessments (11%) were signed and dated by the clinician upon completion of the written report. The reports received were mostly not copies of the originals so overall this metric could not be accurately assessed. • Sixteen of 18 individuals' Communication assessments (89%) were dated as completed at least 10 working days prior to the annual ISP; • Sixteen of 18 individuals' Communication assessments (89%) included diagnoses and relevance of impact on communication; • Sixteen of 18 individuals' Communication assessments (89%) included individual preferences, strengths, and needs • Sixteen of 18 individuals' Communication assessments (89%) included medical history and relevance to communication • Fourteen of 18 individuals' Communication assessments (78%) listed medications and discussed side effects relevant to communication; • Twelve of 18 individuals' Communication assessments (67%) provided documentation of how the individual's communication abilities impacted his/her risk levels; • Fourteen of 18 individuals' Communication assessments (78%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; • Eighteen of 18 individuals' Communication assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Five of five individuals' Communication assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; • Fourteen of 18 individuals' Communication assessments (78%) included discussion of the expansion of the individuals' current abilities. • Fourteen of 18 individuals' Communication assessments (78%) provided a	

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		discussion of the individuals' potential to develop new communication skills; • Thirteen of 18 individuals' Communication assessments (72%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification; and rationale as to whether or not the individual would benefit from AAC or EC. • Fourteen of 18 individuals' Communication assessments (78%) offered a comparative analysis of health and functional status from the previous year • Thirteen of 18 individuals' Communication assessments (72%) gave a comparative analysis of current communication function with previous assessments. • Fifteen of 18 individuals' Communication assessments (83%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. • Fifteen of 18 individuals' Communication assessment (83%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; • Fourteen of 18 individuals' Communication assessments (78%) had a reassessment schedule; • Twelve of the 18 individuals' Communication assessments (67%) supplied a monitoring schedule. The SLP assessment did not discuss monitoring results from the previous year and did not recommend the implementation of a monitoring schedule for the upcoming year. • Twelve of 18 individuals' Communication assessments (67%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. • Fourteen of 18 individuals' Communication assessments (78%) made a recommendation about the appropriateness for community transition. • Twelve of 18 individuals' Communication assessments (67%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. **SLP and Psychology Collaboration:** Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans (PBSPs), the following was noted: • Six of six communication assessments reviewed (100%) contained evidence of review of the PBSP by the SLP. This was noted in the behavioral considerations section of the SLP assessment. • For four of six individuals (66%) communication strategies identified in the assessment were included in the PBSP. This was an area that had significantly improved. For example, Individual #429's behavior was identified as being as	

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		being a result of his inability to communicate and therefore a SAP was developed to improve social interaction and communication. • For six of six individuals (100%) communication strategies identified in the assessment were included in the ISP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 1/1/13 to 6/30/13, the SLP participated in 0% of the meetings. In order for the Facility to move towards substantial compliance, there must be increased collaboration and participation by the SLP with the Behavior Support Team as well as increased integration of strategies that are consistent within the PBSP, ISP and SLP plan of care.	
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.	**Integration of Communication in the ISP** Based on review of the ISPs for individuals in Sample R.1 and R.2 the following was noted: • The Monitoring Team was unable to assess if the SLP attended the ISP as the signature sheets with signatures were not provided with the document request. • Eleven of 18 ISPs reviewed (61%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. • Communication Dictionaries for 0 of two individuals (0%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. • Eight of 18 ISPs reviewed (44%) included how communication interventions were to be integrated into the individual's daily routine. • Eleven of 18 ISPs reviewed (61%) contained skill acquisition programs to promote functional communication. **Development And Implementation Of Functional Individual-Specific Assistive Communication Systems** For zero of two individuals in Sample R.1 for whom the IDT directed a revision in the communication dictionary (0%), the communication dictionary was revised within 30 days. Observations were conducted in homes with AAC systems in Sample R.4 Findings included the following: • Three of five individuals (60%) found AAC devices present in each observed setting and readily available to the individual. • AAC systems for one of five individuals (16%) were noted to be in use in each observed setting.	Noncompliance

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		• AAC systems for five of five individuals (100%) were portable. • AAC systems for five of five individuals (100%) were functional. • For two of five individuals (40%), staff instructions/skill acquisition plans related to the AAC system were available. • For zero of five individuals (0%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. **General Use AAC Devices:** Observations were completed in six homes and to determine the presence and use of general AAC devices. Findings included the following: • Four of the six homes (67%) had general use AAC devices present in the common areas. In four of six homes and other environments (67%), general use AAC devices were operational. • Eight of the twenty general use AAC devices (40%) noted contained clear directives on how staff should use these devices. • Ten of twenty general use AAC devices (50%) noted had a clear function within that setting/situation. • Zero of twenty general use AAC devices noted (0%) were used. Observations were provided in which the use of the board/devices would have been appropriate (for example: mealtimes, washing hands, music) but were not prompted by staff or utilized by the individuals. Overall, General area devices were not well marked with directions and had no evidence of being utilized. Many devices were either broken or not used by individuals or encouraged to be used by staff. In order to move towards substantial compliance, RSSLC must develop a consistent monitoring process that will ensure all devices are working properly and staff are provided consistent modeling on how to use the devices. It should be noted that the Four Rivers area had shown significant improvement in the presence of meaningful AAC. AAC devices developed by Carol Elliot MS CCC-SLP were relevant and meaningful to the individuals as many of the pictures utilized on boards or Picture Exchange Systems were developed collaboratively with the individuals. In one case, the individual actually helped draw the pictures of items that were important to him. While implementation was virtually nonexistent, this was still a significant improvement in how devices were chosen for the locales and individuals. **Direct Communication Interventions**	

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		Review of the individuals' records from Sample R.2 showed the following: • Two of three individual's direct intervention plans (67%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. The SLP recommended that Individual #651 utilize a switch to activate a sensory device in October 2012; however as of this review the objective had yet to be implemented. • For three of three individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. • For zero of three individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For two of three individuals (67%), information was present regarding whether the individual showed progress with the stated goal. • For zero of three individuals (0%), a description was found of the benefit of the device and/or goal to the individual. There was no evidence that the therapist reported on a monthly basis how the goal would support communication for the individual in their daily activities. • For two of three individuals (67%), a report was found regarding the consistency of implementation. • For two of three individuals (67%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • For two of three individuals (67%) progress notes contained the consistency of implementation. • For two of three individuals (67%) progress notes occurred at a minimum monthly. **<u>Indirect Communication Supports:</u>** Programs for individuals in Sample R.5 who received indirect communication supports were reviewed and found: • Zero of four individuals' indirect plans (0%) (i.e., SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. Although plans were identified in the SLP assessments as skill acquisition programs, there was no evidence of actual implementation. For example, the SLP recommended a goal for Individual #508 to match symbols to objects and Individual #508 to utilize basic signs but neither of these recommendations were developed into actual goals and monitored for progress. • For four of four individuals' records (100%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale.	

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		For two of five individuals in Sample R.4 (40%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. Zero of four individuals (0%) receiving indirect Speech Services (Sample R.5) were provided with comprehensive progress notes that contained each of the indicators listed below. • Quarterly documentation for zero of four individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. There was no evidence of review of goal/objective status. • Quarterly documentation for zero of four individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of four individuals (0%) identified consistency of implementation. • Quarterly documentation for zero of four individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. **Staff Interviews** Three of eight staff interviewed (38%) were knowledgeable of the individuals in Sample R.4 and R.5 and their communication related programs; direct support professionals had difficulty with the following questions • Stating whether the individual had an AAC system. • Stating whether there was a communication program. • Describing the communication program goal. • Describing the schedule for implementation of the communication program. • Identifying how communication skills in the program were addressed throughout the day. **Competency-Based Training and Performance Check-offs:** 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 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. Per the SLP Lead, this was an area that	

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		required improvement and that increased modeling and training was going to be provided in the future. One hundred seventy seven of 177 new employees since October, 2012 (100%) had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs. **Individual-Specific Competency-Based Training** To determine whether the Facility had a process to determine whether staff had been trained on their communication devices, the Monitoring Team requested evidence that all assigned staff for the five individuals in Sample R.4 had received training related to Communication SAPs and programs. One of 5 (20%) individual's staff assigned had completed competency check-offs regarding the individuals' communication programs. RSSLC was unable to provide evidence of training records that verified staff had received training regarding the devices utilized by the other four individuals. The one staff responsible for training other staff was a Speech Therapist and was competent to train other staff regarding implementation of the device. In order to move towards substantial compliance, RSSLC must develop a system that will allow them to determine who has and who has not receive the training necessary to fully implement individual specific plans of care. An option may be to utilize the system that is in place for individual specific PNMP strategies and interventions.	
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	**Policy and Procedure** 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 PNMP Training and Monitoring Policy (K.07 rev 6/11/13) 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. • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work). Missing from the policy was: • The frequency of monitoring.	Noncompliance

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	available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	• The process for identification, training, and validation for monitors. • The process of inter-rater reliability. Per the Speech Lead, the PNMPCs provided monitoring; however, monitoring was not being done consistently nor were all individuals being monitored according to policy. In addition to the monitoritng of the working condition and presence of AAC devices, to be conducted by non-clinicians, there was also effectiveness monitoring that was to be be provided by the Speech Pathologists; however there were no formal guidelines or schedule to ensure completion and therefore the process was inconsistently implemented. **<u>Monitoring of Implementation of Communication Supports</u>** Compliance Monitoring forms for implementation of communication supports the last six months for three individuals from Sample R.4 were reviewed and the following was found: • For four of five individuals (80%), monitoring of communication supports was outlined in the assessment. • For zero of five individuals (0%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. There was not a formalized guideline that identified the frequency of monitoring. AAC monitoring was conducted that focused on presence and working condition, but this monitoring lacked a formalized process. Effectiveness monitoring of AAC was to occur as well but again limited evidence was available that this consistently occurred.	

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 8/9/2013 2. RSSLC Action Plans 8/7/2013 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 #120 and #264. **People Interviewed:** 1. Davondra Brown – Director of Education and Training 2. Angela Hernandez – QIDP Educator 3. Douglas Cameron – Vocational Director 4. Cynthia Davis – Contract Procurement Specialist 5. Jim North – Human Rights Officer 6. Lloyd Robert Buckner, MS, BCBA – Behavior Services director 7. Approximately 25 direct care staff in the following residences and day treatment areas: Guadalupe, Lavaca, Leon, Sabine, San Antonio, and Trinity residences, as well as multiple employment areas **Meeting Attended/Observations:** 1. Section S Strategic Planning meeting 2. Human Rights Committee 3. The following residences and day treatment areas: Guadalupe, Lavaca, Leon, Sabine, San Antonio, and Trinity residences, as well as multiple employment areas
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S. 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. At the time of the site visit, RSSLC reported in the Self-Assessment that no Provision was in substantial compliance with the Settlement Agreement. The Monitoring Team concurred 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.

	Based Upon the Self-Assessment and Action Plan, it was apparent that the Facility had developed and submitted a brief but strikingly frank appraisal regarding the lack of compliance with the Settlement Agreement. Using a tool that contained many of the elements from the tool used by the Monitoring Team, the Facility reviewed a sample of 17 records. From this sample, RSSLC reported that the majority of records lacked skill acquisition programs (SAPs), and that in the records which included SAPs, those SAPs did not include several of the key components. Regarding assessments, the Self-Assessment revealed thorough Vocational Assessments in all records. Functional Skill Assessments, however, lacked many of the essential elements and the majority of records did not include preference assessments. The Action Plan submitted by the Facility consisted of a broad outline of steps intended to achieve compliance with the Settlement Agreement. The steps outlined an adequate albeit general strategy for implementation. In other words, while the plan appeared to move practices in the appropriate direction, the specifics about implementation were at times absent. For example, one of the steps was described as, "Create a critical thinking infused system for proper task analysis." This represented a laudable goal, but no details were provided about how this was to be attained. It was possible that generalities in the Action Plan were due to the sizable task of making a fresh start concerning Section S. Nevertheless, increased specificity will be needed as implementation of the plan progresses. Overall, although atypically brief, the RSSLC Self-Assessment was better than most Self-Assessments as it reflected a comprehensive review that included specific expectations as well as clear indications of performance.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 8/26/2013 through 8/30/2013. 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. Due to ongoing changes at the Facility, it was agreed that the review of Section S would be limited to the two most recent ISPs as those ISPs were the first to involve a new ISP methodology. A sample of two records is not sufficient to determine global performance or compliance with the Settlement Agreement. The two ISPs, however, did allow for a limited comparison between the previous practices and the new methodology. In this capacity, there were suggestions of positive changes. • There were some indications that assessments were better integrated into the ISP documentation. • The ISP documentation from the new process was modestly better at supporting the need for SAPs. • SAPs developed under the new ISP process reflected improvement in some areas relative to the status of ISPs at the previous site visit. It was concerning, however, to note that the new ISP process had not resulted in substantially better outcomes. The first attempts in any new process are likely to include some missteps. It is still expected, however, that at least some areas will stand out in stark contrast when compared with previous efforts. Regarding Section S efforts at RSSLC, no elements stood out as distinct reflections of improvement. In some

	aspects, there was little to no improvement. • Most of the SAPs reviewed did not include specific instructions, operational definitions of targets, adequate documentation procedures, or necessary consequences for correct and incorrect responses. • SAP development did not make use of task analyses where appropriate, and there at times discrepancies between the assessments and the SAPs those assessments were intended to support. Observations also reflected some additional improvement concerning Section S. This primarily involved the level of functional engagement. For example, although weaknesses remained, the percentage of observed locations with functional engagement for more than half the individuals present increased and was well above baseline data. Based upon the available documentation, it was not evident that the new ISP process or the resulting SAPs were likely to enhance the skills of the individuals living at the Facility. It should be noted, however, that the changes to the ISP process were only one part of a broader plan to improve most aspects of skill acquisition at RSSLC. It was reported to the Monitoring Team, and supported by documents, staff interviews, and observed meetings, that a comprehensive effort to improve SAPs, community employment, and quality of life was to be initiated immediately following the current site visit. It appeared that this plan was well-organized and included many of the components necessary for compliance with the Settlement Agreement. Further review at future site visits will be necessary to determine if the plan produced the necessary results.

#	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	<u>Use of Assessment Information in Planning Skill Acquisition</u> Adequate assessment is essential for understanding an individual's capabilities, 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 person who is to participate in the training. <u>Historical Perspective</u> 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 methods. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	use of restraint.	reveal 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. During the November 2012 site visit, a sample of 10 records reflected that, although assessments were at times reviewed during the ISP, seldom was assessment information used to identify needs or to develop skill acquisition programs. <u>Current Site Visit</u> At the time of the current site visit, RSSLC had just initiated a new ISP process. The first two ISP meetings to utilize the new process were conducted during the site visit. It was agreed with the Facility that the assessments and procedures from these two ISP meetings would comprise the sample for this portion of Provision S.1. Because of the limitations of this sample, the Facility recognized that the primary purpose of this review would be to assess status for informational purposes rather than to determine whether the Facility was in substantial compliance. The two individuals for whom the ISPs were conducted were Individuals #120 and #264. The documentation from the ISP meetings was provided by the Facility approximately two weeks following the site visit. For each of the two individuals, two SAPs had been recommended and developed. These four SAPs were submitted with the ISP documentation. Ratings from the review of the two ISP documents and assessments are presented in the table below. Two ISPs and four SAPs were not sufficient to allow a full grasp of the strengths, weaknesses and potential benefits of the new ISP process. As a result, reported ratings and comments must be read and interpreted with caution. |	5/2010	11/2012	8/2013 | |---|---|---|---| | Skill acquisition plans are implemented to address needs identified in: | | | | | ISP | 0% | 0% | 50% | | Adaptive skill or habilitative assessment | 0% | 0% | 25% | | Psychological assessment | 0% | 0% | 0% | | Skill acquisition plans are chosen in an | 0% | 0% | 50% |	

#	Provision	Assessment of Status	Compliance

individualized manner.			
Skill acquisition plans are related to the individual's preferences.	0%	0%	50%

Based upon the sampled ISPs, SAPs, and related materials, it appeared that the new ISP process included some potential improvements.

- Two of the four SAPs (50%) were supported by information provided in the ISP. These two SAPs were developed for Individual #264.
- One of the four SAPs (25%) was clearly supported by the assessments submitted as part of the ISP documentation. This SAP was provided for Individual #264.
- Two of the four SAPs (50%) reflected an individualized process for selected SAP targets and procedures. These two SAPs were developed for Individual #264.
- Two of the four SAPs (50%) were related to personal preferences documented in the relevant assessments and ISP documentation. These two SAPs included one each for Individuals #120 and #264.

Despite the potential improvements suggested by the above ratings, several issues reflected substantial weaknesses and areas of concern related to the assessment and ISP process.

- For Individual #120, documentation reflected that the individual was non-verbal and communicated through eye gaze, vocalizations, and pushing others away. The Communication Evaluation, although acknowledging those weaknesses in communication, indicated that assistive communication technology was not required. No rationale was given for that conclusion and no assessments addressed the need for assistive communication devices.
- For Individual #120, the Self-Administration of Medication assessment indicated that the individual was able to receive objects from the nurse, grasp a cup, and raise the cup to her mouth. Rather than build upon these skills, it was recommended that the individual continue a SAP to come for medicine when called even though the individual was noted not to recognize her own name. The content of the SAP reflected a compliance-oriented rather than communication-oriented teaching strategy.
- For Individual #264, two informants used for the Vocational Assessment provided substantially different ratings about the individual's personal interaction styles, work abilities, tolerance for change, and ability to learn complex tasks. The ISP did not discuss or address the divergent scores.
- Individual #264 was recommended to participate on a different employment contract due to perceptions that she was bored with the existing contract work. Despite concerns regarding task preferences, when assessed for the new contract, documentation did not include information about the individual's preference for or

#	Provision	Assessment of Status	Compliance

enjoyment of the new contract work, but only whether she had the ability to perform the work tasks.

It was a positive step that the ISP process and assessments were suggested to be more thorough and better utilized than in the past. Nevertheless, the limitations noted suggested that the Facility should continue to develop and improve the new ISP procedures and provide additional training and/or coaching to improve the use of information from assessments when selecting habilitation services and goals for learning.

Teaching New Skills

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 essential 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 elements are lacking, the ability to provide adequate habilitation services is severely compromised.

As noted above, it was agreed with the Facility that only SAPs from the two most recent ISPs would be included in the current review. As the two individuals associated with the ISPs had each been provided two SAPs, the current sample consisted of four SAPs. The table below reflects the degree to which SAPs included the necessary components.

Area	5/2010	11/2012	8/2013
Plan reflects development based upon a task analysis	0%	30%	0%
Behavioral objective(s)	0%	40%	50%
Operational definitions of target behavior	0%	0%	25%
Description of teaching conditions	0%	0%	75%
Schedule of implementation comprised of sufficient trials for learning to occur.	0%	0%	0%
Relevant discriminative stimuli	0%	80%	50%
Specific instructions	0%	10%	0%
Opportunity for the target behavior to occur	0%	60%	100%
Specific consequences for correct response	0%	100%*	75%
Specific consequences for incorrect response	0%	100%*	25%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%

#	Provision	Assessment of Status	Compliance

Documentation methodology	0%	90%	0%

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

Some relative strengths noted in the current sample of four SAPs included the following.

- Four of four SAPs (100%) included the opportunity for the behavior being taught to occur. This suggested an improvement from the previous site visit.
- Three of four SAPs (75%) included adequate descriptions of teaching conditions. This suggested an improvement from the previous site visit.
- Three of four SAPs (75%) included adequate consequences for correct responses. Due to limitations during the previous site visit, status cannot be assessed.

There were also noted to be several areas in which relative weaknesses were noted in the four SAPs.

- None of four SAPs (0%) reflected development based upon a task analysis even though the skills being taught and structure of the SAP suggested a task analysis to be appropriate. This was suggested to be a regression from the previous site visit.
    - For Individual #120, the SAMS assessment indicated that the individual was able to receive objects from the nurse, grasp a cup, and raise the cup to her mouth. It was likely that a task analysis, if conducted, could have identified additional skills that would build upon the three skills already demonstrated. Instead, a task analysis was not conducted and the SAP targeted compliance with staff requests.
    - For Individual #264, it was indicated that training was necessary to teach the individual to complete new work tasks in a specific order. Identifying the necessary order of sub-tasks in a larger skill is one purpose of conducting a task analysis. Such a task analysis would likely facilitate learning and simplify the data collection process. There was no indication that a task analysis had been completed.
- One of four SAPs (25%) included adequate operational definitions of behavior. This was suggested to be a modest increase from the previous site visit.
    - For Individual #120, the target of the SAP was indicated to involve teaching the individual to manipulate her radio. Operational definitions of the skill being taught, however, included only selecting and opening a CD.
- None of four SAPs (0%) included specific instructions on how to implement the SAP. This was essentially unchanged from the previous site visit.
    - For Individual #264, the instructions described that staff were to sign "trash" to the individual, point to the visual schedule, and then sign "gloves to the individual. Staff was then to model putting on and removing the gloves. In the SAP and ISP, there was no indication of what the individual

#	Provision	Assessment of Status	Compliance
		did incorrectly concerning putting on and taking off gloves. A number of errors were possible, such as putting gloves on the wrong hands or not inserting her fingers into the appropriate glove fingers. The only instructions to staff were to demonstrate putting on and taking off the gloves. Without specific instructions to address the identified errors, the potential for not teaching the necessary skills to the individual was increased. • One of four SAPs (25%) included specific consequences for incorrect responses. Due to limitations during the previous site visit, status cannot be assessed. One example of the lack of a specific consequence is presented below. o For Individual #264, the following instructions were provided as a consequence for an incorrect response. If performed as written, this consequence held the potential to strengthen the use of physical aggression as an escape method. "*Provide the next level of assistant (sic). If [the individual] becomes frustrated, staff should back away and give her a five-minute break. If [the individual] expression (sic) aggression once she has taken a break, staff should discontinue the trials.*" If physical aggression was a potential response to the SAP, an SFA should have been completed to determine the function of the aggression. In addition, data regarding physical aggression should have been collected and reviewed to determine if physical aggression did increase after having resulted in escape. An SFA was completed, but physical aggression was not targeted in the assessment procedures. The lack of physical aggression as a target could have been an error or might have reflected the low frequency of physical aggression. • None of four SAPs (0%) included a specific plan for the maintenance and generalization of the skill learned. This suggested a modest improvement from the previous site visit. o For Individual #120, the plan for generalization lacked specific instructions about teaching strategies and procedures for monitoring skill utilization. The statement below comprises the entire generalization strategy included in the SAP. "*This skill can be used in the community, at a group home, home visit and anywhere that [the individual] may need to be independent in following simple directions. This skill will promote her independence and allow her to succeed in community placement through medication administration and directions.*" • None of four SAPs (0%) included adequate procedures for documenting program	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
implementation. This suggested a regression from the previous site visit.
o For Individual #264, data collection instructions required staff to circle the level of prompting required for success. As the program included in a single step multiple tasks the individual had not mastered in sequence, it was likely that several prompts of varying intensity could be required for success. There were no instructions as to which level of prompting would be documented on the data form. As discussed above, had a task analysis been conducted as part of the development of the SAP, it was possible that the task analysis would have led to a chaining procedure for teaching the skills, If so, this could have simplified the data collection process by requiring only one prompt level to be recorded.

Although comparisons must be interpreted with caution due to the small sample size of four, the new ISP procedures appeared to offer mixed results, with some areas suggested to have improved while others had regressed. It should also be noted that, although the ISP process had changed, the procedures for writing the SAPs had not yet changed. Beginning in September 2013, however, RSSLC indicated a substantially revised SAP development process was scheduled to begin. Based upon the four most recent SAPs, as well as previous examples of SAPs, at the time of the current site visit, documentation reflected that SAPs continued to lack the components necessary for skill acquisition.

<table>
<tr><td></td><td>5/2010</td><td>11/2012</td><td>8/2013</td></tr>
<tr><td>Overall, the set of skill acquisition programs promote growth, development, and independence</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

<u>Implementation of formal and informal skill acquisition training</u>
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.

<table>
<tr><td></td><td>Staff Present</td><td>Individuals Present</td><td>Individuals Functionally Engaged</td><td>Percent Functionally Engaged</td></tr>
<tr><td>San Antonio</td><td>4</td><td>14</td><td>11</td><td>79%</td></tr>
<tr><td>Leon</td><td>3</td><td>9</td><td>1</td><td>11%</td></tr>
<tr><td>Workshop</td><td>3</td><td>8</td><td>8</td><td>100%</td></tr>
<tr><td>Workshop</td><td>3</td><td>4</td><td>2</td><td>50%</td></tr>
</table>
</td><td></td></tr>
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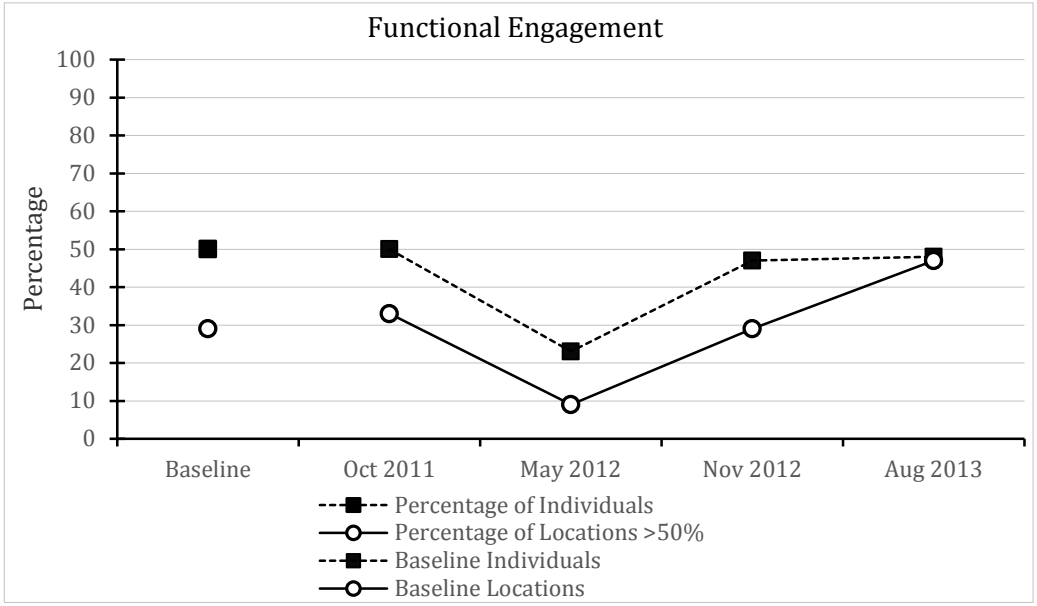
Workshop	4	6	3	50%
Sabine	2	2	0	0%
Lava	5	5	0	0%
Guadalupe	1	8	1	13%
Guadalupe	3	8	1	13%
Sabine	3	7	3	43%
Trinity	8	7	7	100%
San Antonio	9	11	8	73%
Leon	8	14	8	57%
Leon	3	3	1	33%
Leon	5	9	0	0%
Trinity	2	8	3	38%
Trinity	1	4	4	100%
Total percentage of individuals functionally engaged				48%
Percentage of locations with greater than 50% functional engagement				47%

Longitudinal data involving functional engagement are presented in the graph below.



Based upon the observations conducted during the current site visit, it was evident that

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		overall functional engagement had increased from 47% in November 2012 to 48% of individuals in August 2013. Observations did reflect that eight of the 17 observed locations (47%) reflected functional engagement for at least 50% of the individuals present during the observation. This increase represented a substantially improving trend that began with a low of 10% of locations in May 2012 and that progressed through the 30% of locations noted in November 2012.. In addition to reflecting progress since May 2012, the current level of locations with adequate functional engagement much higher than noted at baseline. As noted in the table above, some locations at RSSLC were observed to have high levels of functional engagement. In these settings, not only were functional activities provided, but staff was also observed to interact with and support the individuals present. • On the patio outside of San Antonio D, several activities such as music, art, snacks, and music were provided to individuals who lived at that residence. Staff floated from individual to individual, and made frequent use of prompts, praise, and informal teaching. Individuals were smiling and interacting. As both staff and individuals demonstrated familiarity with the activities and materials, it was suggested that the observations reflected a common occurrence. Despite improvements noted in functional engagement in some locations, there were places at the Facility where the lack of functional engagement was concerning. • On the patio outside of Leon C, individuals were observed sitting about with few materials available and little interaction from staff. One individual began running about the courtyard. Staff chased the individual and made him sit on a bench away from others. No investigation of reasons for the running was conducted. Shortly after being required to sit alone, the individual began to scream and repeatedly hit his thigh. Staff ignored the individual's behavior. No activities were available either to provide opportunities for learning, or at least to provide preferred activities that might encourage the individual to remain engaged. Furthermore, seating the person away from others might be considered time out from reinforcement, a punishment procedure for running, depending on whether being with other people was or was not a reinforcer. • In the Guadalupe residence, an individual was observed sitting in front of a television. The television was on, but the sound was turned off. Although the individual had not attended to the television and had been looking about the room at peers, staff walked over to the individual, stated, "Let me turn that up for you", and walked away. The individual did not orient toward the television following this, but continued to watch peers. It would have been appropriate for staff to have offered choices of activities to the individual, and then acted to ensure that the selected activity was provided. Alternatively, an informal training could have been done to teach the individual to turn up the sound independently or to engage in	

#	Provision	Assessment of Status	Compliance
		socialization with peers. Based upon the information provided as part of the site visit, the ISP process was suggested to have improved somewhat, although conclusions were precluded by the limited sample. SAPs reflected minimal changes from the previous site visit. It was noted that the percentage of locations with functional engagement for more than 50% of individuals had improved substantially. Despite the noted improvements, the Facility had not progressed sufficiently to gain substantial compliance with the Settlement Agreement.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	A sample of two ISPs, the number limited by the recent implementation of a new ISP process, precluded an in-depth appraisal of the adequacy of the ISP process. Information presented in Provisions K.5, K.6, and K.7, as well as S.1, of this report, suggested that limitations did exist in relation to the provision and use of various assessments. • Although 91% of individuals living at the Facility were provided a Psychological Evaluation report or Psychological Update report, essentially none of those reports involved timely intellectual and adaptive skill assessments. The Facility indicated that such testing was seldom conducted on a routine basis. • Facility tracking data suggested that 39% of all individuals with PBSPs had not had the associated assessment reviewed or updated in over a year. • Only 10% of reviewed SFAs included a differentiation between learned behavior and symptoms of mental illness. • Only one of four available SAPs (25%) reflected development based upon adequate skill and clinical assessments. • None of the four SAPs (0%) reflected development based upon a task analysis even though the SAPs included steps such as included in a task analysis or targeted skills for which a task analysis would have been appropriate. Without a task analysis, it would be difficult to determine an individual's current skills relevant to the goals of the SAPs. The small number of ISPs limited the ability to interpret the use of assessments. Nevertheless, it was not evident that the assessments 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.	Noncompliance
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,		

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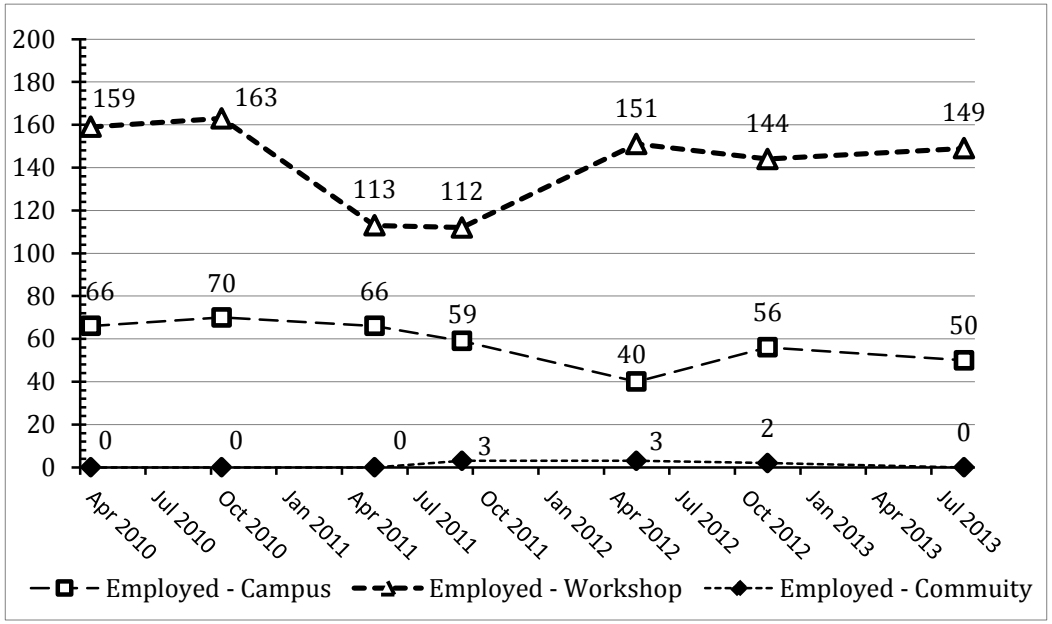
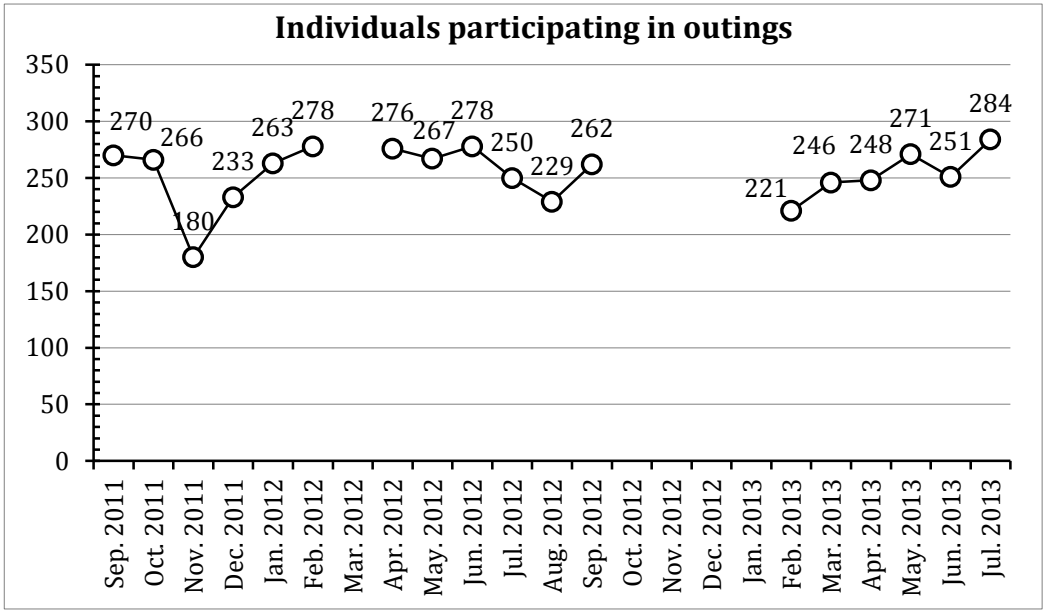
	education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As noted in Provisions S.1 and S.2 of this report, several limitations were noted in the four most recent SAPs, as well as the assessments included in the ISPs the produced those SAPs. The recent changes in the ISP process precluded review of further SAPs. Furthermore, the Facility reported that a new SAP development process was scheduled to begin implementation in September 2013. Based upon these factors, it was not possible to conduct a comprehensive review of SAPs at the time of the current site visit. Regarding the SAPS that were provided, each ISP resulted in two SAPs for each individual. It was not evident that the necessary consideration had been given to identifying specific needs or to developing interventions that were likely to increase either individuals' skills. Only one of the four SAPs (25%) was clearly derived from the provided clinical assessments, and none of the four SAPs (0%) reflected the use of a task analysis. Furthermore, as noted previously, SAPs appeared to emphasize training each individual to comply with requests rather than to develop skills that might lead to greater independence. Based upon this review of the ISPs and SAPs, it was not apparent that the skill acquisition plans addressed the specific needs of each individual. In addition, the focus upon compliance rather than skill acquisition substantially limited the degree to which the SAPs were functional for the individuals.	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 persons residing 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 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 additional community employment opportunities had been created beyond the three individuals documented during the previous site visit. In November 2012, campus employment had increased by almost half to a total of 56 individuals. At the same time, workshop employment and community employment	Noncompliance

#	Provision	Assessment of Status	Compliance
		decreased. Current Site Visit Of the four SAPs submitted by the Facility, none (0%) included a specific strategy for implementation in the community. In consideration of the skills targeted, such as coming to the medication cart when called and completing a specific job sequence, it was not evident that any of the SAPs could be taught as described in any location other than at RSSLC. It therefore did not appear that the Facility had considered the need for or process of providing community instruction when developing the SAPs. During the current site visit, campus employment had decreased by six, with a total of 50 persons employed. Two jobs had been lost in the community resulting in no community employment opportunities. At the same time, workshop employment increased to 149 individuals.  In order to address the lack of community jobs, the Facility indicated that an aggressive effort to locate and develop community employment opportunities had been developed. This plan involved contacting via telephone and in person a minimum of 17 potential employers each week. In addition, the Facility was developing educational materials for	

#	Provision	Assessment of Status	Compliance
		community employers, business organizations, and families, to increase awareness of RSSLC and emphasize the vocational abilities of individuals living at the Facility. Information provided by RSSLC reflected that community outings had remained relatively stable since the previous site visit, although data for the final three months of 2012 was not reported.  The Facility did not provide specific information about the provision of skill acquisition training in the community. The Facility did indicate, and documents reviewed during the site visit supported, that SAPs contained substantial weaknesses. RSSLC indicated that the new SAP development process would target both Facility and community SAPs. Based upon available information, RSSLC was not in substantial compliance for Provision S.3.b.	

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 8/09/2013 2. Richmond State Supported Living Center Action Plans, updated 8/07/2013 3. Richmond State Supported Living Center Settlement Agreement Presentation, dated August 2013 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 8/11/11 9. RSSLC Policy G.5 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement, Revised 8/11/11 10. RSSLC Policy G.05.1 Admitting/Moving Individuals: Community Exposure, Revised 9/11/11 11. RSSLC Policy G.6.1 Admitting/Moving Individuals: Post Move Monitoring, Revised 8/11/11 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. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 15. Since last on-site review, a list of all individuals who have been referred for placement 16. 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" 17. Since last on-site review, a list of all individuals who have died after moving to community living 18. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 19. For the last twelve months, a list of individuals who were reported to have been assessed for placement 20. Community Placement Report, dated Monday, August 26, 2013 21. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 22. Community Transition Process from a SSLC 23. Annual Report: Obstacles to Community Transition, Fiscal Year 2012, dated November 2012 24. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 25. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #177, #261, #290, #298, #372, #399, #480, #499, #569 and #612 26. Staff CLOIP Questionnaires from July 29, 2013 and August 5, 2013 27. Individual Support Plans (ISPs) including assessments for Individuals #27, #82, #106, #107, #120, #155, #264, #320, #630, and #753

	28. Completed CLDPs for Individuals 29. Partial CLDPs for Individuals #162, #164, #508, #511, #711 and #748 30. CLDP Assessment Checklist, undated 31. Pre Move Site Reviews for Individuals #81, #113, #213, #267, #459, #463, #480, #685, and #728 32. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #81, #113, #213, #267, #459, #463, #685, and #728 33. Completed Post Move Monitoring (PMM) checklists for Individuals #81, #113, #115, #152, #213, #267, #315, #369, #405, #459, #463, #480, #685, and #728 34. Discharge Summaries and assessments for Individuals #287 and #624 **People Interviewed:** 1. Terri Carter, Acting Admission/Placement Coordinator (APC) and Post Move Monitor 2. Cynthia Newton, DADS Consultant 3. Latonya Akorede, Transition Specialist 4. Corneshia Fowler, Transition QIDP 5. Georgette Brown, QA Director 6. David Savage, QA Auditor 7. Angela Hernandez, QIDP Educator 8. Davondra Brown, Director of Education and Training 9. Cynthia Fannin, Assistant Director of Programs (ADOP) 10. Dr. Tran Quan, Medical Director 11. QIDP for Individual #165 **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #120 and #264 2. Pre-ISP meeting for Individual #324 3. PMM visit for Individual #267 4. CLDP for Individual #165 5. Self-advocacy 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, as its QA/QI processes for this Section were essentially non-existent at this time. The Facility should use 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 focused recommendations being provided in the Monitoring Team's current 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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. This would change the focus of the Action Plans from measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. 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 the following Provisions: T1c1, which requires the Facility to specify actions to be taken to implement the CLDP in coordination with provider staff; 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; T1c3, which requires the CLDP to be reviewed with the individual, and LAR as appropriate, to facilitate their decision-making; T1e, which requires the Facility to verify essential supports are in place prior to an individuals' transition to the community; and T1h, the issuance of the Community Placement Report. The Monitoring Team concurred with Facility findings of substantial compliance and noncompliance for T1c2, T1c3, and T1h, but did not concur for T1g. For Provision T2, the Facility self-rated substantial compliance in Provision T2a due to timely completion of all PMM visits and reports. The Monitoring Team could not substantiate compliance due to deficiencies in the monitoring process during this particular PMM visit and concern noted about the diligence of the PMM process. 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 rated itself as substantially compliant. The Monitoring Team found that two alternate discharges had occurred but one was not completed in compliance with CMS discharge requirements.
	Summary of Monitor's Assessment: The Monitoring Team continued to find noncompliance for the Section. More work remained to ensure transitions were effectively planned and successfully implemented. Positive developments noted included increased integrated discussion by Interdisciplinary Teams (IDTs) and additional 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. It was noted that RSSLC was making significant changes to its approaches to the interdisciplinary processes supported the ISP planning. The Facility requested the Monitoring Team to focus its review on two ISPs held during the monitoring visit to provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope. The findings and recommendations found below and throughout this section should be read within this context. Overall, the Monitoring Team was impressed with the effort and resources devoted to this initiative and believed it held promise for future

	development. The Monitoring Team found there was progress in the implementation of the ISP process, particularly in one of the on-site ISP annual planning meetings, but significant deficits remained that continued to hamper efforts to develop and implement adequate transition planning. Other specific findings are detailed below: For Provision T1, nine individuals had transitioned to community living and there were 13 active referrals. The Monitoring Team did find substantial compliance for Provisions T1c2 and T1h. Respectively, these addressed the identification of Facility staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed and, the issuance of the Community Placement Report. 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. 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. The Monitoring Team recommends an additional layer of formalized 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 two Alternate Discharges during the past six months; one of these was not completed in compliance with CMS discharge planning requirements and DADS policy related to providing an appropriate post-discharge plan of care.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a	<u>Transition Outcomes During Last Six Months:</u> • Community Transitions: The number of community transitions showed a stable or increasing trend. o There were nine transitions to community living in the last six months.	Noncompliance

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	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.	With 340 individuals currently living at RSSLC, this represents approximately three percent of the population. This figure was a decrease over previous monitoring periods for which 15 and 17 individuals had transitioned during each six-month period respectively. o The transition process took more than 180 days for seven of the nine (78%) individuals. • Referrals for Community Transitions: o The number of community referrals indicated a decreasing trend as well. Eight had been made in the past six months, according to the Community Placement Report. o Thirteen individuals were on the active referral list (approximately four percent of the current population at RSSLC). o Five of the 13 (38%) individuals had been on the referral list more than 180 days; only one had been on the list for more than one year. • Individuals requesting placement, but were not referred: Of the nine individuals who requested placement during this six months, but were not referred, three (33%) had an LAR who made this decision. • Rescinded Referrals: o There were three rescinded referrals reported since the last review. o Of these, the reasons for the rescinding appeared to be well-documented by the IDT for each (100%). All three were rescinded due to LAR choice. • Returns from Community Placement o No individuals had returned from a community placement. This number of individuals who returned to the SSLC after a failed community placement indicated a stable trend over the previous two monitoring site visits. • Deaths Following Community Placement o Since the last onsite review, there had been three deaths of individuals who had moved from RSSLC to the community. None had occurred within the 90-Day PMM period, but one did occur within approximately six months after transition. • Other Adverse or Unexpected Outcomes o One of nine (11%) individuals who transitioned in the past six months had experienced an unexpected hospitalization due to a bowel obstruction. This occurred approximately three months after transition and just shortly before the 90-Day PMM visit. Another individual died of a heart attack just a little over six months after transition. As reported in Provision L1, the Monitoring Team noted significant concerns with multiple examples of clinical issues not being adequately	

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		represented at the CLDP meeting for the latter individual, nor expressed within the context of the CLDP report. In addition, the post move monitoring assessment this individual was devoid of specific monitoring parameters for the individual's clinical issues. There was no documentation provided of any review conducted by the Facility to determine if changes in the referral and transition planning processes at the Facility should be made. See also Provisions T1e and T2a. 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, and, more importantly, whether this information should lead to specific improvements in the CLDP and transition process. <u>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting:</u> 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. Actions included: • RSSLC had created a Transition QIDP pilot position to assist IDTs to develop appropriate CLDPs. This position was to be assigned to lead the development of the CLDP document. • RSSLC had assigned its two Transition Specialists to assist IDTs with referrals that were approaching or had exceeded 180 days. This appeared to have been successful in achieving a number of transitions. • <u>Conclusion:</u> 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	<u>Policies and Procedures related to transition and discharge processes</u>: At parties' meetings in July 2012, the parties agreed that the Monitors would rate Provision T1b as just the development of an adequate policy. The sections T1b1 through	Noncompliance

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	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:	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.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	<u>Status of Process and Training on ISP Development:</u> The Facility continued 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 as it related to identifying the services and supports needed in the most integrated setting, the obstacles to movement to the most integrated setting, or the development of strategies to address those obstacles. 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. <u>Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting:</u> 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 compliance with Provisions F.1.d, F.2.a.1, and F.2.a.3. Additional details are provided in the sections of this report that address these provisions. For the two focus ISP annual planning meetings held during the monitoring visit, neither (0%) adequately described the services, supports and protections that would be needed in a more integrated setting. For example, for Individual #120, all of the IDT members indicated the individual could be served in the community, but identified only the following protections services and supports: 24 hour supervision in a PICA safe environment, a fenced back yard with a covered patio, and a private room and bathroom. <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:	Noncompliance

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		• Individual's reluctance for alternate placement • LAR's reluctance for alternate placement • Lack of supports for people with significant challenging behaviors • Lack of availability of specialized therapy supports • Lack of availability of specialized medical supports • Lack of funding due to an individual's legal and citizenship status • Lack of specialized mental health supports • Need for environmental modifications to support the individual • Need for services and supports for persons with forensic needs/backgrounds • Lack of specialized educational supports • Need for transportation modifications to support the individual Overall, the Monitoring Team found that obstacles to transition were not yet consistently addressed by the IDTs. None (0%) of the eight sample 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 few of the ISPs, the teams indicated in the narrative they would develop a plan, but the Action Plans found were generic. For example, for Individual #753, the obstacle identified was LAR choice. The action plan stated "continue educating" the LAR on community living options, with follow-up to be made annually or as needed. The Monitoring Team was unfortunately not able to observe the entirety of one of the focus ISP annual meetings, due to the length of the meetings, but was able to observe one to conclusion and reviewed both of the finalized documents after the site visit. Overall, as an example of the IDT's process in identifying and addressing obstacle to transition, these meetings still failed to demonstrate proficiency. In both cases, as described above, the disciplines did not identify barriers in their assessments, but went on to conclude as the Facility's professional team that obstacles did exist, in that he individuals' preferences were unknown. Both IDTs developed Action Plans related to individual awareness, but these tended to be written as staff interventions and/or service objectives (SOs), without an adequate methodology for evaluating change in the individuals' awareness or ability to communicate a preference. There was some improvement noted in the creativity and integration of the IDT strategies that could serve as the basis for an adequate plan, however. Examples included: • For Individual #120, the IDT planned to obtain a CLOIP workbook, which illustrates community living options, to review with the individual on a repeated basis to prepare for tours and as a tool to reinforce awareness that may have been gained during the actual tours. The Monitoring Team was pleased to see the IDT developing a strategy that acknowledged the experiential learning needs	

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		of the individual. The Action Plans also indicated there would be an SO for staff to review the CLOIP materials with the individual once each day and for the individual to make a discernible preference about living options. There was a written SO included, but it did not provide an adequate description of the steps for staff to use in presenting the materials or any description of how the individual's "discernible preference" would be gauged. The Action Plans indicated data was to be documented on a data sheet/progress note, but the data was related only to participation and not whether any learning had occurred or preference discerned. There was also no information in the SO that indicated how this would be used to support her participation in tours. Overall, there were good ideas but they were not developed into a meaningful or measurable plan. • For Individual #264, the IDT indicated the obstacles included both individual and LAR lack of awareness. Despite a living options discussion that tended to cause the LAR to become increasingly vociferous about her opposition, there was an agreement the QIDP would engage the LAR in a monthly conversation to share living options information. The Monitoring Team was pleased to see the IDT developing a plan that did not limit interaction with the LAR on this subject to one time a year. Overall, however, the Action Plan related to living options lacked any real specificity as to the methodologies or desired outcomes; rather they were very general in nature and not captured in an integrated written SO. The steps included were: o Develop a way for staff to communicate to the individual about living options. o Develop a rapport with the LAR in an effort to provide living options information. o The individual "should have the opportunity" to go on more community tours, including day programs o Develop strategies to help the individual deal with anxiety in unfamiliar territory. Again, there were good ideas but they were not developed into a meaningful or measurable plan. For this individual, there were a number of other opportunities to integrate living options awareness with leisure preferences and important relationships, but this integration did not occur. <u>Preferences of Individuals and LARs</u> In addition to the description of Facility progress and continuing needs in this area included in the discussion in the previous paragraphs, the Monitoring Team reviewed a sample of eight completed ISPs. None resulted in a referral. Of these, none (0%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational	

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		activities). For the most part the documentation indicated the individual's preference was unknown. Preferences of LARs and families for living arrangement continued to be more often understood and documented. The Facility was providing some opportunities for families and LARs to learn more about community options, but these were limited, as described in Provision T1b2 below, and many families were not interested in participating in them. The annual ISP process typically did not lend itself to a comfortable discussion of community living opportunities, as described above and in Provision F1e. <u>Conclusion:</u> This provision was found to be not in compliance.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	<u>Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices:</u> 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: <u>An Individualized Plan For Each Individual</u>: As described in Provision T1b1 above, the Monitoring Team did observe some progress in the IDTs' development of strategies that addressed the individual's learning needs, for Individual #120. In eight sample ISPs, however, 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 none of the eight (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 Facility did not yet succeed in developing individualized plans for community education and awareness. <u>An Annual Provider Fair:</u> The Facility had held its most recent semiannual provider fair on May 30, 2013. Ninety-six individuals and one family member were reported to have participated. Another fair was held on November 30, 2012. For the November Fair, the attendance sheets indicated 31 individuals and two family members participated, although the Self-Assessment data reported by the Facility put those numbers at 58 and three respectively. <u>Regular SSLC Meeting With Local LAs</u>: The Admissions and Placement staff continued to meet jointly with local LAs and transition staff from Brenham State Supported Living Center on an occasional basis, usually quarterly. There was no set or formal agenda, but topics of discussion were reported to be status of admissions and discharges, forthcoming referrals, and any other activities related to transitions.	Noncompliance

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		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. It had been reported during the previous monitoring visit that a plan was being developed to track such Action Plans once initiated by the IDT. This process would require the QIDP 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. There was no evidence provided as to any progress made on this strategy. • 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 requested for review a sample of ten CLOIP Worksheets selected at random from ISPs held in June 2013. For these individuals, the Facility provided current CLOIP Worksheets for only four of the individuals; the remainder were from the previous year or, in three instances, from 2011. Only one of the four individuals with a current worksheet actually participated in the CLOIP process, and was reported to not have been receptive to the information. DADS should assess how the CLOIP process, materials and/or information might be modified to more effectively meet the needs of the individuals. Tours Of Community Providers: There did not yet appear to be a consistent, formalized 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 ten names of those who had participated in CLOIP community tours. In April through the most of July 2013, for various reasons, no individuals living at RSSLC participated in any tours. In some cases, the homes to be toured cancelled; in others, RSSLC staff and individuals did not show up for the scheduled tours. As this was the only	

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		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. • 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 still not a consistent or formalized process described for choosing tour sites based on individual preferences and needs. It had been reported at the time of the last monitoring visits that the Transition Specialists would be assigning individuals to specific tours based on the preferences and needs described in their ISPs and Action Plans. This had not yet been effectively implemented. • 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, when they occurred, appeared to be conducive to both individual learning and assessment of responses. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the most integrated setting. RSSLC had reported during the last monitoring visit that it had 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 had been 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, it had also reported at that time that this process was not yet being effectively or consistently implemented unless an individual had been referred for transition planning. There was no evidence provided this process had been improved since that time. Staff had begun completing a CLOIP questionnaire to be submitted to the APC's office related to their impressions of the homes they toured, but these did not document individuals' responses. Opportunities Are Provided To Visit Friends Who Live In The Community: The Facility indicated there had been some opportunity for individuals to visit with friends who had moved to the community, but there was no specific evidence or documentation provided	

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		regarding this activity. 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 prior to this monitoring site visit, the Facility provided documentation for eight staff participating in such activities, including tours and visits. Staff also had the opportunity to attend the semi-annual Provider Fairs and the Facility documented 44 staff who attended in November 2013, but did not provide documentation of attendance or other information related at the Provider Fair held in May 2013. The Facility also included training regarding community integration and the *Olmstead* decision in new employee orientation on a regular basis. 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. There had been some materials developed, but the Facility had been unable to make use of them due to HIPAA requirements. Conclusion: This provision was found to be not in compliance. The Monitoring Team commends the efforts of the Facility toward promoting education and awareness. Overall, RSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness, as described in Provisions T1, F1 and F2. IDTs continued to need additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual. 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	Assessment Practices Pursuant to Transition and Discharge Policies and Procedures:	Noncompliance

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	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.	In describing its process for assessing individuals for community living, the Facility provided a document entitled "Community Transition Process from a SSLC," dated June 2013. The Facility provided a list that indicated 233 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, the IDTs continued to lack proficiency in identifying 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 yet 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. Only 49% of the assessments for a sample of eight recent ISPs made a statement as required. Even for the two new ISPs held during the monitoring visit, not all assessments included this recommendation. In many 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. • For eight recently completed ISPs, there were a total of 68 discipline-specific assessments reviewed. Of these, 33 (49%) included a determination of whether the individual could be served in a less restrictive setting. • Of the 33 assessments reviewed that did make a determination, seven (21%) included recommendations for how the individual's needs could be met in a more integrated setting. These findings are discussed further in Provision F1e. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team	

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		found there was not an adequate formal assessment process that included a substantive interdisciplinary evaluation and discussion.	
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 APC was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. She indicated she intended to designate the Transition QIDP, a newly created pilot position, to take on this responsibility. 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 7/1/2013. <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. The Monitoring Team reviewed a sample of four completed and three CLDPs in progress for referrals made during the past six months. Overall, the Monitoring Team found that documentation was more frequent and more detailed once the Transition Specialists were designated to maintain the referral status updates, so this appeared to be a successful modification to the process: • Six of the seven (86%) CLDPs were initiated within 10 calendar days of referral as required by policy. o Individual #748 was referred on 7/1/13, but the Facility had not yet initiated the CLDP document as required by DADS Policy 018. • Four of the four (100%) completed CLDPs included adequate documentation to show that they were updated throughout the transition planning process. • Two of three (67%) CLDPs in progress included adequate documentation to show that they were being updated throughout the transition planning process. • For one of three (33%) individuals whose referrals had been rescinded in the past six months, the Facility did not provide documents which would have demonstrated the level of activity had been undertaken to achieve a transition during the active referral period. Rather, it indicated this CLDP had not been started because the referral had been rescinded before the process began, but the original referral meeting date was documented as having taken place in May 2012. The Monitoring Team reviewed an updated Community Placement Report, updated on August 26, 2013 covering the previous six months. Seven of the thirteen (54%) current referrals had exceeded the 180 days allowed in the current policy. Five of the nine (55%) 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	Noncompliance

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		exceeded. DADS policy 019 also acknowledges this and provides an avenue to apply for and receive a waiver when needed. One of the two Transition Specialists had been assigned to work 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. This appeared to have been successful in achieving transitions for seven individuals who had been on the referral list for more than 180 days. 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 APC's office 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. 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. <u>Development of CLDP in coordination with the LA:</u> 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. <u>Conclusion:</u> 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/Placement Office was making use of the two Transition Specialist positions in a manner that should contribute to a timelier outcome for most individuals. It would also be helpful for the APC 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. There did remain, however, 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	<u>Actions to be taken by the Facility Specified:</u>	Noncompliance

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	to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	None of four completed CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed in the below six bullets occurred adequately and thoroughly. • Training of community provider staff, including staff to be trained and level of training required. There were materials and in-service signature sheets provided for each of the four CLDPs reviewed, but the CLDP itself did not typically specify the level of training that would be provided or the competency achieved by those trained. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). Collaboration with community providers was typically limited to the doctor to doctor consultation. The Facility may want to consider how and under what circumstances this model may also be effectively applied in other disciplines. • Assessment of settings by SSLC clinicians (e.g., OT/PT) • Collaboration between provider day and residential staff is ensured • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community) • Collaboration between Post-Move Monitor and Local Authority staff Four of the four CLDPs reviewed (100%) did clearly identify a set of activities to occur on the day of the move and the responsible staff member. There was not always documentation that the activities did indeed occur, although for one individual there was a personal possessions inventory signed by the RSSLC representative and the provider staff. <u>Coordination of CLDP with provider staff:</u> A review of completed CLDPs indicated provider staff were typically involved throughout the CLDP process. In four of four (100%), there was documentation of training of provider staff, visits by the individual to the provider sites and the individual's responses, and provider staff attendance at the CLDP. In addition, provider staff participated in the CLDP for Individual#165 held during the monitoring visit. <u>Conclusion:</u> 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.	<u>Responsible staff identified for needed actions:</u> 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. <u>Completion timeframes for needed actions identified</u>: For four of four (100%) completed	Substantial Compliance

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		CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. Conclusion: This provision was found to be in substantial compliance.	
	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 Monitoring Team reviewed the documentation for four completed CLDPs and three CLDPs in process, for a total of seven, to assess compliance with this provision. For six of seven (86%), 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. The remaining CLDP had not been initiated, so it was not possible to assess the level at which any transition activities may have been reviewed with the individual and LAR in the process. See Provision T1c. Conclusion: Although the Facility did not provide one of the requested CLDPs, this provision was found to continue to be in compliance, as 100% of sampled CLDPs had evidence of review with the individual and LAR. At the next compliance visit, in order to ensure continuing compliance, the Facility must take care to provide all requested CLDPs and supporting documentation.	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 Acting APC 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 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 T1e below, 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,	Noncompliance

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		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 #165, whose CLDP was held during the monitoring visit. The Monitoring Team found there were significant issues that could impact a safe transition to community living that were not adequately addressed in the assessments nor discussed at the CLDP meeting until raised by the Monitoring Team. For example: • There was evidence in the record that the individual was potentially at risk for sexual victimization, including two related incidents during this past year and reports that the individual was known to leave the residence on occasion through her window without staff knowledge. This issue was not adequately discussed in any assessment. • As discussed in Provision L1, the Monitoring Team noted significant concerns with multiple examples of clinical issues not being adequately represented at the CLDP meeting, nor expressed within the context of the CLDP report. The Monitoring Team met with leadership, including the medical director, to discuss specific concerns with the CLDP process. The medical director concurred with the Monitoring Team's concern, and made assurances that the process would be enhanced. The Monitoring Team also met with the Facility's medical staff, to review concerns with the medical providers' participation in the CLDP process. <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. Specifically, to move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: • RSSLC should renew its efforts to develop an adequate quality assurance mechanism to ensure the adequacy, accuracy and comprehensiveness of assessments for use in the CLDP, as well as to support all other planning purposes for individuals at the Facility. As discussed with leadership, this might include implementing a pre-CLDP meeting by the IDT to review the assessments to identify and resolve any discrepancies or concerns. • As discussed with leadership, increase the participation and responsibility of the individual's QIDP in the CLDP process. • As reported in Provision L1, medical providers must ensure that all clinical issues are fully explored at the CLDP meeting, and clearly delineated within the context of the CLDP report. The risks associated with each medical condition, specific monitoring parameters for each condition, and all necessary supports	

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		and services must be clearly delineated on the CLDP, and expressed at the CLDP meeting. All clinical professionals and clinical services must be obtained prior to discharge from the Facility.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	<u>Identification of Pre and Post Move Supports</u>: In none of the four completed CLDPs reviewed (0%) was there identified a comprehensive set of pre and post move supports, in measurable/observable terms, to be implemented. This was also found to be true for the CLDP for Individual #165 observed while the Monitoring Team was on-site. This finding was based on an evaluation of presence or absence of each of the following criteria: • The list was comprehensive and inclusive, demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. o All safety, medical, healthcare, risk, and supervision needs were addressed. o What was important to the individual was captured in the list of Pre and Post Move supports. o The list of supports thoroughly addressed the individual's need/desire for employment. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of Pre and Post Move supports. o There were Pre and Post Move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. o There were Pre and Post Move supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. o Topics included in training had a corresponding Pre and Post Move support for implementation. • The wording of every Pre and Post Move support was in appropriate, measurable, and observable terms. • Every Pre and Post Move support included an adequate description of what the Post Move Monitor should look for when doing PMM (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. • Any important support identified in the assessments or during the CLDP meetings that was not included in the list of Pre and Post Move supports has a rationale as to why it was not included.	Noncompliance

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		Examples of deficiencies as to the above criteria in the CLDPs reviewed included: • For zero of four CLDPs (0%) reviewed was there sufficient descriptions or adequately defined criteria. No evidence was developed for the CLDP for Individual #165 held during the monitoring visit. There was no significant progress noted in the description of the evidence that was required to demonstrate a support was adequately in place. The CLDP 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. This is 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 she should observe and what staff should be able to explain about the supports to be provided. See also Provision T1d regarding the need for careful identification of monitoring indicators. • For Individual #165, whose CLDP was observed during this monitoring visit, there were a number of supports that were not adequately described. As reported in Provision T1d, documentation in the individual's record clearly indicated behavioral, psychiatric and health care needs that were not addressed in the CLDP at all. • Also for Individual #165, the IDT failed to identify any evidence that would be required for the Post-Move Monitor to observe or obtain to ensure supports were being adequately provided as required. • For Individual #267, the post-move supports indicated the provider staff were to document any behavioral difficulties, including psychiatric indicators for bipolar disorder, but there was no description in the pre-move supports or in the narrative of the CLDP of what the specific indicators would be. The Pre-move supports should have included the specific psychiatric indicators to be documented. As reported in T2b, the Post-Move Monitor asked the provider staff if there had been any psychiatric symptoms, but there was no evidence requested to indicate the staff knew what those specific indicators were and no follow-up by the Post-Move Monitor to ascertain that. <u>LA Continuity of Care Process:</u> The Monitoring Team reviewed documentation for individuals who had transitioned to the community in the last six months and found for seven of nine (78%) the LA Continuity of Care Pre-Move Site Review Instruments was completed within the required timeframe and included the required DADS QRS report as an attachment. Of the remaining two, one was not provided for review (Individual #480) and the other (Individual #81) was dated as having been completed after the individual's transition date.	

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		Pre-Move Site Visit Completed by Facility: The Acting APC or the Post-Move Monitor was designated as the responsible Facility staff for completion of the Pre-Move Site Visit. No such visits were conducted during the monitoring visit, so the 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 nine 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 four of the Pre-Move Site Reviews, for Individuals #213, #267, #459 and #480 more extensively to assess thoroughness in addition to timeliness: • The Pre-Move Site Reviews did not routinely address the due dates or specific plan for post-move supports that would need to be in place between the transition date and the 7-Day visit. • The Pre-Move Site Review did not specifically document if it included a visit to each service provision site. • The Monitoring Team also reviewed the Pre-Move Site Visits for any testing of staff knowledge of individual's needs for supports, services and protections prior to the move. For none of four (0%) was any such documentation found. Each called for staff interviews related to at least some supports, but there was no documentation in any of that suggested staff interviews were in fact completed. Only observations of the completed in-service materials and signature sheets were documented. As there tended to be no competency requirements for the provider staff in the in-services, reviewing a sheet that simply documented staff presence was not sufficient to confirm adequate knowledge to provide the supports and services required in the CLDP. • In at least two of the Pre-Move Site Reviews, the reviewer indicated the required in-services were to take place following the date of the Pre-Move Site Reviews. There was no indication as to how the actual completion or efficacy of this critical training was to be documented. • 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. Conclusion: 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	

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		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. To move in the direction of substantial compliance, 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 plans for which the Facility is responsible, consistent with the provisions of this Section T.	Quality Assurance Processes to Ensure Development of CLDPs: 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 APC using the Assessment Checklist. The APC or designee was also to review the assessments on an ongoing basis to attempt to identify any issues that needed clarification prior to the meeting. Given the concerns related to the adequacy of the CLDP as detailed in Provision T1c1 and T1d, the Monitoring Team strongly suggests the Facility undertake a focused initiative within the Quality Assurance Department and in conjunction with the Department of Admissions/Placements, 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. Quality Assurance Processes to Ensure Implementation of CLDPs: The Pre-Move Site Review conducted by the Post-Move Monitor or APC 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. Conclusion: This provision was found to be not in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: • Clear performance goals and outcome measures should be defined, along with appropriate methodology for obtaining the data. RSSLC should also ensure these are coordinated with quality assurance measures that address the overall quality of assessments at the Facility.	Noncompliance

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T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	<u>Facility Annual Obstacles Report:</u> The Facility provided an updated Annual Report: Obstacles to Community Transition, Richmond State Supported Living Center, Fiscal Year 2012 for review. The report was dated November 2012. This report provided fairly minimal data regarding obstacles to referral, addressing primarily a total of six individual who had indicated a desire for movement but were not referred. The reasons cited for three of the individuals was LAR choice. This approach did not sufficiently represent the actual number of individuals at RSSLC who are not referred primarily due to LAR choice. The Facility did describe a set of strategies it intended to implement to address obstacles to referral, most of which were representative of existing practices, including the following: • The QIDP will be responsible for documenting the living options discussion and identification of obstacles. • The QIDP Coordinator will develop a plan to monitor and track obstacle identification for all living options discussions and development of action plans to address obstacles. • The QIDP Coordinator will develop and present an Obstacle Trend Report to QA/QI on a bi-annual basis to develop corrective actions as appropriate. • The Quality Assurance division will monitor tracking/trending obstacles on a bi-annual basis and will monitor any corrective action plans implemented. RSSLC also reported a plan to undertake specific strategies to address LAR reluctance, including: • The IDT will develop resident specific action plans addressing educational needs at the ISP. • The Admissions/Discharge staff will provide educational materials through quarterly mail outs to the LARs and involved family members and friends providing addition information. The Monitoring Team also noted that for the other three individuals who were reported to prefer community but were not referred, the reason given was citizenship status resulting in a lack of funding. There was no strategy provided for addressing the needs of these individuals. The Facility and DADS should examine this obstacle to ensure that individuals are not required to remain institutionalized simply for a lack of citizenship. There are eleven individuals currently living at RSSLC who potentially could be impacted by this due to their citizenship status. <u>DADS Annual Obstacles Report:</u> DADS had also issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following	Noncompliance

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		summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the Facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • <u>Definitions</u>: Section T.1.b.1 of the Settlement Agreement required that the Facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The State's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." This definition does not seem to adequately capture those issues, barriers or impediments that could prevent an individual from making a choice of a more integrated setting, including a lack of awareness on the part of the individual or LAR or LAR reluctance. These are frequently identified obstacles to individuals' movement to the most integrated setting, and the data in the report reflect that this is so. • <u>Referrals</u>: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. It appeared Facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • <u>Transitions</u>: Adequate methodologies were not in place to collect data on	

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		obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In addition, the plans included in the Facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The Facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the Facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives; however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statements about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Conclusion: This provision was found to be not in compliance.	
T1h	Commencing six months from the	Issuance of the Community Placement Report:	Substantial

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	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 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.	The Facility did provide an accurate Community Placement Report for six months ending on Monday, August 26, 2013 that included the following information as further detailed in T1a: • Number and names of individuals placed in the community • Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference Conclusion: This provision was found to be in substantial compliance. The report was made in a timely fashion.	Compliance
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,	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. It reported it had begun using a revised PMM Checklist in May 2013. This Checklist was condensed from the most recent version and closely resembled an	Noncompliance

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	shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	earlier document. Staffing: There was a single Post-Move Monitor at RSSLC. At the time of the monitoring visit, the Post-Move Monitor had recently been selected to fill the vacant APC position, and was filling that role on an acting basis until the official start date of October 1, 2013. She also continued to serve as the Post-Move Monitor until that position was otherwise filled. 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 90-day PMM visits (100%) were made within the required timeframes. • Locations visited: For the PMM visits conducted for which documentation was available and for which the day program had begun, each (100%) included visits to all sites at which the individual lived and worked/day activity (e.g., day program, employment, public school). • 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 or, more recently the checklist as revised in May 2013. 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: The PMM Checklists reviewed 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 often took actions and maintained a record of emails and phone logs that documented follow-up and loop closure. However, the findings in T2b below indicated the PMM process was not as vigilant in this regard as necessary. Facility's Efforts to Ensure Supports are Implemented: The Post Move Monitor maintained a file with materials to verify the implementation of supports as well as to document follow-up. The Monitoring Team appreciated the work of the Post Move Monitor in maintaining supporting documentation in some instances, but the process was not yet consistently implemented nor was it sufficient to ensure supports were implemented. See Provision T2b below.	

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		The IDT no longer completed a routine review of each PMM Checklist, which would assist the Post-Move Monitor in evaluating any emerging issues. This was no longer required as a matter of routine, but was to occur only if there was a concern. There was not a clear process in place to determine what might constitute a special concern that would require IDT review, however, and the Facility indicated only one had occurred, in April 2013, for any of the nine individuals who had transitioned during the past six months. In at least one case, for Individual #119, the individual had undergone surgery related to a bowel obstruction about 75 days after transition, had a fairly lengthy recovery requiring hospitalization for approximately a month afterward and was re-admitted to the hospital for several days for vomiting shortly after returning to the group home. Although the Post-Move Monitor did stay in touch with the provider during this period, which was commendable, there was no IDT review documented throughout the process. In the Monitoring Team's estimation, this appeared to have been a situation that should have been identified as a special concern calling for the IDT to convene. The Facility should, at least, define the criteria that would constitute a special concern, including, for example, when an individual's status changes, an adverse event occurs, or problems arise with provision of supports and services. The Facility may also want to reconsider whether it is valuable, for the health and safety of individuals who have transitioned, to provide IDT scrutiny in every case. In addition to providing this extra level of interdisciplinary scrutiny, it would facilitate the overall involvement of the teams in post-move monitoring and inform their development of well-defined and measurable support in the future. <u>Barriers to thorough PMM Review and Improvements Needed in Monitoring:</u> The IDTs still did not yet provide adequate direction to the Post-Move Monitor as to the evidence required to accurately ensure the presence of essential and non-essential supports. • As reported in Provision L1, the Monitoring Team found the post move monitoring assessment process needed to be significantly improved by ensuring that specific clinical monitoring parameters are in place for each clinical condition, and ensure that relevant clinical staff review monitoring parameters, and when necessary make direct observations at the community home. • As reported in Provision T1e, for the CLDP held during the monitoring visit, the IDT failed to specify the evidence that would be required for any of the pre or post-move supports. In many instances the IDTs continued to indicate the evidence required in very general terms. <u>Conclusion:</u> This provision was found to be not in compliance. Continuing deficits in the process remain as described above and in in the next provision.	

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T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	<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 #267. The CLDP and accompanying assessments were also reviewed. One of the Transition Specialists, who had previously been a QIDP for the individual, also attended. Although she was reported to be familiar staff to the individual, she did not actually participate in the PMM process. There were extenuating circumstances that interfered to a degree with the PMM process and made it difficult to make an accurate assessment of the usual thoroughness of the PMM review. 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. Several of these potentially impacted health and safety in an immediate way. They included: • The PMM visit was intended to begin at the day program followed by and concluded at the home. Upon arrival at the day program, it was discovered the individual had already left for the day. There were also staffing irregularities at the individual's home on the day of the PMM visit. A regular staff had called-in, such that the day program staff who provided transport to the home appeared to be the only staff available for the individual, the two roommates of the individual as well three other individuals living in another home across the street and also operated by the same provider. This continued for a period of more than one hour. Without knowing the needs of the five other individuals, it was not clear whether this situation provided a safe environment. The Post-Move Monitor did not have knowledge of these individuals' needs and did not independently identify the need to follow-up with the provider to ensure adequate coverage plans were in place for that specific day or on an ongoing basis, or take appropriate action until prompted by the Monitoring Team. • The Post-Move Monitor did not identify that individuals' ability to evacuate the home in an emergency was restricted by keyed deadbolt locks in two of the doors. The keys were not being kept in the locks and it was uncertain whether the individuals living in the home could have operated the locks in any event. The only other egress was door into the garage and the Post-Move Monitor did not verify whether individuals would be able to open the overhead garage doors, which appeared to be unlikely. • The Post-Move Monitor did not independently observe an environmental hazard in the backyard of the individual's home.	Noncompliance

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		The Post-Move Monitor did take appropriate follow-up action to these concerns at the Monitoring Team's behest, including speaking by phone to management staff for the provider regarding both the locked doors and the hazard in the backyard. She also spoke with staff at the LA to inquire about fire and life safety codes to which homes must adhere. The Monitoring Team remained concerned that there appeared to be a lack of clear understanding on the part of the provider, the LA staff and the Post-Move Monitor as to these critical safety issues as none of them were able to cite the regulatory requirements or even where to find them. The Monitoring Team noted that DADS had issued an Information Letter No. 09-174 which indicated the Texas State Fire Marshal's Office recently adopted the 2009 NFPA 101 Life Safety Code published by the National Fire Protection Association and that therefore, in accordance with 40 TAC §9.178(e)(1), HCS providers must ensure that a four-person residence (as defined in 40 TAC §9.153) is in continuous compliance with applicable provisions concerning Residential Board and Care Occupancies - Small Facilities of the 2009 NFPA 101 Life Safety Code. It is incumbent upon the Facility and the Post-Move Monitor to be aware of the requirements contained within these provisions. Locked egress can and has contributed to deaths of individuals with intellectual disabilities when fires have occurred in group homes, both in Texas and in other parts of the nation. In addition, there were several other supports not adequately addressed: • The Post-Move Monitor asked staff if the individual was exhibiting any "psychiatric" symptoms, but as noted in Provision T1e, the CLDP did not provide adequate information as to the individual's specific symptom. The staff simply answered in the negative and there was no follow-up probing. There was also no probing regarding side effects to psychiatric medications. • There were several other supports that were not specifically addressed in the PMM visit, including whether there were Spanish-speaking staff available and whether the individual was being afforded the opportunity to attend church. • The Post-Move Monitor questioned staff about the individual's diet and adaptive dining equipment, but did not verify staff knowledge regarding the individual's needs for extra fluids or to be monitored for appropriate pace at mealtimes. <u>Conclusion:</u> This Provision was found to be not in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: • Ensure the CLDP provides an accurate and complete description of each individual's needs for services, protections and supports, including the specific evidence to be reviewed by the Post-Move Monitor, as described in T1e. • Additional training should be provided to all staff responsible for Post-Move	

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		Monitoring, focused on overall assessment skills. • The Facility should consider identifying appropriate disciplines or clinicians, particularly familiar clinicians from the respective IDTs, to participate in PMM visits with the Post-Move Monitor when there are complex health and/or safety support needs. This will assist in ensuring supports are being adequately implemented and positive outcomes are being obtained; it would also provide technical assistance to the Post-Move Monitor in improving assessment skills. • Ensure PMM staff are educated on and able to monitor for critical fire and life safety concerns, such as ability of individuals to evacuate the home in an emergency.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		Not Rated
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	<u>Number and Categories of Alternate Discharges:</u> In response to the document request, RSSLC reported two alternate discharges during the past six months. Both moved to another SSLC. <u>Compliance with CMS-required Discharge Planning Procedures:</u> A review was conducted to determine whether or not the Facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: • If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or	Noncompliance

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	admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	discharged for good cause. Based on the information provided, in two out of two records reviewed (100%), good cause was identified in the discharge summaries. • The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies): Based on the information provided, for two out of two individuals (100%), it would appear reasonable time was given to prepare. This impression was based on the documentation the transfers were undertaken at the behest of the individual and in concurrence with the family members, although the discharge packets did not explicitly state when the planning process began. • At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: The final summaries included each of these components, and the information was adequate for two of the two (100%) individuals. • With the consent of the individual, parents (if the client is a minor) or legal guardian, the Facility provides a copy to authorized persons and agencies: Although it would be expected the Facility provided a copy of the discharge summary and related assessments to the receiving Facility, there was no explicit documentation to show that this had occurred. • The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDT for one of the two individuals (50%) adequately described the key supports that the individual would need in the new setting. This finding was based on the insufficient behavior support information provided for Individual #287, whose transfer to another SSLC was predicated on, in addition to his preference, his need for an environment with intense behavior intervention. The discharge narrative did not adequately define the nature of the behaviors or their current levels, specific interventions, reinforcement or replacement behaviors, or provide the current Positive Behavior Support Plan as an attachment. The attached Psychological Update was about one page in length and very general in nature. It provided a chart of data that indicated the individual had been subject to restraint at least several times a month for seven of the last eight months, but there was no narrative discussion either in the update or in the body of the discharge summary narrative. <u>Conclusion:</u> This provision was found to be not in compliance. The Facility must provide an adequate post-discharge plan of care that will assist the individual to adjust to the new living environment.	

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Richmond State Supported Living Center (RSSLC) Self-Assessment, 8/09/2013 2. Richmond State Supported Living Center Action Plans, 8/07/2013 3. Section U Presentation Book materials 4. Richmond State Supported Living Center Settlement Agreement presentation, dated August 2013 5. DADS Policy 019: Guardianship, effective 3/7/2012 6. DADS Policy 057: Self-Advocacy, effective 5/30/2012 7. RSSLC Policy C.3: Guardianship, dated 3/7/2012 8. RSSLC Policy C.18: Self-Advocacy, effective 7/20/2012 9. RSSLC Policy F.1: Scheduling Annual Personal Support Meetings, dated 8/2/2011 10. 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 7/17/2013 11. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 12. Over the six (6) months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates 13. Rights Assessment, Form 6614, dated September 2011 14. ISPs for Individuals #27, #82, #106, #107, #120, #155, #264, #320, #630, and #753 15. Completed Rights Assessments for Individuals #155, #320 and #753 16. Self-Advocacy Minutes for the past six months **People Interviewed:** 1. Jim North, Human Rights Officer (HRO) 2. Georgette Brown, Quality Assurance (QA) Director 3. Angela Hernandez, Qualified Intellectual Disabilities Professional (QIDP) Educator and Interim QIDP Coordinator 4. Leroy Thompson, incoming QIDP Coordinator **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #120 and #264 2. Pre-ISP meeting for Individual #324 3. Human Rights Committee (HRC) 4. Guardianship Committee
	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. The Monitoring Team reviewed the RSSLC Self-assessment., which indicated the Facility was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. For Section U, in conducting its self-assessment, the Facility had not used monitoring/auditing tools to any significant level, although there a review of a sample of ISPs for several indicators. While the Monitoring

	Team commends the Facility for its efforts to utilize data in its self-assessment, there must be a clear outcome basis and a careful choice of indicators for the data to be useful in evaluation. As an example, to evaluate compliance with Provision U1, ten ISP documents were reviewed to assess whether IDTs discussed several items as they relate to an individual's ability to render a decision. Zero out 10 (0%) of ISP discussions were found to have included a discussion of the individual's capacity to make decisions. To evaluate compliance with Provision U2, ten ISP documents were reviewed to assess whether the IDTs also discussed the individuals' needs related to guardianship, but those findings indicated 100% included such a discussion. There was no acknowledgement of the obvious conflict, in that guardianship needs cannot be adequately discussed without first making an appropriate assessment of an individual's capacity to make decisions. A finding that 100% of the IDTs discussed guardianship is not a positive outcome indicator when 0% discussed decisional capacity in the process. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. The Action Steps should be designed and implemented with the outcomes first and foremost in mind. The Facility did appropriately include several steps related to development of a monitoring tool to ensure the Individual Rights Assessment is included in the ISP. These included meeting with data analysts to include the tool in the data base, implementation, and data analysis. As an essential first step in the process, however, development of this tool should be based on a set of desired outcomes and indicators the Facility believes would be likely to lead to substantial compliance. Other Action Steps included training of QIDPs in the use of the Rights Assessment, which was projected to start in November of 2013, and continuing implementation of the Guardianship Committee. Just as with the development of the monitoring tool, the implementation of each of these Action Steps should also be tied to desired outcomes. The training of the QIDP staff and the Committee members should not be viewed as outcomes, but rather as steps to reach them.
	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 initiated its Guardianship Committee. It also continued to provide substantial supports for self-advocacy and had begun using materials from a formal decision-making curriculum designed for adults with intellectual disabilities, which the Monitoring Team commends. Specific findings for each provision are as follows: **Provision U1:** This provision was found to be not yet in compliance. The Facility maintained a prioritized list of individuals needing guardians. 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 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 form was still in use, but the specific probes in each of seven categories of informed consent were not being used effectively by IDTs to provide a thoughtful assessment of the input each individual was able to provide. Overall, there actually appeared to be less attention paid to this process than in the previous visit, and the Facility acknowledged much more training was needed for the QIDPs and IDTs to effectively implement this process. Lack of such a tool or methodology founded in objective standardized criteria and its effective implementation by the IDT remained the most significant barrier to achievement of substantial compliance for this Section. To move in the direction of substantial compliance, DADS and the Facility will need to prescribe an assessment process and/or tool rooted in objective evidence-based principles of decisional capacity, and further, ensure the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully. **Provision U2:** This Provision was found to be not in compliance. A Guardianship Committee had been constituted and had met three times, including a meeting held during the monitoring visit. An Advocacy Program was not yet in place as the Facility awaited the final promulgation of the statewide policy on the topic. 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. RSSLC did continue to provide commendable support for self-advocacy as noted above.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those	<u>Policies and Procedures related to functional capacity to give consent and/nor need for LAR:</u> No new DADS policies had been issued related to this provision. DADS Policy 019: Guardianship, effective 3/7/2012, addressed the development and maintenance of a prioritized guardianship list as required. The Monitoring Team has expressed concern in previous reports that the 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 needed to be provided as to how, and how often, a need for guardianship should be periodically reviewed. <u>Maintenance of Prioritized List:</u> The Facility maintained a prioritized list, using prioritization ratings from one (most in	Noncompliance

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	with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	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 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. The Monitoring Team reviewed the Priority List, dated 7/17/2013, which contained 330 names. The list had prioritized rankings from Priority 0 through Priority III. Individuals with current guardians (216) 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 (16); 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 (47); and, Priority III included those who had a relatively high need for decision making but had an involved family member or correspondent (51). This was essentially consistent with DADS Policy 019, which calls for priority rankings for individual's need for guardianship of I-III, with Priority I representing the highest need. There were some local refinements of the prioritization criteria. In addition to the three categories called for in the policy, RSSLC utilizes a Priority 0 category for individuals who already have guardians. Also, for the 16 individuals identified as Priority I, the HRO had further prioritized this group, by reviewing their Integrated Risk Rating Form (IRRF). This was for use of the Guardianship Committee in determining which of these individuals had the highest need for decision-making. The list was being updated more frequently than the required six month intervals. The HRO reported he made updates whenever he received new information, such as referrals from IDTs or even changes made by the IDTs to the priority determination. <u>Assessment of Functional Capacity to Render a Decision:</u> The Facility indicated it did not routinely use standardized or valid instruments and/or processes to assess functional decisional capacity and the Monitoring Team concurred. The HRO reported DADS was preparing to introduce in the near future an instrument and/or process adopted from another state for this purpose. In the meantime, the Facility reported it continued to use Rights Assessment Form 6614, dated September 2012, campus-wide. This document included an expanded section for assessing an individual's ability to provide informed consent, but was not predicated on any objective or standardized criteria related to decisional capacity, nor were the IDTs using it in a thoughtful manner. The decision to place someone on the prioritized list therefore	

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		remained without a sound basis for the most part. The Monitoring Team reviewed ten ISPs for the purpose of evaluating the completion of Rights Assessment and the discussion of decisional capacity by the IDT. It should be noted the Facility indicated it was in the process of making significant improvements to its ISP process and requested the Monitoring Team focus its review on the two of the ISPs being held during the monitoring visit to provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope. While the Facility acknowledged that determination of capacity to provide informed consent had not yet been an area receiving attention, the Monitoring Team will provide comment specifically on this facet of the proceedings and documentation for the two focus individuals who had an ISP annual meeting during the site visit. The findings of the review of the Rights Assessments continued to 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. Overall, there actually appeared to be less attention paid to this process than in the previous visit, as indicated by the following findings: • Only three of ten (30%) ISP packets provided for review included a completed Rights Assessment. • For the three in which a completed Rights Assessment was found, only one (33%) included any information as to the individual's ability to provide input in any of the areas of decision-making. • There continued to be no discernible difference in the process or outcomes in the two focus ISPs. For Individual #120, for whom the Monitoring Team was able to observe the entire meeting, the IDT did not substantively address the Rights Assessment as a whole and did not address informed consent at all. Neither of the final ISP packets received following the monitoring visit included a completed Rights Assessment, and the QIDP Educator acknowledged this had not been fully addressed in either of the two focus ISP annual planning meetings. IDTs should provide in the Rights Assessment specific expectations for how staff will be expected to support individuals' participation in decision-making, consistent with a thoughtful assessment of the input each is able to provide. The QIDP Educator and incoming QIDP Coordinator both indicated in interview that much more training was needed for the QIDPs and IDTs to effectively implement this process. According to the Facility's Action Plans, this training was slated to begin in November 2013. These staff also indicated there would be consideration given to adding a specific prompt in the ISP Preparation meeting to include strategies related to enhancing decision-making capacity	

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		for individuals. The Monitoring Team also observed the review of the Rights Assessments for two individuals (Individual #413 and Individual #535) at a meeting of the Facility's HRC and found for neither of the two (0%) did the HRC members address the informed consent restrictions in a substantive manner. The process observed consisted of a review of the information provided and little to no discussion prior to approval. There was no discussion as to how any input indicated had been integrated into the ISP. The HRC should address the informed consent restrictions in the same manner as other restrictions, including requiring rationale for and plans to reduce any restrictions. <u>Conclusion:</u> This Provision was found to be not yet in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility will need to prescribe an assessment process and/or tool rooted in objective evidence-based principles of decisional capacity, and further, ensure the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	<u>Policies and Procedures related to obtaining LARs for individuals in need:</u> No changes had been made to DADS or local Facility policies since the previous monitoring visit. <u>Facility Efforts to Obtain LARs:</u> RSSLC reported two new LARs had been obtained for individuals living at RSSLC during past six months. Facility activities related to supporting decision-making for individuals during the past six months included: • <u>Guardianship Committee</u>: The Facility had established an operational Guardianship Committee as called for in DADS Policy 019 and in RSSLC Policy C.3: Guardianship . The membership included the HRO, the RSSLC Director of Behavioral Services or his designee, two individuals serving as guardians to residents at RSSLC and three Community Representatives, two of whom were completing their required volunteer training. The third, a registered nurse and attorney, was actively participating. The Committee had met twice prior to the monitoring visit and also held a meeting during this visit. The meeting observed was largely informational, with the HRO providing updates regarding current and pending policy revisions, followed by a brainstorming discussion around future plans for recruitment of advocates. The Committee was not yet reviewing individuals' needs or requests for guardians or advocates. • <u>Advocacy Program</u>: An Advocacy Program was not yet in place, as the Facility	Noncompliance

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		indicated it was awaiting the final promulgation of the statewide policy on the topic before initiating a response. It was reported that DADS had recently issued a directive to the SSLCs to cease allowing employees to serve as advocates, regardless of any provisions in place to avoid potential conflicts of interest. • Self-Advocacy Program: The Facility continued to provide much support for self-advocacy. The HRO was designated as the Self-Advocacy Coordinator and was responsible for providing support for the Self-Advocacy program, which meets twice a month. The Facility had begun using materials from a formal decision-making curriculum designed for adults with intellectual disabilities, which the Monitoring Team commends. The Monitoring Team was also encouraged the Facility continued to support individuals' participation in the statewide Self-Advocacy Conference. • Other Activities of the HRO/ Guardianship Coordinator: The HRO continued to provide training about guardianship and advocacy at new employee orientation. Conclusion: This Provision was found to be not yet in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility need to prescribe an assessment process and/or tool rooted in objective evidence-based principles of decisional capacity and, further ensure the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully. The Guardianship Committee should be provided with training regarding the assessment process as well to facilitate their appropriate review of referrals made as a result.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment 8/9/13 2. RSSLC Action Plans 8/7/13 3. Presentation Book for Section V 4. DADS Policy 015.1 Dental Services 8/15/13 5. DADS Policy 003.2-Quality Assurance 5/22/13 6. DADS Policy and Procedures 007.3 Psychiatry Services 05/01/2013 7. RSSLC Policies and Procedures a. A.1 Developing/Revising Policy or Procedure 4/4/13 b. A.6 Recordkeeping 8/2/13 c. A.06.1 Individual Notebook 8/2/13 d. A.28 Quality Assurance 7/31/13 e. A.29 Discipline Department Head Monthly Quality Assurance 7/26/13 f. A.30 Unit Quality Assurance Monthly Meeting 7/31/13 g. A.31 Program & Residential Services (PRS) Quality Assurance Team Meeting 8/19/13 h. B.23 Processing Employees Not Passing Training or Competency Evaluation 1/9/13 i. B.25 Accomplishing Annual Training 1/1/13 j. C.01 Incident Management 2/11/13 k. C.02 Abuse, Neglect, and Exploitation 4/18/13 l. C.19 Injury Audits 4/1/13 m. D.08 Completing/Routing Client Injury Report 6/14/13 n. D.23 Using Bed Rails 5/8/13 o. D.25 Completing/Routing Fall Evaluation Forms 4/19/13 p. E.17 Completing Incident Information Forms 2/11/13 q. F.04 Individual Support Plan (ISP) Process 12/11/12 r. I.00a Medical Services 6/17/13, and several prior versions s. I.15 Actions Following Choking Incident 6/12/13 t. I.17 Referrals to Habilitation Services 6/12/13 u. I.20 Changing Diet, Diet Texture, and Desirable Weight 4/19/13 v. I.32 Modified Barium Swallow Study 6/17/13 w. I.42, PCP Hypoglycemia Protocol 4/24/13 x. I.43 The Vest Policy 6/21/13 y. I.44 Morning Report Policy 6/28/13 z. K.01 Physical Nutritional Management 3/20/13 aa. K.04 Developing/Revising PNMP & Dining Plan 7/17/13 bb. K.05.2 Occupational Therapy/Physical Therapy Services 7/3/13 cc. K.06.2 Speech-Language Pathology Services 7/3/13 dd. K.07 PNMP Training & Monitoring 6/11/13

	ee. K.08 Developing Pathway to Oral Intake 3/20/13 ff. K.09 Wheelchair & Accessories Maintenance 7/17/13 gg. K.09.1 Wheelchair Clinic & Ordering 7/18/13 hh. K.10 Meal Time Procedure 7/17/13 ii. RSSLC Procedure Clinical Pathway for Standard of Care and Documentation Guideline Policy 4/15/13 jj. RSSLC Policy: Individuals Immunization Policy, dated 2/26/2013, unnumbered 8. List of each new/revised Facility Policy relevant to Requirements of the SA 9. RSSLC policy approval form 10. Policy & Procedure Tracking Database screenshots 11. Active Record Order & Guidelines 5/24/13 and draft 8/23/13 12. Guidelines for Monitoring Active Record 8/23/13 13. Guidelines for use during monitoring of Individual Notebook 6/12/13 14. Settlement Agreement Cross-Referenced with ICF-MR Standards Section V (referred to in this report as Section V monitoring tool) 15. Definitions for use with the State Office-issued Monitoring Tool (undated) 16. Minutes and attendance roster of Unit Clerk meeting of 5/29/13 regarding reorganization of active records 17. Implementation of Individual Notebook, documentation of meetings at units and with Habilitation and Behavioral Services departments 18. Tips for Use of Individual Notebook 10/25/12 19. Count of Internal Audits by Month for May, June, and July 2013 20. List of record audits to be completed in August 2013 21. Record Audits, including emails regarding corrective actions for 15 audits conducted May. June, and July 2013 for Individuals #44, #142, #144, #402, #415, #424, #477, #501, #525, #546, #559, #634, #779, #787, and #796 22. Active Record, Individual Notebook, and Master Record for Individuals #278 and #589 23. Plans of Correction for the last 10 audits (provided on-site in response to the document request) 24. Active Record and Individual Notebook for Individual #44 25. V-Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 data reports for 6/1/2013-6/30/2013 and 7/1/13-7/31/13 26. V-Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 Trend Analysis Report covering June 2012-June 2013, with percent of compliance 27. Graph—Annual Assessments to be Filed 10 Days Prior to PST Compliance by Unit 6/1/2013-6/30/2013 28. Graph—Annual Assessments to be Filed 10 Days Prior to PST by Assessment 6/1/2013-6/30/2013 29. PSP Tracking Log 11/1/12-8/6/13 30. Annual Assessments Filed 10 Days Prior to Meeting for Meeting Dates 11/1/12-8/6/13 31. Share Drive list of assessments for Individual #154 **People Interviewed:** 1. Group interview of Wanda Hartensteiner, Medical Records Director, and Unified Records Coordinators (URCs) Susan Steamer and Eileen Holmes

	2. Group interview of Program Monitors Andrea Faniel, Suzanne Royer, and Adelia Pavliska 3. Brenda McClendon, Program Auditor, and Georgette Brown, Director of Quality Assurance 4. Group interview of Angela Hernandez, QIDP Educator, Leroy Thompson, QIDP Coordinator, and QIDPs Mia Lunn and Grace Ishola **Meeting Attended/Observations:** 1. Individual Support Plan annual planning meeting for Individual #120 2. ISP Preparation Meeting for Individual #711 3. Records storage at Guadalupe, Lavaca, Leon B, Trinity B, San Jacinto, and Texas Trail 7
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V. 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 V, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. 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: ▪ Record audits using the Active Record Review and the Individual Notebook Review ▪ Interview Tools for use of the record o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement Provisions V1, V3, and V4, in conjunction with additional information. o The monitoring tools included adequate methodologies, including review of records and interviews with staff. Additional information such as observations of interdisciplinary planning meetings would also be needed for assessment of Provision V4. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. This sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Unified Records Coordinators. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were competent in the relevant area(s). o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ Used other relevant data sources and/or key indicators/outcome measures. Other data included number of policies implemented and percent current. No data were provided about correction of

	deficiencies found in record audits; as this is required for compliance with Provision V3 and would contribute to achieving compliance in Provision V1, the Facility should identify a way to assess status. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Most data came from the monitoring tools. That and the data on policies were based on specific, measurable indicators. The Facility broke down data from the Section V monitoring tool into specific items; similar review should be part of the Facility's regular QA review (for which the Facility only identified global measures as being presented to the Facility committee that oversaw quality assurance. The Facility may also want to use, in its assessment and/or its quality assurance process, the data provided by the audits on presence of current documents in the records. o Measured the quality as well as presence of many items on the Section V monitoring tool and of responses to the Interview Tool, although that was not clear in the self-assessment data. Some items, such as clinical assessments, would be more appropriately measured by clinicians and are discussed in other sections of this report. o All data reported in the Self-Assessment for Section V were collected by the QA Department. ▪ The Facility rated itself as being in compliance with no provisions of Section V. This was consistent with the Monitoring Team's findings. 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, In Process, or Not Started. ▪ The Facility data identified in the Self-Assessment areas of need/improvement. However, these areas were not consistently addressed in the Action Plan. For example, the Facility stated it did not comply with Provision V1 because "review of the results of the record audits indicates many of the records are not yet consistent with the guidelines listed in Appendix D, specifically in the areas of legibility; gaps left between entries; and the records not being accurate, current, and complete" but did not have actions in Provision V1 or Provision V3 to connect the findings of audits to systemic improvement plans. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. All actions in Provision V1 had been completed, but both the Self-Assessment and this monitoring report identify numerous issues that require improvement, and the Action Plan should address these (including additional actions in Provision V3 to address how findings of the record audits are addressed to minimize recurrence and improve compliance with Appendix D). The actions in Provision V2 were sequential and detailed enough to suggest they would address the needed steps. For Provisions V3 and V4, the "In Process" steps were actually steps that have already been put in place, are ongoing, and have not yet led to compliance with either Provision V3 or Provision V1 regarding minimizing recurrence of errors, or with Provision V4 regarding use of the record; the Facility should continue to assess whether these steps will be adequate. The Monitoring Team recommends the Facility identify issues noted in this report that need to be

	addressed with additional actions.
	Summary of Monitor's Assessment: The Facility maintained all required components of a Unified Record and continued to implement a thorough audit process. 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 there have been no systemic initiatives to improve compliance with Appendix D requirements. One significant change occurred since the last compliance visit; an Individual Notebook was implemented. This implementation was completed in August 2013, and direct support staff still made more use of the individual section of the Group Notebook that had already been in place. In addition to the Unified Record, assessments and 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. Facility audits and Monitoring Team reviews found all individuals monitored had an Active Record, Individual Notebook, individual section of a Group Notebook, and a Master Record. 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 problematic, including gaps in documentation (usually gaps of lines between entries or at the bottom of pages of notes or orders) and legibility; these were consistent with findings from Facility audits. 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; Individual Notebooks were kept with the individual (for example, in a pocket in a wheelchair). Each home had a checkout book, but these did not consistently document accurately which records were out or had been checked back in. 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. Furthermore, the Facility had not identified and acted on areas of need for systemic improvements to recordkeeping processes. 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. Although staff interviews reported records were available at IDT meetings, observations by the Monitoring Team did not find this consistently to be the case. Furthermore, observations of meetings showed use of information from the records was variable. 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 has begun to implement a database that would track status of revisions. The Facility has begun to implement a process to track training of staff on new and revised policies, but that was not yet fully in place, and the Facility did not provide documentation that would permit the Monitoring Team to assess status of training on policies.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	<u>Policies Governing Recordkeeping</u> The Facility had a policy to maintain a unified record; this policy was consistent with statewide DADS policy. Recordkeeping was guided by RSSLC Policy A.6 Recordkeeping, which was revised 8/2/13. The Facility policy governed maintenance of a Unified Record with the required components and consistent with requirements of Appendix D. The policy had been revised to include the use of the Individual Notebook and to change the location of Dental Progress Notes, which continue to be entered into the Dental Section of the Active Record but now require a copy in the IPN. The policy included an attachment that described disciplinary actions for falsification of records; this attachment included illustrative examples of prohibited practices. RSSLC Policy A06.1 Individual Notebooks was implemented in August 2013 to describe the content and procedures for use of the Individual Notebook. <u>The Facility Maintains a Unified Record for Each Individual</u> To review this, the Monitoring Team requested records for many individuals as part of the reviews for several Sections of this report. The Monitoring Team also audited the Active Record, Individual Notebook, and Master Record for two individuals. In addition, the Monitoring Team reviewed the Facility record audits from May, June, and July 2013 to determine whether they reported the presence of all three required components. The Facility maintained a Unified Record for each individual. The unified record at RSSLC consisted of an Active Record, Individual Notebook (as well as an individual	Noncompliance

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		section of a Group Notebook), and Master Record. In addition, assessments and some other information were copied to a share drive that was not considered part of the unified record but allowed information to be easily accessible to members of the IDT. 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, or four binders, depending on the amount of documents involved. An Active Record Order & Guidelines listed the order of documents and the maintenance guidelines that stated how long each document should remain in the Active Record; this was filed in the front of every binder. At the prior compliance visit, the Facility used an individual section of a Group Notebook. The Individual Notebook was recently implemented; it had been rolled out gradually over a period of months, and the final units had just recently begun using it. It contained information needed by people providing daily services and supports. The Group Notebook was still in use; it contained some needed information (some of which was also in the Individual Notebook) plus data sheets to be completed for skill acquisition programs and service objectives, among other information. At the last compliance visit, the Monitoring Team was informed that the Individual Notebook (per policy) was to supplement the Group Notebook and permit information to accompany the individual, whereas the Group Notebook stayed at either the home or daytime program. Of six homes where the Monitoring Team asked staff where to find an individual's notebook, staff at five (83%) brought or directed the Monitoring Team instead to the Group Notebook. Clearly, the staff providing direct service were more familiar with and attended more to the Group Notebook. That is not a concern if it includes all information staff need, but the Facility will need to develop procedures to ensure the information is consistent across types of records. 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. At the time of the last compliance visit, 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 was the potential that	

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		individuals' original Health Management Plans may not be updated if the working copies in the Care Plan Books were updated. Currently, the Integrated Health Care Plan was no longer placed in a separate binder but was located in the Active Record, and the Monitoring Team was informed that the DSP Instruction Sheet is also placed in the Active Record after staff are trained. Review of the table of contents of the active record and individual notebook confirm that Integrated Health Care Plan is to be filed in the Active Record. The DSP Instruction Sheet was not listed in either record, nor was there a separate binder at the home for these sheets. Although this reduces the potential for error when plans or instructions are updated, it also reduces the usability of the record for ensuring staff providing direct support (including staff newly assigned to the home and pulled staff) are familiar with the supports they are to provide to individuals with healthcare needs. Shortly before the last compliance visit, 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. This process continues to provide a way to ensure purged documents are retained as required, and documents are purged in a manner consistent with the Facility's guidelines. Based on audits of 15 records conducted by the Facility in May, June, and July 2013: • Fifteen of 15 (100%) included an Active Record. • Fifteen of 15 (100%) included a Master Record. • Four of 10 audited in May and June 2013 (40%) and five of five audited in July 2013 (100%) included an Individual Notebook. The lower percentage in May and June 2013 were expected, as some audits were done in homes to which the Individual Notebook had not yet been implemented. The Monitoring Team audited records for Individuals #278 and #589. Both included an Active Record, Individual Notebook, and Master Record. • For two of two individuals (100%), the Active Record was provided to the Monitoring Team for review. • For two of two individuals (100%), the Monitoring Team found the Individual Notebook with the individual as required. • For two of two individuals (100%), the Master Records was in the central records area as required. <u>Staffing and Responsibility for Filing in the Record</u> The Facility had staff assigned to oversee the Unified Record. The Facility had two	

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		Unified Records Coordinators (URCs) and a Director of Medical Records. In addition, the Medical Records department had staff including a Medical Records Clerk and Medical Records Administrative Assistant. Primarily Unit Clerks filed documents in records; they were assigned to Residential Services. <u>Training of Staff on Documentation</u> There had been no changes in the training provided to staff. All staff are trained on documentation during New Employee Training (NET). Training included a presentation on Recordkeeping policy, the active record and individual notebook, accurate and inaccurate recordkeeping practices, the Active Record Order & Guidelines and Individual Notebook Order, and accessibility of the record and the checkout system. Staff were required to pass a competency test that was a brief true/false test; the competency test did not require employees to demonstrate any competence in documenting or in identifying correct and incorrect examples. The Facility should consider revising the competency test to require actual documentation. As a way of evaluating the effectiveness of the NET, the URCs continued to the Facility's practice of doing a follow-up assessment with a sample of 20% of new employees, in which URCs check documentation and follow-up training as needed. This process, if implemented for all new employees, could serve as the competency test for NET if there were specific criteria for success. 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>Accessibility and Security of Records</u> To assess whether records were accessible to staff for use in providing supports and in making decisions, and were secure, the Monitoring Team observed the records at Guadalupe, Lavaca, Leon B, Trinity B, San Jacinto, and Tejas Trail 7. In six of six homes (100%), Active Records were kept in a secure area. Staff were easily able to access these records in all locations. The Monitoring Team asked to see the Individual Notebooks for six individuals. Staff were readily able to provide either the Individual Notebook or the individual's section of the group notebook. According to the URCs, staff should have provided only the Individual Notebook when asked; as this is a relatively new process, many staff still did not differentiate between the two books. However, much of the information needed by direct support staff (DSPs) was found in the group notebook, as were the data sheets for tracking program data. Thus, the group notebooks were usable by DSPs for their everyday work. Having two separate books with overlapping documents may increase	

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		the likelihood of error, such as having updated documents in one book but not the other. The Facility should continue to review this new system and make revisions as needed. The Facility had a process for checking out Active Records, but errors in use of the process made this process less than fully effective. Each home had a checkout book in the chart rack where Active Records were kept. In six of six homes (100%), the checkout book was readily available. The Monitoring Team reviewed the checkout book to determine accuracy for nine individuals in the six homes. For six of nine individuals (67%), the checkout book was accurate. Of these, the Checkout Book accurately reflected that charts were checked out for three individuals and were all present for three individuals. For one person, a chart was not present but was not checked out, but three charts were present but had been checked out and not checked back in. For one individual, all charts were present but remained checked out. For one individual, some charts were not present but had not been checked out. The Facility should establish a process to ensure the Checkout books are accurate. <u>Accuracy and Completeness of Records</u> To determine whether records were completed in compliance with Facility policy and Appendix D of the Settlement Agreement, the Monitoring Team: • Reviewed the documents V-Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 data report for 6/1/2013-6/30/2013 and Trend Analysis providing overall percent of compliance for each month covering June 2012-July 2013 • Reviewed record audits conducted by the Facility in May, June, and July 2013 for Individuals #44, #142, #144, #402, #415, #424, #477, #501, #525, #546, #559, #634, #779, #787, and #796 • Conducted audits of the Active Record and Individual Notebook, and Checklist for Minimum Documents Included in Master Record, for Individual #278 (selected by computer randomization from the list of records to be audited in September 2013) and Individual #589 (selected by computer randomization from the list of individuals admitted to RSSLC in calendar year 2013). For Individual #589, staff provided the individual section of the Group Notebook rather than the Individual Notebook, so the Monitoring Team reviewed that instead, but still used the Individual Notebook Review tool. Completeness of Active Record and Group Notebook: The Monitoring Team used the Active Record Review and the Individual Notebook Review (the forms used by the Facility to audit presence of current documents in these records) to check for the presence of each item in the records. The Monitoring Team reviewed the guidelines for these records but did not search databases as noted in the guidelines for the Individual	

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		Notebook. Following collection of this information, the Section V monitoring tool (titled Settlement Agreement Cross Referenced with ICF-MR Standards) was completed. The Active Record Review and Individual Notebook Review listed the tabs and documents to be filed within tabs, guidelines (primarily maintenance guidelines identifying how long documents are to be retained, but also identifying whether the most current or also older documents are to be retained), columns for "Y," "N," or "N/A," and a column for comments. Many documents are not applicable in each record. The Monitoring Team made an effort through review of other documents in the record to determine whether such a document, if not in the record, was applicable. For example, if an individual had in the record an action plan with a specific learning goal, there would be an expectation that a matching Specific Program Objective/Skill Acquisition Plan would be in the appropriate section of the record. For Individual #278, 88 documents were current in the Active Record, 15 were not present or not current, and 76 were not applicable. The percent of applicable documents present and current was 85%. In the Individual Notebook, 10 documents were present and current, and three documents were not present or not current; two of those (the PNMP and the PBSP) were present but were not the current version. Six documents were not applicable. The percent of applicable documents present and current was 77%. For Individual #589, 67 documents were current in the Active Record, six were not present or not current, and 106 were not applicable. The percent of applicable documents present and current was 92%. As noted above, staff provided the Monitoring Team with the individual section of the Group Notebook; nevertheless, in comparing the documents to the list in the Individual Notebook Review, eight documents were present and current, three were not present (although one of these was blank note sheets for documentation of significant events rather than an actual document), and eight were not applicable. The percent of applicable documents present and current was 73%. The major difference in documentation between the Group Notebook and the documents listed on the Individual Notebook Review was the order of the documents in the binder. The findings from this small sample were consistent with those for a sample of records audited during the last compliance visit for Individual #278 but somewhat better for Individual #589. In general, the records were neat, and it was usually easy to find documents. There were no examples of torn pages or missing tabs, tabs were in the correct order, and all pages were readable.	

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		Consistency with Appendix D Requirements: Neither record met all requirements of Appendix D. The Monitoring Team completed the Section V monitoring tool. For Individual #278, the records met 17 of 26 requirements (65%) assessed by the Monitoring Team and found applicable. For Individual #589, the records met eighteen of 26 requirements (69%). As noted below regarding compliance found by the Facility audits, these figures are slightly higher than the compliance ratings by the Facility. Nevertheless, they do not indicate records are yet substantially compliant with Appendix D requirements. Examples of requirements not met included: • Both records had examples of documents that were not legible. These were limited and not widespread, but they were frequent enough potentially to cause problems with usefulness of the information. For example, for Individual #278, QIDP notes were illegible; these are essential or future review of decisions made. For Individual #589, the Client Injury Report of 7/26/13 section on Describe Injury & Circumstances was illegible; it is possible information could be reconstructed from the UIR, but the information in the Active Record would not be usable for reviewing the incident. • Both records had gaps between entries or at the bottom of pages in Observation Notes and Integrated Progress Notes. For Individual #589, there were also gaps at bottoms of pages in the Physician's Orders. • Both records had examples in which the record was not consistent with the table of contents. These were not widespread, and most documents did follow the table of contents order. • 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. Although the percentage of Appendix D requirements met was not adequate, the errors were not as widespread as in past reviews. The Monitoring Team reviewed many more records in review of other Sections of the Settlement Agreement. Findings included: • Some post-consultation physician IPNs were not signed or dated. • As noted in Provision M1:	

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		o Late entries documented in the Integrated Progress Notes were not consistently documented correctly. o When entries in the Integrated Progress Notes were carried over to the next page, the time was not consistently included with the date of the entries. o Reviews of Campus Nurses' Universal Signature Sheets found they were current for nurses that administer medications with their printed names, signatures, and titles. In response to a document request for the most recent reports of data developed from the audits and of trends, the Facility provided the following: • V-Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 data reports for 6/1/2013-6/30/2013 and 7/1/13-7/31/13. These included bar graphs of overall internal and external audit compliance percentages on the Section V monitoring tool for each of those two months as well as a database for those months that provided item-by-item compliance (Refer to Provision V3 for explanation of internal and external audits). The database forms had columns for 12 rolling months and a statement that the current month is shaded; apparently, the whole database is available to the Facility and could be useful in identifying specific items that consistently do not meet Appendix D standards. Data were not provided on presence of current documents. • V-Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 Trend Analysis Report covering June 2012-July 2013, with percent of compliance. This was a bar graph of monthly compliance on the Section V monitoring tool for13 months; there was one graph for internal audits and one for external audits. Because the Facility provided graphs from June 2013 and July 2013, 14 months of data were available. Level of compliance on the Section V monitoring tool was consistently within the range of 48% to 57% for internal audits and 48% to 65% for external audits; compliance had not shown improvement. The purpose of an audit process is to identify processes to address and improve. As noted above, the errors appeared less widespread, but the same types of errors were still occurring. It is possible there had been improvement in the presence of current documents, as the record for Individual #589 had the highest percent of present and current documents found in these Monitoring Team audits at RSSLC. Without Facility audit data, there is no way to determine whether improvement was occurring. Review of 15 audits from May, June, and July 2013 found consistency on both the Section V monitoring tool and the presence of current documents (which varied in specific documents but had documents not present or not current in all records). For example:	

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		• Legibility was rated Y (yes) for 1 of 15 records (7%). • In July 2013 audits, the ISP was current in three of five records (60%), and 0 of five records (0%) were rated Y for Current. RSSLC also provides an audit of the Master Record using a Checklist for Minimum Documents Included in Master Record. This is done only at admission and is not part of the random audits. It would not be difficult to include this in the random audits and would complete the review of all three components of the Unified Record. The Monitoring Team completed the checklist for Individuals #278 and #589. For Individual #589, eight required documents of 11 (73%) were present, one (9%) was not present, and two (18%) were not applicable (so eight of nine applicable documents, 89%, were present). For Individual #278, seven documents (64%) were present, two (18% were not present), and two (18%) was not applicable (so seven of nine applicable documents, 78%, were present); it should be noted that two documents were admission documents—one marked No and one marked NA per checklist definitions. <u>Use of Virtual Client Folder (VCF)/Share Drive</u> 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. One component of the VCF is a folder to post assessments; the Facility can use this both to make assessments available to IDT members for review in preparation for the ISP annual planning meeting and for tracking of completion and timeliness of assessments. DADS and RSSLC policy on ISP documentation require IDT members to file their assessments and recommendations on the Share drive 10 working days prior to the PSP meeting. Graphs for June 2013 show that each type of assessment was filed 10 days prior to the "PST" (the annual planning meeting) for at least 90% of ISP meetings for each type of assessment required and for each unit. However, as reported in Provision F1c for a sample of eight ISPs completed prior to the monitoring visit, one (13%) had all assessments completed on a timely basis, at least ten working days prior to the ISP annual meeting. Of the 87 required assessments, however, 61 were completed according to the timeliness requirements. Overall for this sample, the rate of timeliness was 70%. For a sample of nine individuals who had upcoming ISPs during the week following the monitoring visit, only one (11%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. The overall compliance rate was improving, however; 100 of 116 (86%) required assessments were completed 10 working days prior to the ISP date. As part of an interview with QIDPs, the QIDP Educator, and the incoming QIDP	

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		Coordinator, the Monitoring Team asked them to select an individual who had an ISP annual planning meeting scheduled within the next 10 working days. For that individual, the QIDP easily accessed and reviewed the assessments due and posted to the Share Drive. Ten of fifteen (67%) required assessments had been completed and posted at least 10 working days prior to the annual planning meeting. Many other documents are also posted to the VCF, making them readily accessible to members of the IDT. This Share Drive is an excellent tool for making information easily accessible to clinicians and increasing efficiency of their work.	
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.	<u>Facility Process to Develop and Revise Policies</u> A Facility process existed and was followed to develop and revise policies, protocols, and procedures. RSSLC Policy A.1 Developing/Revising Policy or Procedure governed the process of policy development. This policy had been revised on 4/4/13. The revision had been to include requirements from DADS regarding revised/new policy/procedure due to a new/revised policy from DADS. When DADS revises or implements a new policy, DADS directs the Facility on which staff are to be trained on the policy and the timeframes by which staff are to be trained and the policy is to be fully operationalized. Per interview with Brenda McClendon, Program Auditor, who was assigned responsibility for maintaining the policy development process, and Georgette Brown, Director of Quality Assurance, the process otherwise remained the same. The policy did not require periodic review and revision as needed. The Facility used a policy approval form that states the policy, who developed or revised it, the changes in the revised policy, and has a statement the Policy &Procedure Committee has reviewed and recommended training requirements (and lists those requirements), and has a place for RSSLC Director/Designee signature and date. <u>Training on Policies</u> The Facility had a process to identify what type of training is needed on new and revised policies (including what competencies must be trained, if any), and to ensure and document that training was provided. Per Policy A.1, the Policy and Procedure Committee reviews the final draft and recommends training requirements; the policy lists questions for the Committee to consider, including whether staff need to be knowledgeable or competent, who is responsible for certifying staff have completed training, and what documentation is needed to confirm training has occurred. Requirements for training were to be listed on the policy approval form. When the policy was based on one newly revised or implemented by DADS, these requirements were directed by DADS. The Facility did not have a process fully in place to track training identified as needed	Noncompliance

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		and to report status. In response to a request for new and revised policies, and a copy of communication to staff to inform them of the policy, a description of training provided (with a copy of training materials), and/or blank competency evaluation tools, the Facility provided the table of contents of policies. Per interview, the Facility informed the Monitoring Team that this information is available for some but not all policies. The Facility provided screenshots of a database implemented in July 2013 to track policy reviews and approvals, and to enter and track training. However, this was not yet populated with training records. The Program Auditor reported that training materials and sign-in sheets (or, when a large number of individuals are trained, sample sign-in sheets) are sent to her. At this time, the Monitoring Team was unable to confirm the status of training on policies. However, as reported in Provision M4, the Nursing Department did track all training. There was training record documentation that validated that 100% of the nursing staff had been trained on the new/revised state and RSSLC policies, procedures, guidelines, and protocols. <u>Development and Revision of</u> <u>Policies to Implement Part II of the Settlement Agreement</u> There is evidence that many protocols and procedures required to implement Part II of the Settlement Agreement have been revised as needed; however, some essential protocols and procedures remain to be developed and implemented. <u>New and Revised Policies</u> DADS policy development, revision, and implementation: DADS had continued developing and revising policies. New and revised policies since the last compliance visit included the following: • DADS Policy 015.1 Dental Services 8/15/13 • DADS Policy 003.2-Quality Assurance 5/22/13 • DADS Policy and Procedures 007.3 Psychiatry Services 05/01/2013 • Numerous DADS Nursing Procedures and Protocols, as reported in Section M RSSLC Policies and Procedures: New and revised policies and procedures included: • A.1 Developing/Revising Policy or Procedure 4/4/13 • A.6 Recordkeeping 8/2/13 • A.06.1 Individual Notebook 8/2/13 • A.28 Quality Assurance 7/31/13 • A.29 Discipline Department Head Monthly Quality Assurance 7/26/13 • A.30 Unit Quality Assurance Monthly Meeting 7/31/13	

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		• A.31 Program & Residential Services (PRS) Quality Assurance Team Meeting 8/19/13 • B.23 Processing Employees Not Passing Training or Competency Evaluation 1/9/13 • B.25 Accomplishing Annual Training 1/1/13 • C.01 Incident Management 2/11/13 • C.02 Abuse, Neglect, and Exploitation 4/18/13 • C.19 Injury Audits 4/1/13 • D.08 Completing/Routing Client Injury Report 6/14/13 • D.23 Using Bed Rails 5/8/13 • D.25 Completing/Routing Fall Evaluation Forms 4/19/13 • E.17 Completing Incident Information Forms 2/11/13 • F.04 Individual Support Plan (ISP) Process 12/11/12 • I.00a Medical Services 6/17/13 • I.15 Actions Following Choking Incident 6/12/13 • I.17 Referrals to Habilitation Services 6/12/13 • I.20 Changing Diet, Diet Texture, and Desirable Weight 4/19/13 • I.32 Modified Barium Swallow Study 6/17/13 • I.42, PCP Hypoglycemia Protocol 4/24/13 • I.43 The Vest Policy 6/21/13 • I.44 Morning Report Policy 6/28/13 • K.01 Physical Nutritional Management 3/20/13 • K.04 Developing/Revising PNMP & Dining Plan 7/17/13 • K.05.2 Occupational Therapy/Physical Therapy Services 7/3/13 • K.06.2 Speech-Language Pathology Services 7/3/13 • K.07 PNMP Training & Monitoring 6/11/13 • K.08 Developing Pathway to Oral Intake 3/20/13 • K.09 Wheelchair & Accessories Maintenance 7/17/13 • K.09.1 Wheelchair Clinic & Ordering 7/18/13 • K.10 Meal Time Procedure 7/17/13 • RSSLC Procedure Clinical Pathway for Standard of Care and Documentation Guideline Policy 4/15/13 • RSSLC Policy: Individuals Immunization Policy, dated 2/26/2013, unnumbered <u>Areas in Which Efforts Are Needed</u> To move toward compliance, the Monitoring Team recommends the Facility establish a clear set of procedures to ensure training on policies meets the needs for implementation of those policies, and can be tracked to ensure all staff who need training receive it.	

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		In response to various document requests, the Facility provided different versions of Policy 1.00a with differing revision dates ranging from 1/21/11 to 5/15/11, and with a more recent version of 6/17/13 on a list of revised policies. It is essential that the Facility ensure that only the most recent version of a policy is being implemented. The Monitoring Team identified some areas the Facility should consider for revision to policies: • Although policy for PNMP training and monitoring identified frequency of monitoring for high risk individuals, it did not include frequency of monitoring for individuals who were not at a high risk, resulting in lack of a system that ensured all individuals at an increased risk or potentially requiring increased OT/PT related supports were monitored on a regular basis. Also, the PNMT policy should include a clear method in which the PNMT would participate in the analysis of trends related to PNM. • The Facility did not have an OT/PT policy(s) that substantially included the needed components of a monitoring process to address treatments and interventions. • There was no a clear policy that outlined how individuals would be provided with the needed monitoring to ensure staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. • The Facility should identify those policies that actually guide integrated services or develop such a policy, and then should review the remainder of the policies to see what revisions should be made to comply with such policy. • The Statewide policy had been updated effective 5/1/13; however, it was unclear if the Facility policy addressing at-risk Individuals had been updated to reflect the current state policy. The Facility reported it was following the current State policy, and had modified the Facility policy; however, an updated Facility policy was not provided to the Monitoring Team. • 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. • Policy for Adverse Drug Reactions should document who is to participate in the review process. In addition, some policies remain to be completed so that policies and procedures cover all areas needed for implementation of the requirements of the Settlement Agreement. • According to the State Office Nursing Coordinator, the State was still in the process of revising the Death Review. • In response to a request for "any State or Facility policy or procedure guiding	

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		integrated clinical services," the Facility provided a list of policies related to specific areas, including committees and areas of care, which apparently included a requirement for integration. However, there was no single policy that established requirements for integration, provided procedures to facilitate integration, or directed staff to the other policies that included requirements for integration.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	<u>Audit Policy and Process</u> Both RSSLC policies A.6 on Recordkeeping and A06.1 on Individual Notebook include a requirement for random audits for quality assurance. 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 Order 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 the Individual Notebook, using the Individual Notebook Review form. Based on information documented on these forms, the URC completes the Section V monitoring tool, which provides the data for reporting and trend analysis. At the last compliance visit, the Facility reported it was 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. The Facility did not provide such database information to the Monitoring Team at this visit. The Facility should consider implementing such a database, if it has not already done so, to provide more specific information that would be useful in determining items to address for improvement. The Facility provided lists of audits conducted in May, June, and July 2013 and of those selected by computer for audit in August 2013. Eight records were audited in May 2013, five in June 2013, and five in August 2013. This was less than the expected 10 audits because a vacancy occurred in URC staffing in May, and a new URC began conducting audits during July 2013. In any case, this number met or exceeded the requirements of the provision in three of three months (100%). For August 2013, ten records had been selected for audit. The Monitoring Team requested, as part of the documents requested prior to the compliance visit, the last 10 audits done. The Facility provided the last five audits completed in May 2013 and all five completed in June 2013. At the beginning of the	Noncompliance

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		compliance visit, the Facility provided the five audits completed in July 2013. This verified that at least five audits were completed monthly. Audits did not include the other books that the Facility does not consider part of the unified record (the Group Notebook, the monthly flow notebook, PNMP notebook, Dining Book, or Active Treatment book). These books must have documents that are consistent with those in the Active Record and Individual Notebook. Per interview, the Facility informed the Monitoring Team that Program Monitors conduct additional audits that ask different questions; this includes an audit of the Group Notebooks. Audits of Group Notebooks include questions about whether PNMPs and Special Consideration forms are current. Review of July audits verified these audits were completed for four of five audits (80%). This is a positive effort to ensure the documents found in these are consistent and current. The Monitoring Team did not review whether a similar audit process was in place for the other books to ensure consistency across all sources of information for those providing services and supports. The Facility reported that its processes to determine whether staff use information from the record when making decisions on treatment, supports, and services included: • The use of the statewide interview form. Each URC selects one record on which to complete the tool; this selection is not random (although it is from the randomly selected records to be audited), and URCs reported trying to ensure this is done routinely at all units. The URC interviews each applicable discipline clinician face to face or by telephone. URCs reported they review the record first so they can ask follow up questions to get a good decision on whether staff were using the record. • Review Individual Progress Notes (IPNs) to see what disciplines documented. They did not have specific definitions other than what was on the monitoring tool. They also reported looking at reports and consultations to determine whether there was follow up. In addition to the random audits of the Active Record and Individual Notebook, the Facility audited the Master Record for individuals when they were admitted using a checklist of minimum documents required. The Facility may wish to consider including this Master Record review as part of the random audits in order to ensure all three components of the Unified Record are audited. In addition, the Medical Records Clerk conducted an audit of the overflow records on a random sample of one record monthly from each unit, using a checklist of documents that should have been purged, and notifies the Unit Clerk if a document that should have been sent to overflow is missing. The Unit Clerk then is to review the Active Record to determine if the document was not purged, and to purge and send it to Medical Records. The Monitoring Team did not review this checklist but does compliment the Facility on developing a process to check whether	

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		documents that have been or should be purged are sent to Overflow. Although there is no database for the findings, the Director of Medical Records reported that compliance is generally good, and they are not finding cases in which there are lengthy periods in which documents are missing, nor extensive numbers of documents missing. DADS may wish to consider whether other Facilities should be made aware of this process. <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 (Active Record and Individual Notebook) on the same day at the same time without discussion. After completing the audits, the Program Monitor and URC discuss their findings but do not make any changes in their ratings. If they determine their was a misconception or difference in definition, they record that; the Program Monitors showed the Monitoring Team a draft of a sample active record with definitions; this is still in progress and should be completed and then updated regularly so that it can serve as the definitions for audits and can be used to train new auditors. According to the monitoring data report for 6/1/13-6/30/13 and 7/1/13-7/31/13, the levels of agreement on the monitoring tool between audits conducted by URCs and by program monitors were 84.91% and 86.21% respectively. These were lower than reported at the last compliance visit but consistent with agreement reported for the period of 5/1/12-7/31/12. Monthly data reported in the Self-Assessment for December 2012 through May 2013 showed reliability ranging from 87% to 99%. The slightly lower figures for June and July may reflect the learning process of the new URC, or may indicate that some definitions had shifted across experienced auditors but were not reflected in the definitions and training provided to the new URC. Nevertheless, even the newer data reflect a generally acceptable level of agreement. The Monitoring Team also audited one record along with the URC, for Individual #278. This was selected by computer randomization from among the five records that URC was assigned for August 2013 and had not yet audited. On the monitoring tool, the URC and Monitoring Team agreed on 81% of applicable items. The Facility did not report reliability data for the audit tools for the Active Record and Individual Notebook. The Monitoring Team calculated agreement on the Active Record Review and the Individual Notebook, and suggests this would be an easy and productive action for the Facility also to take. This would give information at a more detailed level than provided by data only on the Section V Monitoring Tool. Agreement between the	

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		Monitoring Team and the URC on the Active Record Review was 88%. When only documents found applicable by both auditors is considered (a much more conservative measure), agreement was 80%. Agreement on the Individual Notebook was 89%; for only applicable documents, agreement was 85%. All of these agreement figures reflect adequate levels of reliability. The Monitoring Team could not review whether any specific items frequently showed low levels of agreement; the Facility processes for review of disagreements and of redefinition should identify those, but caution should be used to ensure all changes in definition and in what is reviewed are written. <u>Audit Findings</u> The Facility provided trend data for compliance percentage as rated on the Section V monitoring tool for June 2012 through July 2013. Level of compliance on the Section V monitoring tool was consistently within the range of 48% to 57% for internal audits and 48% to 65% for external audits; compliance had not shown improvement. The monthly data report on level of compliance showed the percent of audited records each month for which each item was compliant. This provided a way to determine whether specific requirements were showing improvement, regression, or no change. Although the audit process itself seems effective at identifying deficient practices and notifying responsible staff of the need for corrections of errors (as, as noted below under Corrective Actions), that has not led to identification of systemic actions needing to be addressed nor to improvement in meeting Appendix D requirements. To move toward compliance with this provision, the Monitoring Team recommends the Facility identify and address requirements needing improvement, and use the audit process to provide data on effectiveness of the actions. This may require also providing data from the Active Record Review and Individual Notebook review to identify what specific documents might be contributing regularly to deficiencies in meeting Appendix D requirements. From the June and July monthly reports, requirements that were found in compliance less than 60% of records in both months included: • Legible • Accurate • Current • Complete • Time if needed • Signature with first/last name • No gaps between entries • Record consistent with table of contents • Portions no longer needed are disposed of properly • Inaccurate recordkeeping practices	

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		• Based on information from the V4 interview tool, there is evidence the facility routinely uses the records to make decisions Some of these, such as Accurate, Complete, and Inaccurate recordkeeping practices, require that most other requirements are in compliance. Most, though, reflect a single requirement that could be addressed. To move toward compliance, the Monitoring Team recommends that the Facility identify one or more of these and develop an integrated corrective action plan that involves the staff responsible for overseeing the direct documentation (including residential administration and supervisors, and department directors) to work with recordkeeping staff to implement improvement actions. The Facility did not provide data on compliance record by record, nor did the audits show the percent of compliance. The Monitoring Team did not, therefore, review the variability in compliance across records for the different individual records. <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," a table titled "Corrections Needd for Individual Notebook," 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. The email requests that the staff responsible for corrections notify their supervisions when the corrections are completed, and the supervisors will in turn notify the URCs and Program Monitors. The emails state that the URCs are to be notified when corrections are made; however, neither the emails nor the tables identify who is responsible for making the corrections and notifying the URCs. Per interview, URCs are notified of some corrections, but this is not consistent. The Facility should consider implementing a process to identify the specific staff who are responsible for ensuring the corrections are made, and for holding them accountable for making corrections and notifying the URCs when they are completed. This was recommended in the report for the last compliance visit. Two weeks after sending the email, 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. When notified	

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		of corrections and/or when the URC determines that a correction has been made, the required action is crossed off the URC's Corrections Needed list or a note is put in stating what correction was made. The Facility provided emails and Corrections Needed sheets for all the audits done in May, June, and July 2013. These verified continuing follow up by the URCs until completion. Review of the Corrections Needed forms provided in response to a request for Plans of Correction for the Last 10 Audits contained a number of strike-through items indicating completion, or items that had documentation of completion, but also a significant number of items that had not been crossed through and for which there was no statement of completion. Review of the emails about corrections for five audits conducted in May also showed a lack of completion of corrections; follow up was continuing into August for five of five audits (100%) conducted in May 2013. Corrections must be made more timely. The Monitoring Team randomly by computer selected one individual record from among those audited by a URC in May 2013, Individual #44, and checked the Active Record and Group Notebook for corrections. All corrections that were identified on the Corrections Needed form as having been corrected were found to be corrected. Some items for which correction is not possible, but for which actions can be taken to limit reoccurrence, were being done correctly, such as legible signatures, documentation in reverse chronological order, and gaps in documentation. Still some signatures remained missing, and some documents were still not present. Overall, most corrections had been made, and no corrections were reported that had not been made. <u>Review of Trends and Use of Audit Information for Systemic Improvement</u> As noted above, the Facility had not identified and addressed systemic issues needing improvement. The review of trends at the QA/QI Council included limited information about overall compliance on the monitoring tool. More detailed information might make specific needs for improvement more evident. <u>Conclusion</u> The audit system and procedures for URC follow up to items needing correction both are sound and are implemented regularly. Audits are done of more records than the provision requires. Follow up to items needing correction is thorough. To achieve compliance, the Facility needs to ensure corrections are made timely and must address systemic actions to reduce reoccurrence of the same errors.	

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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> As reported in Provision V1, Active Records and Individual Notebooks were readily available and accessible. Audits of 15 records found 15 (100%) to be accessible. Observations by the Monitoring Team at six homes found the Active Record readily accessible in all six (100%). The Monitoring Team could not determine whether all Individual Notebooks were accessible; as reported in Provision V1, staff generally provided the individual section of the group notebook when the Monitoring Team requested the Individual Notebook. Two of two Active Records and Individual Notebooks audited by the Monitoring Team (100%) were accessible. As noted in Provision V1, implementation of the checkout system needs to be more accurate. The Share Drive made assessments and other documents readily available to clinical staff, residential directors, QDDPs, and others who might need to refer to them; additional documents continue to be added. <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. Responses to that item on the reviewed audits showed zero of 15 records (0%) was rated as Current. That was true also for the two records audited by the Monitoring Team. The Facility did not provide data on the percent of documents rated as present and current in the Active Record Review and Individual Notebook Review; data from the Monitoring Team audit are reported under Provision V1 and show most, but not all, documents were present and current. The Facility should consider whether it would be helpful to have a more sensitive measure of presence and timeliness of filing in the record to supplement the Section V monitoring tool and provide a clearer indication of the need for, and progress on, improvement in timeliness. 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. The Facility provided a log of assessments due and dates completed for these meetings occurring from 11/1/12 through 8/6/13. In addition, the Facility provided a summary table by unit of the number of assessments provided and the number provided 10 days prior to the annual ISP planning meeting. Per interview, although this stated it was for 10 days prior, it actually reflected presence of assessments 10 working days prior to the meeting. This table showed percentages of timely posting of assessments ranging across units from 87% to 100%. However, based on the numbers of assessments reported, those figures	Noncompliance

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		were inaccurate. Although some assessments are required for only a few individuals, some assessments are required for all individuals. For example, annual medical assessments are required for all individuals, but they were not all provided timely (except for the two individuals at the Infirmary), with percentages as low as 69% (33 of the 48 ISP meetings) for Three Rivers. The table reported similar findings for Nursing, Pharmacy, Nutritional, and Rights Assessments, among others. To make this table useful, the Facility should ensure the calculations are based on the assessments required per policy and per the results of the ISP preparation meetings. In any case, given the lack of timely completion of assessments that are required per policy, improvement is needed. The Monitoring Team also viewed the assessments available on the shared drive for Individual #154, who had an annual ISP planning meeting scheduled within the next ten working days. For 15 assessments that were required per the ISP preparation meeting, 12 (80%) current or updated assessments were posted, and nine (60%) had been posted by 10 working days prior to the meeting. No evidence was provided of systemic actions being taken to improve timeliness of assessments. <u>Data are documented/recorded timely on data and tracking sheets</u> For the most part, data were recorded timely. For example, there were no issues with lack of timely recording on MARs. There were a few issues related to lack of timely completion or documentation: • As reported in Provision O7, Aspiration Trigger Sheets contained multiple gaps in data due to lack of completion. • As noted in Provision L1, clinical review of records found examples of seizure logs not being updated timely. For example, several months had elapsed in which the seizure log was not updated monthly; there were examples of IPNs indicating that the Individuals had experienced a seizure, but the seizure was not recorded on the seizure log/record. <u>Staff surveyed/interviewed indicate how the unified record is used</u> The Facility provided a sample of the completed interview tool for Individuals #501 whose record was audited in May 2013, #787 whose record was audited in June 2013, and #546 whose record was audited in July 2013. This verified that one interview was done each month. The documents recorded both a summary of the information provided by these two staff and recommendations from the interview (the URC) to these staff about how the records could be used. • For Individual #501: The Behavior Analyst and Physician were interviewed. Both reported examples of their use of the record and of using information from	

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		a report from another discipline in planning treatment or intervention. Both reported the record is present at interdisciplinary meetings; the physician reported using the record during the meetings, whereas the behavior analyst reported greater use of notes from review of the records prior to the meeting and consulting the record at the meeting if clarification is needed. • For Individual #787: The QIDP and Behavior Analyst were interviewed. Both reported the active record is present at meetings and reported in general terms about how it is used in meetings but did not give specific examples. • For Individual #546: The QIDP and Active Treatment Manager were interviewed. Both staff reported the share drive was the first source for their reviews of information from the record. Both reported the active record is present at meetings, but neither reported examples of use of the record. Both provided an example in which a report from another discipline helped in planning treatment or intervention. The interviews indicated staff use of the records. However, interviewing a more varied set of clinicians might give a more representative sample. Other than the question on the Section V monitoring tool, the Facility did not have any other process to track trends in responses to specific questions from the interviews. The Monitoring Team also interviewed two QIDPs and asked these questions. They provided an example of using information from the record when making a decision about services and supports for an individual. They stated the record is available at IDT meetings and gave examples of what information would be checked during meetings to ensure information discussed at the meetings is current. <u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u> To assess this, the Monitoring Team observed the annual ISP planning meeting for Individual #120 and the ISP Preparation meeting for Individual #711 to assess whether and how the unified record was used. At the meeting for Individual #120, the Monitoring Team did not observe the records being present. Extensive discussion was held about what had been discussed during a "three-day meeting" held prior to the annual meeting to prepare and draft information and recommendations, and to ensure staff have reviewed assessments reported by other disciplines and determine if they needed additional information or clarification. For IDT members who had not participated in that meeting, information was repeated. The Monitoring Team could not determine whether information from the records had been	

#	Provision	Assessment of Status	Compliance
		used at that prior meeting. During the observed meeting, there was little presentation of information that appeared to have been in the record. At the meeting for Individual #711, the Monitoring Team did not observe the records being present. Much of the discussion included impressions of various IDT members, but data were not consistently provided except for number of injuries and extensive data on vitals and health status by the nurse during the integrated risk review. Monitoring Team observations at other IDT meetings indicated the following: • Records were present during PBMC clinics and the psychiatrist used them from time to time to look up information. It seemed to flow well in the sense that participants were readily able to find the information needed. The Active Record was not used at all meetings, but nursing and psychology brought data sheets with them, so that actual data from the records was available and used. <u>Additional Information from the Monitoring Tool</u> In addition to the agreed-upon measures, the Facility used other information from the Section V Monitoring Tool in assessing compliance with this provision. One question on the monitoring tool was whether reviews of the integrated progress notes provided evidence the Facility routinely uses the records to make decisions. For eight of the fifteen records (53%), this was recorded as Yes. The URC commented on reasoning for findings that this did not occur; these included finding notes from few disciplines and lack of follow up documentation from relevant disciplines regarding specific issues. The URCs should be complimented on their thorough review of this requirement. The Monitoring Team rated this item as Yes for one of two records audited (50%), and had the same rating as the URC for the one record audited by both.	

List of Acronyms

Richmond State Supported Living Center

August 26-30, 2013 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
BAIP	Behavior Assessment and Intervention Program
BAP	Behavioral Assessment Program
BCBA	Board Certified Behavior Analyst
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BMD	Bone Mineral Density
BP	Blood Pressure
BSC	Behavior Support Committee
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
MRP	Medication Response Profile
MRSA	Methicillin-resistant Staphylococcus Aureus
MSP	Medical Support Plan

MTC	Mealtime Coordinator
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
PMTP	Psychiatric Medication Treatment Plan
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)
PRP	Polypharmacy Review Panel
PSA	Prostate Specific Antigen
PSP	Personal Support Plan; Psychiatric 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
RRC	Restraint Reduction Committee
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