United States v. State of Texas

Monitoring Team Report

Richmond Supported Living Center
March 3-7, 2014

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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, and Melissa Salina. 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 335 individuals.

Facility Self-Assessment. RSSLC continued to improve its process of assessing status of compliance. 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. As is noted for some Sections of this report, the Facility sometimes reviewed samples of documents or provided other information that would have been available through its routine quality assurance process. It is essential that the Facility have a quality assurance process that reports accurately on the status of important aspects of the Facility's services, staffing, and administrative functioning; for compliance with Settlement Agreement requirements to be sustained over time, the Facility must use this quality assurance process to identify when improvements or corrective actions are needed. Therefore, the self-assessment process should use information from the routine quality assurance activities and reports to the greatest extent possible.

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 should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. In doing so, the Facility may recognize that some actions will have impact across various Sections. The Facility referenced actions for Section I in its action plan for Section H. These referenced actions certainly would be relevant for compliance with Section H requirements. In addition, though, the Facility should consider 1) identifying other actions that would be needed to accomplish compliance with Section H requirements (many of which were actually in process but not reported in the Action Plan), and 2) referencing Section H actions in process that would have significant impact on compliance with Section I.

Specific Findings

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal for the Monitor and DOJ's review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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

Restraints

It appeared the use of crisis intervention restraint had decreased significantly (as much as 30% when comparing six month periods); however, because of questions associated with data validity, the Monitoring Team was unable to confirm this. Issues with documentation remained problematic.

- Positive Practices and Improvements Made
  - Restraints were terminated as soon as the individual is no longer a danger to him/herself or others.
  - Staff training was done, and staff knowledge, as demonstrated through answering seven questions, improved significantly from that observed at the last review.
  - The Facility had implemented a more formalized process for video review of restraints than that described at the last review. Video surveillance tapes that had recorded a restraint episode are used with regularity as part of the restraint review process.
- Improvements Needed
  - Because of lack of specificity in ISPs and Physician Orders the Monitoring Team could not determine that the use of the abdominal binders was not a restraint.
  - Little improvement has been noted on meeting requirements associated with the use of medical restraint.
  - Not all requirements associated with the use of the Physical Mechanical Restraint for Self-Injurious Behavior (PMR-SIB) policy had been followed.
  - Most individuals still lacked needed plans to reduce the need for pre-treatment sedation.

Abuse, Neglect and Incident Management

The majority of provisions in this Section are in substantial compliance, but improvement remains needed for several provisions. The Facility self-assessed several provisions in compliance that the Monitoring Team did not find in substantial compliance. The Facility should review the findings of this section carefully so that it can address those areas, both in terms of improvement and in determining how to assess status.

- 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 video surveillance program remained an important administrative tool in investigating abuse and neglect and other serious incidents.
  - 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.
- Improvements Needed
  - Lack of timely reporting of allegations of abuse/neglect and other serious incidents remained a significant problem at the Facility.
  - Although training for staff on abuse and incident reporting was in place, and all staff was current in that training; however, as noted in the last three reports, staff knowledge of abuse/neglect reporting requirements needed improvement.

<u>Quality Assurance</u>
Many elements of the QA program were described as "under construction" at the time of this review. For example, a plan for data analysis by both the QA staff and the departmental/discipline staff was in the very early stages of development. Additionally, the QA plan matrix was described as "under construction" and no document was provided to the Monitoring Team to review.

In its last report the Monitoring Team noted that the Facility recently appointed a new QA Director and that little progress had been made in implementing a QA program since the previous review. At that time the new QA Director reported the Facility's entire QA program was undergoing a major overhaul. The Monitoring Team was pleased to see the strides forward in organizing a QA program that had occurred since the last review; however, the status of the QA program at the Facility is still very much in an early stage of development.

- Positive Practices and Improvements Made
  - Since the last monitoring visit, the Facility developed a tracking system to identify what sections of the Settlement Agreement had external monitoring taking place by the Quality Assurance staff (i.e. Inter-rater reliability).

- Improvements Needed.
    - It did not appear the Facility had conducted a comprehensive review, through the QA/QI Council or some other mechanism of executive review, to determine the extent to which departmental/discipline policies addressed QA requirements.
    - The Facility's QA process reviewed by the Monitoring Team did not demonstrate consistency among and between departments/disciplines in the organization and collection of data, review and analysis of data, interaction between the QA Department, SA Coordinator (SAC) and section leads, and presentation and review of data and analysis by the QA/QI Council.
    - The Facility did not maintain a complete and adequate data list/inventory.
    - The QA Plan did not address specific requirements associated with the development and use of key indicator data.
    - Improvement is needed throughout the Facility in understanding the purpose of a Corrective Action Plan (CAP) and expectations regarding data to be included in a CAP.

<u>Integrated Protections, Services, Treatments and Supports</u>
There were several areas of progress, and the Facility continued to brainstorm new initiatives toward improving planning and integration, including Organizational Culture Change and an Engagement Campaign. The Monitoring Team commended these efforts; however, it was concerned that fundamental processes, including the quality of assessments and ongoing ISP implementation and monitoring, were not receiving adequate attention.

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. Overall, the Monitoring Team found there was some continued improvement in the ISP annual meeting interdisciplinary process as observed during this visit, but found significant problems with the development and implementation of an integrated ISP for each individual that ensured individualized protections, services, supports, and treatments were provided.

- Positive Practices and Improvements Made
    - RSSLC had continued to devote considerable resources to coaching and training for QIDP staff. As requested, the Monitoring Team focused attention in this regard on two ISP annual meetings observed during the monitoring visit.
    - There was a continued improvement in the organization of meetings observed.
    - The Facility continued to implement the "Supporting Visions" Individual Support Plan (ISP) process, which was intended to reinforce the concept that planning is intended to support the individuals' vision for the future.
    - There was continued progress noted in the facilitation process to enhance participation of the individual.
- Improvements Needed

- Considerable training and coaching continued to be provided to the QIDPs and IDTs. 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.
- IDTs were not yet proficient in identifying the most integrated setting appropriate to an individual's needs, although there was some improved discussion in the ISP annual planning meetings observed. 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.
- There were some examples of improved coordination of services at the Facility as well as a degree of improvement in integration observed in on-site planning meetings, but these were not yet sufficient to result in meeting the requirements of this Section.
- 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 identified outcomes related to each preference and meet identified needs.
- ISP strategies did not reflect encouragement of community participation in a meaningful or purposeful manner, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies.
- ISPs were not consistently implemented as written or monitored for progress.

<u>Integrated Clinical Services</u>
The Facility has continued to make progress in meeting the requirements of this provision. Although there is no overall policy guiding integrated planning, many policies include procedures to facilitate integration or requirements for integration. Various meetings and committees provide opportunities for integrated planning for individuals and system-wide processes. Nevertheless, this was still variable across disciplines.

- Positive Practices and Improvements Made
  - There was continued improvement in ISP meeting interdisciplinary process.
  - The Morning Report meeting continued to be an integrated, multidisciplinary meeting. Additionally, the Grand Rounds provided integrated review of one or more individuals who are experiencing a significant medical issue.
- Improvements Needed
  - The Facility did not yet have an accurate and useful process to track required attendance at annual ISP planning meetings, although there were indications that attendance was adequate or had improved.
  - Integrated Health Care Plans (IHCPs) did not consistently show adequate integration among all appropriate disciplines.
  - Review of consultations from non-Facility clinicians remained in substantial compliance.

Minimum Common Elements of Clinical Care

Progress continued for most provisions of this Section. Improvement continues to occur, but also more improvement is needed. The Facility had begun using statewide standardized assessment templates, with the exception of the Rights Assessment, Structural & Functional Assessment, and Pharmacy. These were intended to ensure all assessments would have a consistent foundation of information and analysis to be included.

- Positive Practices and Improvements Made
  - One area of considerable progress was the development and use of clinical indicators to guide medical care, particularly for chronic health conditions. For these databases, the Facility conducted comprehensive trend analyses and addressed both individual and systemic actions.
  - Response to acute medical conditions and dental emergencies remained timely.
- Improvements Needed
  - Facility tracking did not provide accurate data on timeliness of assessments. The Facility must implement a process for accurate tracking of completion of required assessments, as determined during the pre-ISP preparation meeting. Review of documents indicated annual and admission assessments by most disciplines were timely, and there was also improvement in timeliness of assessments when there was a change in status, but further improvement is needed.
  - There remained a need to ensure diagnoses were consistent with the findings from assessments.
  - Although response to acute medical conditions and dental emergencies remained timely, implementation of other interventions such as PBSPs, dental restorative treatment, and action plans identified by the Physical and Nutritional Management Team (PNMT) were delayed, or there was not evidence of timeliness provided to the Monitoring Team.
  - Outside of chronic health conditions, the use of clinical indicators had not yet progressed to the same degree; there was progress identifying indicators for physical and nutritional management (although not for recording of identified individualized triggers or monitoring of those indicators), but less progress for symptoms relevant to psychiatric care.
  - QIDP Monthly Reviews were not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development.

At-Risk Individuals

The statewide risk assessment procedure, with guidelines for rating risk, was in use at the Facility. The Facility policy for implementation of the State directed at risk policy had been revised subsequent to the most recent revision to statewide policy.

- Positive Practices and Improvements Made
    - Staff responsible for implementing various aspects of the At-Risk policy demonstrated an improved understanding of risk assessment policies and procedures. Considerable training of staff involved in risk identification activity and of IDTs responsible for the development of risk action plans had occurred, which was likely responsible for continued improvement in some compliance scores.
    - Although there remained some lack of clarity about data presented in discussion of risks, IDTs were for the most part incorporating clinical data and indicators into the risk assessment process.
    - IDTs were for the most part incorporating clinical data and indicators into the risk assessment process.
    - Plans to address risks were generally 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.
- Improvements Needed
    - The Facility's management system to identify individuals whose health or well-being is at risk lacked consistency in implementation.
    - Integration of PNMT recommendations into IHCPs and/or ISPs at the Facility remained a problem.
    - 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. Psychiatric staffing was adequate and the psychiatrists are well qualified. All individuals who require comprehensive psychiatric assessments had them, and psychiatrists have started to do annual reviews of those assessments. Nursing monitoring for safety during medical restraints improved. Good Reiss Screen procedures were in place for new admissions and for change of status evaluations. Psychiatry's participation in the Reiss screen process was satisfactory. The Facility introduced Psychoactive Medication Treatment Plans (PMTPs) to help link diagnoses, treatments, and monitoring for efficacy. The Facility was newly in compliance with Provisions J5 and J7, and substantial compliance with Provisions J1 and J15 was retained.

Although there was progress, much work on key items remains. Many psychiatric diagnoses do not have adequate diagnostic justifications, the reason for the use of many psychotropic medications remained unclear, and the Facility system to track medication treatments for efficacy was not adequate.

- Positive Practices and Improvements Made
    - The Facility had a sufficient number of FTE psychiatrists to ensure the provision of required services.
    - All individuals who are seen by psychiatry had Comprehensive Psychiatric Evaluations (CPEs) in place.
    - Monitoring for safety during and after pre-treatment sedation has improved.

- There continued to be good communication between the neurologist and psychiatrists around medications prescribed for both epilepsy and psychiatric indications.

- Improvements Needed
  - Many diagnoses were not fully justified according to DSM IV criteria since they did not provide sufficient information on the behavioral symptoms that supported the provided diagnoses.
  - Behavioral treatment programs still do not provide needed information about psychiatric treatment and the role of psychotropic medications. Facility efforts to improve moved forward with the introduction of the Psychoactive Medication Treatment Plan (PMTP).
  - Difficulties with development, implementation and tracking of supports to minimize the use of pre-treatment sedation persist, although the Facility has started a new initiative to address the matter.
  - Timely physician reviews of DISCUS and MOSES were not yet in place for many individuals.
  - Although all individuals had CPEs, only 73 of 138 (52%) of CPEs were in the required Appendix B format.
  - Improvement is still needed on combined case analysis and formulation.

<u>Psychological services</u>

There were numerous areas of improvement. At the same time, the Facility continued to demonstrate limitations or a lack of progress in several areas.

- Positive Practices and Improvements Made
  - The administrator of the Behavioral Health Services department continued to possess board certification as a behavior analyst.
  - Counseling services developed at the Facility had improved substantially and reflected a systematic approach to providing counseling supports.
  - Readability statistics for behavior interventions reflected that interventions were written in accessible language.
- Improvements Needed
  - The number of BCBAs employed by the Facility had dropped.
  - A sizable portion of behavior assessments and intervention plans were developed by employees who were not BCBAs.
  - There were considerable weaknesses in the internal and external peer review process. More than one third of individuals with behavior intervention plans had not been reviewed in over a year. In addition, it was not reflected in documented that all reviews were consistently conducted using a standard set of tools and procedures.
  - It was not evident that the Facility maintained adequate procedures for monitoring the psychological assessment process and ensure that all individuals received the necessary assessments.

- Behavioral assessments did not routinely reflect a adherence to practices accepted in the field of applied behavior analysis, including a lack of comprehensive functional assessment procedures and the identification of setting events, antecedents and consequences involved in maintaining challenging behavior.
- Behavior interventions did not consistently include procedures necessary of avoiding challenging behaviors or teaching replacement behaviors.
- The Facility reported no curriculum or strategy for providing competency-based training regarding behavioral principles or specific behavior interventions.

Medical Care

The Facility has continued to move forward towards substantial compliance in medical services by developing a medical QA process, adding a clinical performance process to enhance the DADS internal medical audit process, ensuring appropriate clinical care and follow-up of acute medical conditions, developing a new process to perform mortality review, and ensuring that all clinical issues addressed by the medical provider are documented in SOAP format, and are legible, in addition to many other improvements.

- Positive Practices and Improvements Made
  - There were some improvements in the area of follow-up to acute care issues and medical provider documentation.
  - The Facility's medical quality assurance (QA) process has continued to expand and has demonstrated effective use of QA information to improve status of healthcare. The Monitoring Team compliments the Facility for developing a comprehensive and clinically relevant quality assurance 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, utilizes clinical pathways that emphasize clinical performance issues, and specifically addresses medical providers' clinical performance against standardized clinical indicators. Development continued on 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, and development of meaningful corrective action plans. There were indications of follow-up on action plans to determine efficacy.
  - The Facility had continued to develop new policies for medical services and revise policies.
- Improvements Needed
  - There is a need for continuing enhancement of management of chronic conditions.
  - All medical conditions that are active, and/or require regular monitoring by the medical provider, must be listed on the active problem list.

- Medical providers must also develop, implement and assess necessary supports and services for diagnosed medical conditions, and ensure that direct care, and nurse staff are made aware of specific monitoring and reporting parameters for conditions that require specific and/or close monitoring.
- The DADS external medical performance review should be enhanced to 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.

Nursing Care

The Nursing Department continued to showed progress in Section M Provisions, more so in some than others. Provision M.3 showed significant improvement was made in the content and quality of Acute Care Plans and associated documentation in the Integrated Progress Notes. There was no significant improvement found in Provision M.5. Provision M.6 continued to maintain the positive practices found in previous reviews.

- Positive Practices and Improvements Made
  - Significant improvements were found in the assessment and documentation of acute change in health care status. This was no doubt attributed to the recent revision to the Acute Care template and continued daily Assessment and Documentation audits by the Nurse Managers and relevant Administrative/Management nursing staff.
  - The Quality Assurance processes were well established, including inter-rater reliability processes.
  - The Nursing Department worked collaboratively with other relevant disciplines and conducted a Diabetic Fair for individuals and their families/guardians to provide diabetic education.
  - Significant improvement was found in review of Acute Care Plans regarding the individualization, content, and quality of the plans, as well as in the associated documentation in the Integrated Progress Notes. Relevant Nursing Protocols were incorporated into the Acute Care Plans.
  - 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 medication variances, as well as for taking corrective actions to mitigate medication variances.
- Improvements Needed
  - Although the incidences of pressure ulcers were low, the Skin Integrity Committee needs to continue to analyze underlying causes of skin breakdown and ensure that the all required committee members consistently attend the meetings.

- The Emergency Response Committee recently procured a full body mannequin to use in conducting realistic mock medical emergency drill scenarios. However, more practice with these scenarios is needed to ensure competency.
- Integrated Risk Review Form (IRRF) and Integrated Health Care Program (IHCP) processes were still evolving. Since this is an integrated process, this will require Facility-wide improvement.

Pharmacy Services and Safe Medication Practices

The Monitoring Team noted significant improvement in the pharmacy's progress towards substantial compliance.

- Positive Practices and Improvements Made
  - Quarterly Drug Regimen Reviews (QDRRs) were significantly improved. The majority of the QDRRs were noted to be more coherent, addressed relevant clinical issues, and provided more structured recommendations.
  - The Facility conducted a clinically appropriate systems review for polypharmacy.
  - There were significant improvements in individual reviews for metabolic syndrome, benzodiazepine, anticholinergic and polypharmacy usage.
  - The Adverse Drug Reaction (ADR) process was much improved. The Facility had enhanced its training for all relevant staff on the ADR identification and reporting process, revised its ADR reporting form to include a section for pharmacists comments, ensured that pharmacists and medical providers document on the ADR, and ensured that there was clinical follow-up by the medical provider for all reported ADRs.
  - The Facility had continued to enhance its medication variance process by ensuring a robust reporting process, conducting efficacious medication variances committee meetings, and addressing medication variances once identified. Also, the Facility had a reporting process for documenting medication variances made by medical providers and pharmacy staff.
- Improvements Needed
  - Although QDRRs were improved, none of the QDRRs included a section for the medical providers to document if they agreed or disagreed with the pharmacist's recommendations.
  - The Facility must significantly improve its process for monitoring dyskinesia and other side effects associated with psychotropic medications.
  - The Facility did not conduct a meaningful system review for stat medication usage or systems review for benzodiazepines or anticholinergic drug usage.
  - There were not clinically meaningful individual reviews for stat psychotropic medication usage.

Physical and Nutritional Management

Overall, significant improvement was noted throughout all provisions. The PNMT continued to improve their process as well as their assessments. Physical and Nutritional Management Plans (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. Staff knowledge improved but proper implementation continued to be a concern of the Monitoring Team. A serious issue was an apparent lack of accuracy in monitoring; unless monitoring accurately identifies problems with implementation of PNMPs, there is little likelihood that implementation will improve and individuals will remain safe.

- Positive Practices and Improvements Made
  - A PNMT existed that contained all the required participants with the needed training. The PNMT met consistently and received the proper continuing education to expand their knowledge of PNM issues.
  - PNMPs, overall, continued to show significant improvement and demonstrated the information needed to guide staff in mitigating risks associated with PNM. PNMPs were mostly 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 ISP Addendum (ISPA) and/or PNMT minutes as well as training and implementation of the PNMP in a timely manner.
  - Improvement was found in positioning in bed.
  - All staff, new and existing, received both foundational as well as individual-specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Individual specific training was provided in a timely manner and was competency based as indicated by the change in the plan. The provided trainings resulted in improved staff knowledge.
- Improvements Needed
  - 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.
  - The Facility PNMT did not have a sustainable system that was fully implemented for resolution of systemic issues/concerns. All areas related to PNM were not effectively tracked and analyzed.
  - Measurable outcomes were missing related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. The referral criteria identified as part of the PNMT assessment were general and focused primarily on if pneumonia reoccurred, and did not utilize baseline data to help develop indicators of change.
  - While the ISPs contained review of the PNMP, the ISPs did not contain evidence of review as it relates to the effectiveness of the PNMP.
  - 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. The concern was that monitoring lacked accuracy, which calls into question the validity of the process and whether or not there is a true system in place to provide the monitoring needed to ensure implementation of the PNMP. The Monitoring Team was conducting an observation during lunch in which a therapist and two PNMP coordinators were present providing

monitoring. During this time, the three staff were observing the same tables and individuals as the Monitoring Team but failed to identify any of the concerns that were seen by the Monitoring Team.

Physical and Occupational Therapy

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.

- 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. 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. It appeared the plan to improve skill acquisition was working as evidenced by improvements from 56% to 75% regarding expansion of the individual's current abilities and 25% to 50% regarding the individual's potential to develop new functional skills.
  - All staff, new and existing, received both foundational as well as individual specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Individual specific training was provided in a timely manner and was competency based as indicated when there was change in the plan.
  - RSSLC PNMP Training and Monitoring Policy- K.07, the policy had been expanded to include monitoring for those who were moderate risk.
- Improvements Needed
  - 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.
  - Facility staff observing dining at the same time as the Monitoring Team missed issues of concern, calling into question the validity of the PNMP monitoring process.

Dental Services

The Monitoring Team noted substantial improvements in the area of dental services, and the Facility is moving closer to substantial compliance with Sections Q.1, and Q.2. Noted improvements included ensuring that oral healthcare programs

were developed, providing timely and comprehensive annual dental examinations, ensuring efficacious monitoring during and following dental anesthesia, and the initial development of an electronic mechanism to track and trend dental related services.

- Positive Practices and Improvements Made
  - The Facility provides close monitoring of individuals during and after TIVA anesthesia for dental services.
  - Oral health care plans were up to date and that they included all necessary instructions for living area staff.
  - Annual dental examinations were completed within a 12-month period, and were available to the IDT for review prior to the ISP meeting. In addition, the annual dental examinations were comprehensive and included assessment of periodontal disease, carries, oral hygiene, and behavior related issues.
  - The Integrated Risk Rating Form (IRRF) included issues related to suction toothbrushing. Policy was revised to ensure that there is a mechanism to help ensure on-going assessment of individuals for the possible need for suction toothbrushing in the future.
- Improvements Needed
  - The Facility must continue to enhance dental services, especially in areas such as tracking and trending restorative treatments.
  - Dental IPNs must be written in a language that can be interpreted by living area staff and include documentation informing the living area staff of the reason for the dental visit, assessment, treatments provided and pending, follow-up date, and monitoring parameters.
  - The Facility must also ensure a standardized approach to obtaining preventive dental health imaging studies, per recommendations by the American Dental Association, and in cases when such standards were not followed, or cannot be followed, ensure that the clinical rationale is documented in the dental record and the IDT is informed.
  - The Facility should also ensure that nursing staff complete a medical or nursing assessment documenting vital signs and general condition of the individual prior receiving anesthesia for dental services.
  - The Facility had redeveloped its dental QA process but had not yet implemented data collection or analysis. The Monitoring Team is concerned that the newly developed program is not designed to evaluate the effectiveness of dental services, and to track adverse outcomes secondary to dental services.
  - The Facility had yet to fully implement its newly developed project to help minimize the need for dental restraint.

<u>Communication</u>

RSSLC showed overall improvement with Provision R. Assessments continued to become more comprehensive and provided a much clearer picture of the individuals' level of functioning. General area communication devices continued to be reviewed and implemented in a more functional manner but implementation continued to be severely lacking. Direct and Indirect programs continued to need to be expanded to those Individuals who are most in need. Monitoring of these programs once in place was also an area that was in need of review to ensure appropriateness.

- Positive Practices and Improvements Made
    - A comprehensive Speech Policy existed that included but was not limited to information regarding staffing effectiveness, assessment schedule, IDT attendance expectations, and monitoring guidelines.
    - All positions were filled with permanent staff.
- Improvements Needed
    - 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.
    - Assessments that were provided were not consistently comprehensive in identifying methods to expand communicative functioning if there was not an indirect direct treatment plan in place. .
    - Programs were not developed and many of the ones in place were not being consistently implemented or monitored.
    - Communication strategies and programs were not consistently integrated into the ISP, and DSPs interviewed were not knowledgeable of the communication programs.
    - 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. Additionally, there were concerns over the validity of the monitoring results.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>
Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved.

- Positive Practices and Improvements Made
    - The percentage of individuals provided functional engagement continued to increase, with observations from the current sit visit reflecting the highest percentage of individuals actively engaged since the beginning of the Settlement Agreement monitoring process.
    - The Facility had substantially expanded the number of skill acquisition programs implemented in community settings, initiated a staggered approach to diversifying community training, and expanded the ability to track community activities.
- Improvements Needed
    - There was little evidence to indicate that the Facility made effective use of skill assessments when developing skill acquisition training programs. Few of the reviewed training programs were supported by assessment results, and assessment reports were frequently no available for the ISP meetings.
    - Skill acquisition programs continued to lack several components essential to effective teaching. Behavioral Objectives seldom included objectively defined and measureable goals. Staff instructions were unlikely to result in correct and consistent program implementation. In many circumstances, training opportunities were inadequate,

scheduled to occur once per day or less. Plans also lacked strategies for expanding the individual's ability to use the targeted skills outside of the specific training exercise.
  - Data from skill acquisition training continued to be recorded inconsistently and incorrectly.
  - Opportunities for competitive employment in the community were very limited. In the six months prior to the current site visit, one individual was provided a job in the community. This individual represented the only person living at RSSLC who had community employment.

Most Integrated Setting

Eleven individuals had transitioned to community living and there were 12 active referrals. More work remained to ensure transitions were effectively planned and successfully implemented. Positive developments noted included the development of a Grand Rounds process for reviewing CLDP assessments in advance of the actual CLDP meeting in order to identify any questions, concerns, or discrepancies that might need to be addressed. The Monitoring Team was also particularly pleased to see the Facility's increased in-service training and competency testing for provider staff.

- Positive Practices and Improvements Made
  - The Department of Admissions and Placements staff, including two Transition Specialists and a Transition QIDP, were working collaboratively with individuals, IDTs and families to foster encouragement of community living exploration and to effect transitions on a reasonable pace.
  - Facility staff responsible for required CLDP actions and the timeframes in which such actions are to be completed were consistently identified.
  - The individual and, as appropriate, the LAR, were involved in transition planning.
  - Post Move Monitoring (PMM) Checklists continued to be 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 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.

- Post move monitoring did not consistently identify all issues needing to be addressed, in part because RSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDPs, nor did the CLDPs yet provide adequate monitoring parameters for the Post-Move Monitor to reference.

Consent

The parties agreed the Monitoring Team would not monitor this Section, as the Facility was awaiting development of a process for assessing capacity of individuals to provide consent.

Recordkeeping and General Plan Implementation

The Facility maintained a unified record for each individual.

- Positive Practices and Improvements Made
  - One positive process that was unique to this Facility is the use of an 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.
  - Active Records were accessible and secure.
  - There was improvement in compliance with Appendix D requirements; additional improvement is needed, but the processes to continue improvement seem to be in place.
  - There was a robust audit process for which a new database had been developed to make the audit and correction process more efficient. Additional audits by Records Clerks expanded the information needed to identify corrections needed; this was a systemic action the Facility took to improve consistent compliance with Appendix D requirements. The Facility has a system for tracking corrections. The Facility has addressed systemic issues; although most of the actions are relatively recent, the improvement in compliance with Appendix D requirements had been ongoing since the last compliance visit, which indicates that actions to limit reoccurrence may be showing effect. The Facility should continue to develop processes to ensure corrections are made consistently and to minimize future errors.
- Improvements Needed
  - The checkout/checkin process needs to become more accurate
  - Documents in records were not consistently current, and there were several examples of documents not filed timely. There were also a few lapses in documenting timely in the record.
  - Although staff were able to describe how they used the records for decision-making, actual use of the records in interdisciplinary meetings was improved but variable. The Facility should develop a process to monitor and assess whether information from records is used for planning of supports and services during interdisciplinary meetings.

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

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment 2/13/14 2. RSSLC Action Plan 2/13/14 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. Facility training materials for restraint monitors 7. Sample C.1: 18 crisis intervention restraint records and related documentation. This consisted of 15% of the crisis intervention restraints reported by the Facility as having occurred between 9/1/13 and 1/31/14. This included restraint of 15 different Individuals, including the two most frequently restrained Individuals. 8. Sample C.2: 15 medical restraint records and related documentation. This consisted of 15% of the medical restraints reported by the Facility as having occurred between 9/1/13 and 1/31/14. 9. Sample C.3: a subsample of Sample C.1 of four records and related documentation associated with use of chemical restraint for crisis intervention. This sample of four represented 100% of the chemical restraints between 9/1/13 and 1/31/14. 10. Sample C.4: records and related documentation of restraint for the two incidents of use of restraint off-campus 11. Sample C.5: documentation associated with those Individuals restrained four or more times within a rolling 30 day period. 12. Sample C.6: documentation associated with the one Individual involved with physical mechanical restraint for self-injurious behavior (PMR-SIB) 13. Sample C.7: documentation associated with four individual who use abdominal binders 14. State report "Percent of All Employees Completing Courses of Training Program" 3/1/14 15. Restraint related monitoring/QA forms and reports 16. Crisis Intervention Restraint log 9/1/13 to 1/31/14 17. Medical Restraint log 9/1/13 to 1/31/14 18. Facility Restraint Trend Analysis 12/31/13 **People Interviewed:** 1. Lloyd Robert Buckner, MS, BCBA – Behavior Services Director 2. Pat Newell, Behavior Health Specialist 3. Georgette Brown, Quality Assurance Director 4. Dr. Carol Heath, Dental Director 5. Dr. Roger Joe, Psychiatrist 6. Alice Ramirez, Senior Data Analyst 7. Ten Direct Care Professionals

	Meetings Attended/Observations: 1. Incident Management Team (IMRT) 3/4/14 2. Three Rivers Unit Morning Meeting 3/5/14 3. Three Rivers Unit QA Committee meeting 3/4/14 4. Quality Assurance/Quality Improvement (QA/QI) Council 3/4/14 5. Restraint Reduction Committee 3/5/14
	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 109 crisis intervention restraints that occurred between 9/1/13 and 1/27/14. 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 and the absence of inter-rater reliability resulted in the absence of reliable 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 Provisions C.1 and C.2 of Section C. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with Provision C.2 and C.3. Noncompliance ratings were determined as a result of insufficient and/or incomplete documentation, inadequate clinical practices with respect to frequently restrained Individuals, and, in the case of medical restraint, practices which were not consistent with 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 as 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, most action steps focused on meeting with some other departments, developing plans to implement strategies, training as necessary and similar general non-specific actions. 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. As of this review period these audits had not been occurring.
	Summary of Monitor's Assessment: It appeared the use of crisis intervention restraint had decreased significantly (as much as 30% when comparing six month periods); however, because of questions associated with data validity, the Monitoring Team was unable to confirm this. Because of lack of specificity in ISPs and Physician Orders the Monitoring Team could not determine that the use of the abdominal binders was not a restraint. Complete and 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 remained problematic with little improvement was observed over the last two reviews. Not all requirements associated with the use of the Physical Mechanical Restraint for Self-Injurious Behavior (PMR-SIB) policy had been followed. The RSSLC's self-assessment reported that the Facility was in substantial compliance with Provisions C.1 and C.2. The Monitoring Team confirmed 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 and C.3, which addresses staff training. Staff knowledge, as demonstrated through answering seven questions, improved significantly from that observed at the last review. 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. The Facility had implemented a more formalized process for video review of restraints than that described

	at the last review. Video surveillance tapes that had recorded a restraint episode are used with regularity as part of the restraint review process. Most individuals still lack needed plans to reduce the need for pre-treatment sedation.

<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 governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>Data provided by the Facility for the past two six month periods, showed:
<table>
<tr><th>Type of Restraint</th><th>3/1/13 to 8/31/13</th><th>9/1/13 to 2/28/14</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>199</td><td>140</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>18</td><td>5*</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td><td>5*</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>217</td><td>150</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>21</td><td>28*</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>11</td><td>8</td></tr>
<tr><td>Medical restraints/dental
Medical restraints/medical procedures</td><td>50
124</td><td>50*
92*</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons*</td><td>174</td><td>142*</td></tr>
</table>
*NOTE: The Monitoring Team could not validate the data reported by the Facility as accurate with respect to chemical crisis intervention restraint and medical restraint due to conflicting information received in pre-visit document requests and interviews during the review. In fact, when the Monitoring Team counted restraints individually from logs prepared by the Facility for the pre-visit document request these numbers were substantially different than those reported in the above table. For example, the pre-visit document request reported four instances of crisis intervention chemical restraint. At the entrance conference the Facility reported 21 instances for essentially the same time period. The pre-visit document request reported approximately 40 instances of use of pretreatment sedation (medical restraint) for dental procedures. During the review in a meeting with both the Director of Behavioral Services and the Dental Director a much higher utilization of pre-treatment sedation was reported (well over 100 instances). These data problems were brought to the attention of the Facility on the first day of the review and the Facility was unable to satisfactorily resolve the issue and present accurate data by the end of the review. The Monitoring Team made a similar observation in its last report. It is imperative that the Facility better coordinate the assembly of valid data</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		among and between departments and among and between databases to ensure accurate data is reported to the Monitoring Team in the future and, even more importantly, so the Facility can use valid information to determine need to improve processes and respond to changes that may occur in restraint usage. It appeared the use of crisis intervention restraint had decreased significantly (as much as 30% when comparing six month periods); however, because of questions associated with the validity of data noted above, the Monitoring Team could not confirm this. <u>Prone Restraint</u> 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. Based on a review of the restraint records for individuals in Sample C.1 involving 15 Individuals none showed use of prone restraint. Based on questions with 10 direct support professionals, all (100%) were aware of the prohibition on prone restraint. This was a significant improvement from the 36% noted in the last compliance review. <u>Other Restraint Requirements</u> 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 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 18 of the 18 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • For the 18 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 18 (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 18 of the records (100%), there was evidence that restraint was used only	

#	Provision	Assessment of Status	Compliance
		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 18 restraints, involving 15 Individuals, 18 (100%) were approved restraints. In 18 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 (#302) had been the subject of physical mechanical restraint for self-injurious behavior (PMR-SIB). This restraint (use of a helmet) was initiated on 8/26/13 and lasted until 9/16/13. The Monitoring Team determined that most, but not all, requirements of PMR-SIB policy had been followed. Required circulation checks did not always occur within prescribed timeframes. The Monitoring Team selected five daily restraint checklists to review. In two (40%) circulation checks did not occur as specified in policy. This was the case on 9/6 and 9/12. Additionally, the checklist for 9/9 showed the nurse conducted the daily onsite observation after the restraint (helmet) was removed and but checked "yes" for "proper use of device" which could not be correct since the Restraint Checklist shows the device was removed 15 minutes before the nurse observation. The Monitoring Team reviewed four Individuals who used abdominal binders related to G/J tube placement (Individuals #16, #73, #77, and #500). This review was done to ensure the use of an abdominal binders was not to inhibit controllable behavior on the part of the Individual. The Monitor Team reviewed the physician order for the abdominal binder, the Individual's most recent ISP, and any ISPAs that addressed the subject of abdominal binders. In only one case (25%) could the Monitoring Team determine with clarity that the use of the abdominal binder was not a restraint. This was the case for Individual #77. For the other three Individuals either the ISP contained no discussion of the use of an abdominal binder (Individuals #16, #73, and #500) and/or the physician order provided no rationale for the use of the abdominal binder (Individuals # 73 and #500). Consequently based on review of this documentation the Monitoring Team could not validate the purpose of the abdominal binder and could not rule out its use as a restraint. Based on this review this Provision was not in substantial compliance.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to	The restraint records involving the 15 individuals in Sample C.1 were reviewed. Of these, eight of the individuals had Crisis Intervention Plans at the time of restraint that defined the use of restraint.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	him/herself or others.	For the eight Individuals who had Crisis Intervention Plans (CIP), eight (100%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. For the seven Individuals who did not have Crisis Intervention Plans at the time of restraint, six (86%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. This was not the case for Individual #140 (restraint on 11/20). In this case the wrong restraint Checklist was used and did not contain sufficient documentation to determine compliance. Overall, 14 of 15 (93%) Individuals were released from restraint according to policy. Based on this review this Provision was in substantial compliance.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The 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: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. In order to validate staff training the Monitoring Team reviewed the training transcripts of 23 staff who were listed on the Restraint Checklists associated with Sample C.1 as having applied restraint. This review showed that: • 23 of the 23 (100%) had current training in RES0105 Restraint Prevention and Rules. • 23 of the 23 (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. • 23 of the 23 (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: • 99% RES0105 Restraint: Prevention and Rules for Use at MR Facilities • 99% RES0110 Applying Restraint Devices • 99% PMA0320 – PMAB Basic • 99% PMA0400- PMAB Restraint	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• 99% PMA0700 –PMAB Prevention • 100% PBS0100 – Positive Behavior Support In order to evaluate staff knowledge in the area of restraint, 10 Direct Care Professionals were asked a series of questions. These questions came from Facility training materials. The 10 staff were selected by the Facility and included both am and pm staff. Each response was evaluated by one member of the Monitoring Team, the Facility's Behavior Health Specialist, and the Facility's Quality Assurance Program Monitor assigned to Section C of the SA. Consequently, for each question, responses were subjected to 30 evaluations (ten individuals' times three raters). Based on responses to questions, 10 direct support professionals provided satisfactory responses to the following questions as follows: • "When is the only time we should restrain an individual?" Twenty-seven of 30 responses were evaluated as satisfactory (90%). • "What other things should we have done before we restrain?" Twenty-six of 30 responses were evaluated as satisfactory (87%). • "Give an example of verbal redirection that you have used." All 30 responses were evaluated as satisfactory (100%). • "Tell me two of the three kinds of restraint we can use here." All 30 responses were evaluated as satisfactory (100%). • "What level of supervision should happen when an individual is in restraint?" All 30 responses were evaluated as satisfactory (100%). • "Is it ever OK to restrain a person face down (prone)?" All 30 responses were evaluated as satisfactory (100%). • Name the two staff that should be contacted immediately regarding restraints?" All 30 responses were evaluated as satisfactory (100%). Overall for the seven questions, 203 of 210 (97%) responses were assessed as satisfactory. In 18 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 in substantial compliance.	
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	Based on a review of 18 restraint records (Sample C.1), in 18 (100%) there was evidence that documented that restraint was used as a crisis intervention. In review of 10 Positive Behavior Support Plans, in 10 (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was	Noncompliance

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	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.	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. In order to document that "no restraint shall be used that is prohibited by the individual's medical orders or ISP" 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 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 15 Individuals in Sample C.1. The form was present for each Individual; however, for eight (53%) 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. This was the case for Individuals #278, #513, #543, #151, #74, #140, #513, and #561. As a result of this review the Monitoring Team determined that for eight of 15 Individuals (53%) 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. This deficient practice was reported by the Monitoring Team in its last review and had not been addressed by the Facility. The Facility reported it was aware of this and intended to address this issue prior to the next review. Additionally, as noted in its last report, no documentation was provided to the Monitoring Team 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. The Facility reported it was aware of this and intended to address this issue prior to the next review. 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 18 of 18 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 Sample C.2 (15 ISPs for individuals for whom restraint had been used for	

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		the completion of medical or dental work): • Thirteen (87%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • Three (20%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and • One (33%) of the treatments or strategies developed to minimize or eliminate the need for restraint was implemented as scheduled. 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	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 18 restraint records (Sample C.1), a face-to-face assessment was conducted: • In 16 out of 18 incidents of restraint (89%) the assessment indicated the restraint was monitored by an adequately trained staff member. This was not the case for Individual #140 (restraint on 11/20). In this case the wrong Restraint Checklist was used and did not contain sufficient documentation to determine compliance. This was also not the case for Individual #561. In this case the Facility reported no restraint monitor had been notified of the restraint	Noncompliance

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	signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	episode. This was a chemical restraint administered in the Facility's Infirmary and the nurse did not notify campus administration that a restraint monitor was needed. Following this error the Facility re-inserviced all nurses on their responsibilities with respect to restraint policy. • In 12 of 18 instances (67%), 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, #630, #363, #151, and #140 (2x). • In 16 of 18 instances of restraint (89%), the documentation showed that an assessment was completed of the application of the restraint. This was not the case for Individual #140 (restraint on 11/20). In this case the wrong Restraint Checklist was used and did not contain sufficient documentation to determine compliance. This was also not the case for Individual #561. In this case the Facility reported no restraint monitor had been notified of the restraint episode. • In 16 instances (89%), the documentation showed that an assessment was completed of the consequences of the restraint. This was not the case for Individual #140 (restraint on 11/20). In this case the wrong Restraint Checklist was used and did not contain sufficient documentation to determine compliance. This was also not the case for Individual #561. In this case the Facility reported no restraint monitor had been notified of the restraint episode. • In no case had a physician ordered an alternative monitoring schedule. Based on a review of 18 restraint records for restraints that occurred at the Facility (Sample C.1), of which four of 18 (22%) restraint records were for chemical restraint and 14 of 18 (78%) were for physical restraints. For the 14 nonchemical restraints in Sample C.1 There was documentation that a licensed health care professional: • Conducted monitoring at least every 15 minutes from the initiation of the physical restraint in 13 of 14 (93%). • Monitored and documented vital signs in seven of 14 (50%) of the instances of physical restraint. Records that did not contain documentation of this included: o Individual #306: On 10/9/13 at 4:03 p.m., Individual #306 was physically restrained. The nurse documented that Individual #306 refused to allow a full set of vital sign monitoring. There was no documentation that the nurse visually observed for respiratory and cardiac/circulatory distress. o Individual #368: On 10/18/13 at 6:50 p.m., Individual #368 was physically restrained. The nurse documented that Individual #368 refused to allow vital sign monitoring. There was no documentation that the nurse visually observed for respiratory and cardiac/circulatory distress.	

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		o Individual #140: On 1/15/14 at 3:40 p.m., Individual #140 was physically restrained. The nurse documented that Individual #140 refused to allow vital sign monitoring. There was no documentation that the nurse visually observed for respiratory and cardiac/circulatory distress. o Individual #475: On 12/3/13 at 6:00 p.m., Individual #475 was physically restrained. The nurse documented that Individual #475 refused to allow vital sign monitoring. There was no documentation that the nurse visually observed for respiratory and cardiac/circulatory distress. o Individual #363: On 12/11/13 at 5:45 p.m., Individual #363 was physically restrained. The nurse documented that Individual #363 refused to allow vital sign monitoring. There was no documentation that the nurse visually observed for respiratory and cardiac/circulatory distress. o Individual #151: On 12/28/13 at 4:30 p.m., Individual #151 was physically restrained. The nurse documented that Individual #151 refused to allow vital sign monitoring. There was no documentation that the nurse visually observed for respiratory and cardiac/circulatory distress. o Individual #74: On 1/8/14 at 1:00 p.m., Individual #74 was physically restrained. The nurse documented that Individual #74 refused to allow vital sign monitoring. There was no documentation that the nurse visually observed for respiratory and cardiac/circulatory distress. • Monitored and documented mental status in 13 of 14 (93%) of the instances of physical restraint. o Individual #74: On 1/8/14 at 1:00 p.m., Individual #74 was physically restrained. The nurse documented that due to Individual #74's aggressive behavior mental status was unable to be assessed. There was no documentation that the nurse visually observed Individual #74's mental status. For Sample C.3 (Chemical restraint) which was a subsample of Sample C.1: • Conducted monitoring at least every 15 minutes from the initiation of the chemical restraint for at least two hours, according to policy for Post-Med Monitoring of Chemical Restraint, in three of four (75%). Records that did not contain documentation of this included: o Individual #140: On 11/20/13 at 0400 Individual #140 received a chemical restraint. The Facility did not use the correct Restraint Checklist to document nursing monitoring.	

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		• Monitored and documented vital signs in three of four (75%) of the instances of chemical restraint. Records that did not contain documentation of this included: o Individual #140: On 11/20/13 at 0400 Individuals #140 received a chemical restraint. The Facility did not use the correct Restraint Checklist to document nursing monitoring. • Monitored and documented mental status in three of four (75%) of the instances of chemical restraint. o Individual #140: On 11/20/13 at 0400 Individuals #140 received a chemical restraint. The Facility did not use the correct Restraint Checklist to document nursing monitoring. • Monitored and documented whether restraint-related injuries occurred for both chemical and physical restraint episodes. In 16 of 18 (89%) instance of restraints the Restraint Checklists for Injury were documented. One of 18 (6%) restraint episodes indicated that minor injuries were sustained, of which one occurred during restraint from aggressive/self-injurious behaviors. One of 18 (6%) restraint episodes did not document whether injuries occurred. The records that did not contain documentation of this included: o Individual #74: On 1/8/14 at 1:00 p.m. Individual #74 was physically restrained but the Crisis Intervention Restraint Checklist was not marked to indicate whether or not an injury had occurred as a result of the restraint episode. 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. The Facility should ensure that the correct Crisis Intervention Restraint Checklist is used for documenting monitoring for chemical restraint use. Based on documentation provided by the Facility, two restraints had occurred off the grounds of the Facility in the last six months. A sample of two was reviewed (Sample	

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		C.4). A licensed health care professional: • Conducted monitoring within 30 minutes of the individual's return to the Facility in two out of two (100%). • Monitored and documented vital signs in zero of two (0%). Records that did not contain documentation of this included: o Individual #32: On 11/5/13 at 7:47 p.m., a physical restraint was applied. The nurse documented that Individual #32 refused to allow vital sign assessments. There was no documentation that the nurse visually observed for signs and symptoms of respiratory or cardiac/circulatory distress. 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. • Monitored and documented mental status in two of two (100%). • Monitored and documented whether injuries occurred during the restraint episodes. Zero of two (0%) restraint episodes resulted in an assessment by a licensed health care professional documenting whether injuries were sustained as a result of the restraint episodes. Sample C.2 was selected from the list of individuals who had medical restraint in the last six months. It represents 20% of the individuals for whom medical restraint was used. (Sample C.2 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In four out of 15 (27%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • In zero out of 15 (0 %), the physician specified the type of monitoring required if it was different than the facility policy. • In 15 out of 15 of the medical restraints (100%), 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	A sample (Sample C.1) of 18 Restraint Checklists for individuals in crisis intervention restraint was selected for review. Note: For restraint of Individual #140 (restraint on 11/20) the wrong Restraint Checklist was used and did not contain sufficient documentation to determine compliance. This will account for one deficient practice noted for each of the compliance rates reported below. The following compliance rates were identified for each of the required elements: • In 17 (94%), continuous one-to-one supervision was provided; • In 17 (94%), the date and time restraint was begun;	Noncompliance

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	medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	• In 17 (94%), the location of the restraint; • In nine (50%), 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 nine restraints (50%) information addressing this was either overly general or nonexistent. This deficient practice was reported by the Monitoring Team in its last review and had not been addressed by the Facility. • In 15 (83%), the actions taken by staff prior to the use of restraint were described on the restraint checklist and FFAD with enough data to permit adequate review of restraint application per Provision C.8. This was not the case for Individuals #140 (11/20/13 and 12/10/13) and #561. • In 17 (94%), the specific reasons for the use of the restraint; • In 17 (94%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • In 17 (94%), 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 17 (94%), 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 17 (94%), the level of supervision provided during the restraint episode; • In 17 (94%), the date and time the individual was released from restraint; and • In 16 (89%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. This was not the case for Individuals #140 (11/20/13) and #74 (1/8/14). In five other instances data entered on the checklist was contradictory to data reported on the restraint debriefing form. This was the case for Individuals #278, #306, #513, #630, and#543. Overall, in seven of 18 (39%), data regarding restraint related injuries could not be accurately determined. • In a sample of 18 records (Sample C.1), restraint debriefing forms had been completed for 16 (89%). This was not the case for Individuals #140 (11/20/13) and #561. As reported in the previous paragraph, data recorded on debriefing forms was not always consistent with data recorded on the restraint checklist. • In 17 instances (94%), the documentation showed that an assessment was completed of the application of the restraint. A sample of 15 Individuals subject to medical restraint was reviewed (Sample C.2), and in	

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		four (27%), there was evidence that the monitoring had been completed as required by the physician's order Sample C.3 was selected using the list the Facility provided of individuals who had had chemical restraint since the last on-site review. Sample C.3 consisted of all four Individuals who had chemical restraint, In three (75%), 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. This was not the case for restraint of Individual #140 (restraint on 11/20/13 at 12:40am). Based on this review this Provision was not in compliance.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(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, a total of six individuals were placed in restraint more than three times in any rolling 30-day period. A sample of six 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. • Records for four of six individuals reviewed (67%) reflected documentation of a timely ISPA following each episode in which the individual experienced more than three applications of restraint in a rolling 30 day period. Of the remaining two individuals, one (Individual #787, 17%) had no documented ISPA reviews despite nine applications of restraint within a 48-day period. The second remaining individual (Individual #74, 17%) experienced four restraint applications on 1/8/2014; the Facility conducted no ISPA review until 1/31/2014. • Of the five individuals reviewed who were provided ISPAs following more than three restraint applications in a rolling 30-day period, one (Individual #74, 20%) was provided an adequate ISPA review of adaptive skills and biological, medical, and psychosocial factors. • For Individual #74, none of the factors required by this provision was hypothesized to affect the behaviors that provoke restraints.	Noncompliance

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	(b) review possibly contributing environmental conditions;	Records for four of six individuals reviewed (67%) reflected documentation of a timely ISPA following each episode in which the individual experienced more than three applications of restraint in a rolling 30 day period. Of the remaining two individuals, one (Individual #787, 17%) had no documented ISPA reviews despite nine applications of restraint within a 48-day period. The second remaining individual (Individual #74, 17%) experienced four restraint applications on 1/8/2014; the Facility conducted no ISPA review until 1/31/2014. • Of the five individuals reviewed who were provided ISPAs following more than three restraint applications in a rolling 30-day period, one (Individual #74, 20%) was provided an adequate ISPA review of environmental factors. • For Individual #74, environmental factors were not hypothesized to affect the behaviors that provoked restraints.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Records for four of six individuals reviewed (67%) reflected documentation of a timely ISPA following each episode in which the individual experienced more than three applications of restraint in a rolling 30 day period. Of the remaining two individuals, one (Individual #787, 17%) had no documented ISPA reviews despite nine applications of restraint within a 48-day period. The second remaining individual (Individual #74, 17%) experienced four restraint applications on 1/8/2014; the Facility conducted no ISPA review until 1/31/2014. • Of the five individuals reviewed who were provided ISPAs following more than three restraint applications in a rolling 30-day period, one (Individual #74, 20%) was provided an adequate ISPA review of potential environmental antecedents to the behaviors that provoke restraint, • For Individual #74, environmental antecedent factors were not hypothesized to affect the behaviors that provoked restraints.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	Records for four of six individuals reviewed (67%) reflected documentation of a timely ISPA following each episode in which the individual experienced more than three applications of restraint in a rolling 30 day period. Of the remaining two individuals, one (Individual #787, 17%) had no documented ISPA reviews despite nine applications of restraint within a 48-day period. The second remaining individual (Individual #74, 17%) experienced four restraint applications on 1/8/2014; the Facility conducted no ISPA review until 1/31/2014. • Of the five individuals reviewed who were provided ISPAs following more than three restraint applications in a rolling 30-day period, one (Individual #74, 20%) was provided an adequate ISPA discussion of the variable or variables that potentially are maintaining the behavior provoking restraints, • For Individual #74, no function was hypothesized to affect the behaviors that	Noncompliance

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		provoke restraints.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	Of the six individuals reviewed who experienced more than three restraint applications in a rolling 30-day period, none (0%) were provided an adequate PBSP and crisis intervention plan. Six of six individuals (100%) were provided a PBSP, but none of the six PBSPs (0%) reflected all necessary components. Three of six individuals (50%) were provided a crisis intervention plan, but none of the three plans (0%) reflected all necessary components. • Two of six PBSPs reviewed (33%) had operationally defined target behaviors. • None of six PBSPs reviewed (0%) contained functional replacement behaviors. • None of six PBSPs reviewed (0%) specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint. • None of six PBSPs reviewed (0%) contained adequate interventions to weaken or reduce the behaviors that provoked restraint that are clear, precise and based on a functional assessment. • None of the three crisis intervention plans (0%) delineated the type of restraint authorized. • None of the three crisis intervention plans (0%) specified the maximum duration of restraint authorized. • Two of the three crisis intervention plans (67%) specified the designated approved restraint situation. • Two of the three crisis intervention plans (67%) specified the criteria for terminating the use of the restraint.	Noncompliance
	(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	Although each of the six individuals (100%) was provided at least one treatment integrity observation during the previous six months, none (0%) was provided sufficient treatment integrity checks to establish valid and reliable treatment integrity.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Records for none of the six individuals reviewed (0%) reflected that the IDT conducted an adequate review of the existing PBSP to determine if revisions to the PBSP were necessary. No ISPAs documented a recommendation for a revision to a PBSP and none was noted to have occurred as a result of an ISPA review.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the	In its last report the Monitoring Team noted that if an individual does not have a Crisis Intervention Plan (CIP), RSSLC did not require that the IDT meet and review each use of restraint. During this review, Behavioral Services staff reported this requirement had not	Noncompliance

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	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.	as yet been added to Facility policy; however, when the Monitoring Team reviewed Facility policy J.1 (4/10/12) the following language was found on page 16: "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. For Individuals with a Crisis Intervention Plan, the IDT determines the review schedule based upon the individual's needs, but at least quarterly." Seven Individuals in Sample C.1 had Crisis Intervention Plans and in no instance (0%) did the CIP specify a review schedule. In Sample C.1, in only five of 18 (28%) restraints was documentation available to support either an IDT review within one working day (in the case of those without a CIP) or at the next quarterly review (in the case of those with a CIP). The Facility reported that it had recently issued a requirement that IDT's are to review each restraint episode as required by Policy. 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 18 incidents of crisis intervention restraint was reviewed (from Sample C.1 – selected restraints number two, five, eight, eleven, and thirteen from the list of 18. This included restraints of Individuals #278, #798, #543, #151, and #140 on 1/15), including the Unit morning meeting minutes, IMRT meeting minutes, ISP addenda, debriefing meeting minutes, etc.. This documentation showed that: • In five (100%), the review in the Unit morning meeting occurred within three business days of the restraint episode as documented by signature on the Restraint Checklist. In two (40%), Individuals #278 and #151, the Facility was unable to produce minutes from the Unit morning meeting; therefore, there was no way to validate these reviews occurred. Consequently the compliance rate for this metric was 60%. • In four (80%), the review by the IMRT occurred within three business days of the restraint episode as documented by signature on the Restraint Checklist.	

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		Documentation for restraint of Individual #140 did not. IMRT minutes in each case confirmed the date of IMRT review. • In five (100%), the circumstances under which the restraint was used were determined and 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. Minutes of the IMRT meetings were provided for all five (100%) restraints. In no case did minutes reflect substantive discussion of the circumstances associated with restraint use and merely served as a mechanism to record the restraint occurred. This deficient restraint review practice was reported by the Monitoring Team in its last review and had not been addressed by the Facility. Behavioral services staff acknowledged this problem and anticipated improvement for the next review. This issue may be primarily a matter of properly documenting restraint review in meeting minutes as the unit restraint review observed by the Monitoring Team at Three Rivers on 3/5/14 was thorough, substantive, and adequately addressed SA requirements. It is important that minutes reflect the substantive discussion that occurs at a unit morning meeting to ensure that intended follow-up actions by the IDT are articulated and their occurrence can be verified. • In one (20%), referral was made to the IDT, as appropriate (Individual #278). The Monitoring Team was not provided with any documentation which could validate the IDT met as requested by the IMRT and therefore could not substantiate whether appropriate changes had been considered and made to the individuals' ISPs and/or PBSPs in a timely manner as required by this Provision. The Facility had implemented a more formalized process for video review of restraints than that described at the last review. When video surveillance video footage of a restraint is available a group typically consisting of at least the Director of Behavioral Services, a QA Program Monitor, a CTD instructor, and the Incident Management Coordinator review the video together, discuss what they saw, reconcile any differences of opinion, and record their collective conclusions on a Restraint Video Review Checklist recording 10 specific points of inquiry. These included conclusions reached with respect to the details on the restraint checklist matching the video, notation of any environmental issues, appropriate application of restraint, appropriate restraint release, timely response of the restraint monitor and nursing staff. The Facility will need to determine how this	

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		important information is fed back through the policy required elements of restraint review, especially the IMRT requirements. Based on this review this Provision was 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 2/13/14 2. RSSLC Action Plans 2/13/14 3. RSSLC Section D Presentation Book 4. DADS Policy 021.3 Protection From Harm – Abuse, Neglect, and Exploitation 11/5/13 5. DADS Policy 02.5 Incident Management 11/5/13 6. RSSLC Policy C.01 Incident Management 11/25/13 7. RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 11/25/13 8. RSSLC Policy C.19 Injury Audits 4/1/13 9. RSSLC Policy D.8 Completing/Routing Client Injury Report 8/16/13 10. RSSLC Policy E.17 Completing Incident Information Reports 1/22/14 11. Log of Department of Family and Protective Services (DFPS) cases 9/1/13 to 1/31/14 12. Log of serious injuries 9/1/13 to 2/28/14 13. Log of serious incidents 9/1/13 to 2/28/14 14. Log of witnessed Injuries 9/1/13 to 3/3/14 15. Log of discovered Injuries 9/1/13 to 3/3/14 16. Log of peer to peer injuries 9/1/13 to 1/31/14 17. CMS 2567 survey reports since the last review 18. Acknowledgement of Reporting signed forms for 25 randomly selected employees 19. 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 since the last review. The sample was 26% of reported investigations initiated and completed since the last review and included DFPS cases 43005290, 42858283, 42876783, 42877983, 42884962, 42891348, 42896188, 42909330, 42919661, 42958963, 42969152, 42974329, 42984981, 43001455, and 43010886. The sample represented investigations that resulted in confirmed, unconfirmed, inconclusive, and administrative referral findings. 20. Sample D.2: included a sample of Facility-only investigation reports selected from the document the Facility provided listing investigations completed since the last review. The sample was 33% of reported investigations initiated and completed since the last compliance visit. Sample D.2 included UIRs 012, 013, 046, 074, and 050. The sample included two discovered serious injuries and three unauthorized departures. 21. Sample D.3: a sample of 11 completed Record Audits to determine whether significant injuries had been reported. 22. ISPs for Individuals #349, #723, #758, #86, #302, #184, #125, #324, #503, and #144 23. DADS report MHMR0102 Percent of All Employees Completing Course of Training 3/1/14

	24. QA/QI meeting minutes 10/8/13 and 11/19/13 25. Abuse/neglect quiz used by campus administrators (undated) 26. Self-Advocate meeting minutes for two meetings since the last review 27. RSSLC Trend Reports 12/31/13 **People interviewed:** 1. Robert Muhammad, Incident Management Coordinator 2. Georgette Brown, Quality Assurance (QA) Director 3. Vincetta Williams, Facility Investigator 4. Autumn Patrick, Facility Investigator 5. Linda Zepeda-Narvaez, IMC Administrative Assistant 6. Alice Ramirez, Senior Data Analyst 7. Yolanda Jones, OIG Investigator 8. Ten Direct Support Professionals **Meetings attended/Observations:** 1. Incident Management Team Meeting (IMRT) 3/4/14 2. Three Rivers Unit morning meeting 3/6/14 3. Quality Assurance/Quality Improvement (QA/QI) Council 3/4/14 4. ISP meetings for Individuals #718 and #675
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section D, in conducting its self-assessment: • The Facility did not report if it used any specific monitoring/auditing tool in its review of a 29% sample of the 70 abuse/neglect investigations or the 77% sample of the 26 Facility only investigations that occurred between 8/1/13 and 1/14/14. 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. • The Facility in its self-assessment 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. • 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 although the IMC recorded observations on a spreadsheet. • The absence of use of any type of formal monitoring/auditing tool resulted in the absence of indicators to allow the Facility to determine compliance with the Settlement Agreement. • 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 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. • 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, f, g, h, and i, 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 ongoing. The Facility data identified areas of needed improvement. For example, the Facility self-assessment reported a need to develop additional strategies to improve the timeliness of incident reporting. The actions did not always provide a set of detailed steps likely to lead to compliance with the requirements of this Section. For example, action steps included "analyze data monthly", "develop corrective action as needed", and "track late reporting on unusual incident log and make recommendations". The action plan steps did not include any detail with regard to how this was to happen.
	Summary of Monitor's Assessment: 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. Seven 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.e which addresses communicating reporting abuse/neglect with Individuals and LARs. 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. 7. Provision D.4 which addresses trend analysis and follow-up.

	One Provision was rated as noncompliance in the Facility self-assessment but was determined as in compliance by the Monitoring Team. This was the case for Provision D.2.i. Timely reporting of allegations of abuse/neglect and other serious incidents remained a significant problem at the Facility. The Monitoring Team determined that only 47% of serious incidents were reported within policy and Settlement Agreement required timeframes. The Facility self-assessment reported that only 58% of serious incidents were reported within policy and Settlement Agreement required timeframes. This problem had been reported in previous reports by the Monitoring Team and actions taken by the Facility to address it have been ineffective. The Monitoring Team found no evidence that a formal Corrective Action Plan, either in response to the last review by the Monitoring Team or the Facility's self-assessment, had been established. 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. 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 three reports, staff knowledge of abuse/neglect reporting requirements needed improvement. 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.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. In its last report the Monitoring Team noted that 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 and noted that some of the Facility's administrative practices directed at abuse/neglect and incident management needed additional management oversight to ensure their effectiveness in protecting Individuals and keeping them safe. The Facility took several actions in this regard since the last review (e.g. creating additional posters addressing reporting, tracking late reports, and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		random quizzes of staff) yet the significant problem of late reporting of incidents highlighted in the last two reports by the Monitoring Team remains. For example: • As reported in Provision D.2.a, the Monitoring Team was only able to validate timely reporting to DFPS in three of 10 (30%) allegations of abuse/neglect. • As reported in Provision D.2.a, the Monitoring Team was only able to validate timely reporting to the Facility Director/designee of four of five (80%) other serious incidents. • Therefore, collectively, only seven of 15 (47%) of serious incidents were reported timely. • As reported in Provision D.2.a the Facility self-assessment reported with respect to allegations of abuse/neglect that in only nine of 20 cases the Facility reviewed (45%) was reported within the required timeframes. • As reported in Provision D.2.a the Facility self-assessment reported with respect to serious incidents other than allegations of abuse/neglect that in only 14 of 20 cases the Facility reviewed (70%) was reporting within the required timeframes. • Therefore, based on the Facility self-assessment collectively only 23 of 40 (58%) serious incidents were reported timely. While an improvement from the compliance rate of 36% reported in the last review by the Monitoring Team this remains unacceptable potentially placing Individuals at risk. As noted above, the review of the Monitoring Team sample showed a compliance rate of only 33%. • 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. 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 appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report	Although in the paragraphs that follow, the Monitoring Team has provided some figures	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>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 investigated by DFPS for the past year were:
<table>
<tr><th></th><th>3/1/13 to 8/31/13</th><th>9/1/13 to 2/28/14</th></tr>
<tr><td>Total abuse allegations</td><td>91</td><td>75</td></tr>
<tr><td>Physical</td><td>56</td><td>54</td></tr>
<tr><td>Verbal/Emotional</td><td>35</td><td>21</td></tr>
<tr><td>Abuse confirmed</td><td>5</td><td>5</td></tr>
<tr><td>Physical</td><td>2</td><td>5</td></tr>
<tr><td>Verbal/Emotional</td><td>3</td><td>0</td></tr>
<tr><td>Abuse inconclusive</td><td>5</td><td>14</td></tr>
<tr><td>Physical</td><td>5</td><td>12</td></tr>
<tr><td>Verbal/Emotional</td><td>0</td><td>2</td></tr>
<tr><td>Total neglect allegations</td><td>63</td><td>57</td></tr>
<tr><td>Neglect confirmed</td><td>10</td><td>1</td></tr>
<tr><td>Neglect inconclusive</td><td>0</td><td>4</td></tr>
<tr><td>Total exploitation allegations</td><td>2</td><td>2</td></tr>
<tr><td>Exploitation confirmed</td><td>0</td><td>0</td></tr>
<tr><td>Exploitation inconclusive</td><td>0</td><td>0</td></tr>
</table>
According to data the Facility provided in a report prepared for the Monitoring Team the numbers of Unusual Incidents investigated by the Facility over the past year included:
<table>
<tr><th></th><th>3/1/13 to 8/31/13</th><th>9/1/13 to 2/28/14</th></tr>
<tr><td>Deaths</td><td>5</td><td>0</td></tr>
<tr><td>Serious Injuries</td><td>21</td><td>10</td></tr>
<tr><td>Sexual Incidents</td><td>0</td><td>0</td></tr>
<tr><td>Suicide Threat (credible)</td><td>7</td><td>2</td></tr>
</table></td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Unauthorized Departure	2	9
Choking	2	0
Other	1	0

*NOTE: The Monitoring Team could not validate the data reported by the Facility as accurate. With respect to DFPS investigations the Facility reported (above) a total of 134 investigations occurring between 9/1/13 and 2/28/14. When the Monitoring Team tallied up the number of investigations from a log of investigations for the same time period the total was 57. The Facility reported (above) six instances of confirmed findings. When the Monitoring Team tallied up the number of confirmed findings from a log of investigations for the same time period the total was three. The Facility reported (above) 14 instances of inconclusive findings. When the Monitoring Team tallied up the number of inconclusive findings from a log of investigations for the same time period the total was seven. The Facility needs to better coordinate the assembly of valid data among and between departments and among and between databases to ensure accurate data is reported to the Monitoring Team in the future.

Based on the Monitoring Teams' review of DADS revised policies, including Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 11/5/13: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy 002.4 on Incident Management, dated 11/5/13: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.

According to RSSLC Policy C.01 Incident Management (11/25/13) and RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (11/25/13), 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 (11/25/13) and RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (11/25/13), 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 10 Direct Care Professionals were asked four questions. The 10 staff were selected by the Facility and included both am and pm staff. Each response was evaluated by one member of the Monitoring Team, the Facility's Incident Management Coordinator, and the Facility's Quality Assurance Program Monitor assigned to Section D of the SA. Consequently, for each question responses were subjected to 30 evaluations (ten staff times' three raters).

#	Provision	Assessment of Status	Compliance
		Based on responses to questions, 10 direct support professionals provided satisfactory responses to the following questions as noted: "Describe the reporting procedure and timeframe when abuse/neglect is suspected." Thirteen of 30 responses were evaluated as satisfactory (43%).This was slightly lower than the 46% reported in the last review report. "Describe the reporting procedure and timeframe for other serious incidents." Seven of 30 responses were evaluated as satisfactory (23%). This was significantly lower than the 30% reported in the last review report. "Describe two acts/events that would constitute abuse." Ten of 30 responses were evaluated as satisfactory (33%). This query was not reported in the last review report. "Describe two signs/symptoms of neglect." Nineteen of 30 responses were evaluated as satisfactory (63%). This query was not reported in the last review report. Overall for the four questions, 49 of 120 (41%) responses were assessed as satisfactory. The above data suggests staff are not retaining information learned in formal training classes, and ostensibly reinforced through periodic competency checks. This likely contributes 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 10 investigation reports (five of the 15 did not report a time/date of the alleged incident or provide other data from which a determination of date/time could be determined) included in Sample D.1: ▪ Three (30%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to DFPS within the timeframes required by DADS/Facility policy. This was the case for investigations 42919661, 42896188, and 43010886. During the review, the Monitoring Team informed the Facility of those allegations that were deemed to have not been reported timely and afforded the Facility an opportunity to provide explanatory documentation. This increased the number of allegations deemed timely from one to three. ▪ Three (30%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party (DADS central office and/or DADS regulatory) within the timeframes required by DADS/Facility policy. This was the case for investigations 42919661, 42896188, and 43010886. During the review, the Monitoring Team informed the Facility of those allegations that	

#	Provision	Assessment of Status	Compliance
		were deemed to have not been reported timely and afforded the Facility an opportunity to provide explanatory documentation. This increased the number of allegations deemed timely from one to three. ▪ For the seven allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, three UIRs (43%) included recommendations for corrective actions. This was the case for UIRs 079, 005, and 026. Additionally, during the review the Monitoring Team observed a unit morning meeting which reviewed an allegation made the previous evening. At this meeting it was determined that this allegation was not reported timely. Finally, the Facility self-assessment reported that in only nine of 20 cases reviewed as part of the self-assessment (45%) was reporting within the required timeframes. Based on a review of five investigation reports included in Sample D.2: ▪ Four (80%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. The exception was UIR 050, a serious discovered injury. ▪ Four (80%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. The exception was UIR 050, a serious discovered injury. ▪ For the one unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs did not include recommendations for corrective actions. Additionally, the Facility self-assessment reported that in only 14 of 20 cases reviewed as part of the self-assessment (70%) was reporting within the required timeframes. In its last report the Monitoring Team noted that timely reporting of incidents and allegations had, after showing a period of improvement, regressed and was at an unacceptable level. Facility corrective action taken since the last review had not corrected this most fundamental premise of an incident management system. This places the health and safety of Individuals living at the Facility at risk and must be addressed immediately and aggressively. Finally, the Monitoring Team found no evidence that a formal Corrective Action Plan, either in response to the last review by the Monitoring Team or the Facility's self-assessment, had been established. The Facility did have a standardized reporting format as required by the SA.	

#	Provision	Assessment of Status	Compliance
		Based on a review of 20 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. 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 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. As noted in the last four reports (all of which reported significant issues related to timely reporting of allegations and serious incidents), the Facility should understand the relationship between late reporting (refer to Provision D.2.a) and this SA requirement. When late reporting occurs this can impact the Facility's ability to immediately remove alleged perpetrators from direct care responsibilities and as a result 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.	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.	The parties agreed the Monitoring Team would conduct reduced monitoring for this subsection, because previous reviews showed substantial compliance and that required training had been completed. In reviewing the DADS report "Percent of All Employees Completing Course of Training" compliance with abuse/neglect and unusual incident training classes was confirmed. As reported in Provision D.2.a staff knowledge of abuse/neglect reporting responsibilities was not good. This may suggest the effectiveness of the training should be further probed by the Facility through quality assurance monitoring. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(d) Notification of all staff when commencing employment and	The Monitoring Team asked for copies of the DADS Form 1020 Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation (7/09) for staff named as	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	alleged perpetrators in the investigations identified for Sample D.1. This consisted of 25 staff. There was a properly completed and signed 1020 in 23 of 25 (92%) instances. 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 pervasive and are noted in Provision D.2.a of this report. In only 43% of the cases were those staff that were identified by the Facility through its investigation report review process as having reported incidents late received some form of administrative follow-up such as 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 more accurately identify instances of late reporting and follow-up accordingly. Based on this review this Provision was in 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 LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The Facility reported that materials were provided to LARs prior to each individual's ISP meeting including the Recognizing Abuse and Neglect brochure and a rights booklet. This was to be documented in each ISP. Additionally, subject matter related to abuse reporting was to be discussed at every ISP meeting and duly noted in the ISP document. These activities were described by the Facility as the Facility's primary method of demonstrating compliance with this Provision. Ten ISP documents were reviewed by the Monitoring Team (Individuals #349, #723, #758, #86, #302, #184, #125, #324, #503, and #144). Eight of 10 (80%) included information with respect to abuse and neglect identification and reporting procedures. The exceptions were for Individuals #503 and #144. The Facility regularly checked 10 ISP documents each month for compliance with this requirement. For the 50 ISPs checked by the Facility (September, 2013 through January, 2014) 33 (66%) contained the required information. Additionally, the compliance rate the last three months (of this five month period) had declined to 50%. The Facility had not initiated any formal Corrective Action Plan to address this issue. While ISP meetings attended by the Monitoring Team during this review included presentation of information on, or discussion of, abuse and neglect identification and reporting procedures, the Monitoring Team's sample and the Facility's monitoring data did not validate this as occurring with enough regularity to demonstrate compliance. For example, the Monitoring Team reviewed 10 ISPs (Individuals #349, #723, #758, #86, #302, #184, #125, #324, #503, and #144) and eight (80%) included language addressing this subject. Those that did not were for Individuals #144 and #503). Additionally, the Facility self-assessment reported a compliance rate of 71% when reviewing 60 ISPs as part of its self-assessment.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Also considered in assessing compliance with this Provision are Self-advocate meetings, which occurred periodically at the Facility. In reviewing minutes of the two meetings held since the last review the Monitoring Team found agenda topics relevant to this provision were not presented in either (0%) meeting. Based on this review this Provision was not in substantial compliance. This Provision had been in substantial compliance but had experienced regression in essential components that measure 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.	The parties agreed the Monitoring Team would conduct reduced monitoring because previous reviews showed substantial compliance. The reduced monitoring consisted of validating the Facility's internal QA process to confirm whether or not substantial compliance continues. Monitoring of this Provision was limited to checking the Facility's audit process to demonstrate continued compliance. The Facility had an auditing process that included checking on the proper display of these posters. Results of these audits presented to the Monitoring Team were consistent in application and demonstrated compliance with this provision.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 it was evident retaliation would not be tolerated and this was reinforced in training and during the course of individual investigations. The Facility continued to use 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 was one concern noted related to potential retaliation. This case (43001455) involved an allegation reported by a former employee which was unconfirmed by DFPS and unsubstantiated by the Office of Inspector General (OIG). This former employee reported the allegation the day after she was terminated for unrelated reasons. In response to this fear of perceived retaliation the Facility initiated individual consults with each staff person who worked in the home of the former employee as well as provided general training on retaliation reporting. During this review an OIG Investigator was onsite and interviewed by the Monitoring Team. The OIG investigator reported she did not feel retaliation against reporters of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		abuse or against collateral witnesses was a problem at the Facility. Based on this review this Provision was in substantial compliance.	
	(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. In fact, at RSSLC these audits were done monthly. According to Policy C.19 the semi-annual review should consist of a sample of 20% of the Individuals living at the Facility. This was found to be the case at the Facility. Audits for the month of January, 2014 (N=11) were reviewed by the Monitoring Team and were sufficient to determine whether significant resident injuries had been reported for investigation. Summary reports for September, October, November, and December were also reviewed. During these five months 62 audits were completed by the Facility. In thirteen (21%) of these audits the Facility determined that not all injuries were documented and reported. In eight (13%) of these audits the Facility determined that injuries meeting the CMS definition of unknown source were not documented and/or resulted in a non-serious injury investigation or a UIR. In each case the Facility took appropriate corrective action to ensure injury reports were completed and filed. When failure to report and/or document an injury occurred and was identified in these audits, the Facility had not investigated the cause of this failure to report or document. As a result no administrative action had been taken with employees who failed to carry out their duties and responsibilities. Based on this review this Provision was in substantial compliance.	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	The parties agreed the Monitoring Team would not monitor this provision, because the	Substantial

#	Provision	Assessment of Status	Compliance
	such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. As noted in its previous reports the Monitoring Team remains concerned that no action had been taken regarding an important provision of State and Facility regarding testimonial evidence. According to State and 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 State and 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." The Monitoring Team found no 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	Substantial Compliance

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		some cases the first witness interviews did not occur until 6-7 days after the reported incident. 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**.** The Facility was unaware of any action in this regard. To its credit the Facility had taken some steps to address the issue of protection of testimonial evidence. This consisted primarily of adding statements to AP reassignment forms making it clear that discussing any of the circumstances associated with the investigation with others was prohibited and failure to comply would lead to disciplinary action up to and including termination of employment.	
	(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. In reviewing Sample D.1the Monitoring Team observed a pattern of DFPS investigators being onsite at the Facility within the first 24 hours, almost always to interview the alleged victim. Additionally, DFPS demonstrated reasonably good response time in beginning interviews with collateral witnesses and alleged perpetrators. On average, interviews began the third day following a reported allegation. As described in the previous reports, 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 DFPS investigation report format summarizes at the beginning of each report investigatory activity undertaken by DFPS within 24 hours of an allegation being reported. Typical activity reported in investigation 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	Noncompliance

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		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. The form (SSLC Commencement Checklist) that documents this activity was only present in two of 13 (15%) documentation files prepared for the Monitoring Team. Note: two investigations in Sample D.1 were administrative referrals and an SSLC Commencement Checklist would not be required. Despite the absence of this form the narrative in the body of the investigation report was sufficiently detailed to establish compliance with this SA requirement. All 15 (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 two 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 15 DFPS investigations in the sample: • Fifteen of 15 (100%) commenced within 24 hours or sooner, if necessary. This was 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. • 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. • Thirteen of 15 investigations (87%) were completed within 10 calendar days of the report of the incident. Based on documentation provided by the Facility for the two that were not completed within 10 days, approved extension requests were provided. In one case the reason for the extension did not appear to be justified. The extension request was noted as necessary because of	

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		uncooperative witnesses. There was no mention of uncooperative witnesses in the investigation report, but the extension request itself is considered a part of the report. This was the case with investigation 42969152. • Consequently, 14 of 15 (93%) investigations were completed within 10 days or had approved extensions acceptable to the Monitoring Team. In its last report the Monitoring Team expressed concern with the high number of cases requiring extensions and was now impressed with the improvement noted in investigations generally being completed within 10 days. • All 15 (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 two (13%) DFPS had concerns and recommendations for corrective action noted in the report. In each case the recommendations were appropriate to address issues identified by the DFPS investigator. <u>Facility Investigations (Sample D.2)</u> The following summarizes the results of the review of Facility investigations of serious incidents: • Four of five (80%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing the UIR section "Chronology of the Incident/Injury" and determining the time of the first entry indicating on site work activity by a facility investigator. This did not occur for UIR 050. In the case of UIR 050 the UIR shows the incident (serious discovered injury) as being reported on 11/20/13 at 10:00am and the first onsite work by the Facility Investigator occurring on 11/21/13 at 1:00pm. • Four of five (80%) were completed within 10 calendar days of the incident, including sign-off by the supervisor (IMC). Evidence was provided to the Monitoring Team to demonstrate that for the one that was not (UIR 050), an extension had been requested and approved. Therefore the compliance rate for this metric was 100%. • Five (100%) resulted in a written report that included a summary of the investigation findings. • The quality of the summary and the adequacy of the basis stated for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. • All five (100%) included recommendations for corrective action. Based on this review this Provision was not in substantial compliance as only 60% of Facility investigations in Sample C.2 commenced within 24 hours of the incident being	

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		reported.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person 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.	Based on the Monitoring Teams' review of DADS revised Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 11/5/13: 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. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In 15 out of 15 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 15 (100%), each unusual/serious incident or allegations of wrongdoing. o In 15 (100%), the name(s) of all witnesses. o In 15 (100%), the name(s) of all alleged victims and perpetrators; o In 15 (100%), the names of all persons interviewed during the investigation; o In 15 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. o In 15 (100%), all documents reviewed during the investigation; o In 15 (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. o In 15 (100%) investigation reports were sufficient to provide a clear basis for its conclusion. o In 15 (100%), the investigator's findings; and o In 15 (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 of five investigations reviewed (60%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that did not include: o UIR 012 - the investigation of this serious discovered injury (fracture) did not attempt to establish a timeline (when the Individual was last observed without the injury and first observed with the injury) which is necessary in order to more appropriately focus interviews, video	Noncompliance

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		review, and other investigation protocols which could lead to a determination of cause, or to rule out abuse/neglect. The investigation lacked sufficient detail probing possible causes of the injury. o UIR 013 – the investigation of this unauthorized departure concluded the Individual was upset because his girlfriend was recently placed in the community. The only recommendation in the investigation report was to place the Individual on 1:1. An appropriate recommendation could have been to request the IDT to explore options for social engagement which could include maintaining social contact with his recently discharged girlfriend, or, alternatively exploring other social arrangements which might be available at the Facility; IMRT review should identify the need for, or make, recommendations. • The report utilized a standardized format that set forth explicitly and separately: o In five (100%), each unusual/serious incident or allegations of wrongdoing; o In five (100%), the name(s) of all witnesses; o In five (100%), the name(s) of all alleged victims and perpetrators; o In five 100%), the names of all persons interviewed during the investigation; o In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. Those that did not included UIRs 153, 212, and 215; o In five (100%), all documents reviewed during the investigation; o In five (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; o In five(100%), the investigator's findings; and o In five (100%), the investigator's reasons for his/her conclusions. o Only one of the five Facility investigations (20%) can be considered thorough and complete. This was for UIR 050. For the other four investigation not all staff identified in the "staff involved" section of the UIR were interviewed nor was any explanation provided in the UIR as to why they were not interviewed. For example, for UIR 012 seven staff were named as "involved" and only five were interviewed. For UIR 074 eight staff were named as "involved" and only three were interviewed. For UIR 046 seven staff were named as "involved" and only four were interviewed. For UIR 013 three eight staff were named as "involved" and only one was interviewed. Based on this review this Provision was not in substantial compliance.	

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	(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 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. Additionally, each report was also reviewed by the QA department to validate completeness and accuracy. This review was documented on a form (unnamed) designed for this purpose. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In none out of five investigation files reviewed (0%), 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. The supervisor signed off on each UIR but no documentation was presented to the Monitoring Team which would substantiate the review required in this Provision. For DFPS investigations the IMC completed an "Investigation Review/Approval Form" to validate review required by this Provision. This should also occur for Facility investigations. ▪ Consequently, for none, the supervisor had identified and documented concerns. ▪ For the four 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 subparagraph g, for each unusual incident.	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
	(i) Require that whenever	The Facility policy and procedures did require disciplinary or programmatic action	Noncompliance

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	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.	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 Monitoring Team reviewed the "Recommendations for Current/Future Actions" section of each UIR associated with each DFPS investigation in Sample D.1 and documentation provided by the Facility to demonstrate that all recommendations had been carried out. This included both administrative/disciplinary recommendations and programmatic recommendations. Documentation to validate that all recommendations had been carried out was acceptable for 15 of 15 (100%) investigations. In none (0%) of the 15 cases was there any evidence that the Facility had tracked and documented the corresponding outcomes associated with the planned actions. Based on a review of 15 investigations for which recommendations for administrative/programmatic action were made, the following was found: ▪ For 15 of 15 of the investigations reviewed (100%), prompt and thorough actions had been taken and documented. ▪ For none of 15 investigations (0%), 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year,	For all categories of unusual incident categories and investigations, the Facility did have a system that allowed tracking and trending by: ▪ Type of incident;	Noncompliance

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	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.	▪ 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 still "under construction." As a result many elements of corrective action planning were sporadic and not centrally coordinated. Through this review the Monitoring Team, in reviewing Section D data provided by the Facility, identified three subject matters that were clearly in need of a formal Corrective Action Plan (CAP): 1. As reported in Provision D.2.a the issue of late reporting requires corrective action planning. 2. As reported in Provision D.2.e the issue of abuse reporting being addressed at ISPs requires corrective action planning. 3. As reported in Provision D.2.i the issue of injury reporting and documentation requires corrective action planning. Compliance with this Provision requires not only tracking and trending of data but also analysis of data, and, depending on what the data describes, appropriate corrective action planning. The trend reports and related data maintained by the Facility showed that corrective action plans were oftentimes needed but generally not initiated. Because of the lack of an organized and structured QA process and the current informality of corrective action planning the Monitoring Team was unable to determine if plans could reasonably be expected to result in necessary changes, identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. Based on this review this Provision was not in substantial compliance.	

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D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 2/13/14 2. RSSLC Action Plan 2/13/14 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 2/10/14 7. RSSLC Policy A.30 Unit Quality Assurance Monthly Meeting 2/10/14 8. RSSLC Policy A.31 Database Request 1/29/14 9. RSSLC Policy K.12 Habilitation Therapies Departmental QA Plan 11/1/13 10. RSSLC Policy A.31 Program & Residential Services (PRS) Quality Assurance Team Meeting 8/19/13 11. RSSLC Quality Assurance/Quality Improvement (QA/QI) meeting calendar 12. RSSLC QA Plan 11/13 13. RSSLC Process for creating, submitting, and disseminating Corrective Action Plans 2/3/14 14. Data Collection List 1/23/14 15. Unit QA Monthly Team Meeting Notes for San Antonio, Three Rivers, and Four Rivers units 16. Facility QA/QI meeting minutes for 10/1/13, 10/15/13, 10/22/13, 11/26/13, 12/3/13, 12/10/13, 1/14/14, and 1/21/14 17. QA Director/Department Director (Section S) meeting minutes 2/26/14 18. Notes documenting January meetings between the Settlement Agreement Coordinator and Section Leads 1/14 19. Facility Trend Reports 12/31/13 20. QA/QI Council Meeting Minutes for eight meetings between 9/1/13 and 1/31/14 **People Interviewed:** 1. Georgette Brown, Director of Quality Assurance 2. Judy Miller, Settlement Agreement Coordinator 3. Alice Ramirez, Data Analyst 4. Brad Hines, Data Analyst **Meetings Attended/Observations:** 1. Quality Assurance/Quality Improvement (QA/QI) Council 3/4/14 2. Three Rivers Unit QA/QI meeting 3/5/14 3. Three Rivers Unit Morning Meeting 3/5/14 4. Restraint Reduction Committee 3/5/14
	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.

	For Section E, in conducting its self-assessment, the Facility reviewed the QA policy, data inventory lists, the QA plan and matrix, the monitoring tools used by the QA department as well as those used by other departments including inter-rater reliability checks, activity of various QA workgroups, and QA/QI Council activities. The Facility QA Department did not use any specific monitoring tools in assessing compliance with Section E. For the most part the Facility presented data in a meaningful/useful way. It was evident that the Facility had made substantial progress since the last review but had not as yet fully operationalized the comprehensive QA program described in policy. The Facility reported continued improvements in the development and refinement of its data system that supports the QA processes. This included the preparation of reports that integrated the monitoring completed (and data) at the discipline department level with that completed by the QA Department. Different departments and disciplines were at different stages of QA implementation. The Facility did not rate itself as being in compliance with any Provision of Section E. 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. The Action Plan was comprehensive and sufficiently detailed to establish a pathway to future compliance. The plan directed itself to improved data collection, data analysis, and development of corrective action plans and related management systems.
	Summary of Monitors Assessment: Many elements of the QA program were described as "under construction" at the time of this review. For example, a plan for data analysis by both the QA staff and the departmental/discipline staff was in the very early stages of development. Additionally, the QA plan matrix was described as "under construction" and no document was provided to the Monitoring Team to review. In its last report the Monitoring Team noted that the Facility recently appointed a new QA Director and that little progress had been made in implementing a QA program since the previous review. At that time the new QA Director reported the Facility's entire QA program was undergoing a major overhaul. The Monitoring Team was pleased to see the strides forward in organizing a QA program that had occurred since the last review; however, the status of the QA program at the Facility is still very much in an early stage of development. It did not appear the Facility had conducted a comprehensive review, through the QA/QI Council or some other mechanism of executive review, to determine the extent to which departmental/discipline policies addressed QA requirements. The Facility's QA process reviewed by the Monitoring Team did not demonstrate consistency among and between departments/disciplines in the organization and collection of data, review and analysis of data,

	interaction between the QA Department, SA Coordinator (SAC) and section leads, and presentation and review of data and analysis by the QA/QI Council. It was apparent to the Monitoring Team that the Facility QA process had not as yet matured to the point where meaningful data and related analysis was consistently presented to the QA/QI Council. The Facility did not maintain a complete and adequate data list/inventory. The QA Plan did not address specific requirements associated with the development and use of key indicator data. The QA Plan also did not address specific requirements associated with a corrective action planning and implementation process. Since the last monitoring visit, the Facility developed a tracking system to identify what sections of the Settlement Agreement had external monitoring taking place by the Quality Assurance staff (i.e. Inter-rater reliability). Across the Facility there did not appear to be a coordinated QA effort directed by the QA/QI Council which was co-chaired by the Assistant Director for Programs and the QA Director. Important decisions were apparently often made without discussion and deliberation by the QAQI Council and/or without consensus between the two co-chairs. Improvement is needed throughout the Facility in understanding the purpose of a Corrective Action Plan (CAP) and expectations regarding data to be included in a CAP. This should be led and directed by the QA/QI Council.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	<u>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. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped	Noncompliance

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		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. The Facility QA Director reported that she was unaware of any State QAQI committees. Also, given that the statewide policy was disseminated two years ago, edits may be needed. State Office should consider this. <u>Facility QA policies and practices</u> In its last report the Monitoring Team noted that the Facility recently appointed a new QA Director and that little progress had been made in implementing a QA program since the previous review. At that time the new QA Director reported the Facility's entire QA program was undergoing a major overhaul. The Monitoring Team was pleased to see the strides forward in organizing a QA program that had occurred since the last review; however, the status of the QA program at the Facility is still very much in an early stage of development. While still in its formative stage the QA process at the Facility is moving forward in a positive direction. Many elements of the QA program were described as "under construction" at the time of this review. For example, a plan for data analysis by both the QA staff and the departmental/discipline staff was in the very early stages of development. The Facility continued to use Policy A.28 Quality Assurance as its primary QA policy. Since the last review this policy was supplemented with three additional policies: 1) Policy A.29 Discipline Department Head Monthly Quality Assurance (QA) Meeting, 2) Policy A.30 Unit Quality Assurance Monthly Meeting, and 3) Policy A.31 Database Request. These policies identified Quality Assurance processes that all departments were required to perform on a monthly basis. These policies were put in place in February 2014 and at the time of this review their implementation had only begun. Nevertheless, beginning to articulate the quality assurance activity expected of residential units and departments through policy expectations was a step forward. In addition to the four policies initiated by the QA Department, the Monitoring Team asked for other Facility policies that had QA components within them. Very little data in this regard was provided. It did not appear the Facility had conducted a comprehensive review, through the QAQI Council or some other mechanism of executive review, to determine the extent to which departmental/discipline policies addressed QA requirements. The exception was Policy K.12 Habilitation Therapies Departmental QA Plan (11/1/13). It is important that departments/disciplines embrace QA and one way of achieving this is to ensure policies that are specific to departments/disciplines address, where appropriate, include QA processes specific to the subject matter of the respective policy.	

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		The Facility's QA process reviewed by the Monitoring Team did not demonstrate consistency among and between departments/disciplines in the organization and collection of data, review and analysis of data, interaction between the QA Department, SA Coordinator (SAC) and section leads, and presentation and review of data and analysis by the QA/QI Council. Consistent implementation of inter-rater reliability was also a challenge for the Facility. Meetings between the Settlement Agreement Coordinator and Section leads had occurred for each section of the SA in January, 2014. For the most part these were not attended by the QA Director. In reviewing data related to these meetings provided to the Monitoring Team it appeared most meetings dealt with administrative organizational issues associated with each section. In no instance was any evidence provided that would validate that data review and analysis by this group occurred. It can be helpful if the SAC, QA Director, and Section Lead review and analyze performance data prior to each section's periodic presentation at the QAQI Council meeting. From review of QA/QI Council meeting minutes, and observation of the QA/QI Council meeting during the review, it was apparent to the Monitoring Team that the Facility QA process had not as yet matured to the point where meaningful data and related analysis was consistently presented to the QA/QI Council. In fact, the meeting attended by Monitoring Team consisted primarily of short presentations by several section leads reporting data with little or no accompanying analysis or engagement by QA/QI Council members. Through interview and document review, the Monitoring Team confirmed that the Facility did not maintain a complete and adequate data list/inventory. The data list that was maintained was not structured around SA sections. While this is not a SA requirement, it is suggested that data items reference relevant SA sections as a good practice for purposes of administrative oversight in the context of achieving SA compliance. The continued development of a data list/inventory was described to the Monitoring Team as a work in progress. The QA plan narrative at the Facility had been finalized (for the first time) in November, 2013. The plan, which was first presented to the QAQI Council in February, 2014, addressed: ▪ a description of the purpose of the QA program, ▪ organizational structure of the QA process (including individual roles and responsibilities), ▪ requirements for a data list/inventory, ▪ requirements for a QA matrix, ▪ how data are summarized and analyzed, ▪ the QA report, ▪ the QAQI Council and its role in reviewing data and guiding the entire QA process The QA Plan did not address any requirements associated with the development and use of key indicator data. The QA Plan also did not address specific requirements associated with a corrective	

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		action planning and implementation process. Through interview, the Monitoring Team discussed each of the 18 elements of the QA Plan with the QA Director and asked her opinion as to the implementation status of each element by assigning a number 0-10, with 0 meaning nothing has started yet and 10 meaning the element is fully implemented. The result of this was: 1. Four elements rated 0 2. One element rated 2 3. One element rated 3 4. Four elements rated 4 5. One element rated 5 6. Two elements rated 6 7. Two elements rated 7 8. Three elements rated 10 Therefore only three of 18 (17%) elements of the Quality Assurance Plan were viewed by the QA Director as fully implemented. These three were Program and Residential Services QA meetings, Unit QA meetings, and QA/QI Council meetings. The Monitoring Team did not find these elements of the QA Plan to be fully implemented. While meetings occurred, the subject matter and substance of the meetings was found to be insufficient as described elsewhere in this Provision. Additionally 11 of 18 (61%) elements of the Quality Assurance Plan were viewed by the QA Director as less than 50% implemented. From review of QA/QI monthly reports and interview with the QA Director, the Monitoring Team determined that for the 19 sections of the Settlement Agreement (not including Section E), a set of key indicators were included for none of the 19 sections (0%). As the Facility moves forward in developing key indicators the Facility should be mindful that key indicators in most cases should be defined in such a way that improvement or regression in a defined metric can be measured. For instance merely keeping track of the number of restraints in a given month, the number of PICA or choking incidents, or the number of infections does not necessarily represent a key indicator without establishing either performance related benchmarks or other measurement criteria. Keeping track of counts of various events can be an important component of establishing key indicators, but key indicators should also record and report data that can identify trends that may require administrative or clinical response. For example, for restraint, in addition to reviewing the number of restraints, it can be useful to also record the number of individuals restrained, total duration of physical and mechanical restraints, percent of restraints that had associated injuries, and restraint associated with newly admitted individuals vs. longer term individuals, For pneumonia, measures could include the number of pneumonias, number of individuals who had pneumonia, number of individuals who had multiple pneumonias in a quarter, etc. Key indicators should be sufficiently detailed to enable the Facility to determine if its administrative and clinical systems do, or do not, seem to be improving the health and safety of the Individuals being served by the Facility.	

#	Provision	Assessment of Status	Compliance
		The QA plan matrix was described as "under construction" and no document was provided to the Monitoring Team to review. As a result the elements of a QA Plan matrix typically reviewed by the Monitoring Team could not be reviewed. This included: 1. Determining which items in the QA Plan matrix were submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). 2. Determining which items in the QA Plan matrix were documented to show review or analysis by the QA department and/or the department section leaders for the last two reporting periods for each item (e.g., monthly, quarterly). 3. Determining which items in the QA Plan matrix were not fully implemented including inter-rater reliability. The Facility maintained a data inventory list that detailed the data that each department tracks. This was updated in November 2013 but was characterized as incomplete and not verified as reliable by the QA department. Since the last monitoring visit, the Facility developed a tracking system to identify what sections of the Settlement Agreement had external monitoring taking place by the Quality Assurance staff (i.e. Inter-rater reliability). Inter-rater reliability monitoring was occurring in 12 out of 19 (63%) Sections of the Settlement Agreement. One is not expected for Section E. There is a need to increase internal and external monitoring to identify areas needing improvement. The table below, provided by the Facility, displays internal (department) and external (QA) monitoring from 9/1/13 through 12/31/13. The percentages represent the monitor/auditors overall calculation of correct responses when administering the respective monitoring tool. For example, for Section C when the behavioral services department reviewed restraint documentation they found overall, for all points of inquiry, that data reflected correct practice 98% of the time. When the QA department did the same thing they found overall correct practice of 95%. This would suggest a high degree of compliance with restraint policy which is not necessarily the case as reported in Section C of this report. While not organized by Settlement Agreement Section it is nevertheless helpful in understanding the current status of some elements of QA activity at the Facility.	

	INTERNAL		EXTERNAL	
Monitoring Tool	**# of Audits**	**Score**	**# of Audits**	**Score**
C – Protection From Harm – Restraints	6	97.77%	8	94.72%
D – Protection from Harm – Abuse, Neglect, and Incident Management	19	94.40%	1	95.35%
Documentation of Contact with PCP	15	70.73%	3	66.67%

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		Documentation of Pre-Treatment and Post Sedation Original	5	65.79%	1	37.50%	
		Documentation of Pre-Treatment and Post Sedation Revised	15	86.44%	3	54.17%	
		Documentation of Antibiotic Therapy	20	97.85%	4	100.00%	
		Documentation of Constipation Original	5	60.00%	1	No data	
		Documentation of Constipation Revised	15	82.24%	3	94.12%	
		Documentation of Initial Head Injury	20	89.47%	4	95.65%	
		HCG I - Urgent Care/Emergency Room Visits, and Hospitalizations	20	85.56%	4	71.88%	
		I – At Risk Individuals	31	59.78%	27	48.40%	
		J - Psychiatric Care and Services	8	84.18%	7	65.49%	
		M - Annual Nursing Assessment	15	95.77%	3	88.55%	
		M - Medical Administration and Documentation Original	19	99.52%	4	99.39%	
		M - Medical Administration and Documentation Revised	6	99.22%	1	97.78%	
		M - Pain Management	5	93.55%	1	75.00%	
		M - Skin Integrity Assessment	20	96.15%	4	91.43%	
		Q - Dental Services	48	86.98%	30	86.78%	
		V – Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4	40	67.59%	20	68.01%	

Note: the Monitoring Team suggested that, in the future, the Facility might consider structuring or categorizing QA tables such as this so data is presented by SA Section as a useful tool for self-assessment.

The table below, provided by the Facility QA Department, displays sections that have not had inter-rater monitoring activity completed between 9/1/13 through 12/31/13.

Monitoring Tool
F - Integrated Protections, Services, Treatments and Supports
K – Psychology
O – Physical and Nutritional Management
P – Physical and Occupational Therapy

#	Provision	Assessment of Status	Compliance
		R – Communication S – Habilitation, Training, Education, and Skill Acquisition Programs T – Review of Community Living Discharge Plan (CLDP), Transitions and Guide T – Review of Post-Move Monitoring (PMM) and Guide T – Serving Institutionalized Persons in the Most Integrated Settings Appropriate to Their Needs U – Consent The Facility maintained a data inventory list (described by the Facility as incomplete) that the Quality Assurance Department used to track the data that each department collects to review at their monthly QA meeting. At the time of this review 15 departments had submitted the required information to the Quality Assurance Department. Much of this had only started occurring just prior to the review by the Monitoring Team. The departments submitting required data to the QA department were: • Admissions and Placements • Incident Management • QA Program Monitors • Rights • Behavioral Services • Medical Records • Nursing • Pharmacy • Dental • Medical Services • Competency and Training Department • Education and Training • Habilitation • Support Services • Maintenance The Facility reported that none of the Monitoring Tools in use at the Facility had adequate and reasonable instructions to assist users in implementation. Since the last review the Facility had initiated a process whereby QA staff and department staff worked together to facilitate improved consistency in interpreting monitoring data and observations. This was described as training but as explained to the Monitoring Team this appeared to be more of a series of meetings to talk through discrepancies in how data and/or observations were interpreted and recorded by staff conducting QA monitoring. At the time of this review this was in place only for the Dental department, Incident Management department, Human Rights department and Nursing	

#	Provision	Assessment of Status	Compliance
		department. Additionally, several other sections of the Settlement Agreement that did not have external monitoring in place had begun conversations with the QA Department expected to lead to external monitoring. For example, the Habilitation Therapies Department (Sections O, P and R) has made efforts to improve the monitoring processes within the department, and three meetings (which included elements of training) occurred between the Habilitation Therapy Director and QA Program Monitor in January, 2014. Since September 2013, there had been a list developed that is maintained by the Quality Assurance Director that includes active committees on campus that address, at least in part, QA activity. This list also includes the members of the committees and the meeting frequency of the committees. The QA Director reported this had been useful in assessing activity at the Facility that should be considered to be included in the QA program. The Facility had increased the number of required topics that are expected to be presented at each QA/QI Council meetings. As a general rule, five or six topics are to be presented at each meeting and these are scheduled such that each section of the SA has a presentation at least once each quarter. Consistent implementation of this schedule has been a problem as noted in the data below. Below is a table provided by the Facility that reflects facility participation in the QA/QI process from scheduled presenters.	

Month	Scheduled QAQI Meetings	Scheduled Topics	Topics Presented	% Participation
Sep-13	1	5	4	80%
Oct-13	4	24	17	71%
Nov-13	2	9	4	44%
Dec-13	2	10	10	100%

Of 48 expected presentations only 35 (73%) occurred.
The 13 scheduled topics between 9/1/13 through 12/31/13 that were not presented are displayed below.

Topic	Scheduled Counts	Presented	Did Not Present	% Participation
Behavior Support Committee	4	0	4	0%
Restraint Data	1	0	1	0%
Restraint Elimination	5	1	4	20%

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Community Placement/Referrals	1	0	1	0%
Section M	1	0	1	0%
Level of Supervision	3	1	2	33%

From the above data it would appear to the Monitoring Team that the QA activity at the Facility needs stronger commitment from upper management, including consequences for those administrative and clinical staff that appear to be recalcitrant in cooperating with the requirements of the QA Plan.
The Monitoring Team was able to observe a Unit based QA/QI meeting. The Monitoring Team noted the content of the meeting focused only on recent successes associated with two Individuals (which is, of course, important to note and celebrate) but did not include any presentation of unit wide data and related discussion which could lead to planned corrective actions. Injury rates and types are often a good starting point for such a venture as data is readily available and progress or regression can be easily measured.

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. These were not produced timely. For example, the most recent reports made available to the Monitoring Team were for 12/31/13 even though this review occurred in March, 2014.

Across the Facility there did not appear to be a coordinated QA effort directed by the QA/QI Council, which was co-chaired by the Assistant Director for Programs and the QA Director. Important decisions were apparently often made without discussion and deliberation by the QAQI Council and/or without consensus between the two co-chairs. For example, one Section lead independently decided to suspend use of the Monitoring Tool for six months. It did not appear this decision was made in the context of QA/QI Council discussion and deliberations, or even in consultation with the co-chairs of the QAQI Council.

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	The Facility reported that there currently was not a system in place to review data and associated trend reports and related information on an ongoing basis. Consequently, there was little for the Monitoring Team to review relevant to this Provision. Through interview it was reported that data was not organized in a manner useful in identifying potential systemic issues. The Facility acknowledged it was deficient in the use of data in developing CAPs as part of the QA/QI Council process. This was especially the case with issues that appeared to be systemic in nature. In the opinion of the QA Director there had been data presented to the QA/QI Council that identified the need to address problems and create a CAP, however it did not result in the development of corrective action plans. For example, the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	issue of late reporting of significant incidents reported in Provision D.2.a has been an outstanding problem at the Facility for some time yet no official recognition of the problem, or initiation of a CAP to address the problem, had emerged from QA/QI Council review and actions. The Facility system for creating, submitting, and disseminating Corrective Action Plans was dated 2/3/14. It was unclear as to how or when appropriate staff were trained on its implementation. The Facility needs to be more intentional in its review of data to identify the need for CAPs and then develop CAPs as part of the decision-making which should be part of the QA/QI Council. The Facility reported they intend to assign a Program Compliance Monitor for each section of the SA to track implementation, modification and completion of the CAPs. As reported in Provision E.1 the Facility did not have a system that effectively required workgroups outside the QA Department to submit data and other documentation to the QA Department. This should be addressed in policy and enforced by senior management at the Facility. The QA Director reported there had been attempts to address the need for Facility committees, Program Improvement Teams, and departments to submit meeting minutes or other relevant data for review by the QA Department but these attempts had been unsuccessful. Since the last monitoring review only the following departments had submitted documentation/data on meetings to the QA Department for review: Competency Based Training, Education and Training, Qualified Intellectual Disability Professional, and Dental. Based on this review this Provision was not in compliance.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The Facility reported in its self-assessment that none of the four CAPs developed since the last review had been disseminated to the responsible parties. This was confirmed through interview with the Facility QA Director. 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.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	Corrective action plans need to be implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified. "Fully" means that all steps of the CAP were implemented, and there was complete implementation of the stated action steps, and "timely" means that the due dates in the CAP were met or a reasonable explanation is provided for any delays. The Facility had not as yet developed a process to determine (and document) whether or not a CAP had been implemented fully and in a timely manner. CAPs are currently being tracked through the CAPs database that was developed in Feb. 2013. Review revealed that four CAPs were implemented since the last review by the Monitoring Team. These four	Noncompliance

#	Provision	Assessment of Status	Compliance

CAPs were summarized by the Facility as follows:

Actual Start	Service Area	Submitted By	Description	Measurable Goal
Dec 2013	L - Medical Care	Medical Director	The purpose of this CAP was to create a process that enables the IDT to be aware of medical consultations and to document this acknowledgment through the Medical Follow Up Database which tracked all clinical consultations. The PCPs, Case Managers, and QIDP were to document acknowledgement for the consultation in the Medical Follow Up Database. This is explained on the data entry page of the Medical Follow Up Database.	QIDP Acknowledgement of all medical consultations. To update the IDT on the latest health care status of individual. Goal of 80%
Dec 2013	S – Habilitation, Training, Education, and Skill Acquisition Programs	Director of Education and Training	No description provided	Five RSSLC individuals to be competitively employed
Jan 2014	M - Nursing Care	Program Compliance Nurse	The State Office Program Compliance Coordinator met with Nursing to discuss issues of Psychology consistently receiving late or not submitting Medical/Dental Restraint Checklist from all homes. It was determined there is a need to develop a tracking system to ensure all medical/dental restraint checklists are being completed and submitted for psychology data entry staff for entry into the Database for Chemical Restraints for Medical/Dental sedations.	Tracking system to ensure all medical/dental restraint checklists are being completed and submitted

#	Provision	Assessment of Status	Compliance
		<table><tr><td>Jan 2014</td><td>F - Integrated Protections, Services, Treatments and Supports</td><td>QIDP Admin Assistant</td><td>All section leads to collaborate on resident #### in an effort to bring her chart to full compliance with Settlement Agreement and present to the monitors at the next visit.</td><td>Will receive 10 additional areas of compliance and 20 additional areas of progress in the next monitoring report.</td></tr></table> None of the above data provided by the Facility demonstrates that these four CAPs were implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified. These CAPs do not articulate a series of implementation steps, and staff responsibilities and timelines; therefore monitoring the progress of implementation would be difficult, if not impossible. Improvement is needed throughout the Facility in understanding the purpose of a CAP and expectations regarding data to be included in a CAP. This should be led and directed by the QA/QI Council. The use of the CAP process to address substantive issues at the Facility was disappointing. None of the four CAPs contained a description of the problem (supported with data) that the CAP was designed to correct. Activity listed in the description column was overly vague and without a better statement of the problem the CAP was intended to address, it was difficult to determine that even the vague description of activity was directed towards improving the identified issue. Only 50% (two of four) of CAPs contained goals that could be easily measured. . There were not any CAPs that were revised due to ineffectiveness, which was not surprising due to the lack of description of activity that is directed towards improving the identified issue and the lack of measurable goals. Based on this review this Provision was not in compliance.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The Facility documents provided in regard to Section E of the SA did not include provisions for the evaluation of CAP effectiveness and methods or processes to modify CAPs. The Facility did not present any evidence with respect to measuring the effectiveness of CAPs. There were not any CAPs that were revised due to ineffectiveness, which was not surprising due to the lack of description of activity that is directed towards improving the identified issue and the lack of measurable goals. None of the four CAPs noted in Provision E.4 were noted as completed so no further evaluation of this Provision was possible. Based on this review this Provision was not in compliance. The Facility was unable to produce any documentation that would adequately demonstrate that implementation of the four active CAPs were being monitored by the QA Department or the QA/QI	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 02/13/2014 2. Richmond State Supported Living Center Action Plans, updated 02/13/2014 3. Richmond State Supported Living Center Settlement Agreement Presentation 4. Section F Presentation Book materials 5. DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 6. DADS Policy 017: Habilitation, Training, Education and Skill Acquisition Programs, effective 5/10/12 7. RSSLC Policy F.04 Individual Support Plan Process 1/29/14 8. RSSLC Policy F.5: Completing Individual Support Plan Meeting Documentation, revised 03/27/12 9. ISP Assessment Tracking Log, dated Tuesday, February 11, 2014, and encompassing the meeting dates of 9/1/2013-2/11/2014 10. ISP Attendance Tracking Log, Log dated Wednesday, January 22, 2014, covering ISPs held from 9/1/2013 - 1/22/2014 11. Team Member Participation in Annual ISP Meetings, undated 12. Number of ISPs Not Filed within 30 days, covering the period of 1/1/2013-1/22/2014 13. 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, February 11, 2014 14. Record Reviews for Individuals #120, #264 and #192 15. 30-Day ISPs and Assessments for Individuals #13, #72, #80, #417 and #463 16. Individual Support Plans (ISPs) including assessments for Individuals #86, #144, #149, #184, #302, #324, #349, #487, #503, #582, #675, #718, #723 and #758 17. Preferences and Strengths Inventory (PSI) for Individuals #86, #144, #149, #184, #302, #324, #349, #487, #503, #582, #675, #718, #723 and #758 18. Sample of Monthly/Quarterly Reviews for Individuals #86, #144, #149, #184, #302, #324, #349, #487, #503, #582, #675, #718, #723 and #758 19. Section F Monitoring Tool 20. Section F Presentation for QA/QI meeting, undated **People Interviewed:** 1. Angela Hernandez, QIDP Educator 2. Leroy Thompson, QIDP Coordinator 3. Georgette Brown, Director of Quality Assurance (QA) 4. Davondra Brown, Director of Education and Training 5. Ashley Smith, Services Coordinator **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #675 and #718 2. Pre-ISP meeting for Individual #501

	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 the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The self-assessment rating did not substantially rely on data collected through the Facility's QA/QI processes, as these were not yet fully implemented. For purposes of conducting its self-assessment, the Facility had not used monitoring/auditing tools. In order to improve its Self-Assessment for use in achieving compliance, the Facility should review the criteria by which it assesses that compliance. The Facility's criteria did not always fully address the noncompliant findings from the Monitoring Team. The Facility also 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 should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. Overall, a comprehensive strategic plan that identifies all requirements and the measurable indicators for each would allow the Facility to not only better prioritize its activities, but would also allow it to better monitor its overall progress toward substantial compliance. For Section F, the Facility provided a projection of benchmarks it hoped to achieve for a series of six month stages, ranging from obtaining positive comments through substantial compliance, but did not have a strategic plan that laid out how those were expected to be achieved. At least, the Facility should determine the priorities for action for the next six months, complete an analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. Sections of the Self-Assessment could reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could 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. This would also allow the Facility to appropriately update or modify its Action Steps based on an evaluation of outcome data. As an example of how the Self-Assessment and Action Steps were not yet integrated into a cohesive plan, for Provision F2f, the Facility reported the activity engaged in for the self-assessment was a review of all ISPs of individuals admitted to Facility between 08/01/2013 and 12/31/2013 to determine if ISPs were completed within 30 days of admission. The results were that all had been completed within the timeframe, but the Facility concluded the provision was in not in substantial compliance due to a small sample size. It would be expected that admissions would constitute a small sample size on an ongoing basis, so this would not in and of itself be a reason for a finding of noncompliance. However, there are

	other criteria by which this Provision is also assessed. Provision F2f also requires that, the ISP shall be revised annually and more often as needed, and shall be put into effect within 30 days of its preparation, except in the case of extraordinary circumstances. The Facility's Self-Assessment did not address this requirement and no related Action Steps were provided in the Action Plan. If the Facility intends to use its Self-Assessment to conclude whether it is in substantial compliance, it must identify and factor in all of the criteria upon which compliance is to be based. It may choose to prioritize only certain components in its Action Plan, but it should be aware these may not be sufficient in achieving substantial compliance.
	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 continuing emphasis on developing increased integrated planning. The Facility continued to brainstorm new initiatives toward improving planning and integration, including Organizational Culture Change and an Engagement Campaign. The Monitoring Team commended these efforts; however, it was concerned that fundamental processes, including the quality of assessments and ongoing ISP implementation and monitoring, were not receiving adequate attention. 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. Overall, the Monitoring Team found there was some continued improvement in the ISP annual meeting interdisciplinary process as observed during this visit, but found significant problems with the development and implementation of an integrated ISP for each individual that ensured individualized protections, services, supports, and treatments were provided. 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. Considerable training and coaching continued to be provided to the QIDPs and IDTs. RSSLC had continued to devote considerable resources to coaching and training for QIDP staff. As requested, the Monitoring Team focused attention in this regard on two ISP annual meetings observed during the monitoring visit. Progress observed included: continued improvement in the organization of meetings observed continued progress noted in the facilitation process to enhance participation of the individual. 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, although there was some improved discussion in the ISP annual planning meetings observed. 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 on-site planning meetings, but these were not yet sufficient to result in outcomes required for this Provision. 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 identified outcomes related to each preference and meet identified needs. Skill acquisition programs were not yet sufficiently constructed. The Monitoring Team found ISP strategies still did not reflect encouragement of community participation in a meaningful or purposeful manner, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies. Two very concerning issues were the failure to implement the ISP as written and to monitor for progress. The Facility was also not yet routinely implementing quality assurance processes to identify and remediate problems and to ensure that the ISPs are developed and implemented consistent with the provisions of this section. The Facility did have monitoring tools available, including a revised Section F Monitoring Tool and the Q Construction monitoring tool, but these were not currently being implemented in a formal or consistent manner.

#	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 18 QIDPs, with two vacancies. Three had been hired during the past six months. The Facility also had a QIDP Educator and QIDP Coordinator. A Services Coordinator position had been created to provide administrative and programmatic support for the QIDP Department and to participate in departmental and quality assurance initiatives. It was noted that the Facility was set to implement a pilot in which the QIDP Coordinator would supervise some QIDPs to determine if this might improve outcomes. <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 currently had no tools for assessing QIDP competency with regard to the facilitation of ISP meetings and the writing of the ISP documents. The	Noncompliance

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		Facility reported it was consulting with other facilities and state office to obtain tools for these purposes. The Facility had available the Q Construction Facilitation curriculum for training in this area, but QIDPs were not currently providing training using the standard curriculum as there were no certified trainers on staff at the Facility. The QIDP Educator reported that she and another staff person were to be trained in the near future. RSSLC had continued to devote considerable resources to coaching and training for QIDP staff. As requested, the Monitoring Team focused attention in this regard on two ISP annual meetings observed during the monitoring visit. Progress observed included: • There was a continued improvement in the organization of meetings observed. • There was continued progress noted in the facilitation process to enhance participation of the individual. This represented continued progress over the previous site visit; however, outcomes in terms of improvements in ISPs were not yet substantial. For example: • For none of the 12 plans reviewed, (0%) did the facilitation process result in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. • For none of the 12 ISPs reviewed (0%) did the facilitation process result in an adequate discussion of the most integrated setting. • For one of two ISP annual meetings observed (50%) the facilitation process resulted in the adequate participation of the individual, although some progress was noted in a second ISP as well. See Provision F1b. • Although progress was noted since the previous monitoring visit, the QIDPs continued to need additional training and/or coaching 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. The QIDP Coordinator was observed providing coaching at one of the ISP annual planning meetings attended. • 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. In fact, this was an area of significant regression since the last monitoring visit. <u>Conclusion:</u> This provision was found to be not in compliance.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation	<u>Composition and Participation of IDT:</u> The Facility tracked the attendance of IDT members at annual ISP meetings. The Facility	Noncompliance

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	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.	provided a document for review, entitled ISP Attendance Tracking Log, Log dated Wednesday, January 22, 2014 and covering ISPs held from 9/1/2013 - 1/22/2014. The data were provided by living unit, but the document was not particularly useful as it appeared to simply indicate actual attendance, but did not indicate required attendance. While it might be possible to make certain assumptions about which disciplines should be in attendance, one of the primary purposes of the ISP Preparation meeting is to define these expectations and establish that benchmark. The Facility also provided a document entitled Team Member Participation in Annual ISP Meetings that tracked required attendance by discipline for each living unit, but it was also not useful as it had multiple entries for the same or similar disciplines. In the Self-Assessment for Section F, the Facility reported that based on the results of this self-assessment, this provision has not met compliance due to data integrity improvement needed. The Monitoring Team concurred. <u>Extent of Individual participation in ISP:</u> Overall, the Facility reported that in its self-assessments that of the 38 ISPs held between 11/01/2013 through 11/30/2013, 19 Individuals (50%) were present at their meeting. The Monitoring Team observed two ISP annual planning meetings as a part of this focused review. For Individual #675, the Monitoring Team observed the IDT encouraged and facilitated the participation of the individual throughout the meeting. It was also noted the QIDPs had developed some materials designed to foster the participation of the individual in the meeting. The Monitoring Team was particularly impressed with the effort made by the QIDP for Individual #718, in which the meeting began with the IDT members talking about the things the individual did well and what they liked about the individual. It was apparent the individual was pleased with the positive feedback and was engaged with rest of the team. The Monitoring Team applauds the QIDPs for this effort. It was noted the IDT did not make much use of these strengths in the development of the ISP and it was recommended that this be a next step in the process. <u>Conclusion:</u> This provision was found to be not in compliance.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	<u>Policy:</u> DADS Policy #004.2 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the "Action Plans" section of the ISP." In Section II.E, the policy stated: "IDT members prepare for the ISP meeting by:	Noncompliance

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		• 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> For annual ISP planning meetings, the expectations remained that the PSI would be completed and posted 90 days prior to the ISP date, such that all disciplines could incorporate the individuals' preferences and individual goals into their assessments and recommendations. The IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting, also held approximately 90 days prior to the ISP meeting. The policy requires in Section III.C that these assessments be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting to permit the entire interdisciplinary team (IDT) to review them. The assessments were to be used by the QIDP to develop an ISP Guide no later than five days prior to the ISP annual meeting. For a new admission, Facility policy requires that the assessments be completed and posted at least five working days prior to the initial ISP planning meeting, with the exception of the PSI, which was to be completed ten days prior. There was evidence the IDTs had begun making use of these processes to ensure needed assessments were completed on a timely basis, as nine of 12 (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 ISP Assessment Tracking Log, dated Tuesday, February 11, 2014, and encompassing the meeting dates of 9/1/2013-2/11/2014, typically 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. The Facility acknowledged it was aware of this flaw in its quality management process. The QIDP Educator indicated the Facility was working on a fix to this problem. The QA Director further explained that the QA Department would be tracking timeliness of the ISP Preparation Meeting and would then monitor the assessments based on the requirements in the ISP Preparation documentation. In order to assess the actual timeliness of assessments, the Monitoring Team reviewed assessments for the sample of nine completed ISPs that included ISP Preparation documentation, a sample of two ISP annual meetings observed by the Monitoring Team	

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		and a sample of ISPs for four newly admitted individuals. While timeliness remained a concern, there was evidence that the Facility was achieving progress in this area. Findings included: • In the sample of nine ISPs completed prior to the monitoring visit for which the ISP Preparation meeting documentation prescribed the required assessments, none (0%) had all assessments completed on a timely basis, at least ten working days prior to the ISP annual meeting. Of the 118 required assessments, 87 were present and completed according to the timeliness requirements. Overall for this sample, the rate of timeliness was 74%. • For the two ISP annual planning meetings observed during the monitoring visit, the overall rate of prescribed assessments present and completed within the required timeframes prior to the meeting was 71% (22 of 31). • Some assessments were not simply late, but were not completed at all. For the nine individuals in this sample, there were 118 total prescribed but only 92 (78%) present in the assessment packets provided to the Monitoring Team. A similar finding of assessments not being completed was found for four newly admitted individuals, as described in Provision F2f. Of these four ISPs, one had no assessments provided as requested and one included only four assessments. In the latter case, only the Water Safety Assessment, FSA, Vocational Assessment and an initial Functional Assessment were present in the material provided; no Medical, Nursing, OT/PT, Communication or Psychological Assessments were provided. • As reported in Provision V4, the Monitoring Team found improved timeliness for one individual for whom assessments were due. The Monitoring Team viewed the assessments available on the shared drive for Individual #306, who had an annual ISP planning meeting scheduled within the next ten working days. For 11 assessments that were required per the ISP preparation meeting, 11 (100%) current or updated assessments were posted, and 11 (100%) had been posted by 10 working days prior to the meeting. <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> Effective October 1, 2013, the Facility had begun using statewide standardized assessment templates, with the exception of the Rights Assessment, Structural & Functional Assessment, and Pharmacy. These were intended to ensure all assessments would have a consistent foundation of information and analysis to be included. These templates were reviewed by the Monitoring Team. Each included specific sections, including the following: I. History	

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		II. Current Status (Diagnosis, Active Problem List, Risk Levels) III. Current Services (Medications, Treatments, Training, Supports) IV. Preferences, Strengths, Goals (from ISP Preparation meeting) V. Evaluation/Assessment Results VI. Additional Strengths, Contraindications to Stated Goals VII. Community Living/Services VIII. Summary IX. Recommendations The Monitoring Team found it was positive that DADS had established certain expectations. For the most part, however, the significant concerns the Monitoring Team had about the quality of assessments in the past had less to do with the format and more to do with the rigor of the assessment process. The Facility should guard against any tendency toward a fill-in-the-blanks approach to assessment as it moves forward with implementation of these new templates. 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, O2, O8, R2, S2, T1b1, T1b3, and T1d. 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: • For one of the two focus ISPs observed during the monitoring visit, for Individual #718, the individual had an audiological assessment completed on1/4/14 that indicated the individual should be evaluated for a possible middle ear disorder. None of the other assessments noted this need; in fact, those that referenced any audiological findings were from an assessment dated in 2011. This was of particular concern because the individual had also had eight falls during the year and was known to be unsteady. The possibility of the middle ear disorder needed to be evaluated for any potential contributory effect. The Monitoring Team brought this to the attention of the QIDP at the conclusion of the meeting for follow-up, but there was no acknowledgement or follow-up evidenced in the written ISP provided for review. • As reported in Provisions L1 and T1e, assessments prepared for Individual #238, 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 L1, assessments for Individual #192 also did not adequately address health care needs including: o Despite initial concerns for the need of an endocrinology consultation in 5/2013, and with documented signs of possible adrenal insufficiency,	

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		the medical provider stated on the medical action plan that there were no symptoms suggestive of adrenal insufficiency, and there was no need for additional monitoring for adrenal insufficiency. The Facility should have ensured that the constellation of clinical findings be urgently provided to a physician who has expertise in the area of adrenal insufficiency. Although recently scheduled, the Individual had not been evaluated by an endocrinologist at the time of this compliance review. o Despite a diagnostic study completed in 2011 indicating dysphagia, the most recent annual medical summary did not list dysphagia as a diagnosis, and there was no medical plan listed for dysphagia. o The etiology of chronic constipation was not fully evaluated, and there was no documented evidence indicating that periodic diagnostic studies were obtained, such as a gastromotility study, or occasional film imaging studies, to further evaluate worsening constipation. Chronic and severe constipation can manifest in emesis, and episodes of emesis have been documented in the clinical record. Specific monitoring and reporting parameters for direct care staff, and nursing staff to observe for worsening constipation, were not identified. o Despite the diagnosis of recurrent aspiration pneumonia, there was no evidence indicating that the Facility assessed the etiology of the recurrent aspiration pneumonia. o Addendums to the ISP did not address possible issues associated with adrenal insufficiency such as hyponatremia, dehydration, mental status changes, and hypoglycemia. • As reported in Provision K5, the information obtained during the current site visit reflected a substantial decline in the ability of the Facility to provide and monitor adequate psychological assessments. The sample reflected 31% fewer individuals were provided a psychological assessment report. 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. <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> Overall, current assessment practices at RSSLC, in terms of timeliness, accuracy and thoroughness, still 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 completed in time for QIDPs to complete the ISP Guide five days before the ISP annual planning	Noncompliance

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		meeting such that IDT members could review before the meeting. Assessments were also not completed with sufficient thoroughness. Even when the results of this assessment process were used in the development of the ISP, the IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary. For example: • The Monitoring Team was requested to attend by teleconference a CLDP for Individual #238 to be held the week following the monitoring visit. While on-site, the Monitoring Team requested the individual's record to review. At the time of the review, on 3/6/14, the ISP in the record was dated 2/7/13. Almost all of the assessments in the record were dated prior to the 2/7/13 ISP. The QIDP Coordinator was able to locate some current materials, including an ISP dated 2/7/14, which were reported to have been inadvertently misfiled in the shared drive. It was not possible to ascertain with certainty what assessments were required because the IDT had not held an ISP Preparation meeting as required by policy, in which it was to designate the assessments to be completed for the ISP annual meeting. There was not a current Positive Behavior Support Plan (PBSP). An addendum dated 12/11/13 stated that the individual had been on a behavior assessment plan since his admission on 1/08/13, with reportedly low rates of target behaviors and that a PBSP was to be required only because the individual received psychotropic medications. The addendum indicated the PBSP would be developed by January 31, 2014. On 3/6/14, there was no PBSP in the record. There was not a current PSI. All of these omissions were particularly concerning as they pertained to the identification of appropriate community living options for the individual and the impending CLDP. • The Monitoring Team also reviewed the record for Individual #192. The ISP in the record was dated 5/21/13, but it was largely incomplete, with many template sections devoid of any narrative, data or other information. The Monitoring Team expressed significant concerns to the Facility about the IDT's attention to this individual's needs, particularly in relation to its failure to address her behavioral needs and the subsequent impact on the individual's health. See Provisions L1, O1 and O3. • As reported in Provision T1e, assessments prepared for individuals with Community Living Discharge Plans (CLDPs) in the past six months did not adequately address significant issues that could impact a safe transition to community living. • As reported in Provision S1, only two of 10 (20%) Skill Acquisition Plans (SAPs) in a sample were supported by the FSA. It was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training or other sources.	

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		• As further described in Provision F2a1, preferences and strengths identified in the PSI were not effectively incorporated into the ISP and Action Plans. Also 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. 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 IDT needed to make a recommendation to the individual/guardian. The Monitoring Team found there was progress evidenced in the presence of the required determination, but it was still not being consistently provided. Findings included: • Of 12 recent ISPs reviewed, for none (0%) did all of the discipline assessments include the applicable statement/recommendation. Of the 121 total discipline assessments that should have had a statement, 57 (47%) included a determination of whether the individual could be 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 occasionally 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 57 assessments that included a determination, six (11%) included substantive recommendations for how the individual's needs could be met in a more integrated setting. • Nine of 12 ISPs (75%) included an independent recommendation from the professionals on the team to the individual and LAR. • 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	Noncompliance

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		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. Overall, the Facility was not yet effectively identifying or addressing obstacles. There was some progress noted in the discussion of obstacles and possible strategies to address them in the two focus ISPs, particularly for Individual #675, but the Action Plans developed did not reflect these. See Provision F2a2. A review of the 12 recently completed ISPs also 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 12 (0%) of the recently completed ISPs reviewed evidenced proficiency in identification and addressing of obstacles. • In none of the ten (0%) that identified LAR or individual choice as a barrier were there specific, individualized action plans developed to address these specific barriers. • In twelve ISPs reviewed, at least some professional disciplines individually opined the individual could be served in a less restrictive setting in their assessments, but the independent IDT recommendation was that the person would not benefit from moving to such a setting. There was no discussion or rationale provided for why these individual opinions were not reflected in the IDT's independent recommendation. There was some progress noted in the presence of a description of 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, which had been largely absent in the ISPs reviewed in the previous six months. IDTs still tended to focus primarily on the supports and services currently being provided at the Facility, however. 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	

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		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. Overall, of 12 recent ISPs, none (0%) adequately identified the protections, services and supports that would be needed by the individual in the most integrated setting. The Monitoring Team was also concerned that the new standardized assessment templates did not always clearly require the IDT members to provide an affirmative description of the individualized needs in a community living setting. Conclusion: 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/coaching should be provided to require, as a part 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:		

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	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. <u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u> DADS Policy 004.2 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 004.2, prior to the Individual Support Plan (ISP) Preparation Meeting, the QDDP was to update 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. Overall, as reported in Provision S2, because of the broad weaknesses in assessment practices at the Facility, it was not possible to identify any areas of substantial progress in preference assessment at the Facility. The Monitoring Team had noted in previous reports that even when strengths and preferences were identified, the ISP was not consistently built around these. The Facility had proposed a revision to the ISP Action Plan template that would specify the preferences/strengths and assessments used in the development of each action plan. This revision had been forwarded to DADS for consideration and approval, but had not been accepted due to the need for statewide consistency. Findings for this visit included: o Preferences continued to be focused on favorite foods and environmental likes and dislikes. The IDTs should expand their approach to include an examination of where and how an individual would like to live, what kind of work and/or avocation is meaningful to the individual, preferences related to social interactions beyond the basics of enjoying staff interaction and/or personal space, and how individuals relax and/or spend spare time. If these preferences are not known or cannot be discerned, this should indicate to the IDTs a need to implement Action Plans to help the person discover them. o Action Plans to address strengths were not typically observed, nor did Action	Noncompliance

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		Plans developed for various needs also incorporate approaches to integrate strengths in the methodologies. In one notable exception, for the ISP annual planning meeting observed for Individual #675, the IDT did identify the individual's ability to activate a switch as a strength and developed a SAP for switch use to gain attention. In another example, the Monitoring Team observed that the IDT for another focus Individual (Individual #718) began the annual planning meeting with a discussion of what the individual was good at and what people enjoyed about her. This was a good practice, but the IDT did not make use of these significant strengths in the development of the ISP, or even refer back to them during the rest of the meeting. One suggestion would be for the QIDP to summarize the feedback about her strengths, state the expectation these would be used in plan development and then remind the IDT as needed throughout the meeting of the need to incorporate them. <u>Extent to which ISP provides an explanation for any need or barrier that is not addressed:</u> The Monitoring Team found that none of the twelve completed plans reviewed (0%) included a list or discussion of prioritized needs in which the IDT clearly indicated whether any needs were to be prioritized for implementation and provided an appropriate justification. <u>Extent to which ISP encourages community participation:</u> There were indications reported in Provision S3b that the Facility was attempting to enhance skill acquisition training in the community. In October 2013, a database was developed to capture and track the implementation of SAPs in the community. Although data entry had begun only in November 2013 and remained incomplete at the time of the site visit, an initial review suggested the new database to be a powerful and helpful tool. Overall, however, at this time the Monitoring Team found that ISPs did not provide adequate strategies to encourage meaningful community participation. As reported in Provision S3b, of 10 SAPs submitted by the Facility, one (10%) included indications of potential implementation in the community. For the remaining nine SAPs, there was nothing in the submitted documentation to indicate the SAP was targeted for community implementation. The Monitoring Team also observed that, for the two focus ISP annual planning meetings observed on-site, there were many leisure and recreational activities identified to be conducted in the community that were related to preferences, but there were no SAPs created for skill acquisition in the community. It therefore did not appear that the Facility had a comprehensive plan for providing community instruction when developing SAPs. As recommended in Provision T1b2, the Facility's IDTs should develop an individualized	

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		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 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 and meet needs: For none of twelve (0%) recent ISPs reviewed, did the IDTs consistently develop 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. As described in Provision F2a4 and further in Section S, ISP programs were still generally not individualized to the individual's needs, nor did they contain the requisite essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions. In addition, for the two focus ISP annual planning meetings, the resulting plans did not reflect a comprehensive complement of individualized goals and objectives. In particular, there was very little focus on skill acquisition: Individual #675 had two SAPs and Individual #718 had only one. Adequacy of processes for identification of and plans to overcome barriers to living in the most integrated setting: 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 developing ISP Action Plans to overcome such barriers. 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 twelve (0%) recent ISPs reviewed evidenced proficiency in this regard. Also see	Noncompliance

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		Provision F1e above. For the two focus ISP annual planning meetings, the Monitoring Team observed thoughtful IDT discussion about such obstacles and potential integrated strategies to address them, but the Action Plans did not adequately reflect this. For example, for Individual #675, five service objectives were discussed during the meeting, including how these would support community education and awareness. One was for participating in community tours, but the IDT concluded there would be no plans to pursue tours at this time and that attending provider fairs and looking at pictures would be a first step in building towards tours. The Action Plan indicated the individual would participate in provider fairs biannually, but there was no outcome objective that would indicate what would determine its success and what would indicate "readiness" for tours. It was also not clear in the ISP what would hamper the individual's "readiness" at this point. Three other Action Plans were finally identified under Living Options, which included the annual CLOIP information to be received by the mother, who was opposed to community living; participation in community recreational and leisure activities on a monthly basis; and, making a trip to a salon for services annually. There was a Service Objective (SO provided for participation in recreational and leisure activities, but it generally indicated the activities would be carried out in the home and did not reference the living options awareness intent, how that intent would be carried out or how it would be measured. There was no SO for the trip to the salon provided, nor was it specified in the leisure SO. Overall, the lack of specificity in the Action Plans and the lack of frequency for their implementation would limit their potential for addressing the obstacles identified. <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. Adequate integration can 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,	Noncompliance

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		etc.) • Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary 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 risk action plans. A 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; incorporation of reinforcement for safe dining behaviors and/or replacement behaviors; and might describe both formal and informal opportunities for community dining. The Monitoring Team noted the Facility was continuing to focus efforts in ISP development on integration of all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. As reported in Provision J8, there was considerable improvement in integrated care between neurology and psychiatry. 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. In addition, as reported in Provision M3, 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 Facility had also composed an ISP Consulting Team to attend, monitor and coach at ISP annual planning meetings. Overall, however, the Monitoring Team found that ISPs still did not reflect an adequately integrated plan that set forth and implemented the full array of protections, supports, and services individuals required as described in the bullets above. There had been some progress noted in the focus ISPs held during the previous monitoring visit. While those would not have risen to the level of substantial compliance, particularly in the execution of the Action Plans, the Monitoring Team had observed 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, individualized schedule and Special Considerations did not provide the level of integration required and unfortunately much of it was never implemented to any degree. See Provision F2d.	

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		Examples that demonstrated that ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual included: • As reported in Provision R3, based on review of the ISPs for individuals in Sample R.1 and R.2: o Two of eleven ISPs reviewed (18%) included how communication interventions were to be integrated into the individual's daily routine. o Seven of 11 ISPs reviewed (64%) contained skill acquisition programs to promote functional communication. • As reported in Provision O2, for zero of six sampled individuals (0%), were all recommendations by the PNMT addressed / integrated in the ISPA, Action Plans, IRRFs and IHCPs. <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 for the next six months on the following: • Additional training continued to be needed on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Extent to which ISP identifies methods for implementation:</u> The Facility did not yet consistently identify adequate methods for implementation. Examples included: • As reported in Provision S1, methods for implementation of SAPs were lacking: o None of the nine reviewed SAPs (0%) reflected adequate behavioral objectives. o Four of the nine reviewed SAPs (44%) reflected adequate operational definitions. o One of the nine reviewed SAPs (11%) reflected an adequate description of teaching conditions o None of the nine reviewed SAPs (0%) reflected sufficient trials for learning to take place. o Only one of the nine SAPs (11%) included adequate instructions for staff. o Five of the nine reviewed SAPs (56%) reflected the opportunity for the target skill to be performed	Noncompliance

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		• As reported in Provision K9, a review of behavioral interventions for required elements indicated that in nine of 17 areas (53%), the Facility was rated as having poorer performance than in the previous site visit. These included methodology for implementation such as clear, simple, precise interventions for responding to the behavior when it occurs (47%) and strategies that include the teaching of desired replacement behaviors (60 %.) <u>Extent to which ISP identifies timeframes for completion:</u> For none of the twelve ISPs reviewed (0%) did action plans include adequate timeframes for completion. ISP Action Plans typically documented an implementation date, but did not consistently provide a projected timeframe and overall projected completion date. This assessment was also based on a review that indicated timeframes were not individualized according to need and activity, but rather consisted for the most part of a standard (i.e. one year) completion date across the board. There were exceptions, but these were very limited. Also, as reported in Provision 02, in three of six individuals' plans reviewed (50%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. <u>Extent to which ISP identifies responsible staff:</u> The twelve sample ISPs typically indicated by position who would be responsible for documentation and data review. This did not appear to be sufficient to achieve the outcomes of ensuring program implementation was accomplished as required, however, as evidenced by the finding described above that methods of implementation were not adequately constructed by those identified as responsible for designing the specifics of the action plans. This was further evidenced by findings in Provision F2f which indicated that ISPs, including the completed Action Plans, were sometimes not being put into place on a timely manner by those identified as responsible for ensuring plan development. <u>Conclusion:</u> This provision was found to be not in compliance.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	<u>Extent to which interventions, strategies, and supports are practical and functional</u>: 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 S3, only one of the 13 sampled SAPs (11%) addressed specific needs reflected in formal assessments and only four of the 13 sampled SAPs (44%) targeted skills that would likely be useful for the individual. • As reported in Provision S3b, the Facility did not provide specific information	Noncompliance

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		about the provision of skill acquisition training in the community. • As reported in Provision P3, for only three of seven individuals' records (38%) reviewed were there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. <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. As reported in Provision S1, none of the nine reviewed SAPs (0%) reflected a potentially adequate documentation methodology. All reviewed SAPs provided only generic instructions for data collection. Documentation provided by the Facility also reflected numerous lapses in ensuring that data were consistently recorded, tracked, and monitored. Of the nine individuals included in the sample, five (56%) had at least one monthly data sheet missing. To further assess whether the documentation methodologies were sufficient to produce adequate data collection, of 13 current SAP data collection forms located in the residences, only two (15%) reflected correctly recorded and complete data. Other examples of deficits in identifying 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 included: • As reported in Provision O2, in zero of the six 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. • As reported in Provision K9, data collection methodologies were found to be adequate for only 27% of Positive Behavior Support Plans (PBSP) reviewed. <u>Extent to which ISP identifies the persons responsible for the data collection and the persons responsible for data review:</u> For eleven of twelve ISPs reviewed (92%), the Action Plans defined the person(s) responsible for data collection. Similarly, for eleven of twelve ISPs reviewed (92%) 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 findings described in Provision F2d below. <u>Conclusion:</u> This provision was found to be not in compliance.	Noncompliance

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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. As noted above in Provision F2a3, the Facility had implemented a Grand Rounds practice that brought together various disciplines to focus on individuals who have complex behavior and medical problems for the interdisciplinary teams to identify issues and explore treatment strategies 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. As an example of circumstances in which coordination of services could have been achieved, but was not, 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. 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 each ISP is accessible and comprehensible to the staff responsible for implementing it.	Extent to which ISP is accessible to staff: As reported in Provision V1, to assess whether records were accessible to staff for use in providing supports and in making decisions, the Monitoring Team observed the records five homes. In five of five (100%), Active Records were kept in an accessible area. It was noted by the Monitoring Team, however, that current ISPs were frequently not in fact currently available to staff for implementation. See Provisions F2f and F1d. Extent to which ISP is comprehensible to staff: The Facility continued to take and/or plan actions designed to promote comprehensibility of the ISP. As reported in Provision K11, according to Microsoft Word 2013, the readability scores for 10 PBSPs all fell below a grade level of 8. A grade level of	Noncompliance

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		8.0 is generally considered the upper range of easily accessible writing. For the two ISPs reviewed, the ISP was not yet 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. 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. The Facility was considering a revision that would integrate the schedule and special considerations that appeared to hold promise in this regard. Overall, observations and review of program data indicated that ISPs did not appear to be comprehensible to the staff responsible for implementing them. For example, there 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 observations conducted by the Monitoring Team indicated nine of 27 sampled individuals' (33%) dining plans/PNMPs 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 58% of individuals. Observations revealed that across all settings 58% of observed individuals were functionally engaged. Furthermore, less than half (42%) of all environments observed reflected at least 50% engagement. • As reported in Provision R3, three of seven staff interviewed (43%) were knowledgeable of the individuals 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. • As reported in Provision T1b1, for Individual #120, there was a Service Objective (SO) for developing a Community Living Options binder that would be reviewed with the individual on an ongoing basis in order to	

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		increase familiarization with those options. The Monitoring Team reviewed data related to implementation of this SO. While SO Progress Notes indicated the level of assistance was usually V, I (Verbal, Independent), the actual data sheets indicated Individual #120 almost always refused to participate, suggesting staff did not understand the data collection methodology. <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 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.	<u>Monthly review of progress</u>: The Facility reported that there were significant concerns about the implementation of monthly reviews of progress by the QIDP. The Monitoring Team confirmed this finding. Overall, the Monitoring Team found that QIDP Monthly Reviews were not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development. • QIDP Monthly Reviews for the past three months for 15 individuals with recent ISPs were reviewed. Of the 15, eight (53%) had all three reviews, two had two reviews and the two had one review. The remaining four had none completed. This was particularly concerning because these ISPs were self-selected to an extent by the facility. • In addition, as reported in Provision S1, five of nine individuals (56%) had at least one IDT Monthly Review report missing. • The Monitoring Team also requested the monthly reviews for individuals who had planning meetings (ISP or ISP Preparation) during this visit. These were either not completed or were nearly identical for month after month. Effective planning for the future cannot take place if the IDT is not implementing and monitoring the progress of individuals on an ongoing basis. The Facility reported it was set to begin having the Unit Clerks track the timeliness and presence of Monthly Reviews in March 2014 and had in-serviced these staff as to their responsibilities. The Monitoring Team would recommend the Section F team develop some approach to sampling the Monthly Reviews for quality as well. In addition to these findings, the Monitoring Team found other concerns related to monthly review of progress. IDTs as a whole did not consistently ensure assessment of progress on a monthly basis, or more frequently as needed, or make revisions if there was a lack of expected progress. For example: • As reported in Provision R3, for one of five individuals (67%), information was present regarding whether the individual showed progress with the stated goal. For zero of five individuals (0%), a description was found of the benefit of the	Noncompliance

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		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. • As reported in Provision R4, for zero of four (0%) individuals monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. • As reported in Provision K4, in five of 10 records (50%), behavior intervention progress notes were not available for all months. • As reported in Provision P2, for individuals with PNMPs, for 0 of 15 sampled individuals (0%) was there evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. • As reported in Provision K4, in five of 10 records (50%), behavior intervention progress notes were not available for all months. <u>Extent to which ISPs are modified as appropriate:</u> The failure to complete timely or meaningful reviews continued to produce 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. For example, the Monitoring Team attended the ISP annual planning meeting for Individual #120 at the time of the last monitoring visit, on 8/27/13, and reviewed the individual's record for evidence of its implementation and any necessary modifications since that time. While there was some documentation that demonstrated some components of the ISP had been implemented, many were not, as indicated by the findings below: • There were no QIDP Monthly Reviews in the record for the past six months. • The ISP called for the individual to make monthly tours of community living options. No tours had yet been completed. • There was a Service Objective (SO) for developing a Community Living Options binder that would be reviewed with the individual on an ongoing basis in order to increase familiarization with those options. The Monitoring Team asked to review the binder and was provided with a copy of the CLOIP Making Informed Choices Workbook. It had not been individualized. The Monitoring Team also requested data related to implementation of this SO. • The ISP called for the individual to attend Catholic services in the community. The only evidence provided was a single Trip Memo request form. • The IDT deferred a money management objective and requested a pica probe be completed to confirm or deny that the individual only attempted to ingest	

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		cigarette butts. It was noted in discussion that this would also potentially allow her to live in a less restrictive setting than her current pica-safe residence. This was not completed as permission was not granted to pursue this approach, but the IDT did not consider any alternative. • The ISP called for a referral to music therapy. No referral was initiated. • The ISP called for an integrated assessment of diet texture by the SLP, OT and BA. As evidence, the Facility provided a texture change order from 4-12-12, which could not be considered responsive to the ISP from August 2013. No other evidence was found in the review of the record. <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-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.	<u>Extent and adequacy of competency-based training for staff responsible for development of ISPs:</u> The Facility stated there were no policies on competency-based training related to the ISP. QIDPs were not currently providing training in facilitation skills using the standard Q Construction curriculum as there were no certified trainers on staff at the Facility. The Q Educator reported that she and another staff person were to be trained in the near future. 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. At the time of the last monitoring visit, it was also reported a plan was underway to develop training to enhance critical thinking and brainstorming skills. This had not been implemented and it was reported to be deferred in favor of Person-Centered Thinking training that would be provided in the future, once two RSSLC designated staff completed the initial training being offered by DADS. <u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u> 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. • 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 three individuals in Samples R.4 and R.5 had received training related to Communication SAPs and programs. Two of three (67%) individual's staff assigned had completed competency check-offs regarding the individuals' communication programs.	Noncompliance

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		• Provision P3 was found to be in Substantial Compliance. All staff, new and existing, received both foundational as well as individual specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Individual specific training was provided in a timely manner and was competency based as indicated by the change in the plan. The provided trainings resulted in improved staff knowledge as identified in Provision O.4. • Provision O5 was found to be in Substantial Compliance. All staff, new and existing received both foundational as well as individual specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Individual specific training was provided in a timely manner and was competency based as indicated by the change in the plan. The provided trainings resulted in improved staff knowledge as identified in Provision O.4. Overall, however, the Monitoring Team found staff were not yet adequately provided with competency-based training. Examples included: • As reported in Provision K12, the Facility reported that there was no process or curriculum for providing competency-based training for implementing behavior support plans. No data regarding staff training in relation to PBSPs or behavioral principles was provided by the Facility. • This finding was also influenced by observing outcomes of the lack of active treatment and engagement and 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. Substantial compliance in competency-based training must be supported by the actual observed competence of the staff trained; otherwise, the training protocol cannot be considered to be effective. <u>Conclusion:</u> This provision was found to be not in compliance.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its	<u>Extent to which ISPs are developed within 30 days of admission:</u> RSSLC reported 8 admissions since the last monitoring visit. 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, or at all, for this sample. Of the four ISPs reviewed, one, for Individual #13, had no assessments provided as requested and one, for Individual #417, included only four assessments. In the latter case, only the Water Safety Assessment, FSA, Vocational Assessment and an initial Functional Assessment were	Noncompliance

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	preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	present in the material provided; no Medical, Nursing, OT/PT, Communication or Psychological Assessments were provided. The lack of appropriate assessments called into question whether the ISPs adequately addressed the needs of these individuals. No PSIs were found for this sample, also calling into question whether the strengths and preferences were adequately addressed. 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 Facility provided a document that indicated 117 of 306 ISPs (38%) held between 3/1/2013 - 2/11/2014 were not filed within 30 days. In addition, there was evidence that discipline specific plans were not always implemented on a timely basis. For example; • As reported in Provision R3, two of five individual's direct intervention plans (40%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. Two of four individuals' indirect plans (50%) (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. Two Individuals were recommended to have communication dictionaries but were not provided with one. • As reported in Provision P2, for individuals receiving OT/PT supports and services, 15 of 15 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. However, only three of seven individuals' direct intervention plans (38%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. The Monitoring Team was unable to determine if the remaining four individuals were implemented. 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	It was reported the Facility was still 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. No data had been collected. The Facility had been making some ongoing revisions to the Section F Monitoring Tool and the Q Construction monitoring tool, but these were not currently being implemented in a formal or consistent manner. The QA Director had been meeting	Noncompliance

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	remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	with the Section F team to offer technical assistance and encourage moving forward with monitoring. In response to the document request, the Facility indicated monitoring was to begin on 2/10/2014, but this schedule had been pushed back to March 2014. The QA office was set to begin tracking the timely completion of the FSA, PSI, and ISP Preparation meeting, as a part of a Corrective Action Plan (CAP). As a part of this endeavor, QA staff would also review the requirements for attendance and assessments established at the ISP Preparation meeting, which would be used for tracking these in the future. This would be an improvement to the current procedures and likely to result in more reliable data. 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.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-Assessment 2/13/14 2. RSSLC Action Plans 2/13/14 3. Presentation Book for Section V 4. Provision Action Information 2/20/14 5. DADS Policy 009.2 Medical Care 5/15/13 6. RSSLC Policy I.00a Medical Services 5/15/13 7. RSSLC Policy I.31 Providing Health Care Services: Chronic Clinical Indicators 10/12/11 8. RSSLC Policy I.12 Routing of Off-Campus Consultations 9/9/13 9. RSSLC Policy I.13 Routing of On-Campus Consultations 1/6/11 10. RSSLC Policy PCP Consultation Letter Policy (no number) 7/2/12 11. RSSLC Policy I.33 Medical Follow Up Database Policy 12/10/13 12. RSSLC Policy I.44 Morning Report 6/28/13 13. RSSLC Policy I46 The Incontinence Brief Tracking Policy 8/29/13 14. RSSLC Policy I47 The Diabetic Education Briefing Policy 8/29/13 15. List and copies of 33 policies and procedures in response to a request for "A copy of any State or Facility policy or procedure guiding integrated clinical services. 16. List of RSSLC policies guiding integrated services 17. Clinical Morning Report minutes for 3/4/14 and for the first morning meeting of each month from September 2013 through February 2014 18. ISP Attendance Tracking Log, covering ISPs held from 9/1/2013 - 1/22/2014 19. Team Member Participation in Annual ISP Meetings, undated 20. Medical consultation reports for Individuals #1, #72, #140, #149, #192, #243, #403, #413, #477, #483, #523, #525, #546, #553, #570, #644, and #693 **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 Individuals #675 and #718 2. ISP Preparation Meeting for Individual #501 3. Clinical Morning Report 3/4/14 4. Grand Rounds 3/5/14 5. Meetings attended by Monitoring Team members noted in several report Sections
	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, as well as the Auditor's Tool for ISP Tracking ISP Tracking, which provided data on attendance of clinicians at a sample of ISP meetings. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with relevant aspects of the Settlement Agreement. The information in the medical audits was consistent with findings regarding consultations for Provision G2. Attendance is data is essential in identifying the opportunity for integrated discussion during meetings but does not reflect actual participation during the meetings. Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The Self-Assessment identified 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). This sample sizes were adequate to consider them representative samples. o Adequate inter-rater reliability was not reported between the various Facility staff responsible for the completion of the tools. The Facility might wish to review the process for internal and external medical audits; these occurred at the same time and provided an opportunity for independent review of a sample of individual records that could be used to determine inter-rater reliability. ▪ Used other relevant data sources and/or key indicators/outcome measures. Such data included: o Number/% of clinical meeting minutes that included documentation of integration. The Facility did not provide (and the Monitoring Team did not request) guidelines or definitions of what would be required to demonstrate integration. Monitoring Team review of the minutes of polypharmacy review panel minutes documented a robust clinical review and were consistent with a finding of integrated discussion. o Number/% of outside consultations/diagnostic studies reviewed by PCPs, documented for acceptance/rejection of the recommendations from the consultant, documented for acceptance/rejection within five days, and with an ISP addendum (ISPA) documenting review by the IDT. ▪ 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. On a positive note, the data were provided on the specific questions from the Internal and External Medical Audits that were relevant to Provision G2.

	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 Identified that the data on attendance at ISP meetings were gathered by the Program Monitors, and identified information from the Internal/External Medical Audits, but did not identify whether data on documentation supporting integration and on review of IPNs/Notes were collected by the QA Department versus the program/discipline. ▪ 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. ▪ Most actions were reported as Completed, with two actions reported as In Process. ▪ The Facility data did not identify areas of need/improvement. Provision G1 was found assessed to be not in compliance "based on the need to further integrate and show integration through documentation in the ISP process"; however, the only data provided on documentation of integration showed that all meeting minutes had such documentation. Data provided on attendance at ISP meetings did show a need for improvement, but the Self-Assessment did not mention that as a reason for an assessment of noncompliance ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. The only actions identified for Provision G1 involved diabetes education; while it would be good for diabetes education to involve integrated planning from multiple clinical disciplines, this is only one topic. There were no actions planned to improve integrated planning for all clinical service areas so that individuals receive the clinical services they need.
	Summary of Monitor's Assessment: The Facility has continued to make progress in meeting the requirements of this provision. Although there is no overall policy guiding integrated planning, many policies include procedures to facilitate integration or requirements for integration. Various meetings and committees provide opportunities for integrated planning for individuals and system-wide processes. For example, Occupational and Physical Therapy interventions were consistently integrated into ISPs and ISP addendums. Nevertheless, this was still variable across disciplines; for example, acute care plans did not consistently include integration of care across disciplines. ISPs observed during the visit provided examples in which assessments did not contribute to the decisions about action plans.

	The Facility did not yet have an accurate and useful process to track required attendance at annual ISP planning meetings, although there were indications that attendance was adequate or had improved, and there was continued improvement in ISP meeting interdisciplinary process. Review of consultations from non-Facility clinicians remained in substantial compliance.

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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.	Although the parties agreed to not monitor this provision due to little progress, along with concentrated efforts on related provisions, the Facility provided extensive information to permit a complete review, and the Monitoring Team conducted a complete review. The Facility has taken steps to provide integrated clinical services. As noted in several Sections of this report, there was improvement in both attendance and participation at various interdisciplinary meetings (to the extent it was possible for the Monitoring Team to assess attendance) and in collaboration across disciplines. <u>Policy</u> In response to a request for "A copy of any State or Facility policy or procedure guiding integrated clinical services," the Facility provided 33 policies related to specific areas, including committees and areas of care. Although most of these policies addressed integrated services in some manner, no policy addressed integrated services as a whole. For example, Policy I.00a Medical Services requires the PCP to share consultation recommendations with the IDT, when applicable. Policy I44 The Morning Report guides the meeting and identifies the numerous disciplines that will be represented at the meeting. Nonetheless, the requirements for integrated services are small sections of these policies, and the Facility does not have a Facility that 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. Nonetheless, there were also examples in which integration was built into policies, an indication that	Noncompliance

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		the Facility seeks to ensure integrated planning occurs. • Policy I46, The Incontinence Brief Tracking Policy, developed following review of trends in urinary tract infections (UTIs) integrates medical services, residential services, and nursing to identify signs of UTIs through tracking and assessment of frequency of changes in briefs, with a clear criterion for referral to Sick Call for medical assessment. • Policy I47, The Diabetic Education Briefing Policy, stemmed from trend analysis of data on clinical indicators of diabetes. This policy requires involvement of the Nurse Educator, dietician, and Medical Director in provided a semiannual diabetic education briefing. <u>Morning Report Meeting</u> The Morning Report meeting, held Tuesday and Thursday mornings, continued to include a wide range of clinical disciplines. 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. The meeting followed a standardized agenda. The agenda included, among other topics: • On-call Report by the on-call PCP • Hospital liaison report • 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 meetings on 3/4/14 and 3/6/14. The disciplines in attendance included Nursing, Behavioral, Psychiatry, Hospital Liaison Nurse, Quality Assurance, Pharmacy, QIDP, and Dietitian. All of the psychiatry and medical providers were in attendance. The meeting was conducted efficiently and the agenda was followed. Observation of the meeting indicated a robust process whereby clinical issues that occurred since the last meeting were reported. Observations noted	

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		the following: • Minutes reflected summary documentation of the events discussed at the meeting and were useful in communicating the discussion. 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. For example, one individual was discussed who had significant effects when contrast from an IV infiltrated during a diagnostic test. An action plan was developed to improve monitoring during this kind of procedure, including a plan to train the IDT on the issue. The minutes did not reflect that a process was established to follow up on that plan. The Medical Director did summarize, at the end of the meeting, the two action plans developed (this systemic action and one action for a specific individual), so it appears there will be follow up, but this was not reflected in minutes. • Integrated discussion was mixed. One individual has his leg elevated for healing, which will continue for an extended time, but there were no questions to habilitation staff (the minutes did not indicate habilitation staff were present) nor any discussion of involvement of habilitation staff. On the other hand, for an individual with a restricted diet who was having increases in behavior problems, psychiatry, behavior services, and the dietitian all contributed, and there was a suggestion to bring this individual to Grand Rounds. Please refer to Provision L1, which describes the meeting on 3/6/14; the observation of that meeting found that it consisted primarily of reports with little interdisciplinary discussion. • The Physical and Nutritional Management Team representative reported on two post-hospitalization assessments and stated the PNMT will meet with the IDTs for three individuals. Review of the meeting minutes for the first morning reports of each month that occurred during the reporting period (9/2013 through 2/2014) indicated that the Facility included staff members from a variety of clinical disciplines, including PT/OT, nursing, medical, psychology, psychiatry, pharmacy, and residential services; however, there was little evidence to indicate that the meeting was conducted in an interdisciplinary format, and each issue addressed at the meeting was mostly presented as a report by the medical provider, or the nurse and there was little discussion regarding the issues, by other staff. For example, the Clinical Morning Meeting Report, dated 1/2/2014 indicated that Individual #160 had "placed a paintbrush in to (the Individual's) mouth. No history of pica. Had a little pink paint in mouth when found by staff. Paint stated it was non-toxic. On medical monitoring but no issues. No vomiting, abdominal pain or discussion". In this example there were no questions asked by other member of the committee	

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		regarding this potentially serious issue. Behavioral health members should have questioned this new behavior and indicated that a review of pica, and mouthing behavior of non-edible items would be conducted, and living area staff should have discussed possible supervision issues. In addition, there were very few examples of action plans developed to follow-up on clinical concerns. For example, the nurse reported that Individual #1 was "scheduled for ureterostomy for hydronephrosis on Monday", and no one questioned if all pre-surgical arrangements were in place, and what type of supports and services were necessary to ensure a successful outcome. For this example, specific action plans to ensure that the Individual was maintained NPO, if necessary, and determination what medications should be given, or should not have been given, as well as ensuring that a nursing or medical assessment was completed on the morning of the surgery, prior to being transported to the hospital. <u>Grand Rounds</u> 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. The Monitoring Team (Independent Monitor and Nurse) attended the Grand Rounds Meeting on 3/5/14, which was attended by relevant interdisciplinary team (IDT) members and other relevant Facility staff. There was an active participation by the team, particularly the Qualified Intellectual Disability Professional, Physical and Occupational Therapist, Clinical Pharmacist, RN Case Manager. The Medical Director led the meeting. The focus of the meeting centered on a thorough review of Individual #227's clinical course regarding recent falls. The team discussed potential underlying causes for the falls, current management plan, and elicited further strategies for management and treatment. The team will provide the recommended strategies for management and treatment to Individual #227's IDT for further review and disposition. 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. <u>Integrated Committees and Workgroups</u> The Facility had several committees and workgroups that brought together numerous disciplines for interdisciplinary reviews of individuals and systemic issues, including the following: • As reported in Provision N3, the monthly polypharmacy review panel meeting includes assessment of the appropriateness of polypharmacy usage for	

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		individuals. The review consists of a pharmacist, medical provider, psychiatrist, psychologist, and nursing representatives. • The Skin Integrity Committee membership included several disciplines. However, all required committee members were not consistently present at the meetings. This was of concern because the Skin Integrity Committee was supposed to be an integrated meeting. If relevant disciples do not attend the committee meetings, efforts to work collaboratively to prevent skin integrity/pressure ulcer cannot be adequately addressed/achieved. • 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 did not consistently attended the meetings. <u>Integrated Planning and Services for Individuals</u> Integrated planning requires disciplines to work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. There were excellent examples of integrated planning being done, such as: • As reported in Provision M1, the Monitoring Team Attended the Pre-Hospital Discharge Planning Meeting for Individual #169 and reviewed the subsequent meeting minutes prepared by the Hospital Liaison Nurse. The Monitoring Team found that the meeting was integrated and well attended with active participation by all relevant disciplines responsible for Individual #169's supports and services. The discussion was substantive and appropriate for Individual #169's change of health status, as reported below. Staff attending the Pre-Hospital Discharge Planning Meeting included the Medical Director, Primary Care Providers, Hospital Liaison Nurse, Infection Control Nurse, Skin Integrity Coordinator, infirmary Director, RN Case Manager, Physical Nutritional Management Team (PNMT) Qualified Intellectual Disability Professional (QIDP), QIDP Coordinator, PNMT Nurse, PNMT Occupational Therapist, PNMT Physical Therapist, Trinity Physical Therapist, Licensed Medical Social Worker (LMSW), QA Nurse, DSPI, Clinical Pharmacist, Psychiatrist, RN Case Manager Supervisor, and Behavioral Services. • As reported in Provision M3 regarding Individual #544's skin ulcers, although there were a number of issues of concern in treatment, documentation showed	

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		that integrated services were provided in management of the wounds. Individual #544's sleep patterns were evaluated by Behavioral Services and a plan was developed to encourage sleeping in his bed. The PNMT and Physical Therapist assessed and developed a position plan to relieve pressure. • As reported in Provisions J8 and J15, there was considerable improvement in integrated care between neurology and psychiatry, as described under Provision J15. Psychiatrists now attend the neurology clinic for individuals treated with anticonvulsants for both seizures and a mental health disorder (and also other individuals treated by both psychiatry and neurology) and there is a good and open discussion about co-management of individuals with both neurological and psychiatric care. • As reported in Provision J13, the Monitoring Team attended the PBMC on 03/05/14. Participants included the psychiatrist, behavioral health specialist, nurse case managers, clinical pharmacist, and DSPs. Nurses and behavioral health specialists reported on individual's progress and the psychiatrist then asked for further details and clarifications. The meeting was an improvement over the PBMC meetings attended in the past. The meeting was interdisciplinary and collaborative. • Speech language pathologists (SLPs) participated in the development of Positive Behavior Support Plans (PBSPs). Based on review of the Positive Behavior Support Committee meeting attendance sheets, the SLP participated in 0% of the meetings. Although he SLP did not participate in the meetings, the process for information sharing between the SLP and the Behavior Analyst was clearly defined as part of Policies J.06 and K.06.2. As reported in Provision R2, based on review of records of a sample of individuals with Positive Behavior Support Plans the following was noted: • Four of four 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 four individuals (100%) communication strategies identified in the assessment were included in the PBSP. Furthermore, a pilot had recently been started that included a process to formalize the involvement of SLPs in development of PBSPs. <u>Interdisciplinary Team (IDT) Attendance, Participation, and Clinical Planning</u> For integrated planning to occur, clinicians must participate in interdisciplinary meetings, such as the ISP annual planning session. During the ISP Preparation meeting, the IDT was to identify the requisite composition of the team for the purposes of the	

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		annual planning meeting. The Facility's self-assessment reported that attendance at ISP meetings for a sample of 13 randomly selected individuals found that there was variation in attendance by various disciplines. Speech therapists (SLPs) attended 46%, and primary care providers (PCPs), occupational therapists (OTs), and physical therapists (PTs) each attended 54%. Other disciplines attended many more. Nurses attended 85% and psychology/behavioral staff attended 92%. Also, the Facility provided a document for review, entitled ISP Attendance Tracking Log, covering ISPs held from 9/1/2013 - 1/22/2014. The data were provided by living unit, but the document indicate actual attendance but did not indicated required attendance. While it might be possible to make certain assumptions about which disciplines should be in attendance, one of the primary purposes of the ISP Preparation meeting is to define these expectations and establish that benchmark. The Facility also provided a document entitled Team Member Participation in Annual ISP Meetings that tracked required attendance by discipline for each living unit, but it was also not useful as it had multiple entries for the same or similar disciplines. There were other indications that attendance was adequate or had improved. For example, an OT or PT attended the ISP or ISPA meeting, unless adequate justification was provided in the Pre-ISP meeting documentation. Fifteen of 15 ISP annual meetings (100%) had a member from either OT or PT present to represent the disciplines. This was a higher level of attendance than reported in the Self-assessment; the difference might be due to the consideration of whether the Pre-ISP meeting documentation indicated attendance was required. The Facility should make a concerted effort to ensure it tracks attendance based on who is required to attend. Attendance alone does not indicate that there was integrated participation. As reported in Section F, the Monitoring Team found there was some continued improvement in the ISP annual meeting interdisciplinary process as observed during this visit. In addition to attendance at ISP meetings, the self-assessment reported on documentation supporting integration at incident management meetings (IMM), PNMT meetings, and psychiatry/polypharmacy meetings. For all three meetings, the self-assessment reported 100% showed documentation of integration. Furthermore, the level of integration of interventions into ISPs and IHCPs provides insight into the integration of clinical services. • Fifteen of 15 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	

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		on the rationale provided in the therapy assessment. Integration was primarily in the form of PNMP review and acceptance. In seven of the eight ISPs or ISPAs reviewed (88%), 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. • As reported in Provision M3, Acute Care Plans (ACPs) showed varying levels of integration across clinical disciplines. o One of two (50%) individuals' Skin Integrity-Pressure Ulcer ACPs included integration with the PNMT, Skin Integrity Nurse, and dietary. o Review of ACPs for infections found six of six (100%) ACPs included integration of care with other relevant disciplines. • As reported in Provision M5, four of nine (44%) IHCPs showed adequate integration among all appropriate disciplines. <u>Examples of Improvement Needed</u> Although clinical services had become much more integrated over time, examples remained which demonstrated a need for continuing improvement. • As reported in Provision M1, only four of nine (44%) Integrated Health Care Plans (IHCPs) showed adequate integration among all appropriate disciplines. o The IHCP for Individual #483 did show adequate integration. Several relevant disciplines were identified as responsible for implementing the plan. o The IHCP for Individual #503 did not show adequate integration. Several relevant disciplines were not indicated as responsible for implementing the plan. • For one of the two focus ISPs observed during the monitoring visit, for Individual #718, the individual had an audiological assessment completed on1/4/14 that indicated the individual should be evaluated for a possible middle ear disorder. None of the other assessments noted this need; in fact, those that referenced any audiological findings were from an assessment dated in 2011. This was of particular concern because the individual had also had eight falls during the year and was known to be unsteady. Although falls were discussed, the issue raised in the audiology assessment was not. The possibility of the middle ear disorder needed to be evaluated for any potential contributory effect. Either the audiologist should have been alert to the information about falls and ensured this issue was addressed, or the QIDP or other IDT members should had noted the middle ear disorder in the audiology assessment and asked about the	

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		possible relationship to falls. Furthermore, the indication of the need for an evaluation for middle ear disorder was not addressed in an action plan. • As reported in Provision K8, PBSPs did not reflect the integration of counseling plans, counseling assessments, or counseling outcome measures into the overall strategy for addressing behavioral and mental health needs. • As reported in Provision Q1, when there were dental emergencies, there was not 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 as, or contributing to, severe behavioral exacerbation.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	<u>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. The following Facility policies addressed aspects of consultation and review of recommendations from non-Facility clinicians. • RSSLC Policy I.12 Routing of Off-Campus Consultations 9/9/13 • 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 I.33 Medical Follow Up Database Policy 12/10/13 • RSSLC Policy I.44 Morning Report 6/28/13 Policies I.12 and I.13 provide steps to be taken for routing off-campus and on-campus consultations. Policy I.12 had been revised since the last compliance visit. The prior version began with the return of documents from the appointment with an off campus consultant physician. The current version added steps to be taken prior to the consultation. It requires the Primary Care Provider (PCP) to dictate a consultation letter and the medical consultation form to be sent to the community consultant. It then describes steps to arrange appointments, inform the Medical Director of delayed appointments, ensure staff are aware of the consultations to be completed each day and the forms to be filled out, and check to ensure consultation forms are signed and filled out prior to return. It describes steps to be completed by the PCP when the consultation form is provided, including acknowledging acceptance or rejection of recommendations and noting whether the consultation needs to be referred to the IDT. The addition of language about the initiation of the consultation sets expectations for the PCP and, with the PCP Consultation Letter Policy (described in detail in the report of the last	Substantial Compliance

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		compliance visit), establishes a structured system to ensure consultants receive the information they need. Policy I.33 on tracking and trending medical consultations had been replaced with a policy titled Medical Follow Up Database Policy. Changes included: • The Schedule Coordinator is now required to send out a list of all clinical consultations attended by the individual during the week to the QIDPs, Unit Case Managers, PCPs, and Medical Director. This should help to both increase involvement by the IDTs (because of notice to the QIDP) and to help PCPs ensure they respond to recommendations from consultants. • The Schedule Coordinator is to create an entry for all medical appoint follow up whether or not an appointment date has been assigned, in order to ensure that all medical appointments are tracked. This should minimize errors in not making such appointments. • The PCP is required to review consultant's recommendations and document acceptance, rejection, or other in the database as well as on the hard copy of the consultation form and indicate in the database which medical consultations need referral to the IDT. Comments will be printed and placed in the active record as the integrated progress note (IPN). There was no change in due date; PCPs continue to be required to enter data within 5 to 7 business days following receipt of the data, which is inconsistent with DADS policy requirement of response within five working days. • Unit Case Managers (CMs) are to receive a list weekly of all clinical consultations scheduled and attended, and to review the list with the IDT in the unit morning meeting. CMs will ensure individuals have timely follow up with all clinical appointments. CMs review the PCP's note for each consultation and print those for the IPNs. • Quality Assurance (QA) will monitor the database report monthly. The involvement of the QA department in this process should help ensure there is no slippage and ties this database into the Facility QA system. • The QIDP will receive a list of all consultations completed or not completed weekly and will discuss these at unit morning meetings. For consultations that require an IDT meeting (which can be requested by the PCP or any other IDT member, the QIDP is to document the discussion in the Medical Follow Up Database and ISP addendum. The QIDP is to schedule an IDT meeting when there are two or more consecutively missed consultation appointments. All these requirements provide a process for integrating review of consultation requirements into the ISP. <u>Procedures and Forms</u>	

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		The Facility provided copied of the forms used as templates for the consultation letters for initial and follow up consultations and the consultation report form. The letters provide to the consultant information about the individual, including history of present illness, significant past medical history, and diagnostic results, and has checkboxes to indicate enclosures such as current medications list and annual medical summary if provided. The consultation report form had checkboxes for whether the report is attached or will be faxed, or whether there are other notes. 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." <u>Consultation Database</u> The Medical Director showed the Consultation Database to the Monitoring Team and provided copies of screenshots. The database includes appointments scheduled, including type (initial or follow-up), date, whether attended, whether follow up is needed, reason if not seen, acknowledgement by the PCP of consultant's recommendations, checkboxes for the CM to document receiving PCP's acknowledgment of consultation and filing in the Medical Chart, and acknowledgement by the QIDD of the consultant's/PCP's recommendations. The notes made on the database by the PCP are converted into an IPN, so that the information is consistent from database to active record and minimizing the effort required of the PCP. The database can supply reports by individual or unit as well as facility aggregate, by consult and diagnostic type, and by date. Reports include status of appointments and missed appointments (including individuals with two or more missed who require IDT review). This is a most impressive database that should improve the ability of the Facility to ensure appointments are kept and that information is reviewed as needed. The Medical Director also provided a description of actions that had been taken since the last compliance visit to improve functionality of the database. <u>Review of Consultations by Facility Clinicians</u> The Monitoring Team reviewed a sample of 19 consultation reports for 17 individuals; 15 reports for 13 individuals were for medical consultations (Individuals #1, #72, #149, #192, #243, #403, #483, #525, #546, #553, #570, #644, and #693), and four were for modified barium swallow study (MBSS) consultations (#140, #413, #477, and #523). Of the 19 sampled reports: • For 18 of 19 ((95%), review was documented on the consult form. • The MBSS sample was not checked for IPNs; however, PNMPs for all four individuals showed revisions related to the MBSS findings. For the 15 medical	

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		consultations: o For fourteen (93%), an IPN was found; the other did not have documentation in the Active Record (and was therefore not considered by the Monitoring Team as completed) but did have an entry in the database.. o For 12 IPNs (80% of consultations), IPNs were dated within five working days. o Eighteen of 18 IPNs (100%) documented agreement with consultant recommendations. These data were consistent with information in the self-assessment. No consultations were specifically documented as referred to the IDT. However, the process requires notification to the IDT, and any IDT member can request a meeting to discuss it. In addition, the agenda for the Morning Report conducted twice per week included reports of consultations. Six consultations were reported at the meeting observed by the Monitoring Team; minutes did not report referral to IDT for any of these, but for Individual #544, information from "direct care staff" was discussed, and for Individual #82, minutes reported that "Behavioral will take a look again" and involve the psychiatrist, and the dietitian discussed the individual's diet concerns. Both these discussions were verified by Monitoring Team observation, and the discussions provided evidence that the individuals' IDTs had been reviewing the issues. The Monitoring Team did not request or review ISP addendums (ISPAs) to determine what reviews and actions had occurred. If these two of six consultations were reviewed by the IDT and documented in an ISPA, that would be consistent with information in the self-assessment. The data from the sample reviewed by the Monitoring Team was consistent with data reported in the Self-Assessment. In addition, the Self-Assessment provided a great deal of detail that demonstrated ability to track information on consultations at the level of the individual consultation. The Self-Assessment also provided data from the External and Internal Medical Audits regarding completion of documentation on the Consultation Letters. Processes for review of consultations by Facility clinicians are defined in policy and are implemented consistently. Therefore, this provision continues to be rated 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 2/13/14 2. RSSLC Action Plans 2/13/14 3. Presentation Book for Section H, including, among other documents, a. Relevant policies b. Chronic care database screenshots for diabetes, osteoporosis, preventive healthcare screening, neuromotor/musculoskeletal disorder, pneumonia, and urinary tract infection c. Trend analysis reports for diabetes, osteoporosis, preventive healthcare screening, neuromotor/musculoskeletal disorder, pneumonia, and urinary tract infection d. Medical follow-up database screenshots e. Daily sick call logs with integrated progress notes (IPNs) from nurses and primary care providers f. Minutes of pre-hospital discharge planning meetings g. Documentation to support diagnoses for a sample of individuals diagnosed with osteoporosis, diabetes, hyperlipidemia, seizure disorder, GERD, chronic kidney disease, hypothyroidism, cataracts, osteoarthritis, and constipation h. Documentation to support psychiatric diagnoses for a sample of individuals 4. Provision Action Information 2/20/14 5. DADS Policy 004.2 Individual Support Plan Process 11/21/13 6. RSSLC Policy I.00a Medical Services 5/15/13 7. RSSLC Policy I.31 Providing Health Care Services: Chronic Clinical Indicators 10/12/11 8. RSSLC Policy I.44 Morning Report 6/28/13 9. RSSLC Policy F.04 Individual Support Plan Process 1/29/14 10. Table of annual assessments filed 10 days prior to meeting (annual ISP planning meeting) 1/1/13-1/22/14 11. Share Drive list of assessments for Individual #306 12. Clinical Morning Report minutes for 3/4/14 **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 #675 2. ISP Preparation Meeting for Individual #501 3. Grand Rounds addressing Individual #227 4. Morning Report 3/4/14
	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, among others: o Number and percent of assessments completed timely. o Number and percent of quarterly summaries and drug regimen reviews completed timely. o Number and percent of applicable individuals for whom post-hospitalization PNMT assessments were completed and were present in the active record and showed IDT integration. o Number and percent of quarterly assessments that ensured treatment to be clinically appropriate. o Number and percent of Pre-Hospital Discharge meetings that had clinical assessments completed and documented in IPNs by appropriate disciplines and had healthcare plans and IDT evaluations as indicated. These data did not address all requirements of the relevant provisions. For example, for Provision H3 that requires treatments and interventions to be timely and clinically appropriate, the Self-assessment provided ratings of clinical appropriateness but did not provide any information documenting review of timeliness of implementation of medical treatments and interventions. The Self-assessment for Section K provided some information about timeliness, but not all that could be useful, as it reported that 66% of Positive Behavior Support Plans (PBSPs) were implemented within 14 days of receiving consent but did not indicate the timeliness of drafting PBSPs and seeking consent; this information was not referenced in the Provision H3 self-assessment. The Self-assessment for Section O provided data from an audit of implementation and effectiveness of intervention when an individual was discharged from the PNMT involvement—an excellent idea; it reported implementation and effectiveness monitoring were in place for 0% of a sample of four individuals; again, information about implementation was not referenced in Provision H3. For

	Provision H1 regarding performance of assessments, the Facility did address timeliness. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations, as well as to integrate relevant information from various provisions and from the Facility's quality assurance data reports. • For many data items, the Facility reported that the sample was selected through a Randomizing Database. This was a positive step to ensure representativeness of the sample. ▪ 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 did not indicate whether any of the data were included as part of the Facility's regular quality assurance data system used for routine decision-making. ▪ The Facility rated itself as being in compliance with no provisions of Section H. 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 or In Process. The plan also referenced action plans for Provisions I1, I2, and I3; these actions were reported as Completed, In Process, or Not Started. ▪ The Facility data identified and addressed only limited areas of need/improvement. These related only to the risk rating process. Section I actions also related to health care plans and bedrails. Interestingly, information from interviews and from documentation reviewed by the Monitoring Team identified a much broader set of action plans more directly related to issues addressed in the Self-assessment. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Although it is appropriate to identify actions that may have a significant impact across Sections (and actions relevant to the risk process and to health care plans would have an impact and were appropriate to reference), the actions identified did not address a broad enough set of the requirements of the Section. For example, the actions listed did not reference clinical indicators, but information gathered by the Monitoring Team found the process of developing and using clinical indicators to be progressing well; use of such indicators not only are required for compliance with Section H but also would be important for compliance with Section I.
	Summary of Monitor's Assessment: The parties agreed the Monitoring Team would not monitor Provisions H1 and H3-H7, as the Facility was concentrating efforts on other provisions and had made little progress on these. The Monitoring Team responded that a reduced review of Provisions H4 and H5 would be preferable. Ultimately, the Facility

	provided extensive information that permitted a full review of Provisions H1, H4, and H7, and reduced review of Provisions H3, H5, and H6. Therefore, all provisions received either reduced or complete review. Progress continued for most provisions of this Section. Improvement continues to occur, but also more improvement is needed. The Facility had begun using statewide standardized assessment templates, with the exception of the Rights Assessment, Structural & Functional Assessment, and Pharmacy. These were intended to ensure all assessments would have a consistent foundation of information and analysis to be included. Facility tracking did not provide accurate data on timeliness of assessments. The Facility must implement a process for accurate tracking of completion of required assessments, as determined during the pre-ISP preparation meeting. Review of documents indicated annual and admission assessments by most disciplines were timely, and there was also improvement in timeliness of assessments when there was a change in status, but further improvement is needed. Comprehensiveness of assessments had improved for most disciplines. Use of information from assessments remained variable. There remained a need to ensure diagnoses were consistent with the findings from assessments. Although response to acute medical conditions and dental emergencies remained timely, implementation of other interventions such as PBSPs, dental restorative treatment, and action plans identified by the Physical and Nutritional Management Team (PNMT) were delayed, or there was not evidence of timeliness provided to the Monitoring Team. One area of considerable progress was the development and use of clinical indicators to guide medical care, particularly for chronic health conditions. Outside of chronic health conditions, the use of clinical indicators had not yet progressed to the same degree; there was progress identifying indicators for physical and nutritional management (although not for recording of identified individualized triggers or monitoring of those indicators), but less progress for symptoms relevant to psychiatric care. QIDP Monthly Reviews were not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development. It was not always possible to determine whether revisions to treatments and interventions occurred in response to clinical indicators and behavioral data, but examples were found in which that did not occur.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations	As noted in the Summary of Monitor's Assessment, the parties agreed the Monitoring Team would not monitor Provisions H1 and H3-H7, as the Facility was concentrating efforts on other provisions and had made little progress on this provision. However, because the Facility provided adequate information, the Monitoring Team conducted a	Noncompliance

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	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.	complete review of this provision. <u>Policy</u> DADS Policy 004.2 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 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. In a sample of twelve ISPs held in the last six months, nine (75%) recent ISPs clearly defined the assessments that were to be completed. This finding was consistent with that in the previous six months. RSSLC Policy F.04 also provides the same timelines for completing assessments, as well as the ISP preparation meeting identification of required assessments. <u>Extent to which assessments are conducted routinely</u> As reported in Provision V4, the Facility assessment tracking tool did not provide accurate data. The Facility provided a table of annual assessments filed 10 days prior to the annual ISP planning meeting, for 1/1/13-1/22/14, by living unit. As noted above, the process to identify required assessments was to do so at the pre-ISP preparation meeting held approximately 90 days prior to the annual planning meeting. Although some assessments are required for only a few individuals, some assessments are required for all individuals. For example, annual medical assessments, annual nursing assessments, and pharmacy assessments are required for all individuals. However, the table reported that none of these matched the number of ISP meetings for any unit. The percentages listed as "filed 10 Days Prior to Mtng (sic) were based on the number of assessments filed timely divided by the number of assessments filed; the number of assessments not filed at all (and therefore not timely) was not reported or considered in determining the percent filed timely. The Facility acknowledged it was aware of this flaw in its quality management process. The QIDP Educator indicated the Facility was working on a fix to this problem. The QA Director further explained that the QA Department would be tracking timeliness of the ISP Preparation Meeting and would then monitor the assessments based on the requirements in the ISP Preparation documentation. The Facility needs to complete development of a tracking system that identifies the assessments required for annual ISP planning meetings and the number of those assessments that are completed and filed timely. This was also noted in the last compliance report. In addition, the ISP Assessment Tracking Log, dated Tuesday, February 11, 2014, and encompassing the meeting dates of 9/1/2013-2/11/2014, similarly included only those assessments that had been filed prior to ten days before ISP annual planning meeting;	

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		thus it did not fully capture timeliness data for all required assessments when they were filed after that timeframe. The Facility acknowledged it was aware of this flaw in its quality management process. The QIDP Educator indicated the Facility was working on a fix to this problem. As reported in Provision F1c, the Monitoring Team reviewed assessments for a sample of nine completed ISPs and for two ISP annual planning meetings observed during the visit, as well as for a sample of four individuals who had been admitted to the Facility. Findings showed that timely completion occurred for 74% of required assessments as noted in the completed ISPs and 71% in the observed ISP meetings, and 78% of required assessments were included in the documents provided to the Monitoring Team. This was relatively consistent with the findings of the last compliance review, which found 70% of assessments were completed timely for ISPs completed prior to the visit and 70% of required assessments for those ISPs were provided to the Monitoring Team. Improved timeliness was found for one individual for whom assessments were due. The Monitoring Team also viewed the assessments available on the shared drive for Individual #306, who had an annual ISP planning meeting scheduled within the next ten working days. For 11 assessments that were required per the ISP preparation meeting, 11 (100%) current or updated assessments were posted, and 11 (100%) had been posted by 10 working days prior to the meeting. This was an improvement compared to the individual sampled during the last compliance visit. It was also an improvement compared to the overall 86% timeliness found for ISP meetings to be held the week following the last visit. The Facility must implement a process for accurate tracking of completion of required assessments, as determined during the pre-ISP preparation meeting. This system should permit assessment of timeliness by discipline, living unit/home, and by discipline at each living unit/home. That would permit identification of improvements that need to be addressed. The QIDP Educator indicated the Facility was working on such a process. The QA Director further explained that the QA Department would be tracking timeliness of the ISP Preparation Meeting and would then monitor the assessments based on the requirements in the ISP Preparation documentation. Additional information on timeliness of assessments for disciplines includes the following: • As reported in Provision J2, for seven admissions to the Facility for individuals who took psychotropic medications prior to admission, all individuals were seen by psychiatry and had timely psychiatric assessments (CPEs), as needed, within 30 days. • The Monitoring team reviewed the CPEs of the 15 individuals in Sample J1. All	

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		had CPEs done between 2010 and 2013. For one of 15 (7%) individuals the most recent CPE was in the form of an annual review. Furthermore, the Facility reported that for 82 of 134 (61%) individuals, the CPE is place used the Appendix B format. • As reported in Provision K5, 60% of records sampled included psychological assessments. As reported in Provision K6, it was not possible to determine whether intellectual or adaptive skill assessments had been conducted at least annually. As reported in Provision K6, the Facility reported that tracking information regarding intellectual ability and adaptive skills assessments was unavailable due to a transition to a new database system. As reported in Provision K5, the Facility did not provide several structural and functional assessments (SFAs) requested by the Monitoring Team for document review. As reported in Provision K7, psychological assessments had been conducted within 30 days for individuals who had been admitted since the last compliance visit. • As reported in Provision L1, all annual medical assessments in the sample of 18 reviewed were completed at least 10 working days prior to the ISP annual planning meeting. • As reported in Provision M2, six of six (100%) Annual Comprehensive Nursing Assessments were completed at least 10 working days prior to the ISP meetings. For four new admissions sampled, four (100%) Comprehensive Nursing Assessments were completed within 30 days. • As reported in Provision O8, the Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Seven of seven 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. Seven of seven individuals (100%) evaluated had an appropriate evaluation to determine the medical necessity of the tube. 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. • As reported in Provision P1, seven of seven individuals admitted since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Fifteen of 15 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. Fifteen of 15 individuals' OT/PT assessments in sample P.1 and P.2 (100%) were dated as having been completed at least 10 days prior to the annual ISP. • As reported in Provision Q1, annual dental examinations were completed within a 12-month period, and were available to the IDT for review prior to the ISP meeting.	

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		• As reported in Provision R2, eleven of 11 individuals in Sample R.1 (100%) were provided a communication assessment per policy and/or Master Plan. Seven of seven individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission. Eleven of 11 individuals in Samples R.1 and R.2 (100%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. For ten of 11 individuals in Sample R.1 (91%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. <u>Comprehensiveness of Scheduled Assessments</u> As reported in Provision F1c, the Facility had begun using statewide standardized assessment templates, with the exception of the Rights Assessment, Structural & Functional Assessment, and Pharmacy. These were intended to ensure all assessments would have a consistent foundation of information and analysis to be included. Although progress was noted in assessments conducted by most clinical disciplines, they were still not of sufficient quality across all clinical disciplines to be considered comprehensive. • As reported in Provision J6, the overall quality of CPEs continued to improve, compared to past visits. The evaluations provided appropriate information, guided by the sections of the Appendix B format, and focused on elements of treatment that were relevant to the psychiatric aspects of treatment. At the time of the visit, however, only 61% of CPEs conformed to the Appendix B format according to the Facility's Self-assessment (a continuation of improvement compared to prior visits); of the CPEs sampled by the Monitoring Team, 86% conformed to the Appendix B format and were generally comprehensive. One area of improvement needed was documentation of the reasons for selection of the diagnoses. • As reported in Provision K5, assessments did not consistently include all requirements. For each requirement assessed by the Monitoring Team, less than half of sampled assessments met the requirement. This was true for both psychological assessments and SFAs. • As reported in Provision L1, all annual medical summaries reviewed in a sample of 18 were comprehensive. • As reported in Provision M2, there continued to be significant improvement in the quality and content of the nursing assessments. These were found to be substantially compliant with the criteria for a comprehensive assessment. • Physical and Nutritional Management Team (PNMT) assessments were generally comprehensive, with nearly all components included except for measurable outcomes related to baseline clinical indicators. • As reported in Provision P1, the Monitoring Team has recognized significant	

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		improvement in the comprehensiveness of the OT/PT assessments including the identification of skill acquisition programs as it relates to Activities of Daily Living (ADLs). While improvement was noted, there remained a need to further improve the development of ADL skill acquisition as a part of the overall OT/PT assessment process. • As reported in Provision Q1, annual dental examinations were comprehensive and included assessment of periodontal disease, carries, oral hygiene, and behavior related issues. • As reported in Provision S1, records reviewed for seven of 10 individuals included a preference assessment using the Preferences and Strengths Inventory; this tool provides a subjective measure that relies upon self-report and staff observation regarding what the individual prefers in relation to residence, leisure, employment, diet, and numerous other areas. A large number of individuals living at the Facility experienced substantial deficits in communication skills. It was not evident from the preference assessments that vocal, gestural or other non-language-based communication was considered when identifying personal preferences. Furthermore, it was not evident that the Facility had made use of other means to identify personal preference with people experiencing communication limitations. <u>Assessments in Response to a Change of Status</u> The Facility did not provide information on a formalized process to identify and address change of status. Instead, there were several processes that provided opportunities for clinicians and interdisciplinary teams to address change of status. Examples of change of status procedures and whether assessments were completed included: • As reported in Provision J7, the Facility informed the Monitoring Team that the there was 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. Change of status evaluations on Individuals #140, #332, #334, #366, #758 resulted in positive Reiss Screens and those individuals had CPEs. In the Appendix B format. The Monitoring Team reviewed both the Reiss screens and the evaluations and found them satisfactory. • The Pre-Hospital Discharge Planning Meeting, usually attended by the Hospital Liaison Nurse, primary care provider, RN Case Manager, PNMT members (often the PNMT nurse and PNMT QIDP), habilitation staff, and other clinicians as appropriate (refer to Provision M1 for a description of such a meeting observed by the Monitoring Team, which had broad representation of clinicians including the Skin Integrity Coordinator, Infection Control Nurse, behavioral services staff,	

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		pharmacist, and DSP), provided an opportunity to identify whether the reason for hospitalization, or the course of treatment during hospitalization, indicated a change of health status for the individual. At these meetings, risk ratings could be changed and additional assessments assigned as needed. Following each individual's discharge, the Hospital Liaison Nurse completed a Hospital Discharge Summary Report, which was discussed at a Post-Hospital Discharge Planning Meeting held weekly. • As reported in Provision O1, the PNMT RN continued to conduct assessments in response to all changes in status and discussed these 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._Six of six 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). In addition, RSSLC's PNMT RN provides assessment upon return from the hospital in an effort to identify any concerns noted with physical and nutritional management (PNM). Results of the assessment were discussed at the PNMT 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. Six of six 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. There remained examples in which assessments were not completed in a timely manner. For example, for Individual #192, the ISPA dated 1/13/14 requested a Head of Bed Evaluation and in May 2013, an Endocrinology referral was suggested. As of the compliance visit, neither had been provided. Behavior assessment was recommended as part of the 2/7/14 PNMT evaluation but there was no evidence that this was initiated. <u>Use of information from assessments</u> Although clinical staff routinely reported in interviews conducted as part of records audits (see Provisions V3 and V4) that they used information from assessments in making decisions about treatments, services, and supports, there was also evidence that improvement was needed. Examples were found both of use of information from assessments and of lack of use of the information. The following provide examples in which use of information could be improved. • Observations of ISP annual planning meetings for Individuals #675 and #718, and of the pre-ISP preparation meeting for Individual #501, found: o The active record was present at the meetings for Individuals #675 and	

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		#501, but the Monitoring Team did not observe the record being present at the meeting for Individual #718. o At the meeting for Individual #675, the record was referred to for information about several issues. In general, discussion of most issues included objective information rather than general impressions. There were some issues for which a report of data rather than impressions or inferences would have been useful, such as progress on behavior programs and number of community outings attended. Some issues raised in assessments were discussed, but others were not. An example of using information from assessments related to risk versus benefit for Individual #675 of surgery for gallstones and about the individual's status relevant to this issue. An example of not using such information for the same individual involved no discussion of management of CP nor of recommendations for management of constipation. o At the meeting for Individual #501, the record was referenced regarding a skill acquisition plan, and data on incidents and on some lab reports were read. The IDT referred to the record when discussing the individual's history of urinary tract infection (UTI). Data provided for incidences of urinary tract infection were from the 2012 annual nursing assessment, not from more recent information in the record; members of the IDT questioned this, and the record was referenced for more current information. This supported the need for the record to be present even though IDT members bring information from the record to the meeting. • As reported in Provision S1, it was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training or other sources.	
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.	In the Self-Assessment, the Facility reported completing a review of medical diagnoses of 58 randomly selected individuals. For each individual, the Facility selected one diagnosis the individual had from among Diabetes, Osteoporosis, Hyperlipidemia, Seizure Disorder and GERD. The Facility then reviewed each of these based on specific criteria for the selected diagnosis. The Facility also reviewed Psychiatric diagnoses for 18 randomly selected individuals with psychiatric diagnoses. For all of these, the criteria included documentation in records, assessments, and clinical indicators specific to the diagnosis. The Facility reported that all individuals in the sample had valid diagnoses. The Facility provided the documents used in this self-assessment process, as well as documents supporting diagnosis for Chronic Kidney Disease, Hypothyroidism, Cataracts,	Noncompliance

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		Osteoarthritis, and Constipation. For example, for Individual #16, the Facility provided the Active Problem List (APL) that included a diagnosis of osteoporosis, the admission medical summary showing the diagnosis, a DEXA scan report showing the T-score with comparison to the last DEXA scan and an impression of osteoporosis, a patient profile listing calcium and vitamin D as medications, and a table listing lab results including vitamin D 25 OH level. For psychiatric diagnoses for Individual #483, the Facility provided the psychiatric assessment (CPE) documenting diagnoses of intermittent explosive disorder and cyclothymic disorder; the APL listing those and also, on the same line, SIB (self-injurious behavior); a psychiatric & behavior management clinic (PBMC) report that stated the diagnoses, listed a psychiatric medication prescribed for intermittent explosive disorder and one for cyclothymic disorder, and a diagnostic impression that included both diagnoses; and the Positive Behavior Support Plan that listed both disorders and the indicators to be tracked (but not data showing the occurrence of those indicators over time). Although this information showed the Facility's ability to draw out and review a wide range of information that may be relevant to making a diagnosis, the results of the Self-Assessment did not fully match the findings of the Monitoring Team. Specifically, for psychiatric diagnoses, there was evidence of both the use of diagnoses that did not match the DSM format and a need to continue to improve diagnostic justifications. As reported in Section J, the Monitoring Team reviewed the APLs for the 15 individuals in Sample J6. All individuals had a diagnosis in the DSM format, although in four of 15 (26%) individuals, additions were made to the diagnosis that were not in the DSM format. For example the APL for individual #424 was Mood Disorder with SIB and aggression (SIB and aggression are symptoms, not diagnoses, and those symptoms are not coded as part of the diagnosis), and the APLs for Individual #483 and #19 both added SIB to the diagnosis. For each of the individuals in Sample J1, the Monitoring Team also compared the APL, the CPE, and diagnosis listed in the Department of Psychiatry Database, reflecting the most up to date diagnosis. In five of 15 (33%) individuals, there were differences between the database information and the APL. Despite improvements, an area of continued weakness is that of diagnostic justification. For many individuals, descriptions of psychiatric symptoms were cited in some sections of the CPE, for example the history of present illness and past psychiatric history. Those descriptions needed to be cited or referenced in some fashion when the final diagnostic assessment is made so that the basis for the selection of the diagnosis and the manner in which the relevant DSM criteria were met is clear. The Facility has recently developed a "Diagnostic and Treatment Analysis" record audit document. It included sections on	

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		"Symptoms" and "Diagnosis" and "Derivation (of diagnosis)." That form appears to address the matter of diagnostic justification, and the Monitoring Team encourages its use. In many cases it is helpful for the psychiatrist to provide additional information on why particular diagnoses were chosen; for example, an individual could meet criteria for more than one diagnosis and clinical judgment is used to select the diagnosis that is most appropriate for the overall clinical presentation including current state, history of present illness, previous and family mental illnesses and many other factors. That is the process of differential diagnosis and in many cases it is helpful to include a discussion of differential diagnosis and/or their initial inclusion in the diagnosis. To be considered justified, DSM diagnoses must meet all the criteria of the DSM for the diagnosis that was made. Many evaluations did not make clear how the cited symptoms justified the diagnosis that was cited. For medical diagnoses, there were examples of diagnoses that were not adequately specific, where diagnoses evident from diagnostic studies were not documented, or where diagnoses were inconsistent across documentation. For example: • Individual #666: o Had cervical spinal fusion, but the active problem list (APL) did not list active diagnosis for the specific type of vertebral/spinal pathology. o Diagnosed by optometrist with myopia and astigmatism, but this condition was not listed on the active problem list. o Had testicle removed secondary to testicular torsion, but no diagnosis for monarchism was listed on the active problem list. • Individual #133: Diagnosed with seizure disorder, and the specific diagnosis, which the neurologist determined as epilepsy, tonic/clonic, was not listed on the active problem list. It is important to list the specific type of seizure disorder. • Individual #351: A diagnostic study in 2012 indicated degenerative spine disease; however, there was no diagnosis listed for this condition on the active problem list. • Individual #192: o An optometrist diagnosed cataracts, however, this condition was not listed on the active problem list. o Cervical spine arthropathy was noted on CT scan of the spine, on 2012, during an emergency room evaluation. This condition was not listed on the active problem list. o The Individual has significant risks for aspiration pneumonia, and had been hospitalized for recurrent aspiration pneumonia; however, recurrent aspiration pneumonia was not listed on the active problem list. The Monitoring Team recognizes that at the time of the annual medical summary, the Individual did not have an active case of	

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		aspiration pneumonia; however, because of the significant known risk factors for aspiration pneumonia, and history of recurrent aspiration pneumonia, the diagnosis of recurrent aspiration pneumonia, should be listed on the active problem list because the medical provider must regularly assess the individual for this condition, and ensure that an updated, and efficacious medical plan is in place. • Individual #84: o A CT report in 2012 documented cervical osteophytes, and this diagnosis was not listed on the active problem list. o Pulmonary fibrosis was identified on 2012 CT; however, this diagnosis was not listed on the active problem list, and there was no evidence to indicate resolution. Furthermore, pulmonary fibrosis of the lung is generally a chronic condition, secondary to underlying pathology, such as recurrent pneumonia and must be periodically assessed by the medical provider. o The Individual was diagnosed with a "large hiatal hernia" in 2004; however, hiatal hernia was not listed on the active problem list. Furthermore, it was noted that the Individual had a history of a "failed fundoplication", hence, the Individual remains at risk, secondary to the hiatal hernia. o As per Individual #192, the Individual had significant risks for aspiration pneumonia, and had been hospitalized for recurrent aspiration pneumonia, but did not have an active case of aspiration pneumonia at the time of the annual medical summary. Recurrent aspiration pneumonia was not listed on the active problem list. o The medical assessment, as listed under the medical action plan for cerebral palsy, indicated a diagnosis of spasticity and contractures; however, neither of these conditions were listed on the active problem list. o The PT/OT assessment, dated 3/15/2013 indicated that the Individual had scoliosis, constipation, and gastroparesis; however, none of these three conditions were listed on the active problem list.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	As noted in the Summary of Monitor's Assessment, the parties agreed the Monitoring Team would not monitor Provisions H1 and H3-H7, as the Facility was concentrating efforts on other provisions and had made little progress on this provision. However, because the Facility provided adequate information, the Monitoring Team conducted a complete review of this provision. <u>Timeliness of Implementation</u> The Self-assessment did not provide any information documenting review of timeliness	Noncompliance

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		of implementation of medical treatments and interventions. The Self-assessment for Section K reported that 66% of Positive Behavior Support Plans (PBSPs) were implemented within 14 days of receiving consent but did not indicate the timeliness of drafting PBSPs and seeking consent. The Self-assessment for Section O provided data from an audit of implementation and effectiveness of intervention when an individual was discharged from the PNMT involvement—an excellent idea; it reported implementation and effectiveness monitoring were in place for 0% of a sample of four individuals. The Self-assessment for Section Q reported that emergency dental care was provided as needed, and that preventive care was provided as recommended by the dentist. Response to acute medical conditions remained timely. • For fractures, the medical provider consistently conducted a prompt initial triage and follow-through, including obtaining necessary diagnostics and consultation for assessment and treatment. • For a single example reviewed of an individual with seizures, IPNs indicated medical providers promptly addressed reported seizure activity. Implementation of PBSPs was delayed due to time lags between drafting of the plans and receiving consent and Human Rights Committee (HRC) approval. Although receiving consent is not entirely within the control of the Facility, there should be efforts to reduce the average time to gather consent. • An average of 25 days elapsed between BRC approval and consent. • An average of 13 days elapsed between consent and approval by the Human Rights committee. For Individual #314, however, consent was not obtained until 16 days after Human Rights approval. • The Facility reported that it was transitioning information about timeliness of implementation of PBSPs following consent to a new database and could not provide data. The Monitoring Team did not review this for the sample, as delays were significant up to the point of receiving consent. Consistent with the Self-assessment, dental emergencies received prompt clinical attention. Furthermore, individuals received comprehensive annual dental examinations. The information from the Facility did not, however, allow the Monitoring Team to be able to determine the Facility's management of restorative dental treatments. The Facility did not have a efficient mechanism to track and trend delays in restorative treatment, and the data provided to the Monitoring Team was not adequate to permit an assessment of timeliness. As reported in Provision O2, individuals who had a change of status related to PNM or	

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		who returned from hospitalization were seen within five days. As needed, the PNMT made recommendations for actions and established timelines that reflected clinical urgency. However, interdisciplinary teams (IDTs) did not consistently address the recommendations. Once the action plan was handed down to the IDT, the tracking of steps to ensure completion was not evident. The Facility could not determine if action steps were completed in a timely manner. As reported in Provision P1, three of seven individuals' direct intervention plans (38%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. The Monitoring Team was unable to determine if the remaining four individuals were implemented timely as there were no OT/PT progress notes available for review. As reported in Provision R3, 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. <u>Clinical Appropriateness</u> The Self-assessment reported that Physician, Nursing, and Psychiatry Quarterly Assessments and Quarterly Drug Regimen Reviews showed or ensured treatment to be clinically appropriate. No criteria, monitoring tools, or other information were provided to describe how the Facility evaluated that these assessments and reviews determined clinical appropriateness, or that there was inter-rater agreement about that. As reported in Provision K9, although there were some indications of improvement, overall it did not appear that the Facility had developed a coherent and comprehensive plan to improve the quality of PBSPs. Available evidence suggested that the Facility was unable to ensure that individuals were provided with individualized, appropriate or effective behavior interventions. As reported in Provision L1: • For a single example reviewed of an individual with seizures, there was a clinically appropriate medical action plan on the annual medical summary. • For individuals reviewed for management of pneumonia, one out five examples (20%) indicated a specific, and clinically appropriate action plan for recurrent pneumonia. As reported in Provision P2: • For three of seven individuals' receiving direct OT/PT interventions whose records were reviewed (38%), the current OT/PT assessment/note current	

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		OT/PT assessment/note identified the need for direct intervention with rationale. The Monitoring Team was unable to determine if the remaining four individuals were implemented timely as there were no notes available for review. ISP or ISPA consistently described the supports based on the rationale provided in the therapy assessment, which does indicate the possibility that the problem involved lack of information provided to the Monitoring Team.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	As noted in the Summary of Monitor's Assessment, the parties agreed the Monitoring Team would not monitor Provisions H1 and H3-H7, as the Facility was concentrating efforts on other provisions and had made little progress on this provision. However, because the Facility provided adequate information, the Monitoring Team conducted a complete review of this provision. RSSLC provided a tremendous amount of documentation to demonstrate the determination and use of clinical indicators related to medical care, as well as information on the use of such indicators both for individual healthcare and for improvement of health care systems. To evaluate whether clinical indicators of health care efficacy were determined in a clinically justified manner, the Monitoring Team reviewed: • RSSLC Policy I31 Chronic Clinical Indicators 8/20/13 • RSSLC Policy Clinical Pathway for Standard of Care and Documentation Guideline Policy 3/1/14 (unnumbered) • Clinical pathways (all dated April 2013) for: o Osteoporosis o Diabetes mellitus o Dyslipidemia o Seizure disorder o Constipation o Hypertension o Chronic Kidney Disease o Chronic Obstructive Pulmonary Disease (COPD) o Gastroesophageal Reflux Disease (GERD) o Downs (sic) Syndrome o Cerebral Palsy o Degenerative Spine Disease o Aspiration Syndrome • Databases and trend analyses for: o Osteoporosis	Noncompliance

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		o Diabetes o Neuromuscular/musculoskeletal Disorder o Pneumonia o Urinary Tract Infection o Preventive Healthcare Screening • Information from other Sections of this report regarding the development of clinical indicators of efficacy and use in making decisions on treatments and interventions As reported in the last compliance report, 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. The clinical pathway for pain instructed the medical provider to discuss pain assessment and signs and symptoms; these specific indicators presumably are not specified in the clinical pathway because they may be specific to the individual. The databases did provide for reporting of specific clinical indicators. Additional information on these can be found in Provision L3 of this report. • For diabetes, these included HbA1c, blood pressure, complications (microalbuminuria, nephropathy, retinopathy, and neuropathy), and presence of prescription of some specific medications. The Facility provided examples of some of the reports that were periodically reviewed, such as graphs of average HbA1c and the list of individuals with A1c greater than 7, the list of diabetic patients with blood pressure less than or equal to 130/80 and the list with blood pressure greater than that, and the list of those on a statin with LDL greater than 100 (and another subset list of those individuals who were on statins). These reports can provide rapid information on issues needing to be addressed, whether individuals or systemic issues. Note below the discussion of the Trend Analysis for diabetes. • For neuromuscular/musculoskeletal disorders, the database tracked specific conditions such as contracture/spasticity and scoliosis/kyphosis, and the individual's clinical status on those. For those conditions, there were not numerical clinical indicators of status but instead were ratings of whether the condition was stable or changing. In addition, the database included information on types of management of the condition that might be in place, such as orthopedics management, pain management, and neurology management, among others. These could be reported for each individual, by condition type for the facility, by whether certain types of management were or were not in place for each individual with a specific condition type, or whether there had been	

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		referral to the IDT. For each of the databases, the Facility provided a recent Trend Analysis. These were substantive and thorough discussions that summarized the data, provided analysis both of status systemically and of specific individuals who needed to be addressed, discussed actions currently in process, and identified if other actions plans were needed. For example: • For diabetes, the data in the trend analysis reported 12/12/13 indicated HbA1c average level was in an acceptable range (averaging less than 7 each month) but there had been an increase in November to 6.57. Possible reasons were discussed, including diet issues during holidays (for which an action plan for diabetes education for individuals and family members was in place). Specific individuals whose A1c levels were above 7 were discussed and rationales provided, including individual goal levels. Other issues that were reviewed included LDL levels, which medications are being used as well as control by diet, and actions being taken for diabetes education including a new action plan for a diabetes health fair involving several clinical disciplines. • The trend analysis for Pneumonia, dated 2/20/14, reviewed trends in pneumonia rates by month and total and compared that to prior periods and by home. Possible contributing factors were discussed. Actions to be taken included specific positioning post emesis, the relationship of pneumonia to sepsis following UTIs and actions implemented to address UTIs, and a procedure to be outlined to check enteral tubes for proper tube positioning during daily care. A review of efficacy of Vest therapy, which had been implemented in July 2013 for individuals who had high rates of respiratory infections, showed a reduction in pneumonia rates but still some occurrences. This was considered an initial result, indicating effectiveness will continue to be reviewed. The databases have the potential to provide timely information both to medical providers for care of individuals and to the department and Facility to assess health status and identify areas for improvement in healthcare. Clinical indicators or other clinical information were routinely used. This process has been in place and expanding for over a year. Both the Chronic Clinical Indicators policy and the Clinical Pathway state the Medical Director will ensure the Facility expands both clinical indicator databases and clinical pathways to additional conditions. Outside of chronic health conditions, the use of clinical indicators had not yet progressed to the same degree. • As indicated in Provision K4, review of records of a sample of individuals found that target behaviors had data collection sufficient to assess progress in 80% of	

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		records, and replacement behavior had sufficient data collection in 70% of records. • As reported in Provision J13 regarding monitoring of medication effectiveness during observation of a Psychiatric and Behavior Management Clinic, of four individuals reviewed, behaviors for monitoring symptoms had been identified for two (50%) and data were presented for one (25%). • As reported in Provision O2 for six Physical and Nutritional Management Team (PNMT) assessments: o Six of six assessments (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. o Zero of six (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. The referral criteria identified as part of the PNMT assessment were general and focused primarily on if pneumonia reoccurred and did not utilize baseline data to help develop indicators of change. o Six of six (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT/IDT. As stated, in the bullet point above, the criteria for referral were general and not based on clinical indicators. • Twelve of 12 individuals' records (100%) 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. However, only two of 12 trigger sheets sampled (17%) were completed correctly. • As reported in Provision O7, records did not contain evidence of indicators integrated as part of the Integrated Health Care Plans (IHCPs) to assess the individual's PNM status. • Zero of the 12 individuals' records in Samples O.1 and O.2 (0%) 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. QIDP monthly reviews only stated if changes were made to the Physical and Nutritional Management Plan (PNMP) and provided no information regarding status of the individual or if the individual had any issues related to PNM	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established	As noted in the Summary of Monitor's Assessment, the parties agreed the Monitoring Team would not monitor Provisions H1 and H3-H7, as the Facility was concentrating efforts on other provisions and had made little progress on this provision. However, because the Facility provided adequate information, the Monitoring Team conducted a	Noncompliance

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	and maintained to effectively monitor the health status of individuals.	reduced review of this provision. 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 and databases noted in Provision H4. Using the information from the databases as well as additional information, the Facility carried out analyses of trends and produced a Trend Analysis report for several chronic health conditions. Refer to Provisions H4 and L3 for detail on these pathways and databases, and how they are used to monitor health status of individuals. In regard to physical and nutritional management (PNM) for individuals, the use of clinical indicators was more variable. Clinical indicators, including triggers that staff were to observe and report, were identified, but there was little use of the indicators to assess status of individuals. • As reported in Provision H4, individuals' records did not contain 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. • As reported in Provision P2, there was no evidence that progress for individuals with PNMPs was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. As reported in Provision O7, QIDP monthly reviews 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. <u>Regular Reviews of Health Status</u> As reported in Provision F2d, the Facility reported that there were significant concerns about the implementation of monthly reviews of progress by the QIDP. The Monitoring Team confirmed this finding. Overall, the Monitoring Team found that QIDP Monthly Reviews were not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development. As reported in Provision M2, most nursing annual and quarterly reviews were completed and filed.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two	As noted in the Summary of Monitor's Assessment, the parties agreed the Monitoring Team would not monitor Provisions H1 and H3-H7, as the Facility was concentrating efforts on other provisions and had made little progress on this provision. However,	Noncompliance

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	years, treatments and interventions shall be modified in response to clinical indicators.	because the Facility provided adequate information, the Monitoring Team conducted a reduced review of this provision. For medical care of chronic conditions, the Facility had developed a database of clinical indicators that required entry of information important for clinical management of individuals. This database could efficiently provide ongoing trends for each individual's status. 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. As reported in Provision L1, review in depth of individual cases found examples in which attention to clinical indicators led to modification of treatment, as well as cases in which specific monitoring parameters for observation and reporting were not documented or in which documentation did not include important signs or response to clinical indicators. Examples in which attention to clinical indicators needed improvement included: • Regarding Individual #320, the Monitoring Team compliments the medical provider for ensuring to evaluate for pneumonia, especially in an individual with developmental disabilities and an axillary temperature of 102.1. The Monitoring Team is, however, concerned that the final IPN documented on this issue did not include vital signs, or a pulse O2 result, and based clinical improvement on a chest x-ray. • Regarding Individual #412, who was initially reported with coughing, afebrile, and normal pulse O2, no specific monitoring or reporting parameters were documented. Following a second referral three days later, again no specific monitoring parameters were documented. This continued after another referral the following day. As reported in Provision K4, it was not always possible to determine whether revisions to treatments and interventions occurred in response to clinical indicators, but examples were found in which that did not occur. • Due to a lack of markers or indicators of treatment changes on graphs, it was not possible to determine if changes were attempted or if those changes were evidence based. Discussions with staff, however, indicated that in most cases behavior interventions are revised on an annual basis rather than according to changes in treatment targets. • Records for three of ten individuals (30%) reflected intervals during which behaviors targeted for reduction actually worsened but no review or revision of	

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		the intervention was documented. For an additional three of 10 individuals (30%), available data reflected progress. For the remaining four individuals (40%), data reflected no changes in behavior or missing graphs and progress notes did not allow for a clear presentation of treatment monitoring. In some of these cases, it was suggested that behavior interventions continued despite the lack of demonstrable benefits. On a positive note, six of six (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (e.g. revision of the individual's PNMP). However, in regard to plan implementation for Individuals in Sample O.2, in zero of six 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. Once the action plan was handed down to the IDT, the tracking of steps to ensure completion was not evident.	
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.	As noted in the Summary of Monitor's Assessment, the parties agreed the Monitoring Team would not monitor Provisions H1 and H3-H7, as the Facility was concentrating efforts on other provisions and had made little progress on this provision. However, because the Facility provided adequate information, the Monitoring Team conducted a complete review of this provision. The Facility and DADS had developed numerous policies that included requirements for integrated clinical services. As reported in Provision G1, the Facility provided 33 policies related to specific areas, including committees and areas of care. Although most of these policies addressed integrated services in some manner, no policy addressed integrated services as a whole. For example, Policy I.00a Medical Services requires the PCP to share consultation recommendations with the IDT, when applicable. Policy I44 The Morning Report guides the meeting and identifies the numerous disciplines that will be represented at the meeting. Nonetheless, the requirements for integrated services are small sections of these policies, and the Facility does not have a Facility that that established requirements for integration, provided procedures to facilitate integration, or directed staff to the other policies that included requirements for integration. Still, additional examples in which integration was built into policies provided an indication that the Facility seeks to ensure integrated planning occurs. DADS and RSSLC policies on the Integrated Support Plan included requirements for completion of assessments.	Noncompliance

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		The procedures for chronic care clinical pathways were a positive step to promote use of clinical indicators and recommended practices. A DADS state policy that addressed Provisions G and H together remained in draft. The policy was not yet completed or disseminated. To achieve substantial compliance, the Facility should develop and implement a policy that guides integrated clinical services as a whole, ensuring that it involves all clinical services, and not only medical services. To address all provisions of Section H, such a policy should address the development and use of clinical indicators, and how those indicators will be used for integrated clinical decision-making as well as for decisions by specific disciplines.	

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 2/13/14 2. RSSLC Section I Action Plan 2/13/14 3. RSSLC Section I Presentation Book 4. DADS At-Risk Policy 006.1 12/7/12 5. RSSLC Policy I.08 At-Risk Individuals 11/26/13 6. RSSLC Policy K.01 Physical and Nutritional Management (rev: 10/21/13) 7. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 1/15/14) 8. RSSLC Policy K.12 Departmental Quality Assurance Plan (11/1/13) 9. RSSLC Policy D.23 Using Bed Rails (5/8/13) 10. Sample O.1: Individuals #84, #192, #351, #364, #477, #523, #558, and #783 11. Sample O.2: Individuals #31, #84, #159, #360, #500, and #558 12. Sample O.3: Individuals #77, #106, #192, #535, #558, #666, and #675 13. Sample O.4: Individuals #27, #73, #125, #159, #160, #173, #227, #248, #256, #284, #309, #364, #399, #413, #484, #512, #558, #589, #612, #678, #701, #716, #765, #773, #776, #783, and 798 14. Records reviews for compliance analysis for Individuals #80, #111, #417, #192, #558, #84, #477, #351, #783, #483, #723, #503, #585, and #13 15. Integrated Risk Rating Form and accompanying Risk Action Plan for Individuals #426, #585, #758,, #744, #144, #773, #19, #561, #363, #368, #513, #475, #787, #140, #543, #630, #798, #74, #151, #278, and #306 16. List of individuals supported with bedrails 6/4/13 **People Interviewed:** 1. Dana Hatter, QIDP/PNMT Lead 2. Ping Law OTR Habilitation Therapies Director 3. David Taylor OTR PNM OT 4. Brandie Rabe PNMT SLP 5. Jean Cuevo PNMT PT 6. Sally Eastwood PNMT RN 7. Ten DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) 8. Angela Hernandez, QIDP Educator 9. Leroy Thompson, QIDP Coordinator **Meetings Attended/Observations:** 1. ISP Meeting for Individuals #675 and #718 2. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon) 3. PNMT meeting (3/5/14) 4. PNMT/IDT meeting, 3/5/14 (Individuals #324 and #284)
	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 39 Integrated Risk Review Forms (IRRFs) ▪ Reported that it "reviewed" a sample of 23 Action Plans ▪ Reported that it reviewed policies ▪ Reported that it reviewed staff training records ▪ Reported that it reviewed bedrail use and associated risk 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. This was identified as an issue in the last report by the Monitoring Team and had not been corrected. 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, "implement IRRF and IHCP as annual meetings occur", 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: 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 been revised subsequent to the most recent revision to statewide policy.

	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 data demonstrated regression in others. The Facility's management system to identify individuals whose health or well-being is at risk lacked consistency in implementation. Integration of PNMT recommendations into IHCPs and/or ISPs at the Facility remained a problem. Considerable training of staff involved in risk identification activity and of IDTs responsible for the development of risk action plans had occurred, which was likely responsible for continued improvement in some compliance scores. While these improvements are noted, most compliance scores remain at an unacceptable level. Although there remained some lack of clarity about data presented in discussion of risks, IDTs were for the most part incorporating clinical data and indicators into the risk assessment process. Plans to address risks were generally 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 Facility policy had been updated effective 11/26/13. This update provided additional detailed requirements associated with IDT responsibilities regarding the at-risk process, particularly responsibilities related to the Primary Care Physician and Psychiatrist. Facility policy for implementation of the State directed at risk policy had been in place since 8/15/13. Considerable training of staff involved in risk identification activity and of 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 improved assessments with the Facility becoming more consistent (but still at an unacceptable level in some areas) in accurate risk identification, and effective risk action plans. Risk screening was reviewed annually at the ISP planning meeting. In its last report the Monitoring Team noted significant improvement in compliance scores reported in Provision I.2 and I.3. Continued improvement was variable. As reported in Provision I.2 and I.3 some compliance rates showed continued improvement and others showed regression. The Facility's management system to identify individuals whose health or well-being is at risk lacked consistency in implementation. Data associated with this is reported in	Noncompliance

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		Provisions I.2 and I.3. Additional examples (from Sample 0.2 and reported in more detail in Section O of this report) regarding the comprehensiveness of PNMT assessments showed that 17% of assessments did not contain evidence of review and analysis of the individual's medical history; did not contain evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition; did not contain evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; did not identify the potential causes of the individual's physical and nutritional management problems; and, did not identify 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. Although the risk rating process in the Integrated Risk Rating Form (IRRF) involved providing relevant clinical information for each risk area on the draft form reviewed at the annual ISP planning meeting, there were issues in which significant risks were not identified. For example: • For Individual #192, the most recent IRRF indicated a medium risk for constipation despite documented imaging studies indicating constipation. • For Individual #195, who had multiple risk factors for falls and fractures, the IRRF documented on the IRRF that the Individual had a low risk for falls and medium risk for fracture. • For Individual #346, the IRRF had not been updated following a fracture and indicated a low risk for fractures. Integration of PNMT recommendations into IHCPs and/or ISPs at the Facility remained a problem. For none of the six individuals (0%) in Sample O.2, were all recommendations by the PNMT addressed and integrated in the ISPA, Action Plans, IRRFs and IHCPs. Examples of recommendations not integrated included: • Individual #159 had a recommendation to check residuals and for impaction post seizure activity but this was not included as part of the IHCP. • Individual #558 had a recommendation to bring the O2 concentrator available during oral care and bathing. This was not included as part of the IHCP. • Individual #500's criteria for referral back to the PNMT were not included as part of the IHCP. • Individual #558's IHCP still had her listed as receiving oral intake when the Individual was to have nothing by mouth. Other concerns noted included: • The IHCP was not consistently updated when there was a change in status. For example:	

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		o Individual #192's IHCP still stated the individual was on a ground diet when the Individual was actually NPO and enterally fed. o Individual #192's IHCP was not updated to reflect change in Bowel Movement criteria. Individual has a significant history of constipation and is high risk but the IHCP was not updated to reflect "notify if no BM in two days". o Individual #558's IHCP still stated the individual ate by mouth when then individual has been enterally fed since 11/2013. 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 #675, 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 #718, 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 related to specific data. Some of the compliance scores reported in Provision I.2 and I.3 had improved from that noted in the last report by the Monitoring Team but most still remain at an unacceptable level. Some of the compliance scores reported in Provision I.2 and I.3 had regressed from that noted in the last report by the Monitoring Team. 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. Provisions I.2 and I.3 must be in substantial compliance to demonstrate the effectiveness of the Facility's regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In	Review of nine records for individuals determined to have had a change in condition meriting risk assessment review by the IDT (Individuals #558, #192, #84, #477, #351, #80, #111, #417 and #13) 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 all nine (100%). Based on a review of records of a sample of six individuals (Individuals #783, #483, #723, #503, #585, and #13) for whom assessments had been completed to address the individuals' at risk conditions, two (33%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Those that did not included	Noncompliance

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	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.	Individuals #783, #723, #503, and #13. This was a decrease from the compliance rate of 50% noted in the last review. The nursing assessments for these four Individuals were either not thorough, did not reflect interdisciplinary review and discussion, or did not include sufficient clinical data that could have led to productive review, discussion, and decision-making. For example, Individual #783's clinical data stated a history of constipation and provided a list of scheduled daily and per necessary (PRN) medications for constipation but did not provide baseline data for bowel elimination patterns or the frequency of the use of PRN suppositories for constipation, if any. The IHCP did not include a plan for daily tracking bowel movements as was indicated in the IRRF clinical data. Refer to Section M for additional information. Based on a review of records of a sample of five Individuals (Individuals #192, #558, #84, #477, and #351) for whom assessments had been completed to address the individuals' at risk conditions, all five (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. This was consistent with the 100% compliance rate noted in the last review. Additionally, six PNMT assessments were reviewed for individuals in Sample O.2 and all six (100%) were initiated within five working days of the referral (or sooner as specified in the PNMT policy). Refer to Section O, Provision O.1 for additional information. Based on a review of records of four individuals (Individuals #80, #111, #417, and #13) with polypharmacy risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, all four (100%) included an adequate risk assessment to assist the team in developing an appropriate plan. This was consistent with the 100% compliance rate noted in the last review. Refer to Section J for additional information. Based on this review this Provision was not in compliance because only 11 of 15 (73%) Individuals reviewed by the Monitoring Team had adequate risk assessments completed. All four that did not were nursing assessments.	
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	Based on a review of 15 records of risks for 14 individuals determined to be at risk, Individuals #13 (two categories of risk), #80, #111, #417, #192, #558, #84, #477, #351, #783, #483, #723, #503, and #585, 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 11 (73%)) cases. Records that did not contain documentation of this included Individuals #80, #111, #417 and #13. This was a decrease from the 81% compliance rate noted in the last report by the Monitoring Team. • Implemented a plan that met the needs identified by the IDT assessment in 13 (87%) cases. Records that did not contain documentation of this included	Noncompliance

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	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.	Individuals #783 and #585. This was an improvement from the 62% compliance rate noted in the last report by the Monitoring Team. • Included preventative interventions in the plan to minimize the condition of risk in 10 (67%) cases. Records that did not contain documentation of this included Individuals #80, #111, #417 #13, and #783. This was an improvement from the 56% compliance rate noted in the last report by the Monitoring Team. • When the risk to the individual warranted, took immediate action in five of five (100%) cases. This was an improvement from the 60% compliance rate noted in the last report by the Monitoring Team. • Integrated the plans into the ISPs in 10 (67%) cases. Records that did not contain documentation of this included Individuals #783, #483, #723, #585, and #13. This was a decrease from the 88% compliance rate noted in the last report by the Monitoring Team. • In eight (53%), 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 #80, #111, #417, #13, #783, #723, and #585. This was a decrease from the 56% compliance rate noted in the last report by the Monitoring Team. • In none (0%) appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. This was a significant decrease from the 69% 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 (60%) cases. Records that did not contain documentation of this included Individuals #80, #111, #417, #13, #783, and #585. This was an improvement from the 56% 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 which are described in Provision I.1. 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 2/13/2014 2. RSSLC Action Plans 2/13/2014 3. Facility Presentation Book for Section J 4. DADS Policy and Procedures 007.3 Psychiatry Services 5/01/2013 5. RSSLC Policy and Procedures: Psychiatry Services 1.00d (policy revised 08/30/2011 with additional guidelines provided 09/13/2012) 6. RSSLC Procedures for Psychiatry Services 9/13/12 7. RSSLC Integrated Neurology Clinic Policy 4/17/12 8. DADS QA J Tool 001 9. RSSLC nursing audit tool for review of safety monitoring during pre-treatment sedation 10. RSSLC psychiatry audit tool (seven items) 11. A description of RSSLC use of Reiss Screen 12. 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 Evaluation (CPE) 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: Case reviews for individuals considered by the Facility to be stable on their current psychotropic medication, individuals who have been prescribed new medications due to clinical difficulties, and individuals with various kinds of polypharmacy regimens (including some whose polypharmacy is being challenged). These were Individuals #19, #27, #32, #66, #101, #160, #200, #238, #424, #483, #501, #526, #588, #600, and #798. Materials reviewed were: a. Social History b. Most recent Comprehensive Psychiatric Evaluation (CPE) c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review d. Two most recent Psychiatric and Behavior Management Clinic (PBMC) notes e. All Psychoactive Medication Treatment Plans (PMTP) f. Most recent Positive Behavior Support Plan (PBSP) and Structural and Functional Behavioral Assessment (SFA) g. Most recent Individual Support Plan (ISP) h. Most recent Annual Medical Summary i. Most recent APL j. All Psychiatric Medication Reviews for the past six months k. All MOSES and DISCUS side effects screenings for the past six months l. All Quarterly Drug Regimen Reviews (QDRR) for the past six months m. Most recent Health Risk Assessment Rating tool and team meeting sheet n. 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) o. Medical and/or dental plans to increase cooperation/participation and reduce the need for pre-treatment sedation p. Most recent Annual Nursing Summary q. Most recent Neurology Consultation r. Informed Consent (IC) for medications s. Most recent Human Rights Committee (HRC) review of psychotropic medications 25. Sample J2: New medication plans. For each newly proposed medication information reviewed materials included a. Information from the clinical record (e.g., progress notes, psychiatric treatment reviews, PSPAs) that will help the Monitoring Team understand the reasons/clinical rationales for choice of the medication

b. Treatment plans related to the new medication
c. IC (signed) for use of the psychotropic medication
d. HRC reviews for the psychotropic medication
e. Materials associated with the treatment plan, provided to HRC to describe how the new medicine will part of the treatment plan (revised PBSPs, PBSP addenda, Psychiatric Treatment Plans, etc, per Facility protocols). Plans reviewed were for Individuals #10 (Luvox), #66 (Trileptal), #68 (Chlorpromazine), #74 (Depakote), #82 (Seroquel and Restoril) #140 (Klonopin), #225 (Ativan), #243(Zoloft), #302 (Luvox and Depakote), #314 (Latuda) #493 (Valium), #537 (Prolixin), #561(Klonopin) #391 (Trileptal) and #714 (Seroquel)

26. Sample J3: Individuals who had episodes of medical restraint. Each episode was reviewed for safety during the procedure: Materials reviewed included medical orders; physician specified monitoring schedules, restraint checklists, pre and post sedation nursing checklists, integrated progress notes, (IPNs) and dental clinic notes that documented medical monitoring for safety during the procedures. Each episode was also reviewed for plans to minimize the need to use medical restraint: Materials reviewed included individual ISP and 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. Episodes of restraint were for Individuals #523 (12/10), #526 (12/10), #180 (9/10), #569 (9/4), #479 (1/13), #387 (12/10), #512 (1/7), #426 (10/1), #542 (11/19), #535 (12/3), #328 (10/3), #43 (11/22), #709 (9/10), #120 (9/27), and #86 (12/30)
27. Sample J4: Individuals who took seizure medications for both neurological and psychiatric indications: Individuals #25, #238, #523, #537, and #746
28. Individuals admitted since the last visit. These were Individuals #13, #72, #80, #111, #272, and #417. Materials reviewed included
    a. A copy of the Reiss Screen
    b. CPE (if done)
    c. A copy of the medical examination done on admission.
    d. Most recent IRRF and IHCP
29. Individual who had a behavioral change of status evaluation. These were Individuals #140, #332, #344, #366, and #758. Materials reviewed included Reiss Screen, and background information on the reason for the change of status evaluation (IPNs and other documents) and any CPEs that were done as a result of the evaluation.

People Interviewed:

1. Olumuyiwa Abdul, MD - Staff Psychiatrist
2. Georgette Brown – Quality Assurance Director
3. Lloyd Robert Buckner, MS, BCBA – Behavior Services Director
4. Roger Joe, MD - Lead Psychiatrist
5. Judy Miller, Settlement Agreement Coordinator
6. Genniffer Moore - Program Compliance Nurse

Meetings Attended/Observations:

1. PBMC Clinic on 03/05/14
2. ISP meeting for Individual #718 on 03/03/14
3. Grand Rounds on 03/05/14

	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J. 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 the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Self Assessment reported that the Psychiatry Department reviewed records of 134 individuals supported by psychiatry over the period of 07/01/13 to 01/10/14 for the presence of services by a board-certified or board eligible psychiatrist (134 of 134, 100%), for the presence Appendix B compliance (82 of 134, 61%), and for PMTP and IC listings of side effects, treatment rationale, and target symptoms (134 of 134, 100%. The Psychiatry Department also reviewed a sample of 14 of 134 (10%) records for the adequacy of psychiatric diagnosis (14 of 14, 100%), target symptom monitoring (14 of 14, 100%), derivation of psychiatric symptoms (0 of 14, 0%), function of behavior (0 of 14, 0%), collaboration between psychiatry and psychology (14 of 14, 100%), risk benefit discussion (3 of 14, 21%), behavioral treatment plans (PBSP, counseling, group therapy , skill acquisition, all reported at 43%) ISP plans (14 of 14, 100%). The Self Assessment did not state whether a particular tool was used for the above analyses. The Self Assessment reported that records were reviewed for 10 of 98 (10%) of individuals who had medical restraints between 07/01/13 and 01/10/14. The Self Assessment reported that documentation for tracking pretreatment sedation was complete for four of 10 individuals (40%). Documentation on plans to minimize the need for restraint was present (exact numbers not specified) but there was no documentation to determine if plans were implemented successfully. Records of 16 admissions between 07/01/2013 and 01/10/2014 found that 16 of 16 (100%) had a Reiss screen and all individuals with positive screens were seen by psychiatry. A review of neurology clinics showed participation by psychiatry. The Facility reviewed documentation of all 21 reported incidents of chemical restraints between 07/01/13 and 01/10/14. In 21 of 21 (100%) cases the Facility reported that the restraint was used only after less restrictive methods had been attempted, the individual presented with a behavioral crisis, and that for those who had a crisis plan, that plan was followed. The Self Assessment did not state whether a particular tool was used for the above analyses. During the visit the Monitoring Team learned from the QA Department about ongoing record audits that were completed by the QA and Psychiatry Departments. The audit used the DADS QA tool J001. The tool consisted of 34 inquiries that addressed Provisions J2, J3, J4, J6, J7, J8, J9, J10, J11, J12, J13, J14, and J15. All items enquired about the presence of items in the record that were important for compliance with the Settlement Agreement (SA). Four records were reviewed each month, two by the QA Department (external audits) and two by the Psychiatry Department (internal audits). For the period reviewed, the Facility reported a level of compliance that ranged from 74% to 95% for the internal audits, and 52% to 83% for the external audits. The level of agreement between the internal audits that were validated by QA's external audits was 47%. The Self Assessment did not explore the reasons for the low inter-rater reliability between internal and external audits for the J001 tool. It is possible that some of the individuals reviewed with DADS QA tool J001 were also included in the sample of 14 individuals reported above.

	During the visit the Monitoring Team also learned that there were Nursing and QA Department audits for nurses' monitoring for safety during pretreatment sedation. Four such audits were done each month, three internal (by the Nursing Department) and one external (by the QA Department). The level of agreement between the internal audits that were validated by QAs external audits was 100% Overall, the Monitoring Team was encouraged by the Facility's use of data in the Self Assessment, although it would have been helpful had the data provided to the Monitoring Team by the QA Department been included in the Self-Assessment. The Facility 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. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. 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. In addition, in some cases, for example Provision J9, the comments of the Monitoring Team from the previous visit and the presentation of the Action Plan for the current visit did not appear to be well aligned. It would be helpful for the Facility to reexamine the extent to which the Facility Action Plan is responsive to Monitoring Team comments regarding what needs to be done to achieve compliance. It might be helpful for the Facility Action Plan to include the Action Step that would be implemented to address the reasons for noncompliance. That could further the integration of the Self-Assessment and Action Plan documents, such that staff could visualize the results of the self-assessment, and address any identified deficiencies and the measurable outcome intended to be achieved. The Facility self-rated for compliance with Provisions J1, J5, J7, J11, and J15. The Monitoring Team concurred with those findings.
	Summary of Monitor's Assessment: Progress has been made in a number of key areas. Psychiatric staffing was adequate and the psychiatrists are well qualified. All individuals who require comprehensive psychiatric assessments had them, and psychiatrists have started to do annual reviews of those assessments. Nursing monitoring for safety during medical restraints improved. Good Reiss Screen procedures were in place for new admissions and for change of status evaluations. Psychiatry's participation in the Reiss screen process was satisfactory. The Facility introduced Psychoactive Medication Treatment Plans (PMTPs) to help link diagnoses, treatments, and monitoring for efficacy. The Facility was newly in compliance with Provisions J5 and J7, and substantial compliance with Provisions J1 and J15 was retained. Although there was progress, much work on key items remains. Many psychiatric diagnoses do not have adequate diagnostic justifications, the reason for the use of many psychotropic medications remained unclear, and the Facility system to track medication treatments for efficacy was not adequate.

	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 had CPEs in place. However, the Monitoring Team found that many diagnoses were not fully justified according to DSM IV criteria since they did not provide sufficient information on the behavioral symptoms that supported the provided diagnoses. Provision J3: Behavioral treatment programs still do not provide needed information about psychiatric treatment and the role of psychotropic medications. Facility efforts to improve moved forward with the introduction of the PMTP, which is a template for required information about medication, needed for various provisions including Provision J3. Implementation of the PMTP should help assure that overall behavioral treatments will properly reflect psychotropic medication treatments. Provision J4: Difficulties with development, implementation and tracking of supports to minimize the use of pre-treatment sedation persist, although the Facility has started a new initiative to address the matter. Monitoring for safety during and after pre-treatment sedation has improved. Provision J5: The Facility has provided needed information that demonstrated that the Facility had a sufficient number of FTE psychiatrists to ensure the provision of required services. As a result, the provision is now newly in substantial compliance. Provision J6: All individuals had CPEs but only 73 of 138 (52%) of CPEs were in the required Appendix B format. Provision J7: The Facility has provided psychiatric evaluations for individuals whose initial screens exceeded the designated cut-offs for the Reiss Screens. Psychiatric evaluations were provided for individuals who were admitted with psychiatric diagnoses/medications, and for individuals found to need them on the basis of change of status evaluations. As a result, this provision is now newly in substantial compliance. 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 Facility plan is to fulfill the requirements of the Provision by implementation of PMTPs, but those were not yet in place. Provision J10: The Facility plan is to fulfill the requirements of the Provision by implementation of PMTPs, but those were not yet in place.

	Provision J11: The Facility had achieved a rating of substantial compliance, and that finding will be continued. Provision J12: 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 Quarterly Drug Regimen Reviews (QDRRs) that address side effects, medication interactions, laboratory reviews and suggestions, and a review of MOSES and DISCUS evaluations. Timely physician reviews of DISCUS and MOSES were not yet in place for many individuals. The Facility has improved its electronic system to include physician reviews but there is not yet data to assess the adequacy of the new system. Provision J13: The Facility plan is to fulfill the requirements of the Provision by implementation of PMTPs, but those were not yet in place. Provision J14: There was improvement in the review of consent by HRC, but presentation of treatment alternatives and risk/benefit assessments for medications was not yet adequate. Provision J15: There continued to be good communication between the neurologist and psychiatrists around medications prescribed for both epilepsy and psychiatric indications.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications and Experience of the Psychiatrists</u> RSSLC had two full time psychiatrists. Roger Joe, MD joined the staff in 2012. He is employed by the Facility on a full-time basis and is the Lead Psychiatrist for the Facility. Dr. Joe 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. Joe is licensed to practice medicine in Texas. Olumuyiwa Abdul, MD joined the staff in 2014. He is employed by the Facility on a full-time basis and is a Staff Psychiatrist for the Facility. Dr. Abdul completed his residency in psychiatry at the Cleveland Clinic in 2012. He has been board certified in psychiatry since 2012. Dr. Abdul is licensed to practice medicine in Texas. Dr. Joe gained experience in developmental and intellectual disability psychiatry when he worked at the Pinecrest Facility in Louisiana, as part of a fellowship. Dr. Abdul gained experience with intellectual and developmental disabilities during his residency in the support of individuals. He had experience working with individuals with Lesch-Nyhan and Down syndromes, and individuals with cerebral palsy. <u>Monitoring Team's Compliance Rating</u> The Facility psychiatrists have appropriate credentials and experience. 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 board-certified or board-eligible psychiatrist.	<u>Individuals who Received Psychotropic Medications</u> One hundred and thirty four of three hundred and thirty five (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. <u>Process for Evaluation and Diagnosis</u> CPEs were needed for all individuals who received ongoing psychiatric care. In the Self-Assessment the Facility reported that 134 of 134 individuals received psychiatric care and all had psychiatry had CPE's in place. Psychiatrists wrote the CPEs on the basis of a face-to-face mental examination and other observations, discussions with other staff members and with family members, and a review of documents and records. DADS Psychiatry Policy required that CPE be re-evaluated on an annual basis. The Facility had just started to do so. The Monitoring team reviewed the CPEs of the 15 individuals in Sample J1. All had CPEs done between 2010 and 2013. For one of 15 (7%) individuals the most recent CPE was in the form of an annual review. CPEs are now all being done using the Appendix B format that is required by the SA. The Facility reported that for 82 of 134 (61%) individuals, the CPE is place used the Appendix B format. Review of the use of the Appendix B format is provided under Provision J6. <u>Use of CPEs across Campus</u> CPEs were needed for individuals who screened positive on Reiss Screens on admission or who had positive Reiss screen during change of status evaluations for new or changed symptoms (behavioral change of status). At the time of the last review CPEs were not in place for six individuals who had screened positive on the Reiss Screen but were not seen in the PBMC clinic. These had now been completed (for more details see discussion under Provision J7). During the review period there seven admissions to the Facility for individuals who took psychotropic medications prior to admission. Those individuals were seen by psychiatry and had timely CPEs, as needed, within 30 days. <u>Ongoing Evaluation of Diagnosis</u> Continued evaluation of psychiatric evaluation and diagnosis was part of many Facility processes and was built into many IDT functions. During the visit the Monitoring Team observed a PBMC clinic and clinical grand rounds. Information on DSM diagnosis was part of the information provided at each of these clinical venues. The Monitoring Team also attended the ISP for individual #718. The ISP had many positive elements (see discussion for Provision J8). However, one of the focuses of the IRRF discussion was the neurologist's assessment that after several decades of seizure free status the client no longer needed anticonvulsant medication. That should have prompted the psychiatrist to reconsider the diagnosis of mood disorder due to seizure disorder, or at least to discuss the basis for its retention. Overall, inclusion of psychiatric diagnoses as part of the overall discussion at many interdisciplinary processes throughout the Facility showed a maturation of the clinical process at the Facility and a deepening of the staff's	Noncompliance

		commitment to a comprehensive understanding of individuals supported by the Facility. Clinically Justified Diagnoses The overall quality of CPEs continued to improve, compared to past visits. The evaluations increasingly provided appropriate information, and focused on elements of treatment that were relevant to the psychiatric aspects of treatment. In years past, evaluations had tended to be reviews of chart contents with insufficient focus on matters that were key to psychiatric diagnosis and treatment. Despite improvements, an area of continued weakness is that of diagnostic justification. For many individuals descriptions of psychiatric symptoms were cited in some sections of the CPE, for example the history of present illness and past psychiatric history. Those descriptions needed to be cited or referenced in some fashion when the final diagnostic assessment is made so that the basis for the selection of the diagnosis and the manner in which the relevant DSM criteria were met is clear. The Facility has recently developed a "Diagnostic and Treatment Analysis" record audit document. It included sections on "Symptoms" and "Diagnosis" and "Derivation (of diagnosis)." That form appears to address the matter of diagnostic justification, and the Monitoring Team encourages its use. In many cases it is helpful for the psychiatrist to provide additional information on why particular diagnoses were chosen; for example, an individual could meet criteria for more than one diagnosis and clinical judgment is used to select the diagnosis that is most appropriate for the overall clinical presentation including current state, history of present illness, previous and family mental illnesses and many other factors. That is the process of differential diagnosis and in many cases it is helpful to include a discussion of differential diagnosis and/or their initial inclusion in the diagnosis. The consolidation of relevant information presented throughout the evaluation should be in CPE sections XII – XIV. The Monitoring Team rated four of 13 (31%) CPEs as having adequate justifications. Those were the records for Individuals #27, #101, #200, and #588. In many other records reviewed by the Monitoring Team the diagnoses provided by the psychiatrists may have been appropriate, but the justification for the diagnoses was not made clear. NOS Diagnoses Review of the Department of Psychiatry database showed three individuals in the database with NOS diagnoses, a number that was unchanged from the last visit. Two of the three instances were for 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 During the review period there six admissions to the Facility for individuals who took psychotropic medications prior to admission. These individuals were seen by psychiatry and had CPEs within 30 days.	

		DSM Diagnoses in the Clinical Record: The Monitoring Team reviewed the APLs for the 15 individuals in Sample J6. All individuals had a diagnosis in the DSM format, although in four of 15 (26%) individuals, additions were made to the diagnosis that were not in the DSM format. For example the APL for individual #424 was Mood Disorder with SIB and aggression (SIB and aggression are symptoms, not diagnoses, and those symptoms are not coded as part of the diagnosis), and the APLs for Individual #483 and #19 both added SIB to the diagnosis. For each of the individuals in Sample J1, the Monitoring Team also compared the APL, the CPE, and diagnosis listed in the Department of Psychiatry Database, reflecting the most up to date diagnosis. In five of 15 (33%) individuals, there were differences between the database information and the APL. Monitoring Team Findings and Compliance Rating All individuals who require CPEs had them, and processes were in place for annual review of CPEs for individuals who are receiving ongoing psychiatric services. The overall quality of the CPEs was good, but to be considered justified, DSM diagnoses must meet all the criteria of the DSM for the diagnosis that was made. Many evaluations did not make clear how the cited symptoms justified the diagnosis that was cited. The Monitoring team also found that in some cases the diagnosis listed in the CPE, the diagnosis listed in the department database and the diagnosis listed on the APL did not match. The likely reason is that for some individuals, up to four years have lapsed since the last CPE and changes were made in the diagnosis during that period of time. Such changes – and their justification - should be documented in the annual updates of the CPE, a process that was started in 2014. Progress has been made toward assuring that all individuals who take psychotropic medication have been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist. However, improvements are needed in the areas cited above.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications	Diagnosis or Specific Behavioral-Pharmacological Hypothesis Psychotropic medications were in place for 134 of 335 (40%) of individuals who lived at the Facility. All had DSM IV TR psychiatric diagnosis in place as documented in a CPE. More details on the process for clinical diagnosis, the use of DSM IV diagnoses, and Facility tracking of those diagnoses are provided under Provision J2. Treatment Programs The Provision requires that psychotropic medications not be used as a substitute for a treatment program. The Monitoring Team reviewed the records of the 15 individuals in Sample J1, all of whom took psychotropic medications. Fifteen of fifteen individuals (100%) had a behavioral treatment program,. The Monitoring Team reviewed those documents to assess whether the programs properly included both behavioral and psychiatric contributions to described challenging behaviors, whether they included appropriate description of psychiatric processes, and whether there was a good understanding of the role of psychiatric medication in the treatment of the individual. Elements contained in the treatment program were as follows: • Psychiatric Supports: The Treatment Plan typically contained a section titled	Noncompliance

	shall not be used as punishment.	"psychiatric supports" that included information on the Individual's diagnosis, the medications the individual was given, and side effects of the medications. Such information was contained in 10 of 15 (67%) records. In two of the records psychiatric support information was partial, including only information on the diagnosis but not the medications. • Differentiation of learned problem behaviors and psychiatric symptoms: The generally accepted role for psychotropic medication is to treat psychiatric disorders, not to suppress challenging behaviors that are the result of learned behaviors. To provide an understanding of whether challenging behaviors were the result of learned behavior, psychopathology or both, the Facility put in place a new format for the Structural and Functional Analysis (SFA) that included a section called "Differentiation of Behavior." Clarity on this matter is a focus for the Monitoring Team since unless it is clear that the medications are being properly use to a psychiatric disorder, there is always a concern that medication could be taking the place of active treatment. Statements on differentiation of function were present for four of 15 (26%) individuals. • Psychiatric Indicators: these were observable behaviors that were included in the treatment plan that represented measure of presumed psychopathology. The term "psychiatric indicators" appeared to be used interchangeably with the term "psychiatric target symptoms" and "behavioral characteristics (of psychopathology)." Psychiatric indicators were provided for six of 15 (40%) individuals. For more information see Provision J13. • Operational Definitions: These were descriptions of what was intended by the psychiatric indicator. For example, for Individual #66 the definition of hyperactivity was "moving from one activity to another after less than five minutes, pacing from one room to another without a clear purpose, and unable to concentrate on one topic or activity." For Individual #600 the operational definition of hyperactivity was "running back and forth shaking her head from side to side." Operational definitions were present for six of six (100%) of individuals for whom psychiatric indicators were reported in the treatment plan. • 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. For example, in the previous visit the Monitoring Team found that PBMC information about medication matched PBMC narratives in only seven of fifteen (46%) of records. The Facility informed the Monitoring Team that to resolve this matter PMTPs would be developed that would be include the relevant information about medications. The plan is for the information to be compiled by the psychiatrist and behavioral services specialist at the PBMC, and for the PBMC to be the common source of information about psychotropic medication for the various documents that require that information. Information would be drawn for the PMTP to the various places where it was needed, including the PBSP/SFA. Use of PMTPs was started in January 2014, and PMTPs were in place for 5 of	

		15 (33%) individuals in Sample J1. The above data showed that a process for inclusion of information about psychiatric treatment in the behavioral treatment program was underway but it was still in very preliminary stages (see also comments for Provisions J8, J9, J10 and J13). <u>Appropriate Use of Medication</u> The Provision prohibited the use of psychotropic medication for staff convenience or punishment. This was done by examination of records, by interviews with staff, and by observations made throughout the visits including during PBMCs and other activities during the visit. There was no evidence that medications were used for staff convenience. <u>Chemical Restraints</u> The Monitoring Team could not validate the data reported by the Facility with respect to chemical crisis intervention restraint as accurate due to conflicting information received in pre-visit document requests and interviews during the review.. This data problem was brought to the attention of the Facility on the first day of the review and was unable to be satisfactorily resolved by the end of the review. It is imperative that the Facility better coordinate the assembly of valid data among and between departments and databases to ensure accurate data is reported to the Monitoring Team, and is available for use by the Facility, in the future. The Monitoring Team was able to review a sample of four administrations of chemical restraints, for Individuals #74 (01/08/14), #140 (11/20/13 and 12/10/13) and #561 (01/20/14). In three of four (75%) cases, the psychiatrist participated in the administration of chemical restraint consult and review. The documents showed that QA processes were in place. For example, the Facility review noted up that in one case, the behavior analyst was not properly consulted prior to the administration of the chemical restraint. That was an example of appropriate monitoring by the Facility review, to allow for correcting needed practices for the future. <u>General Assessment</u> Treatment programs' description of psychiatric processes continued to improve, although as described above key elements – for example descriptions of psychiatric supports – were not adequately present for many individuals. The Facility plan for improvement includes introduction of PMTPs that will provide needed information for inclusion in the treatment program (see discussion under Provisions J8, J9, J10 and J13). The Monitoring Team was not able to fully assess the use of chemical restraints due to Facility difficulties assembling needed data. <u>Monitoring Team's Compliance Rating</u> Progress was not but 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 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	<u>Use of Medical Restraint</u> The Facility reported that between 09/01/13 and 02/28/14 there were 50 uses of medical restraint/pretreatment sedation for dental procedures and 92 uses of medical restraint/pretreatment sedation for medical procedures. However, the Monitoring Team could not validate the data reported by the Facility with respect to medical restraint as accurate due to conflicting information received in pre-visit document requests and interviews during the review. For more information see Section C. <u>Monitoring for Safety during Medical Restraint</u> The Monitoring Team reviewed a sample of 15 individuals who received pretreatment sedation procedures on specified dates (Sample J3). The sample included four cases of pretreatment sedation for dental procedures and eleven cases of pretreatment sedation for medical procedures such as EKGs and imaging studies. Appropriate informed consent was provided for 13 of 15 (87%) individuals. During pretreatment sedation, monitoring for safety was required, as specified by the physician or dentist. Such orders were provided for four of four (100%) individuals who received dental pretreatment sedation, and for zero of 11 (0%) individuals who received medical pretreatment sedation All 15 individuals were monitored using the standard Facility procedure that required vital signs to be monitored for 24 hours, starting with a baseline measure prior to administration of the pretreatment sedation. Per the Facility procedure, general nursing assessments were also provided for 24 hours, including examinations /observations for alertness, any breathing difficulties, and any constitutional symptoms such as nausea, vomiting, etc. At the end of the 24 hour period final nursing summaries were provided that established/confirmed ability to return to usual activities. Documentation was provided on Medical Restraint Checklists and IPNs. Overall, documentation of nurse monitoring for safety was much improved over the last visit. Forms such as the Medical Restraint Checklist were now used consistently. IPN notes that addressed post procedure monitoring were clearly labeled. Information entered used the Data-Assessment-Plan documentation method in a manner that was clear and easy to follow. That allowed nurses from different shifts to provide needed continuity of monitoring. The final nursing note provided assurances that the individuals could safely return to their usual activities without additional monitoring in 15 of 15 (100%) cases. For example, an IPN for Individual #387 on 12/11/13 stated "Medical monitoring completed. Report documented on 24 hour report, for oncoming nurse. Problem resolved." <u>Plans 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	Noncompliance

		non-routine medical procedures. The Monitoring Team reviewed the 15 individuals who received pretreatment sedation procedures (Sample J3). The Facility provided plans to reduce the need for pretreatment sedation for three of 15 (20%) individuals. Records that the plan was implemented were provided for one of 15 (6%) of individuals. During the visit the Monitoring Team was informed about a pilot program, on one residential home, to minimize need for pre-treatment sedation. For each individual on that unit, the IDT was tasked to come together to consider what action the team can recommend to reduce the need for pre-treatment sedation The unit planned to start with an individual who had received pretreatment sedation for dental procedures. Plans were due to be created after completion of the assessments. That had not yet taken place. The home planned to then proceed similarly with plans to minimize the need for pre-treatment sedation for medical procedures as well as for dental procedures . <u>Monitoring Team's Compliance Rating</u> Progress has been made in the documentation of monitoring for safety during medical restraint/pretreatment sedation, but difficulties continue with development, implementation and tracking of supports to minimize the use of pre-treatment sedation. As described in more detail under Section C, there also needs to be an improvement in reporting of data on the frequency of use of medical restraints. 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 Abdul. 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 134 of 335 (40%) individuals who lived at the Facility. According to the Facility Self Assessment the caseloads were 77 of 134 (57%) individuals for the lead contract psychiatrist and 61 of 134 (43%) for the second contract psychiatrist although that totaled 138 individuals . The psychiatrists examined all individuals in PBMC on a quarterly basis, and more often as clinically appropriate. Three individuals assisted the psychiatrists in the work. Mr. Damola Olatoregum, 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> To assess compliance with this provision it was necessary to establish how much psychiatric	Substantial Compliance

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<td>time was needed to complete the tasks required by the various sections of the SA. The following estimates were provided by the Facility:

<table>
<tr><th></th><th>Hours of psychiatry time per individual per year</th><th>Total for 134 individuals</th></tr>
<tr><td>Clinic evaluations</td><td>4</td><td rowspan="10">2814</td></tr>
<tr><td>Psychiatry Summary</td><td>2</td></tr>
<tr><td>Moses/Discus evaluation</td><td>2</td></tr>
<tr><td>Annual Updates</td><td>4</td></tr>
<tr><td>Treatment Plans</td><td>2</td></tr>
<tr><td>Polypharmacy Reviews</td><td>1</td></tr>
<tr><td>IRRF</td><td>1</td></tr>
<tr><td>Annual ISP</td><td>3</td></tr>
<tr><td>IDT Meetings</td><td>2</td></tr>
<tr><td>Total</td><td>21 hours</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Other clinical services: Infirmary rounds (daily), consultation, CLDP meetings</td><td>580</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Administrative Services: Morning meetings (1hour/day) psychiatry department meeting (1 hour/week) QA/QI 1 hour/week), Facility polypharmacy (1hour month), medications variance meeting (1 hour/month), SA meeting (1 hour/week), psychiatry polypharmacy meeting (2 hours/month), neurology clinic (8 hours/month)</td><td>796</td></tr>
<tr><td colspan="2">Total hours needed</td><td>4190</td></tr>
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The above data demonstrated that the requirements of the SA can accomplished with the staffing level of two FTEs psychiatrist, the current level of staffing provided by the Facility.

<u>Monitoring Team's Compliance Rating</u>
The Monitoring Team agreed that the Facility had a sufficient number of FTE psychiatrists and other staffing, to ensure the provision of required services. The provision is found in substantial compliance with the requirements of the Provision.</td>
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<tr>
<td>J6</td>
<td>Commencing within six months of the Effective Date</td>
<td>The Monitoring Team reviewed Appendix B evaluations for the 15 individuals who were part of Sample J1. The length of the evaluations ranged from six to ten single typed pages.</td>
<td>Noncompliance</td>
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</table>

	hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	<u>Use of the Appendix B format</u> In the Self-Assessment the Facility reported that CPEs for all individuals followed by psychiatry had been reviewed and that 82 of 134 (61%) conformed to the Appendix B format. That was a slight improvement over the results at the last visit, at which time 73 of 138 (52%) of individuals followed by psychiatry had CPEs that used the Appendix B formats. The Monitoring Team reviewed the individuals in Sample J1. Thirteen of 15 (86%) followed the Appendix B format, and two of 15 (14%) did not. The overall quality of CPEs continued to improve, compared to past visits. The evaluations provided appropriate information, guided by the sections of the Appendix B format, and focused on elements of treatment that were relevant to the psychiatric aspects of treatment. In years past, evaluations had tended to be reviews of chart contents and did not focus properly on psychiatric aspect of treatment. <u>Justified Diagnosis</u> The Monitoring team found many good qualities in the Facility CPE's but documentation of the reasons for selection of the particular diagnoses (justified diagnoses) were present for only four of the 15 (26%) individuals (see discussion under Provision J2). <u>Case Formulation Section</u> Case formulations should select and 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. These comments have been made in the past, and improvements remain needed. Monitoring Team comments for Provision J8 of the current report review what is needed for case formulations. Provision J8 requires interdisciplinary case formulations while Appendix B case formulations are specific to psychiatry, but the principles of what constitutes a good case formulation are the same. <u>Annual Updates of CPEs</u> These are now being done across the campus. One of the CPEs (Individual #19) provided was in the form of the new update. It properly included information on events that had taken place during the year (Section IX C), although it would have been more helpful to provide a synthesized summary of key events, rather than a month-by-month synopsis of what was done in each clinic. There is of course no single way to write annual updates, but it helpful to think of their key purpose, and that is to provide an easy-to-access reference in years to come to matters that will help guide future treatments, and an index of sort to where to look for more detailed information (such as specific PBMC notes). <u>CPE's Use across the Campus</u> CPEs were needed, not only for individuals followed in the PBMC but also for psychiatric evaluations done elsewhere in the Facility. During the last visit the Facility and the Monitoring Team identified seven individuals who needed CPEs on the basis of Reiss Screen results but had not had them. Those were now completed in the Appendix B format and their quality was good	

		(see Provision J7). No Axis I diagnoses were made. CPEs were done for six new admissions. They were done in a timely manner and contained the needed sections. The Monitoring Team did not review those CPEs in detail. <u>Monitoring Team's Compliance Rating</u> Appendix B evaluations were available for only 61% of individuals, and improvements were needed in the areas of diagnostic justification and case formulation.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Reiss Screens for Individuals who lived at the Facility</u> 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. At the time of the last report, such evaluations were still pending for Individuals #95, #109, #112, #634, #748, #780, and #797. These have now been provided. The evaluations were detailed (typically 6-8 single spaced pages) and they followed the Appendix B format. The evaluations did not result in the addition of Axis I diagnoses or referrals of the individuals for ongoing psychiatric services. <u>Reiss Screens for Recent Admissions</u> Individuals #13, #72, #80, #111, #272, #417 and #463 were admitted since the last visit. Individuals #13, #72, #80, #111, #272, and #417 took psychotropic medications at the time of admissions and received both Reiss Screens and CPEs within 30 days of admission. All were then seen on an ongoing basis in the PBMC for psychiatric services. Individual #463 did not take psychotropic medications and had a negative Reiss Screen. <u>Change of Status Evaluations</u> The Facility informed the Monitoring Team that the Facility had 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. Change of status evaluations on Individuals #140, #332, #344, #366, #758 resulted in positive Reiss Screens and those individuals had CPEs. In the Appendix B format. The Monitoring Team reviewed both the Reiss screens and the evaluations and found them satisfactory. <u>Monitoring Team's Compliance Rating</u> The Facility had administered the Reiss Screen to all individuals who lived at the Facility and psychiatric evaluations were in place for individuals whose initial screens exceeded the designated cut-offs. In addition, an adequate process was in place for the use of the Reiss Screen during change of status evaluations. Reiss screens and CPEs were used during the review period	Substantial Compliance

		as required by the provision. The Provision is found in substantial compliance with the requirements of the SA.	
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.	Policy and Procedure The Provision requires that the Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. That language is repeated in the RSSLC Psychiatry Policy 1.00d (revised 08/30/2011). The RSSLC psychiatry policy clarifications (09/13/2012) addressed Provision J8 of the SA. The policy stated that the PBMC quarterly review was a key meeting of the behavioral health team and a venue where integration of care would take place. The point of guidance stated 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 caseload. 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. In a meeting with the Monitoring Team 03/03/14 the Facility clarified that the various disciplines would discuss and formulate the combined assessment and case formulation at the quarterly PBMC review. The resulting formulation would then guide integrated care. Generally, the formulation could include identification of the maintaining factors (biological vs. environment) for relevant challenging behaviors and/or psychiatric symptoms. The formulation could be a basis for understanding the general outline for treatment strategies, and could guide the selection of needed treatment modalities (behavioral, pharmacology, or other interventions, in combination or alone, per requirement of Provision J9). Medication treatments could then be selected with knowledge of the symptoms that could be the focus for treatment ("target symptoms") and measures could be selected that would assess treatment efficacy (see requirements for Provision J13). Appropriate description of these processes could	Noncompliance

		be included in the treatment plan (see Provision J3). The Monitoring Team reviewed Sample J1 and found that PMTPs that included combined case formulations were in place for four of 15 (26%) individuals. These four formulations are cited in full: • Individual #66: "Biologic: Biological factors contributing included his intellectual disability: The patient does have an ongoing neurofibromatosis type II disorder with possible fibro as growing on his nervous system. Psychological; Psychological factors contributing include lack of stable environment; the patient has been noted to get into trouble with the law. He has been aggressive toward self, others, and the environment. The patient has been known to steal and engage in self-injurious behaviors. The function of behaviors seems to get attention, escape, and/or avoid demands that are placed on him." • Individual #526: "Biologic: She has biological factors contributing to her intellectual disability which include cerebral atrophy, blindness of her left eye, hypnosis and cervical stenosis. Physiological factors contributing include lack of a stable environment as her mother was unable to care for her due to increase in delusions, hallucinations, and aggressive behaviors at home. Functions of the behaviors include responding to internal stimuli to avoid continued hallucinations." • Individual #424: "Contributed by her intellectual disability and her concurred (sic) seizure disorder and hydrocephalus. Of course she has a VP shunt in place. Psychological factors include medical stressor, social stressors from her home visits. Also her behaviors probably include intention and to escape demands that are placed on her." • Individual #600: "her biological factors are contributed to by her intellectual disability along with her concurrent diagnosis of tremor syndrome. The patient's psychological factors probably include learning deficits that lead to lack of concentration and distractibility. Functions of behaviors, the patient's behaviors probably include tension and escape from demands." While each of the above statements includes information from behavioral services and psychiatry, none provided what was needed to guide present or future treatments. <u>Integration of Care at ISP</u> The Monitoring Team attended the ISP for Individual #718 on 03/03/14. The meeting was attended by psychiatry, psychology, occupational therapy, speech, nursing, medicine and others. The team process that took place during the meeting was interactive and substantive. New ideas were explored in a way that tapped comments made by different disciplines such that the meeting reflected interdisciplinary process (see also J2). <u>Integration of Psychiatric and Neurological Care</u> 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 (see detailed comments under Provision J15). Integrated Care at Facility-Level Activities The Monitoring Team attended a Grand Rounds presentation on 03/05/14 that discussed care of an individual with mobility difficulty and falls. Psychiatry participated in the discussion. Past reviews of the Monitoring Team have commented that the meeting is valuable and contributes to overall interactions between the various disciplines. That continued to be the case. Overall Impressions The requirements for Provision J8 are both very broad and very specific. The general requirement to integrate pharmacological treatments with behavioral and other interventions is very broad and the above-cited meetings all contribute to the required integrated care. But the requirement continues and cites the need for combined assessment and case formulation, and that should lead to a specific work product that puts in writing the overall understanding of the individual and his/her needs. That (clinical) case formulation can then serve as a reference to guide IDT's provision of care. At present, there are discipline-specific formulations but the combined product is still lacking. Elements do exist, but the process has not matured to an understanding that guides day-to-day integrated care. Monitoring Team's Compliance Rating The Facility has now selected a route to address the requirements for combined assessment and case formulation. That process will utilize the quarterly review in the PBMC and the work product will be captured in the note for that meeting and the PMTP. Continued work is needed to bring that process into fruition.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the	The Monitoring Team reviewed the process and documentation in place at the Facility for the required elements of the Provision. IDT/Psychiatrist Determination of the Least Intrusive and Most Positive Interventions to Treat the Behavioral or Psychiatric Condition: The Monitoring Team reviewed documentation in the records of the 15 individuals in Sample J1. Statements about the least intrusive and most positive interventions were located for seven of 15 (46%) individuals, in PBSP, PBMC, or PMTP documentation. In the Self Assessment the Facility clarified that in the future, documentation of required items for Provision J9 would be via the PMTP, a document that was introduced to the Facility on 01/01/14. The template for the PMTP is provided as part of the discussion for Provision J13. The Self Assessment stated that " The document will cover risk benefits, behavioral targets, psychoactive medications, symptoms of diagnosis, medication risks and non-pharmacological interventions and will be the basis for the Structure (sic) functional assessment and positive behavioral support plan." During the visit the Facility clarified that IDT review of relevant items would take place at individuals' quarterly	Noncompliance

	individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	review at PBMC, an IDT meeting that is attended by the psychiatrist. The Facility also clarified that PMTP items would be added to the quarterly review template. The overall Facility plan for substantive psychiatrist participation in the needed IDT determinations was the inclusion of required items in the PMTP, and review of that document (and its updates) at individuals' quarterly review at the PBSP. PMTP items will be included in the template of that review. <u>IDT/Psychiatrist Determination Whether The Individual Will Be Served Through Behavioral, Pharmacology Or Other Interventions, In Combination Or Alone</u> The Monitoring Team reviewed the records of the 15 individuals in Sample J1. Documentation of a process that addressed the modality or modalities of treatment was located in 0 of 15 records (0%). The Facility clarified in the Self Assessment and in conversations with the Monitoring Team during the visit that the new PMTP has been developed to address required determinations, including the preferred modalities for treatment via the section on combined behavioral health review and formulation. For further discussion, see comments under Provision J8. <u>ISP Specification of Non-Pharmacological Treatments to Minimize the Need for Medication</u> The Monitoring Team reviewed ISPs for 15 individuals in Sample J1, all of whom took psychotropic medications. Fifteen of 15 (100%) ISPs specified non pharmacological treatments that could minimize the need for medication. <u>Overall Impressions/Conclusions</u> In the Self-Assessment the Facility did not self rate for compliance, since required documentation was not yet place. The Facility Action Plan included action steps for IDTs to implement PMTP documentation and review its contents at quarterly reviews at the PBMC. The Facility completion date for that is 05/01/2014. <u>Monitoring Team Compliance Rating</u> The Facility's plan to fulfill the Provision requirement via review of PMTP elements at the PBMC quarterly was viable but the process was not yet in place. The Provision is not yet in substantial compliance.	
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	<u>Policy and Procedure</u> DADS policy and procedure "Psychiatry Services" dated 05/01/ 2013 required 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	Noncompliance

	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.	through telephonic communication, including during the psychiatric clinic, and the determination must be documented in person." DADs and the Facility policy on psychiatry also required ongoing monitoring for risks and benefits of medication at least quarterly. The Monitoring Team again 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 risk benefit discussions 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. Risk and benefit was also addressed in the psychiatrists' CPE and annual review documents. <u>Monitoring Team Review</u> The Monitoring Team reviewed information on individuals who were prescribed a total of 17 new medications since the last visit (Sample J2). For each of the 17 medications the Monitoring Team reviewed IPNs and PBMC notes 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 forms for use of the Psychotropic Medication, and HRC reviews of the psychotropic medication. <u>Risk/Benefit Analyses for New Medications</u> Side effect information and risk vs. risk information: Informed Consent forms that were completed by the psychiatrist included information about benefits for 17 of 17 (100%) of the medications, a list of common side effects for the medication in question, and a general statement about risk stating that "In the case of serious side effects, the medication will be stopped immediately. 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 side effects outweigh (1) the risks of not taking the medications or (2) the benefits from taking the medication." As presented in previous reports, a more individualized presentation of the individual and his/her circumstances was needed. The Facility clarified to the Monitoring Team that in the future, the single source of the information for this section will be the information provided by the psychiatrist in the PMTP. <u>Alternative Treatments</u> Fifteen of 17 (88%) new medication proposals submitted to HRC during the review period (Sample J2) had sections for alternative treatments and they 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> Progress was evident but 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 to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
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 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. As reported to the Monitoring Team by the Facility in the Self Assessment, the Moses/DISCUS evaluator and provider sections were re-combined electronically as of 10/01/2013. The new electronic system is now the repository for all data collection and reporting.	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. Scores were reviewed and the quality of the discussions was good. Individual Case Reviews: The Monitoring Team reviewed MOSES and DISCUS since the last visit for all the individuals in Sample J1. The Monitoring Team reviewed MOSES and DISCUS forms done since the last visit for the 15 individuals from Sample J1. MOSES screenings were required at a minimum of every six months with additional administrations done as ordered by the physician following dose changes in medications. Twenty four MOSES screen were done for an average of 1.6 screens per individual. Fifteen of 15 individuals (100%) individuals had at least one MOSES screen done during the review period. In some cases MOSES screens were done quarterly although the requirement was for semiannual screenings. Three of 15 (20%) individuals had additional screening(s) that indicated that they were done after a change in medication dose. Two individuals had one additional screening, one had two. Four of 24 (16%) screens were reviewed and completed within one month of administration, for seven of 24 (30%) screens the interval until the review was longer, and for thirteen of 24 (54%) screens did not have a completed physician review section. DISCUS screenings were required every three months, for individuals who took medications that can cause tardive dyskinesia, with additional administrations done as ordered by the physician following dose changes in medications. For individuals in Sample J1 there were 30 administrations (average of 2 per individual). Nine of fifteen (60%) individuals had two DISCUS screenings done during the review period. Three of those nine (33%) individuals also had an additional screen done due to a change in medication dose. Six of fifteen individuals (40%) had only one DISCUS. Four of the 30 DISCUS (13%) administrations had physician reviews within one month, seven of 30 (23%) had physician reviews that took place after one month, and 19 of 30 (63%) screens did not have a physician review. One reason for the low number of completed/timely physician reviews for both MOSES and DISCUS form may have been the introduction of the electronic review section during the review period. Facility-Level Review of DISCUS scores and diagnoses The Facility reported that two individuals were diagnosed with tardive dyskinesia. In addition, there were three for whom there were DISCUS scores of 5 or higher during the review period but were not diagnosed with dyskinesia. One of the individuals took metoclopramide, two took	

		atypical neuroleptics. <u>DISCUS Monitoring for Individuals taking Metoclopramide</u> 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 six individuals at the Facility who took metoclopramide. All were monitored for dyskinesia with the DISCUS <u>Training for Administration of the MOSES and DISCUS side effect screens:</u> 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. On 2/23/14, the Facility provided an annual in-service retraining on the two side effect screens. The training was led by the clinical pharmacist. The training provided both administration guidelines and information and a review of the pathophysiology of dyskinesia. The course was attended by 33 nurses and physicians. <u>Monitoring Team compliance ratings:</u> 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; 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	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, and ongoing monitoring based on the individual's current status and/or changing needs.	Noncompliance

	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.	<u>Facility Development of Psychotropic Medication Plans</u> At the time of last review the Facility did not have medication plans in place. Effective 01/01/14 the Facility introduced the PMTP. The Monitoring Team was provided a template for the PMTP. It contained the following elements: • Psychiatric Diagnosis • Symptoms of the Diagnosis • Target symptoms monitored • Psychological Assessment • Combined behavioral Health Review/Formulation • Psychoactive medication o Brand and generic name o Start date o Dose o Highest dose reached o Blood level (if applicable) o Rationale o Statistical and/or subjective support for efficacy o Time line for medication to be effective 1. Risk of Medication 2. Risk of Illness 3. Risk/ Benefit Discussion 4. Non Pharmacological Treatment The Monitoring Team requested PMTPs for the 15 individuals in Sample J1. PMTPs were in place for 4 of 15 (26%) individuals, as follows: • Individual #66 was diagnosed with bipolar depression, ADHD, and intermittent explosive disorder. The individual was treated with an antipsychotic (Thorazine) an ADHD medication (Guanficine), a mood stabilizer (Depakote) a hypnotic (Ambien), and propanolol. The PMTP stated that symptoms of the diagnoses were impulsive loss of control with agitation outburst and low frustration tolerance. The individual has experienced mania with decreased oral intake, increased goal directed activities and a decrease in sleep. Target symptoms for medication monitoring were noncompliance and refusal, aggression, eating and sleeping. In the opinion of the Monitoring Team, while target symptoms of eating and sleeping could be possible target measures for depression, other measures were needed, for example for ADHD. • Individual #424 was diagnosed with mood disorder secondary to epilepsy and hydrocephalus, and was medicated with an antipsychotic (Geodon), two anticonvulsants, (Dilantin and Trileptal), an antidepressant (Paxil) and a hypnotic (Trazodone). The SFA/PBSP clarified that suicidality had been used as a measure but that was discontinued. The PMTP stated that symptoms of the mood disorder were	

		agitation/aggression and low frustration tolerance. Target symptoms for medication monitoring were outbursts, aggression and inappropriate social behaviors. In the opinion of the Monitoring Team more was needed for the diagnostic justification (see Provisions J2 and J6), the matter of low frustration tolerance needed to be examined for differentiation of function and more specific targets for treatment efficacy needed to be established. • Individual #526 was diagnosed with schizophrenia and dementia. She was medicated with Namenda and Aricept (dementia), an antipsychotic (Risperdal) with a mood stabilizer (tegretol) and with Neurontin. Her disorder was characterized by delusions, hallucinations, disorganized speech and negative symptoms of affective flattening and alogia. She also had symptoms of cognitive decline consistent with dementia. The symptoms cited to characterize her disorder were appropriate, provided adequate operational definitions of the symptoms, and their ratings were provided in the supporting documents that were not examined by the Monitoring Team. • Individual #600 was diagnosed with bipolar disorder with psychotic features, and with ADHD. The individual was treated with two antipsychotic medications (Risperdal and Thorazine), a mood stabilizer (Trileptal) and a medication for hyperactivity (clonidine). The PMTP stated that symptoms of the ADHD and bipolar disorder were impulsivity, distractibility, increased goal directed activity, insomnia and trouble following directions. Target symptoms listed for medication monitoring were aggression, self injury, noncompliance and work refusals. The SFA/PBSP had listed hyperactivity as a possible psychiatric indicator and provided an operational definition for that. A differentiation of function analysis was not available in the SFA. In the opinion of the Monitoring Team the symptoms listed for the diagnoses may have been appropriate (although the CPE had not provided adequate diagnostic justification to be sure of that; see Provisions J2 and J6), but the IDT had not selected appropriate measures for monitoring medication treatment efficacy. <u>PBMC Monitoring of Medication Efficacy</u> The Monitoring Team attended the PBMC on 03/05/14. Participants included the psychiatrist, behavioral health specialist, nurse case managers, clinical pharmacist, and DSPs. Individuals #140, #160, and #570 and #723 were reviewed. Nurses and behavioral health specialists reported on individual's progress and the psychiatrist then asked for further details and clarifications. The meeting was an improvement over the PBMC meetings attended in the past. The meeting was interdisciplinary and collaborative. Monitoring Team observations about medication monitoring were as follows: • Individual #160 was diagnosed with Bipolar Disorder and was medicated with Depakote and Olanzapine. DSM symptoms were listed in the consultation report for the meeting and they were operationally defined (more talkative than usual, impulsivity, psychomotor agitation, insomnia, psychosis, and increase in goal directed activity). The team had not yet developed targets for medication monitoring and no data could be	

		reviewed. • Individual # 140 was diagnosed with bipolar disorder and was medicated with Depakote, Lithium, Geodon, Trileptal, Luvox and Cogentin. For this individual also, the team had developed symptoms that were relevant for the axis I diagnosis including excessive talking, psychomotor agitation, mania, and insomnia. The team had not yet developed targets for medication monitoring and no data could be reviewed. • Individual # 723 was diagnosed with autism and obsessive compulsive disorder. The individual was medicated with Paxil and Geodon. Target behaviors for medication monitoring had been developed (compulsive behaviors such as opening wounds, clothing selection and stereotypy), but no data was presented. • Individual #570 was diagnosed with autism and insomnia and was medicated with Doxepin, Remeron, and Zoloft. Targets behaviors were sleep disturbance (Doxepin and Remeron), pacing and hand clenching (Zoloft). Data was reported on the two symptoms but the graphic presentation was inadequate for the purpose of comparing medication and symptom correlations. (See comments on graphing in section K). <u>Monitoring Team Findings</u> The recent introduction of the PMTP provides the Facility with an opportunity to develop a system to monitor medications for treatment efficacy. As illustrated by the Monitoring Team review of individuals from Sample J1, and the observations in the PBMC clinic, that system is not now in place. The Facility has identified a target date for completion of the process by 12/01/14. 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.	<u>Policy and Procedure</u> 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." <u>Facility Practice</u> 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. <u>Review of Consent for New Medications</u>	Noncompliance

		Since the last period 17 new medication treatments were approved. The Monitoring Team reviewed documentation for each of the 17 medications (sample J2). Documents reviewed included • Informed consent form. 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. • Behavioral Treatment Plan (PBSP or other) • HRC review of added medication. The information presented to HRC included a Safety Plan information that was written by the IDT psychologist and included a Plan Summary to include restrictive /intrusive components (typically the name of the medication), Justification (typically why medication was needed in addition to existing behavioral interventions), Less intrusive approaches previously attempted, risk vs. risk, and plan to remove restriction/intrusive component. The Monitoring Team also 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. Analysis of the 17 proposals for new medication by the Monitoring Team found that all 17 medications had Informed Consent forms that were signed by the LAR. In each case the consent had been obtained by the psychiatrist of record who also signed the consent form. Fifteen of 17 (88%) informed consents used the current medication form. Two of 17 (12%) used an outdated form that had previously been determined inadequate. That was a small improvement over the previous review when 80% of the consents used the current form. It is important to use the new form since the older one does not include all of the required elements. Diagnosis: Informed Consent forms for all 17 medications contained the psychiatric diagnosis that was related to the medication. That was an improvement over the last visit when only five of 10 (50%) consents provided the diagnosis. Medication Name: Informed Consent forms for 17 of 17 (100%) medications provided the name of the consents. Treatment Alternatives: Informed Consent forms included a statement about alternative medication in 17 of 17 (100%) of the medication proposals. As discussed in previous reports, alternatives to the proposed treatments should not be limited to medications alone and, as appropriate, should include non-medication treatments or even no treatment at all. In the 17 proposals reviewed there were no examples of consideration of non-medication treatments. Target Symptoms and Behaviors and Reason for Starting (the medication): Informed Consent	

		forms for 17 of 17 (100%) included target symptoms for the medication treatment. However, in many cases, the stated targets were very general. For example, Individual #66 was diagnosed with intermittent explosive disorder and the stated targets for treatment with Trileptal were physical aggression and property destruction. During the visit the Facility clarified to the Monitoring Team that more details regarding the monitoring will be provided in the PMTP that is not yet in place. In the case of Individual #66, what was needed was a comparison of the behavioral treatment plan, the medication treatment plan and a statement of differentiation of function between learned behavior and psychopathology. Those elements are included in the PMTP, and they will help clarify the IDTs understanding of the causes of the physical aggression and property destruction, the differentiation of behavioral and psychiatric treatment targets, and what is expected from each of several treatments. Expected Duration of Therapy: Informed Consent forms for provide this information for 14 of 17 (82%) individuals. Two of the medications that did not used the outdated form that did not inquire about this matter. Expected Benefits of Treatment: Informed Consent forms included a statement of benefits for 17 of 17 (100%) of the medications. However, many provided 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. During the visit the Monitoring Team clarified that the statement about possible benefits needs to be more specific and individualized. In response, the Facility clarified to the Monitoring Team that in the future, the source of the information for this section will be the information provided by the psychiatrist in the PMTP, and that information will be individualized. Monitoring (for safety) information was provided in 15 of 17 consents (100%). The two that were not were those that used the older form that did not contain this information. Information typically included laboratory and side effect monitoring. Side effect information and risk vs. risk information: Informed Consent forms that were completed by the psychiatrist included information about benefits for 17 of 17 (100%) of the medications, a list of common side effects for the medication in question, and a general statement about risk stating that "In the case of serious side effects, the medication will be stopped immediately. 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 side effects outweigh (1) the risks of not taking the medications or (2) the benefits from taking the medication." Side effect information and risk vs. risk information were also provided in the HRC reviews of	

		added medication that were completed by the psychologist. A list of side effects was also noted but in many cases, the possible side effects cited by the psychologist and the psychiatrist were different. During the visit the matter was discussed between the Monitoring Team and the Facility. As with other items the Facility clarified to the Monitoring Team that in the future, the single source of the information for this section will be the information provided by the psychiatrist in the PMTP. The matter of individualized risk/benefit analysis is a focus of Provision J10 and is discussed in more detail under that provision. In the Self Assessment the Facility recognized that risk benefit information was not present in the final consent product and stated that PMTP information that includes individualized risk vs. risk information (see PMTP template provided under provision J13) will be brought in to the consent forms over the next six months. <u>Monitoring Team's Compliance Rating</u> The process for presentation and review of the medication consent form by HRC has improved. The Facility recognized that information is lacking in the consent form and has plans to improve the consent information within the next six months. For now 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 (Sample J: • Individual #25 was seen in the neurology clinic on 3/26/13; her EEG was pending at that time and the neurologist suggested tapering the anticonvulsant Trileptal if it no longer needed for behavioral reasons. Follow-up for that was provided in the notes from the PBMC clinic from September 2013. In the note from that clinic the psychiatrist clarified that the EEG was abnormal, that the neurologist had recommended continuation of Trileptal for seizures, and the resulting plan was to continue the use of Trileptal to maintain both mood stability and seizure prophylaxis. The Individual was properly treated with Trileptal for both neurological and psychiatric indications. • Individual #238 was seen in neurology clinic on 08/13/14. The neurologist noted his remote history of seizures. The neurologist noted that the individual was new to the Facility, that the date of the last seizure was unknown, and recommended a repeat EEG. The neurologist noted the use of two anticonvulsants, Trileptal and Depakote. The Individual was seen in PBMC clinic on 8/29/13 and 11/05/2013. The psychiatrist noted the presence of the seizure history and bipolar disorder and described that the client took Trileptal and Depakote for both seizure and mood. The notes reflected good exchange of information between neurology and psychiatry, but this client also was not included in the list provided by the Facility of individuals who were treated with seizure medications for both neurological and psychiatric indications. • Individual #523 was seen in neurology clinic on 11/26/13. The neurologist commented on her abnormal EEG, her having had a seizure in October, and recommended continuation of phenobarbital. The neurologist recommended monitoring of the Phenobarbital level and continued use of the medication. The PBMC note of 12/10/13 correctly noted her neurological status and treatment; that showed good communication between psychiatry and neurology. • Individual # 537 was seen in both neurology and PBMC clinics. The neurology clinic note of 5/28/13 reported her need for Depakote, Dilantin, Gabatril, and Trileptal, for seizure control and cites her experience of status epilepticus in the past. In the PBMC note of 11/15/13 the psychiatrist noted the role of Depakote and Trileptal in mood control and use of Gabatril for seizures. That shows awareness of the use of the Depakote and Trileptal for both neurological and psychiatric conditions and good overall understanding between the disciplines of the overall use of anticonvulsant medications for management of the two conditions. • Individual #746 was treated with both Keppra and Depakote and the note from the neurology clinic from 10/23 reflected that. The PBMC notes from 01/06/14 included detailed a report on discussions with the neurologist about the use of Keppra (concern about side effects) and the results of that. The note also commented on the use of both medications for both psychiatric and neurological indications. The notes from both	

		clinics showed good communication and coordination <u>Participation of Psychiatry in Neurology Clinic</u> Psychiatrists now attend the neurology clinic and discussions are raised in the clinic with input from the PCP, pharmacist direct care and nursing. <u>Monitoring Team's Compliance Rating</u> 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. The Facility is found 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 (2/13/2014) 2. RSSLC Action Plan (2/13/2014) 3. RSSLC Presentation Book for Section K (3/3/2014) 4. Positive Behavior Support Committee meeting minutes 9/9/2013 – 12/31/2013 5. Documents that were frequently reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), structural and functional behavior assessments (SFBAs), Integrated Behavior Health Assessments (IBHAs), 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 document reviews were conducted in the context of the Self-Assessment. • The review of data monitoring practices in K.4 included Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799. • The review of Psychological Assessment reports in K.5 included Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799. • The review of SFAs concerning assessment of behavior in K.5 included Individuals #19, #72, #74, #111, #155, #272, #278, #302, #306, #417, #475, #513, #760, #787, and #799. • The review of SFAs in the context of the integration of mental illness and behavior assessment in K.5 included Individuals #19, #72, #74, #111, #155, #272, #278, #302, #306, #417, #475, #513, #760, #787, and #799. • The review of psychological testing, including adaptive skills and intelligence, in K.6 included Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799. • The review of psychological testing and evaluation reports for individuals admitted to the Facility since the previous site visit presented in K.7 included Individuals #13, #72, #80, #111, #211, #272, and #417. • The review of PBSPs in K.9 included Individuals #19, #72, #74, #111, #155, #272, #278, #302, #306, #417, #475, #513, #760, #787, and #799. • The review of data graphs in K.10 included Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799. **People Interviewed:** 1. Lloyd Robert Buckner, MS, BCBA – Behavior Services director 2. Roxanne Wolf, MA, BCBA – Behavior Analyst 3. Sasha Ayad, Med, LPC - Counselor 4. Tranika Jefferson, MS – Behavioral Health Specialist III 5. Approximately 25 direct care staff in the following residences and day treatment areas: Lavaca, Leon, Nueces, Sabine, San Antonio, and Trinity.

	Meeting Attended/Observations: 1. Positive Behavior Support Committee 2. The following residences and day treatment areas: Lavaca, Leon, Nueces, Sabine, San Antonio, and Trinity.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section K, in conducting its self-assessment, the Facility: ▪ Did not indicate the use of specific monitoring/auditing tools. The Facility did demonstrate the following: o Assessment included report indicators from the Monitoring Team's report relevant to making compliance determinations. o Did conduct observations, interviews, and record reviews. o The Self-Assessment identified the sample 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 Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Did not use additional relevant data sources. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings based on indicators used in the Monitoring Team reports o Consistently stated but did not measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with Provisions K.2, K.3, and K.11of Section K. This was not consistent with the Monitoring Team's findings. The Monitoring Team found Provisions K.2 and K.11 to be in substantial compliance. Substantial limitations outlined in the report precluded the Facility achieving substantial compliance for Provision K.3. 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 Not Started. ▪ The Facility data did not identify areas of need/improvement in the Action Plans. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Although the Facility did provide a number of actions to be implemented, these actions were discrete tasks that did not necessarily provide for a sequential approximation of substantial compliance. In addition, these actions in many cases were quantitative rather than qualitative and therefore of limited benefit in achieving substantial compliance.

	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 3/3/2014 through 3/7/2014. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that only Provisions K.2 and K.11 of Section K were in substantial compliance with the Settlement Agreement. Despite the numerous areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas. • The number of BCBAs employed by the Facility had dropped. • A sizable portion of behavior assessments and intervention plans were developed by employees who were not BCBAs. • There were considerable weaknesses in the internal and external peer review process. More than one third of individuals with behavior intervention plans had not been reviewed in over a year. In addition, it was not reflected in documented that all reviews were consistently conducted using a standard set of tools and procedures. • It was not evident that the Facility maintained adequate procedures for monitoring the psychological assessment process and ensure that all individuals received the necessary assessments. • Behavioral assessments did not routinely reflect a adherence to practices accepted in the field of applied behavior analysis, including a lack of comprehensive functional assessment procedures and the identification of setting events, antecedents and consequences involved in maintaining challenging behavior. • Behavior interventions did not consistently include procedures necessary of avoiding challenging behaviors or teaching replacement behaviors. • The Facility reported no curriculum or strategy for providing competency-based training regarding behavioral principles or specific behavior interventions. Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved. • The administrator of the Behavioral Health Services department continued to possess board certification as a behavior analyst. • Counseling services developed at the Facility had improved substantially and reflected a systematic approach to providing counseling supports. • Readability statistics for behavior interventions reflected that interventions were written in accessible language. Based upon information compiled as part of the current site visit, it was evident that RSSLC had not achieved progress in several areas key to the Settlement Agreement. Without substantial changes in practices, it is likely that the Facility will continue to struggle in in ensuring that individuals are provided with adequate behavioral and psychological services.

<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>Historical Perspective
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. In August 2013, the Facility had increased the number of BCBAs to nine, with 89% of the remaining eligible staff pursuing board certification.

Current Site Visit
During the current site visit, Facility records regarding Behavior Support Department staff were reviewed. These records reflected that 6 of 18 staff (33%) were board certified as a behavior analyst. Of the remaining 12 staff, 7 (58%) were actively pursuing board certification. Therefore, it was determined that 72% of the current Psychology Department staff either possessed or were actively pursuing board certification.

<table><tr><td></td><td>Baseline</td><td>8/2013</td><td>3/2014</td></tr><tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>50%</td><td>33%</td></tr><tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>0%</td><td>89%</td><td>58%</td></tr><tr><td>Percent of staff who were BCBAs or were pursuing board certification</td><td>0%</td><td>94%</td><td>72%</td></tr></table>
RSSLC maintained a process for auditing credentials of those staff members who possess board certification in applied behavior analysis.

During the current site visit, the Monitoring Team used a sample of 26 behavior intervention plans developed since the previous site visit to determine the percentage of plans completed by a BCBA. The specific individuals included in the sample were Individuals #1, #13, #19, #27, #66, #72, #74, #80, #111, #155, #238, #239, #243, #272, #273, #314, #344, #372, #417, #456, #529, #543, #708, #760, #787, and #799. Based</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		upon the information provided from the review, nine of 26 behavior intervention plans (35%) were completed by a BCBA. The Facility demonstrated a regression in hiring or developing BCBAs. As fewer BCBAs, were employed by the Facility and only a sizable minority of behavior intervention plans was completed by a BCBA, it was determined that the Facility was not yet in compliance with the Settlement Agreement for this provision.	
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.	<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 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. 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. During the August 2013 site visit, substantial issues worthy of review were documented. For four of 11 individuals in the sample selected by the Facility (36%), more than a year had passed since a BRC review of the most recent SFA. In one of the four, the most recent review for the SFA had occurred 35 months prior to the site visit.	Noncompliance

#	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 hypothesize 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. <u>Current Site Visit</u> <u>Internal Peer Review</u> A review of documentation revealed that the Facility had implemented the latest revision of the DADS Behavior Intervention – Behavioral Health Services Department policy (Policy J.06, Revised 1/8/2014). This policy included guidelines on internal and external peer review. The Facility maintained an internal peer review committee, titled the Behavior Support Committee (BSC). A review of BSC Minutes revealed that the committee met 21 of 24 weeks (87%) between 8/4/ 2013 and 1/22/2014. With exceptions for holidays, this reflected that the BSC met approximately once per week. Membership of internal peer review meetings consisted of BCBAs employed by the Facility, as well as non-BCBA authors of behavior interventions. Committee members with direct participation in the development of an intervention plan did not participate in the review of that plan. Observations of a BSC meeting were conducted on 3/5/2014. During that meeting, a single case was reviewed. Observations reflected that the committee conducted a robust discussion of the case presented. Discussion initially followed the BSC checklist items. Following the completion of those items, discussion continued and focused upon assessment and clinical issues. The case being reviewed presented various challenges due to the involvement of both behavioral and psychiatric factors. All committee members actively participated in the discussion and it was evident that all were invested in the development of an effective and evidence-based intervention strategy. In addition to observations of the BSC meeting, reviews were also conducted of the checklist with which SFAs and PBSPs are rated as part of the BSC process. The Facility used checklists that were completed by reviewers both prior to and following the BSC meeting. The pre-meeting checklist was used to facilitate the discussion and recommendations at the BSC meeting. The post-BRC checklist was conducted following	

#	Provision	Assessment of Status	Compliance
		the completion of revisions or additional actions required by the committee. Both checklists addressed the key components of a behavior assessment and intervention. Documentation revealed that all interventions submitted to the BSC required at least some revision. In a sample of 11 interventions reviewed (Individuals #1, #19, #66, #74, #111, #155, #238, #344, #372, #760, and #799), the pre-BSC scores averaged 82.6% successful with a range of 68.4% to 92.1%. Following revisions, these same 11 interventions achieved an average rating of 99.5% with a range of 97.4% to 100%. These ratings suggested that the BSC was an effective tool in improving the quality of intervention plans. Although the observations and documentation revealed several positive elements, there were notable weaknesses. • The Facility submitted checklist scores for 22 individuals reviewed by the BSC in the six months since the previous site visit. The PBSP tracking spreadsheet maintained and submitted by the Facility, however, reflected that 66 individuals had been reviewed by the BSC during the same time period. It was unclear which of the two sources was correct. • The Facility PBSP tracking spreadsheet revealed a total of 171 individuals with PBSPs. Neither of the figures provided for six months of BRC reviews would allow for all individual's PBSPs to be reviewed within a year assuming a constant rate of review. The Facility PBSP tracking spreadsheet supported this concern, which reflected that 67 of 171 individuals (39%) had not been reviewed by the BRC in over a year at the time of the site visit. This was comparable to the percent found at the last compliance visit of PBSPs not reviewed in over a year; there had not been improvement. • The Facility also provided a list of checklist scores obtained from external peer review. Scores for four individuals from the external peer review (Individuals #1, #74, #155 and #344) were compared with ratings from the BSC. Substantial discrepancies were noted between internal and external peer reviewers (see below for description of external peer review). Documentation did not reflect a discussion of or attempts to address these discrepancies.	

Individual	BSC Review Date	External Review Date	SFA Pre-score	SFA Post-score	External SFA Score	PBSP Pre-score	PBSP Post-score	External PBSP Score
#1	12/31/2013	13/31/2013	87%	100%	95%	64%	100%	100%
#74	2/19/2014	2/26/2014	76%	97%	61%	93%	100%	64%

#	Provision	Assessment of Status	Compliance

#155	12/11/2013	12/11/2013	70%	100%	93%	57%	100%	64%
#344	10/28/2013	10/25/2013	92%	100%	71%	86%	100%	71%

External Peer Review

As indicated above, the Facility did arrange for external peer review. External peer review was provided by a BCBA with experience in working with individuals with intellectual and developmental disabilities. Based upon documentation provided by the Facility, the external peer reviewer was tasked with reviews of a sample of PBSPs prior to revision prompted by a BRC review, as well as assessments of inter-observer agreement and treatment integrity.

Information obtained during the current site visit suggested that the reviews of behavior interventions conducted using the peer-review checklists held the potential to be rigorous and constructive. Due to the discrepancy between ratings from internal versus external review, it was not evident that this rigorous review was provided to all intervention plans. Furthermore, it was noted that more than one third of intervention plans had not been reviewed by the BRC in over a year. Finally, despite documentation from external peer review suggested inaccuracies in the internal peer review ratings, there was no evidence that the Facility had acted to investigate or address the situation.

This was the second consecutive site visit in which substantial lapses were noted concerning the provision of annual BRC review of SFAs and PBSPs. It was disturbing that no substantive effort was demonstrated to address these lapses in providing adequate peer review. Without comprehensive review to ensure the quality of behavior assessments and interventions, it becomes increasingly likely that individuals displaying severe behavior disturbances will continue to present a danger to themselves and their peers. The Facility must act aggressively to correct the peer review process and ensure that all individuals receive adequate treatment and protection from unnecessary risk.

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	Historical Perspective 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

#	Provision	Assessment of Status	Compliance
	pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	During the August 2013 site visit it was evident that some improvement in the collection, presentation, and monitoring of treatment data 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. <u>Current Site Visit</u> During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of data collection and treatment monitoring. These individuals included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799. The table below reflects the results from the current site visit review regarding the collection and presentation of data.	

	5/2010	8/2013	3/2014
Targeted behavior data collection sufficient to assess progress	0%	80%	80%
Replacement behavior data collection sufficient to assess progress	0%	80%	70%
Data reliability is assessed	0%	0%	10%
Target behaviors analyzed individually	0%	60%	80%
Targeted behaviors graphed sufficient for decision-making	0%	30%	50%
Replacement behaviors graphed sufficient for decision-making	0%	30%	30%

Information gained from the record sample reflected that RSSLC had achieved modest improvement in three of the six areas (50%). None of the areas was sufficient for a rating of substantial compliance.

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

- In five of 10 records (50%), behavior intervention progress note graphs and tables did not line up. For example, the position of dates on the horizontal axis on a target behavior graph might not match the position of dates on the psychotropic drug graph immediately below it on the page. When dates and the

#	Provision	Assessment of Status	Compliance

resulting data trends do not match across graphs, it can be difficult to interpret the outcome for changes in interventions accurately.

- Information about the reliability of behavior data was included in only one of 10 records (10%).
- In two of 10 records (20%), symbols included in the data trend lines did not match or were not included in the legend for the graph.

The availability and presentation of treatment data is 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.

	5/2010	8/2013	3/2014
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	0%	60%	60%
Review is conducted by a BCBA	0%	50%	30%
Input from direct care staff is solicited and documented	0%	0%	0%
Modifications to the PBSP reflect data-based decisions	0%	30%	0%
Criteria for revision are included in the PBSP	0%	0%	0%
Progress evident, or program modified in timely manner (3 Months)	0%	60%	30%

Information gained from the record sample reflected that RSSLC had achieved improvement in none of the six areas (0%), demonstrated no change in three of six areas (50%), and regressed in three areas (50%). None of the areas was sufficient for a rating of substantial compliance.

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

- Records for three of ten individuals (30%) reflected intervals during which behaviors targeted for reduction actually worsened but no review or revision of the intervention was documented. For an additional three of 10 individuals (30%), available data reflected progress that would support continuing the PBSP. For the remaining four individuals (40%), data reflected no changes in behavior or missing graphs and progress notes did not allow for a clear presentation of treatment monitoring. In some of these cases, it was suggested that behavior interventions continued despite the lack of demonstrable benefits.

#	Provision	Assessment of Status	Compliance
		If the interdisciplinary team has determined, through input from the psychologist or behavior analyst, that a behavior intervention is warranted, the failure of that intervention to produce a change in behavior is an indication that the needs of the individual are not being met. • Due to a lack of markers or indicators of treatment changes on graphs, it was not possible to determine if changes were attempted or if those changes were evidence based. Discussions with staff, however, indicated that in most cases behavior interventions are revised on an annual basis rather than according to changes in treatment targets. • In five of 10 records (50%), behavior intervention progress notes were not available for all months. • In seven of 10 records (70%), the review of progress notes and treatment outcomes was not conducted by a BCBA. • In none of the reviewed records (0%) was it reflected that input had been solicited from DSP staff or other employees who had regular contact with the individuals. • All reviewed behavior interventions (100%) included criteria for success. None of the interventions (0%) included criteria specifying when it would be necessary to review or revise an intervention due to poor behavior response. Without criteria for poor outcomes, there is no trigger prompting the interdisciplinary team to consider the need to explore alternate treatments that might benefit the individual. Based upon the information obtained during the site visit, it was not evident that the Facility had progressed toward substantial compliance in Provision K.4.	
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>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. At the 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. During the August 2013 site visit, documentation reflected a slight reduction in the number of individuals with annual psychological assessment reports. In addition, no individuals were reported to have received timely assessments of intellectual ability or	Noncompliance

#	Provision	Assessment of Status	Compliance
		adaptive skills. Current Site Visit During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of psychological and behavior assessment. This sample included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799.	

	5/2010	8/2013	3/2014
A Psychological Assessment had been completed.	0%	91%	60%
The Psychological Assessment was less than one year old	0%	91%	60%
The Psychological Assessment contained findings from an intellectual test administered within the previous five years.	0%	0%	30%
The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.	0%	0%	10%

The information obtained during the current site visit reflected a substantial decline in the ability of the Facility to provide and monitor adequate psychological assessments. The sample reflected 31% fewer individuals were provided a psychological assessment report. Data reflected an increase in the number of individuals with timely intellectual ability and adaptive skill assessments. A review of documentation, however, revealed that the single adaptive skill assessment and two of the three intellectual ability assessments involved individuals recently admitted for whom testing was provided by other agencies prior to admission to RSSLC.

In August 2013, the Facility reported that no new intellectual or adaptive skill assessments had been conducted during the previous six months. During the current site visit, the Facility reported that tracking information regarding intellectual ability and adaptive skills was unavailable due to a transition to a new database system. Therefore, it was not possible to determine the facility-wide prevalence of necessary assessments.

Behavior Assessment
The assessment of behavioral function is an essential component of effective behavior change and requires more than the completion of a screening tool, interview or series of

#	Provision	Assessment of Status	Compliance
		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. 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. As noted in Provision K.3 of this report, substantial lapses were noted in August 2013 concerning the provision of peer review for over one third of all PBSPs at the Facility. Current Site Visit During the current site visit, the Monitoring Team selected a sample of 15 individuals for the review of psychological and behavior assessment. These 15 records included the 10 individuals used in the sample of intellectual and adaptive ability assessment (Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799), as well as five individuals from the sample for Provision C.7 (Individuals #74, #278, #306, #475, and #513).	

	5/2010	8/2013	3/2014
Assessment or review of biological, physical, and medical status	0%	64%	40%
Review of personal history	0%	64%	47%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	27%	33%
The process or tool utilizes both direct and indirect measures	0%	64%	33%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	36%	13%

#	Provision	Assessment of Status	Compliance

Identification of antecedents relevant to the undesired behavior	0%	9%	27%
Identification of consequences relevant to the undesired behavior	0%	36%	33%
Identification of functions relevant to the undesired behavior	0%	45%	20%
Summary statement identifying the variable or variables maintaining the target behavior	0%	27%	20%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	27%	7%
Identification of preferences and reinforcers	0%	64%	27%

In nine of 11 areas (82%), the Facility was rated as having poorer performance than in the previous site visit. The average decrease in ratings was 21 percentage points, with a minimum of three points and a maximum of 37 points.

One potential reason for the reduced ratings was a lack of Structural and Functional Assessments (SFAs) to review. Despite repeated requests, no SFA was provided for four of the 15 individuals included in the sample (27%). An additional SFA was determined to be ineligible for review, as it had been completed 15 months prior to the current site visit, which was beyond the one-year limit. Therefore, a total of five of 15 individuals in the sample (33%) lacked an SFA eligible for review.

As the lack of eligible SFAs certainly suppressed ratings and limited the interpretation of findings, the remaining 10 SFAs were reviewed for general trends. Only two of the 10 remaining SFAs (20%) achieved an overall rating of greater than 90% (Individuals #19 and #475). Of the additional eight remaining SFAs, ratings ranged from 0% to 73% with an average overall rating of 30%. It was therefore suggested that, excluding the ineligible or unavailable SFAs, there remained substantial limitations in the SFAs developed at the Facility.

During the current site visit, a sample of 15 Psychological/Functional Assessment reports revealed the following about the integration of mental illness and behavior assessment. These 15 records included the 10 individuals used in the sample of intellectual and adaptive ability assessment (Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799), as well as five individuals from the sample for Provision C.7 (Individuals #74, #278, #306, #475, and #513).

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th></th><th>5/2010</th><th>8/2013</th><th>3/2014</th></tr>
<tr><td>The assessment process included screening for psychopathology, emotional, and behavioral issues.</td><td>0%</td><td>0%</td><td>33%</td></tr>
<tr><td>The assessment process included differentiation between learned and biologically based behaviors.</td><td>0%</td><td>10%</td><td>0%</td></tr>
<tr><td>Identification of behavioral indices of psychopathology</td><td>0%</td><td>20%</td><td>7%</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>27%</td><td>27%</td></tr>
</table>
As with the review of the behavioral aspects of the Structural Functional Assessments, five of the 15 SFAs either were not provided or were ineligible for review. None of the remaining 10 SFAs was rated above 90% in relation to the integration of mental illness and behavior assessment. Overall integration ratings ranged from 0% to 75%, with an average rating of 23%.
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.
</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>
According to information obtained from the review of the sample presented in K.5, the following conclusions were reached.

Intelligence tests had been completed within the past five years for three of 10 individuals (30%).
Testing of adaptive skills had been completed at least annually for one of 10 individuals (10%).
Psychological evaluation reports had been completed at least annually for six of 10 individuals (60%).

In August 2013, the Facility reported that no new intellectual or adaptive skill assessments had been conducted during the previous six months. During the current site visit, the Facility reported that tracking information regarding intellectual ability and
</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>adaptive skills assessments was unavailable due to a transition to a new database system. Therefore, it was not possible to determine the facility-wide prevalence of necessary assessments.</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>Provision K.6 addresses the status of on-going assessments for all individuals living at the Facility. In Provision K.5 of this report, it is stated that 60% of the sample included a psychological assessment report within the past year. This was determined by a visual check of the record for each individual in the sample. During the current site visit, the Facility reported that tracking information regarding intellectual ability, adaptive skills assessments, and annual psychological assessment reports was unavailable due to a transition to a new database system. It was not feasible to conduct a visual audit of the record for every individual living at the Facility. Therefore, it was not possible to determine the facility-wide prevalence of necessary assessments and the item in the table below was rated as "N/A".

To determine whether psychological assessment reports had been completed for newly admitted individuals, the date on the psychological assessment report was compared with the admission date for anyone admitted since the previous site visit.

<table><tr><th></th><th>5/2010</th><th>8/2013</th><th>3/2014</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>91%</td><td>N/A</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>44%</td><td>86%</td></tr></table></td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td><u>Current Site Visit</u>
At the time of the current site visit, the Facility submitted material on 10 individuals receiving counseling services. This material included treatment plans, counseling meeting minutes, and the latest treatment progress notes. This sample included Individuals #1, #19, #151, #243, #325, #475, #530, #576, #600 and #779.

<table><tr><th></th><th>5/2010</th><th>8/2013</th><th>3/2014</th></tr><tr><td>Needed services identified in the psychological assessment are implemented within 6 weeks of the assessment</td><td>0%</td><td>0%</td><td>0%</td></tr><tr><td>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</td><td>0%</td><td>0%</td><td>100%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

skill or intervention target)			
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%	100%
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%	10%
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%	40%
Service identified in ISP and, if applicable, PBSP	0%	0%	0%
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%	100%

Information regarding the counseling Programs at RSSLC reflected a well-organized approach to the provision of services. In each of the 10 plans reviewed, specific issues were identified as targets, intervention strategies were described, and treatment goals and measurements were defined. It was also evident from records that each counseling session was documented with a contact note and that treatment data were recorded.

Although counseling interventions were well organized and documented, it was not evident that counseling was based upon an evidence-based approach to treatment. For example, although every treatment plan included at least one goal, the goals were seldom presented in objective and measureable terms. For example, the following statement reflects one goal from the counseling plan for Individual #19.

> "[The individual] will learn to identify the following emotions expressively and receptively: sad, angry, scared, happy. She will then

#	Provision	Assessment of Status	Compliance
		learn to expressively and receptively identify the following coping skills: getting a hug, taking a nap, looking at a magazine, going on the swing bench, and squeezing a stress ball (90% accuracy). She will then learn to perform the coping skills independently at 90% accuracy. [The individual] will then use an IF /THEN card in session to show which coping skill she can use when experiencing any of the emotions she's learned." The above statement clearly depicted a variety of skills and strategies. What the statement lacked, however, was an objective and quantifiable process for measuring the skills targeted. Even though the statement stated a skill would be learned with 90% accuracy, it was not evident as to how accuracy would be determined. Furthermore, there was no indication of the number of successful trials required for the individual to meet mastery criteria or within what period mastery was expected. It was also not evident that all treatment plans included fail criteria and plans for generalization. For interventions to be beneficial for the individual there must be predetermined criteria prompting review of the intervention when positive changes in behavior are not produced. There must also be a clear plan for extending the learned skills and behaviors beyond the therapy session and into the daily lives of the individuals receiving services. In addition, PBSPs did not reflect the integration of counseling plans, counseling assessments, or counseling outcome measures into the overall strategy for addressing behavioral and mental health needs. It would have been helpful for the SFA or PBSP to present the manner in which assessments led to the use of both behavioral and counseling interventions, how the two intervention modalities might complement each other, and how outcome measures from both interventions would contribute to the overall determination of progress. Although various weaknesses were identified, the counseling interventions at RSSLC were more than sufficient to provide a foundation for effective intervention. The implementation of modest revisions to procedures and terminology would likely produce interventions reflecting sound, evidence-based approaches.	
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	<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. During the May 2012 site visit, documentation for several PBSPs in the sample did not	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>include a consent form or were missing portions of the consent form. Furthermore, no Human Rights Committee reviews were included for many of the submitted PBSPs. The Facility 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>PBSP Approval and Consent</u>
The Facility provided a list of four individuals (Individuals #151, #155, #314, and #630) for whom consent was necessary due to their PBSP, as well as the date of BRC approval, consent, and Human Rights approval for each. The following information was reflected in the list.
• An average of 25 days elapsed between BRC approval and consent. For Individual #151, however, consent preceded BRC approval by 18 days.
• An average of 13 days elapsed between consent and approval by the Human Rights committee. For Individual #314, however, consent was not obtained until 16 days after Human Rights approval.

Based upon the information provided by the Facility, although the necessary consents and approvals were obtained, documentation reflected that approvals and consents were not obtained in the correct order and that substantial delays often occurred.

As indicated in Provision K.3 of this report, considerable weaknesses were evident in the manner that BRC review was conducted, documented and tracked. In addition, due to the lack of tracking data, it was not possible to determine the interval between Human Rights approval and the implementation of behavior intervention plans.

<u>PBSP Review</u>
<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 15 individuals for the review of behavior intervention plans. This sample was the same used for the review of SFAs and included Individuals #19, #72, #74, #111, #155, #272, #278, #302, #306, #417, #475, #513, #760, #787, and #799.

<table>
<tr><th>PBSP Element</th><th>5/2010</th><th>8/2013</th><th>3/2014</th></tr>
<tr><td>Rationale for selection of the proposed intervention</td><td>0%</td><td>55%</td><td>33%</td></tr>
<tr><td>History of prior intervention strategies and outcomes</td><td>0%</td><td>64%</td><td>47%</td></tr>
<tr><td>Consideration of medical, psychiatric and healthcare issues</td><td>0%</td><td>64%</td><td>40%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Operational definitions of target behaviors	0%	64%	73%
Operational definitions of replacement behaviors	0%	64%	53%
Description of potential function(s) of behavior	0%	55%	27%
Use of positive reinforcement sufficient for strengthening desired behavior	0%	36%	13%
Strategies addressing setting event and motivating operation issues	0%	55%	27%
Strategies addressing antecedent issues	0%	27%	40%
Strategies that include the teaching of desired replacement behaviors	0%	36%	60%
Strategies to weaken undesired behavior	0%	45%	27%
Description of data collection procedures	0%	64%	60%
Baseline or comparison data	0%	0%	27%
Treatment expectations and timeframes written in objective, observable, and measureable terms	0%	0%	0%
Clear, simple, precise interventions for responding to the behavior when it occurs	0%	36%	47%
Plan, or considerations, to reduce intensity of intervention, if applicable	0%	0%	0%
Signature of individual responsible for developing the PBSP	0%	0%	53%

In nine of 17 areas (53%), the Facility was rated as having poorer performance than in the previous site visit. The average decrease in ratings was 19 percentage points, with a minimum of four points and a maximum of 28 points. In six of 17 areas (35%), ratings were higher than during the previous site visit, The average increase in ratings was 19 percentage points, with a minimum of nine points and a maximum of 53 points.

Although there were some indications of improvement, overall it did not appear that the Facility had developed a coherent and comprehensive plan to improve the quality of PBSPs. In combination with limitations in assessment and weaknesses in the BRC review process, the available evidence suggested that the Facility was unable to ensure that individuals were provided with individualized, appropriate or effective behavior interventions.

K10	Commencing within six months of the Effective Date hereof and with	<u>Historical Perspective</u> Through August 2013, weaknesses in the presentation of treatment data were frequently	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>noted. Although modest efforts at revising data graphs were reported by the Facility in the past, none had proven generally effective.

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of formal behavior intervention data. These individuals included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799.

<table>
<tr><th>Graph Element</th><th>5/2010</th><th>8/2013</th><th>3/2014</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>100%</td><td>80%</td></tr>
<tr><td>Horizontal axis and label</td><td>8%</td><td>100%</td><td>90%</td></tr>
<tr><td>Vertical axis and label</td><td>8%</td><td>100%</td><td>90%</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>80%</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.

Based upon the information obtained during the site visit, despite sound graphing practices in some areas, the Facility had not achieved substantial compliance.</td><td></td></tr>
<tr><td>K11</td><td>Commencing within six months of the Effective Date hereof and with</td><td>During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of the readability of formal behavior interventions. These individuals included</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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.	individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals ##19, #72, #111, #155, #272, #302, #417, #760, #787, and #799. According to Microsoft Word 2013, the readability scores from the 10 PBSPs all fell below a grade level of 8. A grade level of 8.0 is generally considered the upper range of easily accessible writing. Based upon the information provided, the Facility met criteria for substantial compliance in this Provision.	
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.	The Facility reported that there was no process or curriculum for providing competency-based training. No data regarding staff training in relation to PBSPs or behavioral principles was provided by the Facility.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, the Facility employed six staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 56 individuals residing at the Facility and fell short of the required ratio of one BCBA for every 30 individuals. The Behavior Services department did include a sufficient number of positions to achieve a 1:30 ratio. Should a BCBA credentialed employee fill each available position, the Facility would achieve approximately a 1:19 ratio. The Facility also employed 13 Psychology Assistants, more than sufficient to provide one Psychology Assistant for every two full-time psychologists.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DADS Policy: IRRF Clinical Integration, dated 10/29/2013, no number 2. RSSLC Policy: Medical Services, number I.00a, revised 5/15/2013 3. RSSLC Policy: Morning Report Policy, revised 11/4/2013 4. RSSLC Policy: Clinical Performance Audit Policy, revised 9/27/2014 (this is the actual date listed on the policy) 5. RSSLC: Policy: The Vest Policy, number 143, dated 6/21/2013 6. RSSLC: Policy Providing Health Care Services, Clinical CLDP Review, number I.55, dated 11/25/2013 7. RSSLC Policy: The Incontinence Brief Tracking Policy, number 146, dated 8/29/2013 8. RSSLC Policy A.7 Administration, Actions Following Death of Individual Served, Revised: 10/10/12 9. RSSLC Policy: Addendum to the Death Review Policy (Draft), 12/11/13 10. RSSLC Policy, I.31 Chronic Clinical Indicators, revised 8/20/2013 11. RSSLC Clinical Death Review Committee Minutes for Individual #99 12. RSSLC Administrative Death Committee Minutes Individual #99 13. RSSLC Unusual Incident Investigations for Individual #99 14. RSSLC Death Review Investigation – Nursing Services Reports for Individual #99 15. RSSLC Physician Death/Discharge Summaries for Individual #99 16. RSSLC Clinical and Administrative Death Review Committee Recommendations for Individual #99 17. RSSLC Clinical and Administrative Death Review Committee Recommendation Tracking Data and Follow-up for Individual #99 18. Texas Department of Health Services, Vital Statistics Unit – Certificates of Death for Individual #99 19. All assessments, graphs, summaries, action plans, and quality assurance (QA) reports for internal and external medical audits for round 8 20. Clinical pathway tools for internal and external medical audits for round 8 21. All QA/QI follow-up to action plans for the clinical performance audits, and the medical audits for round 8 22. Clinical record for Individual #99 23. QA database screenshots for Diabetes, pneumonia, seizures, morality review, developmental disability healthcare, and UTI 24. Data, trends analysis and QA reports for trends analysis used by the trends analysis committee for its review of pneumonia, UTIs, and diabetes 25. All clinical pathways audit tools for the Facility-developed Clinical Performance Audits 26. Clinical performance audit results completed during the review period 27. List of all medical providers, including number of hours worked, case load, and employment status 28. For each medical provider a. Curriculum vita for all licensed medical providers b. Copy of current medical license for all medical providers c. Copy of current CPR certificate for all medical providers

	d. List of all CME obtained during the past 12 months for all medical providers 29. Copy of morning medical meeting minutes for the first week of March 2013 30. Annual medical summaries, and medical provider's IPNs for individuals 31. List of all individuals who were prescribed a DNR order 32. RSSL Policy Providing Health Care Services; Designating Out-of-Hospital DNR; 09/17/2010 33. For all individuals of the list of DNRs (Individuals #149): a. Most recent annual medical assessment b. Most recent ISP, or other relevant documentation indicating and 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 rational for the DNR 34. Active clinical records for individuals #340, #35, #192, #463, and #238 35. CLDP for Individual #35, #238, and #463 36. Post move monitoring report for Individual #463 37. Medical provider integrated progress notes (IPN) through full resolution of an the most recent acute medical condition assessed by the medical provider for individuals: #402, #296, #475, #412, #751, #391, #320, #716, #239 and #384 38. Alpha list of all individuals with diagnosed seizure disorder 39. Alpha list of all individuals who experienced an episode of status epilepticus during the reporting period 40. List of all individuals with diagnosis of intractable seizure disorder 41. List of all individuals with implantable VNS 42. 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 report 43. For all individuals diagnosed with intractable seizures (Individuals #475, #712, #130, #402, abd #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 44. Alpha list of all individuals who were diagnosed with pneumonia during the reporting period 45. The first five individuals on the list of all individuals who experienced five or more cases of pneumonia

	with in the past five years (Individual's #666, #523, #351, #192, and #84): 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 46. Most recent annual medical assessment for Individuals #351, #192, #149, #133, #666, and #84 47. Individuals #195, #368, #346, #529, #483)): 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 **People Interviewed:** 1. Tran Quan, MD, Medical Director 2. Sherene Green, BSN, RN, Chief Nurse Executive (CNE) 3. Reneda Simmons, BSN, RN Nursing Operations Officer (NOO) 4. Adriano Soria, Jr., RN, Hospital Liaison 5. Wilma Parker, RN, Quality Assurance Nurse (QA) 6. Robyn Partridge, BSN, RN, QA Nurse 7. Wanda Hartensteiner, Medical Records Director **Meetings Attended/Observations:** 1. Meeting with the above staff to review process for Clinical and Administrative Death Reviews, 3/6/14 2. Medical Provider Meeting, 3/6/2014 3. Morning Medical Meeting, 3/6/2014
	Facility Self-Assessment: The Facility reported noncompliance with Sections L.1, and L.4. In the narrative sections entitled "self-rating," the Facility rated substantial compliance with Sections L.2, and L3. The Monitoring Team would like to point out that on the current self-assessment, Sections L.2, and L.3 were noted to have "N" listed under the compliance headings. The Monitoring Team concurs with the Facility's self-assessment of non-compliance with Sections, L1. And L.4, and substantial compliance with Section L.3; however, the Monitoring Team disagrees with the self-assessment of substantial compliance with Section L.2, and determined noncompliance. For Section L.2, the Facility determined compliance by measuring data elements related to the external audit process, clinical pathway tools, internal audit process, and the Facility's clinical audit process, and its newly developed mortality review process. The Monitoring Team determined that the Facility had to

	enhance the number of medical management audits for the DADs external review process, and that the mortality review process did not evaluate issues related to clinical care of conditions that may have contributed to death.
	Summary of Monitor's Assessment: The Facility has continued to move forward towards substantial compliance in medical services by developing a medical QA process, adding a clinical performance process to enhance the DADS internal medical audit process, ensuring appropriate clinical care and follow-up of acute medical conditions, developing a new process to perform mortality review, and ensuring that all clinical issues addressed by the medical provider are documented in SOAP format, and are legible, in addition to many other improvements. The Monitoring Team continues to be impressed by the Facility's medical QA process, and determined substantial compliance for Section L.3. Because the Facility has not substantially developed all necessary policies, has not substantially ensured that all chronic care issues are managed at the level of generally acceptable standard of care practice, and has not further developed the medical management components of the external medical audit process, among other issues, the Facility remains not in substantial compliance with Sections L.1, L.2, and L.4. The following are some additional comments, and recommendations for each Section reviewed for this compliance visit. **Section L.1:** The Monitoring Team determined noncompliance with Section L.1. Although there were some improvements in the area of follow-up to acute care issues and medical provider documentation, the Facility must continue to enhance the management of chronic conditions, such as seizure disorder, and must ensure all medical conditions that are active, and/or require regular monitoring by the medical provider, are listed on the active problem list. Medical providers must also develop, implement and assess necessary supports and services for diagnosed medical conditions, and ensure that direct care, and nurse staff are made aware of specific monitoring and reporting parameters for conditions that require specific and/or close monitoring. Although the medical provider provides good medical triage and follow-up for acute fractures, medical providers must better identify risk factors for fractures. **Section L.2:** 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. For these reasons, the Monitoring Team has determined that the Facility is not in compliance with Section L.2. **Section L.3:** The Monitoring Team compliments the Facility for developing a comprehensive and clinically relevant quality assurance 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, utilizes clinical pathways that emphasize clinical performance issues, and specifically addresses medical providers' clinical performance against standardized clinical indicators. 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, and development of meaningful corrective action plans. There were 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, and noted the development of two additional clinical indicators. The Monitoring Team noted that through the Facility's monthly trends analysis meetings, which included members of the Facility's QA/QI department, the Facility had assessed action plans for efficacy. In particular, the Monitoring Team comprehensively reviewed the Facility's trends analysis, action plans, and follow-up on action plans for pneumonia, and UTIs. In both cases, the Facility identified that action plans had a positive effect on reducing the number of cases of pneumonia and urinary tract infections. Because the Facility utilized a data-based system that identifies clinical indicators of care, further developed additional clinical indicators of care, identified the need for and developed clinical actions plans to address systems issues related to clinical care, and followed up on action plans to assess efficacy, the Monitoring Team determined substantial compliance for Section L.3 **Section L.4:** The Monitoring Team noted that the Facility had developed many new policies for medical services, and updated many older policies. For the Policies review for this compliance visit, the Monitoring Team determined that the Facility was not in substantial compliance with Section L.4, of the SA. Compliance with require that the Facility develop and policy, and/or procedure, for all major areas of clinical practice at the Facility, and ensure that the Facility has fully implemented the policy, and substantially follows its policy.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the	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 community living discharge planning meeting. Through document review, the Monitoring Team assessed the Facility's medical administration; practice for do not resuscitate orders; clinical management of acute medical conditions; management of seizure disorder and Vagal Nerve Stimulators; pneumonia; medical assessments, and diagnoses; and conducted comprehensive clinical reviews of five individuals. It should	Noncompliance

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	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.	be noted L.1 requires the Facility to address many medical conditions, and the Monitoring Team can only review a certain number of medical conditions at each compliance visit. <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 Medical Providers: The Facility's medical department maintained the following staffing: • One full time medical director, who currently has a caseload of 64 Individual's • Three full-time State employed medical providers • One full-time locum medical provider • Three full-time support staff The caseload for each medical provider is less then 70 Individuals. Medical licenses were reviewed, and noted to be current for all medical providers. One medical provider was a nurse practitioner, and was supervised by the medical director. Although requested, the nurse practice agreement was not provided for review. The Monitoring Team reviewed the medical director's licensure through the State of Texas licensure website, and noted that the Nurse Practitioner was registered under the medical directors medical license. All State employed medical providers were current with State required CME expectations, and CPR certificate. CPR and CME certificates were not provided for the locum medical provider.	

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		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 first morning reports of each month that occurred during the reporting period (9/2013 through 2/2014), in addition to the Monitoring Team's observation of the Morning Medical Meeting on 3/6/2014, indicated that the Facility included staff members from a variety of clinical disciplines, including PT/OT, nursing, medical, psychology, psychiatry, pharmacy, and residential services; however, there was little evidence to indicate that the meeting was conducted in an interdisciplinary format, and each issue addressed at the meeting was mostly presented as a report by the medical provider, or the nurse and there was little discussion regarding the issues, by other staff. For example, the Clinical Morning Meeting Report, dated 1/2/2014 indicated that Individual #160 had "placed a paintbrush in to (the Individual's) mouth. No history of pica. Had a little pink paint in mouth when found by staff. Paint stated it was non-toxic. On medical monitoring but no issues. No vomiting, abdominal pain or discussion". In this example there were no questions asked by other member of the committee regarding this potentially serious issue. Behavioral health members should have questioned this new behavior and indicated that a review of pica, and mouthing behavior of non-edible items would be conducted, and living area staff should have discussed possible supervision issues. In addition, there were very few examples of action plans developed to follow-up on clinical concerns. For example, the nurse reported that Individual #1 was "scheduled for ureterostomy for hydronephrosis on Monday", and no one questioned if all pre-surgical arrangements were in place, and what type of supports and services were necessary to ensure a successful outcome. For this example, specific action plans to ensure that the Individual was maintained NPO, if necessary, and determination what medications should be given, or should not have been given, as well as ensuring that a nursing or medical assessment was completed on the morning of the surgery, prior to being transported to the hospital.	

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		The purpose of an interdisciplinary meeting for healthcare is to help ensure that all necessary supports and services have been appropriately identified, and followed up on, for moderate to high-risk clinical issues. If a clinical issue warrants a comment at the meeting, the team should assertively assess the issue, and ensure that all necessary supports and services are in place. Unlike the medical morning meeting attended by the Monitoring Team at the last compliance visit, the Monitoring Team did not function in an interdisciplinary fashion. 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. The physician on the Monitoring Team did not observe a Grand Rounds Meeting, and did not review Grand Rounds Minutes. 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.	

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		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> 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 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 #149): 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	

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		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 (Individual #149): • The annual medical summary clearly delineated the qualifying condition for the DNR in zero out of one examples (0%). • In zero out of one examples (0%), the ISP clearly delineated the qualifying condition for the DNR, and all supports necessary to support the individual during an end of life event. • In zero out of one 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 one examples (0%) there was a comprehensive IPN by the physician documenting the qualifying condition, possible alternatives to the DNR. • The DNR form was fully completed in one out of three examples (0%). • 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 Review of the DNR policy indicated that the specific withholding of resuscitative acts should be determined when initiating a DNR order. For example, withholding of chest compressions, advanced airway management, artificial ventilation, defibrillation, and transcutaneous cardiac pacing. The policy also requires that a physician document qualifying and terminal conditions, and defined a terminal condition as a condition which would result in death, is approximately six months. The Monitoring Team concurs with these requirements. The Facility reported that one individual was prescribed a DNR order, Individual #149. Review of the DNR order form, dated 2/7/2011, was not signed by a physician. The	

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		resuscitative status on the Individuals current contact information update form indicated that the Individual was not a DNR, and was an "active" resuscitative status. There was an undated "contact note" written by a Facility staff social worker" who questioned if the DNR order was still active or not, and that a nurse had informed the social worker that because of the Individuals "fragile medical condition" the DNR order was active. An IDT note, dated 1/27/2014, indicated that because of the Individual's congestive heart failure, the DNR order will be continued. The IDT note was signed by a nurse practitioner and not a physician. Review of the current annual medical assessment indicated that the Individual did have many medical conditions, including COPD and congestive heart failure, however, the assessment indicated that the Individual was not experiencing difficulties with breathing, and there was evidence that the Individual was tolerating medication for heart failure very well. The Monitoring Team has the following concerns with the DNR for Individual #149: There was no documentation by a licensed physician as to the qualifying and terminal diagnosis, necessitating a DNR order: • The DNR order form was not signed by a licensed physician • There was no ethic committee review for the DNR order • There was no evidence that a non-facility person, such as an outside physician or attorney, as required by the Facility's DNR policy, actually participating in the IDT meeting which was held on 1/27/2014, to determine the continued validity of the DNR. • The Facility's DNR policy did not include a process necessitating periodic evaluation for the continued need for a DNR order • The DNR order form did not provide specifics, as to the qualifying and terminal condition, or document the specific type of DNR. • The annual medical summary did not address the DNR, and indicate the qualifying condition, or list an action plan for end of life issues. <u>Individual Case Reviews</u> The Monitoring Team conducted comprehensive clinical reviews of the active clinical records, current annual medical summaries, annual ISPs and addendum to ISPs, for individuals #340, #35, #192, #463, and number #238. In addition, the Monitoring Team reviewed the most recent CLDP, and post move monitoring checklist for Individual #463, and observed, by telephone, at the CLDP meeting for Individual #238. The following is a summary of some of the Monitoring Team's findings, concerns, and comments. Individual #35: Review of the 12/2/2013 medical summary included as part of the CLDP, indicated a clinically appropriate summary of the medical action plan for documented diagnoses;	

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		however, there were no diagnoses, or action plans for noted small vessel disease of the brain, and cerebellar atrophy, which the Monitoring Team identified by review of neuroimaging results in the active clinical record. The post move monitoring checklist was deficient by not including specific monitoring and reporting parameters for important clinical conditions, such as: osteoarthritis of the knee, degenerative disease of the vertebra, glaucoma, small vessel disease of the brain and associated cerebellar atrophy, constipation, and seizure disorder, among other conditions that were diagnosed, or otherwise indicated by review of the active clinical record Individual #463: Individual #463 was readmitted to the Facility following a failed community placement. Discussion with the medical director, meeting with living area staff, review of the active clinical record, and the CLDP dated 3/20/2013, indicated that the Individual had significantly decompensated following transition to the community agency, developed an extensive stage IV decubitus ulcer, and required emergency resection of the Individual's intestine. Following its clinical review, the Monitoring Team identified several concerns regarding medical care, including, but not limited to the following: • Under the heading of significant past medical history, it was listed "2009: Hepatitis C antibody"; however, this issue was not further addressed within the context of the medical summary, there was no diagnosis indicating hepatitis C and no action plan for Hepatitis C. Because there was no additional documentation noted there was no evidence to determine if the hepatitis C antibodies were positive or negative, and no indication if additional testing was completed to determine the status of hepatitis C. The medical summary should have more clearly delineated this issue. This issue is relevant because community medical provider could interpret the statement as a positive Hepatitis C, and subject the Individual to un-needed testing, or if the Individual is hepatitis positive, the community agency would need to be well informed of necessary medical follow-up, and to develop specific exposure precautions. • The medical summary indicated a diagnosis of "Epilepsy"; however, the specific type of epilepsy was not reported on the active problem list. The medical summary indicated that the Individual's most recent seizures occurred in February 2012, however, the CLDP indicated that the most recent noted seizures occurred in February 2010. The medical action plan for "Epilepsy" was minimal, and did not include specific monitoring parameters, such as observation for specific signs of seizure manifestation. Seizures can manifest in different ways and the community agency must be aware of the type of seizures, and how they have manifested in the past. Furthermore, there were no specific recommendation on how often to monitor for signs and symptoms of adverse effects of the Individuals anticonvulsant medications. The community agency, and accepting physicians should be provided with recommendations for	

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		medication monitoring; this issue is especially important because many individuals with developmental disabilities can not effectively express signs and symptoms of toxic effects to medication, and require closer monitoring for drug side effects, and given the narrow toxicity range for Dilantin, the community agency must be made well aware of signs and symptoms to monitor. • There was no diagnosis listed on the active problem list, or medical action plan, for the Individual's known neuromotor condition, which required a wheel chair, standing box, and gait belt. Furthermore, the etiology of the neuromotor condition, its prognosis, and specific monitoring parameters, were not communicated to the community agency. In addition, during an on-site meeting with living area staff, the Monitoring Team was informed that the individual continued to have functional use of upper extremities, and there was no documentation either in the medical plan, or CLDP, recommending specific physical and occupational therapy supports to help maintain this function. • The medical summary indicated a diagnosis of blindness; however, the medical action plan, and the CLDP did not address the extent of blindness, prognosis, and necessary support and services, other than indicating "will continue eye exams", and that the Individual has "phthisis bulbi". Phthisis bulbi implies a non-functioning eye, and can be caused by various medical conditions or trauma, and can be progressive. The community agency should have been made aware if blindness was unilateral, or bilateral; the extent of vision loss; prognosis of the condition; specific follow-up plans; and specific supports and services, including environmental, and occupational issues. • The medical summary indicated that a DEXA scan could not be obtained because of body habitus, but because of immobility, probable bone loss, the Individual was to continue treatment doses of vitamin D and calcium. There was no diagnosis, or action plan listed for probable low bone density, and there was no plan in place to address possible fractures. Furthermore, the CLDP did not include a plan to address bone loss, and did not include specific monitoring and reporting parameters for possible fractures. Individuals who have been on anticonvulsant medications, such as Dilantin and who are immobile, are at significant risk for osteoporosis and are at high risk for spontaneous fractures. The community agency should have been made specifically aware of this issue, and specific monitoring and reporting parameters should have been developed and implemented for spontaneous fractures, prior to transition. • On 2/23/2012, the Individual was noted to have "recurrent otitis externa", was referred to a medical specialist, and was diagnosed with a "growth in right external auditory canal". The Individual was to be re-evaluated at a subsequent referral. The medical summary did not further comment on this condition, and resolution of this issue was not documented on the medical summary.	

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		Furthermore, the CLDP did not address this issue. • The medical summary listed "lactose intolerance" as a diagnosis under the heading of current medications, and listed Lactase tablets as a prescribed medication. The active problem list did not include a diagnosis of lactose intolerance, and there was no medical action plan listed for this condition. Furthermore, the CLDP did not list monitoring and reporting parameters for exacerbation of lactose intolerance; for example, nausea, anorexia, bloating, flatulence, and changes in consistency and frequency of bowel movements, should have been monitored regularly. • The active problem list on the medical summary indicated a diagnosis of constipation, and for the associated medical action plan, stated "still on Golytely. Which is currently providing augmentation to promote and normalize bowel movements". There was no indication within the context of the medical summary, or CLDP at to the etiology, severity, and prognosis for constipation. Furthermore, specific monitoring and reporting parameters for this medical condition were not developed for the agency. Constipation, especially in individuals with developmental disabilities, can be life threatening and progress to bowel obstruction, bowel perforation, and even death. • The medical summary indicated under the heading of past medical history that the individual had "poor oral motor function" with no evidence of penetration or aspiration, at that time. A modified barium swallow test was reportedly completed in February 2012, that demonstrated no aspiration or penetration with nectar consistency, nor ground consistency foods, and the radiology recommended continuation of ground solids and regular liquids. There was no diagnosis listed on the active problem list, or medical plan developed for "poor oral motor function". Abnormal motor function, can progress with the aging process, and specific monitoring and reporting parameters should have been developed for this condition. For example, close monitoring and observation for signs and symptoms of aspiration, chocking, and coughing should have been regularly assessed. Furthermore, such monitoring and reporting parameters were not informed to the accepting agency prior to transfer. • In March 2000, the medical summary indicated that the Individual was diagnosed with "delayed gastric emptying", however, there was no further elaboration of this potentially serious condition, and the condition was not listed as a diagnosis on the active problem list. Furthermore, the agency was not informed of this issue, and there were no monitoring and reporting parameters developed for community agency to monitor for this condition. This condition can progress, and periodic medical assessments should be completed. Most important, staff should be made acutely aware of this condition, and report specific signs and symptoms, such as nausea, vomiting, regurgitation, non-	

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		productive cough, abdominal distention, liquid stools, and worsening constipation. Gastroparesis can progress and manifest severe constipation; anorexia with severe weight loss; bowel obstruction, and bowel perforation; over growth of pathologic organisms in the intestine, such as C. difficile colitis; aspiration of gastric content into the lungs; fluid and metabolic dysregulation; and even death, if not assertively managed. This issue was not clearly delineated in the CLDP, and there were no specific monitoring and reporting parameters developed for the community agency to monitor. • The medical summary indicated that the Individual had a past medical history of intestinal ileus, secondary to constipation in 2012, however, there was no further delineation of this issue within the context of the CLDP, and follow-up and preventive plans for ileus were not documented in the CLDP. Following its review, the Monitoring Team noted several discrepancies between the medical summary component of the CLDP, and the nursing component of the CLDP. For example, the nursing component indicated that the Individual was diagnosed and treated for C. difficile coli in 2007, but the medical summary did not include that condition. The nursing component of the CLDP also indicated that the Individual had a gastrostomy tube placement in 2008, because of poor nutritional intake, but the medical summary did not document issues related to poor nutritional intake. In fact, the medical summary did not include a diagnosis or medical plan for the placement of a gastrostomy tube. Furthermore, specific monitoring and reporting parameters for community agency direct care staff to monitor placement and possible dislodgement of the enteral tube, was not developed. The nursing component of the CLDP did not indicate a history of intestinal ileus, but the medical summary indicated that an intestinal ileus occurred in 2012. These discrepancies demonstrate a lack of coordinated effort between the two clinical disciplines. The Monitoring Team was informed that following the community placement, the Individual developed a life threatening condition that required emergency surgery and partial resection of the Individual's bowel. The Monitoring Team is concerned that the underlying medical conditions, including history of intestinal ileus in 2012, history of gastroparesis, history of C. difficile colitis, history of chronic constipation requiring daily medications, including Golytely, the need to prescribe daily lactase, and a history of anorexia requiring an enteral tube placement for nutritional support, did not result in a more assertive evaluation of the Individual's gastrointestinal condition, prior to transfer from the Facility. The Monitoring Team is also concerned that the Facility did not develop, and implement a action plan to address the Individuals gastrointestinal issues, which should have included specific monitoring and reporting parameters for the community agency's staff to monitor.	

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		The Monitoring Team strongly encourages the Facility to review the medical care that was provided to this Individual, and if necessary develop and implement staff training on the appropriate management and follow-up on intestinal ileus, constipation, lactose intolerance, gastroparesis, neuromotor conditions, dysphagia, and anorexia. In addition, the Facility must immediately enhance its process for developing the medical component of the CLDP, and the development specific monitoring and reporting parameters for medical conditions, prior to transfer from the Facility. Individual #192: Review of the most recent ISP, dated 5/20/2013, did not indicate specific clinical concerns related to adrenal insufficiency, and the most recent IRRF, dated 5/20/2013, indicated a medium risk for constipation despite documented imaging studies indicating constipation. The IRRF did indicate the diagnosis of adrenal insufficiency, and need for enhanced hydration, but indicated that the need for increased hydration would only be required for three days, and not on-going. Also, the specific amount of increase hydration was not delineated. In addition, the IRRF indicated a need for a consultation with an endocrinology specialist, however, at the time of this compliance review, the consultation had yet to be completed. Addendum reports to the ISP dated, 8/27/2013m 9/10/2013, 9/13/2013, 10/23/2013, 11/21/2013, 11/2/2013, 1/13/2014,2/13/2014, and 2/20/2014 did not comment on the diagnosis of adrenal insufficiency, possible issues related to chronic constipation, and dysphagia, or the etiology of dysphagia, and how these clinical issues could be related. A dictated medical provider IPN was dated 3/2/2014 and indicated that the Individual was seen in sick call for recurrent pneumonia, and history of recurrent pneumonia. The assessment also included a history of adrenal insufficiency, and that the Individual was on cortisone supplement. The medical provider triaged the Individual to the emergency department. A hand written medical provider IPN, dated 3/1/2014, indicated that the Individual was seen for lethargy, hypoxia, hypotension, hyponatremia, and upper GI bleeding, and was transferred to the ER. The IPN also indicated that an additional note would be dictated; however, there was no additional note found in the active clinical record for the 3/1/2014 issue. Nursing IPNs indicated that the Individual was admitted to the hospital on 3/1/2014. A GI consult report, dated 3/12/2013, indicated that the Individual had Barrett's Esophagus, and an active bleeding esophageal ulcer. A GI consult note, dated 4/23/2013, documented a healed esophageal ulcer, Barrett's esophagus, with negative biopsy for dysplasia, and the need to repeat EGD in one year. The Individual was seen again by GI on 12/13/2013, for a consultation to discuss PEG-tube placement, secondary to recurrent pneumonia; however, there was follow-up IPN by the medical provider documentation that the PEG-tube was inserted, or not inserted.	

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		Review of radiology reports indicate a prolonged history of pulmonary congestion, and progressive development of constipation. The most recent radiographic follow-up for constipation was on 11/7/2013, which indicated evidence of constipation that "appears to have not significantly changed since prior study". The radiograph dated 11/7/2013 indicated constipation and phleboliths. An action plan for worsening constipation was not documented by the medical provider. The following is a list of abnormal laboratory results, which are of concern to the Monitoring Team:	

Date	Sodium	Cortisol	Other
8/19		Less then 2	
10/18	143		Glu 66
10/22		6	
12/10		Less then 2	
12/12	137		K 3.5; BUN/CR 24
12/13	132		BUN/CR 24
12/14	134		Glu 68
1/13	123		BUN/CR 30
1/26	129		
2/3	124	4.3	Ca 8.3; BUN/CR 26
2/4	136		BUN/CR 20 (normal)
2/5	135		BUN/CR 25; GLU 71; K 5.6
2/6	131		GLU 64; Ca 8.8; BUN/CR 22
2/7	132		GLU 46; K 5.6; BUN/CR 21
2/16	133	1.5	GLU 52; BUN/CR 29
2/18	132	25	ACTH 6
2/28	124		BUN/CR 26; Ca 8.6
3/1	122		BUN/CR 25; 8.4

BUN: Blood Urea Nitrogen; CR: Creatinine; GLU: Glucose; Ca: Calcium

By review of the lab values, the Monitoring Team identified episodes of possible recurrent dehydration, abnormal cortisol levels, episodes of hypoglycemia, and hyperkalemia; and in context of the Individual's clinical manifestations that included mental status changes, nausea vomiting, and constipation, adrenal insufficiency should have been urgently evaluated by a medical specialist familiar with this potentially life

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		threatening condition. The Monitoring Team noted that within the body of the annual medical summary, dated 5/3/2013, the medical provider indicated that the Individual would be scheduled with an endocrinologist to evaluate adrenal insufficiency, however, the medical plan of the same medical summary stated that the Individual "has no apparent symptoms of adrenal insufficiency", and there was no indication for need for subsequent monitoring, or referral to a specialist. In addition, the annual medical summary, dated 5/3/2013, documented that a swallowing study was completed on 12/21/2011, and diagnosed oral motor deficits, and deficits with bolus formation and bolus propulsion; however, the annual medical summary did not indicate a diagnosis of dysphagia. Based on the documented evidence reviewed, per the active clinical record, the Monitoring Team has the following concerns: 1. Despite initial concerns for the need of an endocrinology consultation in 5/2013, and with documented signs of possible adrenal insufficiency, the medical provider stated on the medical action plan that there were no or symptoms suggestive of adrenal insufficiency, and there was no need for additional monitoring for adrenal insufficiency. The Monitoring Team noted, however, that the active clinical record documented continued evidence to suggest the possibility of adrenal insufficiency, including abnormal cortisol levels, abnormal glucose levels, abnormal sodium levels, elevated BUN/CREATININ ration, signs of clinical dehydration, recurrent episodes of emesis, mental status changes, and chronic constipation. The Facility should have ensured that the constellation of these clinical findings be urgently provided to a physician, who has expertise in the area of adrenal insufficiency. Although recently scheduled, the Individual had not been evaluated by a an endocrinologist at the time of this compliance review. 2. Despite a diagnostic study completed in 2011 indicating dysphagia, the most recent annual medical summary did not list dysphagia as a diagnosis, and there was no medical plan listed for dysphagia. 3. The etiology of chronic constipation was not fully evaluated, and there was no documented evidence indicating that periodic diagnostic studies were obtained, such as a gastromotility study, or occasional plan film imaging studies, to further evaluate worsening constipation. Chronic and severe constipation can manifest in emesis, and episodes of emesis have been documented in the clinical record. Specific monitoring and reporting parameters for direct care staff, and nursing staff to observe for worsening constipation, were not identified. 4. Despite the diagnosis of recurrent aspiration pneumonia, there was no evidence indicating that the Facility assessed the etiology of the recurrent aspiration pneumonia. 5. The Monitoring Team is concerned that the Facility had not updated the IRRF to	

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		reflect current medical issues, such at dysphagia. 6. Addendums to the ISP did not address possible issues associated with adrenal insufficiency such as hyponatremia, dehydration, mental status changes, and hypoglycemia. 7. There was no documented explanation for the apparent chronic dehydration, or other explanation for the recurrent elevated BUN/CREATININ ratios. Individual #340: On 3/4/14, at 1940 the nurse documented Individual #340's vital signs as blood pressure 125/77, temperature 100 axillary, pulse 115, respiration 30, and oxygen saturation 96% on room air. Individual #340 was using accessory muscles for breathing. The Nurse Practitioner was immediately notified of vital sign findings, who ordered one time Tylenol 650mg via G-tube for possible pain, schedule for sick call in the mornings, and to call her back if vital signs were still abnormal after the Tylenol. On 3/4/14 at 2250, the Nurse Practitioner was notified that Individual #340's vital signs continued elevated with rapid respirations with the use of accessory muscles and the oxygen saturation had dropped to 95%. The Nurse Practitioner advised the nurse to continue to monitor. On 3/5/14, Individual #340 was reassessed again at 0000, with vital signs documented as blood pressure 100/58, temperature axillary 95.7, pulse 94, respirations 30, and oxygen saturation 97% on room air and again at 0220, for which they were documented as blood pressure 134/70, temperature axillary, pulse 108, respirations 32 and oxygen saturation 82% on room air. Oxygen at 3 liters via nasal cannula was applied according to protocol. With the administration of oxygen the oxygen saturation came up to 92%. The Nurse Practitioner was notified again of findings. The nurse documented that she emphasized the fact that she did not feel comfortable about Individual #340's condition. The Nurse Practitioner instructed her to call the campus nurse to do an assessment. The nurse insisted again that she did not feel comfortable with Individual #340's condition. Then, the Nurse Practitioner gave an order to transfer Individual #340 to the emergency room via regular ambulance with the diagnosis of difficulty breathing. The campus nurse was notified and the ambulance service was called but was not available. The campus nurse arrived and agreed with the nurse that the Nurse Practitioner should be called to get an order to transfer Individual via 911 Emergency Medical Services. The Nurse Practitioner was notified and an order was given to call 911. Emergency Medical Services arrived at 0300 and Individual #340 was sent to the emergency room or evaluation and treatment. The seemly reluctance of the Nurse Practitioner to send Individual #340 to the emergency room when the nurse notified her at the onset of the respiratory difficulties was of serious concern to the Monitoring Team base on his recent medical history. Individual #340 was admitted to the hospital on 1/15/14 and diagnosed and treated for pneumonia and sepsis. Individual #340 was discharged on 2/1/14 and was readmitted to the hospital on 2/2/14 diagnosed and treated for hypoxia and pneumonia. Further, it was of concern that initially the Nurse	

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		Practitioner gave the order to transfer Individual #340 who was experiencing respiratory distress via regular ambulance that was not fully equipped to manage a frank respiratory distress emergency; therefore, placing Individual #340 and the Facility at risk of harm. <u>Medical Provider's Participation at the CLDP Meeting</u> The Monitoring Team observed the CLDP meeting for Individual #238 on 3/13/2014, by telephone conference call. The following are specific observational comments, and some concerns noted by the Monitoring Team. It should be noted that all comments and concerns were based on review of information documented on the CLDP, and per discussion at the CLDP meeting on 3/13/2014, and may or may not represent all relevant clinical information; therefore it is essential that the appropriate clinical leadership review, and address all clinical issues: • Monitoring parameters for seizure medications stated "Depakote and Trileptal is also used as a mood stabilizer, it is important to note that if once behavior improves, and the Trileptal and Depakote level is weaned that he might have breakthrough seizures, so his seizure monitoring will need to closely monitored when there is any changes made to Depakote or Trileptal based on mood stabilization". The Monitoring Team concurs that close monitoring is necessary any time that an anticonvulsant medication is reduced, or discontinued; however, the Monitoring Team was concerned that the CLDP did not indicate the need to consult with a neurologist prior to making any changes with Trileptal or Depakote, based on improved psychiatric indication. • The issue of incontinence was not clearly delineated, and although not currently utilizing adult incontinent briefs, there was a medical order for such briefs in the past. The issue of incontinence should be better delineated and include the specific type of incontinence, such as bowel, urinary, or both; and what the etiology of the incontinence was, such as secondary to constipation, other medical condition, or secondary to compliance issues. During the meeting, the issue of incontinence was raised; however, staff did not have a meaningful understanding of the etiology of the incontinence, and did not comment on the type of incontinence. The Monitoring Team was also concerned that the Facility staff recommended that the agency monitor the Individual's use of the bathroom to determine how often he needs to go to the bathroom. Toileting frequency should be well known, and communicated to the accepting agency, and specific monitoring parameters be well documented. • Because of the known history of constipation, and potential constipation secondary medication, the Monitoring Team concurred with the CLDP meeting discussion indicating the need for monitoring of constipation. This is especially important because the Individual's anticonstipating medication had recently	

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		been changed. The CLDP recommended close monitoring by determining if the "stomach appears harder, larger, or bloated more than usual", and to notify the nurse if the Individual "has not had a BM for 3 days, straining, and matter appears hard or watery/runny, or bloody", and "notify nurse of any changes in appetite or meal and fluid refusals". The Monitoring Team concurs with the recommendations; however, specific parameters were not developed. For example, how and when would the agency actually assess for a larger, or bloated abdomen. Such details are paramount in helping to determine exacerbation of constipation. Also, the nurse indicated that the Individual should be provided "fluids", however, a specific minimum and maximum amount of fluids was not reported. • The weight range developed for the Individual was reported to be between 130 and 170 pounds, which is a significant range. The medical provider should determine a more clinically rational weight range, specific for the Individual. For example, an individual with small body frames would fall towards the lower end of the expected weight range, while an individual with a large body would tend to fall towards the higher range. Also, the Individual should be regularly assessed for specific changes in weight, such as a weight loss, or gain of more then 5% in a specific period, and specific weight gain, or loss each month. Following the discussion during the CLDP meeting it was determined to monitor for a weight loss or gain of 10 pounds in a month. The Monitoring Team is concerned that the Individual may progressively gain or lose weight , but less than 10 pounds each month. This practice could result in the Individual gaining, or losing significant weight loss/gain, before being reported to the medical provider. In fact, during the meeting, the Facility's medical provider indicated that a weight gain resulting in a weight of 190 pounds would be the reportable weight. • The Facility reported that the Individual has "teeth grinding" habit; however, this issue was not clearly delineated and since the CLDP meeting did not specifically comment on the etiology of the "grinding of the teeth", or develop a clinical plan to address the issue, the Monitoring Team could not determine if this habit was actually a medical diagnosis of bruxism, and possibly secondary to side effects of medications. • It was noted in the CLDP the individual received Benztropine for adverse side effects of psychotropic medications. The Monitoring Team was unable to find any description of the specific side effects for which the individual was prescribed this medication in the CLDP or in the Medical Summary provided. The Monitoring Team had requested some additional documents that were not included with the CLDP packet, including the current IRRF, dated 2/07/14. In the Polypharmacy section of the IRRF, the pharmacist noted a MOSES	

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		assessment on 10/10/13 "appears to reflect EPS side effects (drooling and tremor) induced by antipsychotic use." This specific symptomology was not shared with the provider or included in the CLDP. The pharmacist went on to suggest the IDT "consider an upward titration of the Benztropine from 4/mg per day to 6/mg per day for resolution of these symptoms (if patient continues to remain on both psychotropics.)" The individual was receiving 2/mg per day at that time and at the time of the CLDP, and continued to receive both psychotropics. The Monitoring Team could not find evidence in the materials provided whether the IDT considered the pharmacist's recommendation nor was it discussed at the CLDP. • The Monitoring Team was significantly concerned that despite a known diagnosis of bipolar disorder with psychosis, and a history of severe aggressive and potentially dangerous behaviors in the community, and a current behavior support plan in place, the Facility did not indicate the need for a psychologist, who has experience with supporting Individuals with intellectual disabilities, to follow the Individual at the time of transfer to the group home. Also, there was no discussion on emergency treatments, and other supports in the event of a severe behavioral exacerbation. There was no discussion on how the Facility would manage physical aggression. Staff must be well trained and certified in techniques to help protect the Individual from injury, protect other individuals within the home and community and ensure the safety of staff in the event of a behavioral exacerbation; such issues were not addressed at the meeting. Give the diagnosis of bipolar disorder, with psychotic feature, and the need to monitor for psychosis, the psychiatrist did not indicate that the Individual would possibly require the use of antipsychotics in the future; this is especially important because during the meeting the psychiatrist indicated that the Individual did not need the antipsychotic because there were no signs of intermittent explosive disorder. Furthermore, the CLDP commented on the history of sleep disturbance, however, there were no monitoring parameters discussed for this issue, and there was no discussion on sleep disturbance as a possible manifestation of bipolar exacerbation. • In addition to bipolar disorder, the Individual is diagnosed with intermittent explosive disorder and attention deficit with hyperactivity; however, the psychiatrist commented that such diagnosis were questionable, and it was recommended at the CLDP meeting to continued discontinuation of Zyprexa, following discharge. The Monitoring Team determined that the psychiatric diagnosis should be more clearly determined prior to discharge. Also, given the planned discontinuation of an antipsychotic medication, the CLDP should include guidelines to monitor emergence of both side effects and symptoms of psychiatric disorder and, perhaps, training of provider staff on what to observe and report.	

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		• The Facility did not provide specific recommendations for dental services. It was not clear to the Monitoring Team what the Facility's dental professionals specifically recommended. During the meeting, non-dental office staff read the dental office recommendations that the Individual was receiving dental hygiene every three months; however, the non-dental professional staff person stated "I don't get my teeth every three months", and asked the agency if the Individual could get his teeth cleaned every six months. Based on the discussion during the meeting, the Monitoring Team understood that invasive dental services, including descaling, required TIVA; however, financial issues were raised, and the Monitoring Team understood that the Individual would be provided dental services with TIVA only once per year. • The CLDP indicated that the Individual was Hepatitis A positive; however, this issue was not addressed at the CLDP meeting. Summary The Monitoring Team determined that the Facility had not clearly identified all medical, and dental issues, had not developed specific monitoring parameters for dental and medical issues, and did not ensure that the agency was equipped to manage a potential dangerous behavioral exacerbation. <u>Follow-up to acute care conditions</u> To assess the Facility's ability to triage and follow-up on acute medical conditions, the Monitoring Team reviewed all medical provider IPNs through full resolution of an acute medical condition for Individuals #402, #296, #475, #412, #751, #391, #320, #716, #239 and #384. • In seven out of ten examples (70%), a specific follow-up date was documented on the initial medical provider IPN for an acute medical condition. The medical provider must ensure that all acute medical conditions are assessed through full resolution, and must document a specific date for re-evaluation by the medical provider. • In ten out of ten examples (100%), the medical provider's IPN was written in a SOAP format, documenting subjective information, objective information, assessment, and plan. The following are some specific comments and concerns, regarding the clinical management of acute medical conditions: Individual #384: Initially triaged by medical provider on 9/10/2013 for emesis, and leakage around enteral tube, and was followed up regularly on 9/10/2013 through 9/12/2013. On 9/17/2013, the medical provider's IPN documented "history of	

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		jejunostomy enteral tube leaking", and documented a clinical plan stating "contingent upon clinical course, patient may need jejunostomy exchange". The Monitoring Team has the following concerns regarding the triage of this Individual: • No follow-up documentation was provided indicating that the enteral tube issue had resolved. • There was no plan documented to address the continued leaking enteral tube. Individual #402: Triaged by medical provider for "right conjunctivitis" on 9/6/2013, and was prescribed antibiotics. The Individual was re-evaluated by the medical provider following the course of antibiotics and documented that the issue had resolved. • The medical provider did not indicate on the medical IPN a medical action plan to enhance protective measures to help mitigate transmission of an acute infectious process. Individual #320: Triaged on 12/2/2013 by medical provider for a family report of "fever and congestion". At the time of the assessment the Individual had an axillary temperature of 102.1, pulse rate of 101, and a respiration rate of 20 and associated pulse O2 of 98%. Auscultation of the lungs indicated no wheezing, and diminished lung sounds on the bases. The medical provider was unable to evaluate the oropharynx and stated that the nares had creamy secretions and the auditory canals were clear, and no drainage. The assessment documented was "Fever, cough. Probable upper respiratory infection. Rule out bronchitis, rule out pneumonia and rule out UTI". Appropriate diagnostics were ordered, and the Individual was started on Levaquin, antipyretics, and decongestants, ; nursing instructions were given to provide extra fluids, and nursing assessments every six hours were ordered. On 12/3/2013 the medical provider documented review of the x-ray report, which indicated pneumonia. Specific monitoring and reporting parameters, and follow-up instructions were not documented. The Individual was re-evaluated seven days later, on 12/10/2013, and documented "resolved infiltrate", based on a lung x-ray obtained on 12/9/2013. The IPN further documented ""Continue to monitor for resolution of cough and no treatment needed at this time. Follow up clinically". The medical provider documented lung sounds, but vital signs, including body temperature, pulse, and blood pressure were not documented. • The Monitoring Team compliments the medical provider for ensuring to evaluate for pneumonia, especially in an individual with developmental disabilities and an axillary temperature of 102.1. The Monitoring Team is, however, concerned that the final IPN documented on this issue did not include vital signs, or a pulse O2 result, and based clinical improvement on a chest x-ray. Pulmonary infiltrates typically take a considerable while to resolve, and subtle dehydration may reduce the ability of an x-ray to detect an infiltrate, leading to a false negative report. The diagnosis of pneumonia should always include a	

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		physical examination that includes vital signs and pulse O2. Individual #412: Initially triaged with coughing, afebrile, and normal pulse O2, on 12/15/2013, and diagnosed with bronchitis, and treated with nebulizers and expectorants for "a few days". Follow-up instructions stated "followup with PCP as needed". There were no specific monitoring or reporting parameters documented. On 12/18/2013, nursing staff referred the Individual back to "sick call", and the individuals was triaged by the medical provider, who documented normal vital signs and diagnosed "cough, unresolved. Rhinorrhea, URI vs seasonal allergies and bronchitis. R/O pneumonia due to high risk of aspiration". A chest x-ray was ordered to "rule out pneumonia", and the follow-up instructions were "if symptoms not resolved or getting worse, refer back to sick call". No specific monitoring parameters were documented. On 12/19/2013, the medical provider, who did not examine the Individual, documented a note indicating that the lung x-ray demonstrated "probable atelectasis", and the medical provider documented a plan to "encourage client mobility, deep breathing exercises, incentive spirometer as tolerated"; however, the medical provider did not document specific monitoring instructions or a specific follow-up date to re-evaluate the Individual. The Monitoring Team has the following concerns with regard to the clinical management of this Individual: • Following initial triage on 12/15/2013, there were no specific monitoring parameters documented for nursing staff to assess, and the medical provider did not follow up on the condition through resolution; instead, the medical provider instructed the nurse to have the Individual return if the symptoms did not abate within "a few days". Specific monitoring and follow-up instruction should have been documented. • As part of the evaluation on 12/18/2013, the medical provider documented that an x-ray would be obtained to "rule out pneumonia", and then documented "if symptoms not resolved or getting worse, refer back to sick call". In this case, given a possible concern for pneumonia, specific monitoring parameters should have been documented, and follow-up for re-evaluation should have been documented as well. • Following review of the lung x-ray report, the medical provider indicated an assessment of "left lung base atelectasis", and provided instructions for the nursing staff encourage client mobility, deep breathing exercises but did not document that the Individual was evaluated by the medical provider. Furthermore, the medical provider did not document a date for the Individual to be re-evaluated, but instructed nursing staff to "continue medical monitoring for resolution of symptoms and /or worsening of symptoms refer back to sick call". In this particular situation, "probable atelectasis" may suggest underlying pneumonia, and the medical provider should have regularly re-evaluated the	

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		Individual through full resolution, and not depended on nursing staff to assess for clinical resolution. Individual #239: The Individual was evaluated by the medical provider on 11/27/2013 for continuing cough and sore throat. Physical assessment documented normal vital signs and normal O2 saturation. In addition, lungs sounds were normal and the posterior pharyngeal wall demonstrated mild erythema but otherwise normal tonsils. A diagnosis of viral pharyngitis was determined. Specific monitoring parameters were not documented, and there was no follow-up date documented for the medical provider to re-evaluate the issue through resolution; the follow-up instructions stated "follow up as needed". Although there was a diagnosis of viral pharyngitis, there were no instruction provided to help mitigate exposure of other Individuals to this infection. Subsequently, the Individual was re-evaluated by the medical provider on 12/3/2013, and the assessment indicated that the pharyngitis had resolved. The Monitoring Team has the following concerns regarding the clinical management of this Individual: • The medical provider should document specific monitoring and reporting parameters for staff'. • The medical provider should document specific follow-up instructions through full resolution of an acute medical condition, which was not documented on the 11/27/2013 IPN. • In the event of a potential infectious illness, such as pharyngitis, the medical provider should provide instructions to help mitigate transmission of the infectious agent. Summary: The Medical providers documented clinical contacts in SOAP format, and all medical provider IPNs reviewed were legible and dictated. Seventy percent of the examples reviewed indicated a follow-up date for the medical provider to re-evaluate the Individual through full resolution of the acute conditions. In no cases did the medical provider document specific monitoring and reporting parameters for staff to follow. In cases involving suspected infectious conditions, there was no documentation instructing staff to implement precautions to help mitigate the spread of infections. Management of suspected pneumonia should be enhanced by ensuring regular follow-up, and better understanding of the limitation of chest x-rays when diagnosing or ruling out suspected pneumonia. <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:	

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		• 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 #195, #368, #346, #529, #483): 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 Facility provided a list of all fractures that occurred during the reporting period that indicated a total of eight fractures: • Long bones: 2 • Clavicle: 1 • Digits: 5 The following is a summary of the Monitoring Team's findings for the document reviewed for the last five Individuals on the list of fractures that occurred during the reporting period: • 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 four out of five cases (80%), the medical provider assessed the individual for osteoporosis, and prescribed pharmacological treatment as necessary. • In one out of five cases (20%), the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture. • In zero out of five cases (0%), PT/OT documented a comprehensive assessment of all risk factors for fall, and fracture.	

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		• In one out of five cases (20%), the IRFF documented 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 some comments, and concerns for four of the five examples reviewed: Individual #195: The Individual sustained a displaced fracture to the left clavicle after falling from her wheelchair on 12/2/2013. The ISP, dated 10/9/2013 identified that the Individual was experiencing an increased rate of "bumping into things" while in the wheelchair; however, there was no evidence indicating that this issue was readdressed by the IDT, PT/OT, or the medical provider. The Individual has multiple risk factors for falls and fractures, including treatment for low vitamin D, significant cataracts and the need for bifocal glasses; medication that can promote falls and low bone density, seizure disorder, spasticity, contractures, and hemiparesis. Despite the numerous risk factors, the Facility documented on the IRRF that the Individual had a low risk for falls and medium risk for fracture. The annual medical assessment, and the annual OT/PT report did not document a risk for potential fractures, despite the known risks, and the medical action plan did not include a plan to help mitigate fractures. For example, the medical plan should have considered the potential for low bone mass, as well as document all of the other risk factors noted, and ensured that this information was clearly communicated to the IDt, and that the IDT developed enhanced precautions for the Individual. Individual #346: Not all associated risks for fractures were documented, including medications, seizure disorder, maladaptive behaviors, diagnosis of osteopenia, and low vitamin D levels. There was no evidence that the Individual was on preventative medications, such as appropriate dosage of calcium. Furthermore, the IRRF had not been updated secondary to the fracture, and indicated a low risk for fractures, despite the number of risk factors identified by the Monitoring Team. Individual #529: The Monitoring Team noted that the annual medical summary, dated 9/18/2013, documented a diagnosis of "hairline fracture of the posterior tibia", secondary to a fracture that occurred on the day prior to completing the annual summary. The Monitoring Team was pleased to note that the medical provider documented the Individual's osteoporosis diagnosis as a specific risk for fracture, under the action plan for osteoporosis. Additionally, the action plan documented that the IDT would be notified and an interdisciplinary approach to the management of osteoporosis, such as fall precautions, no PMAB, basket hold, or horizontal hold, among other specific supports. Although PT/OT assessed the fracture, and included the diagnosis of the	

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		fracture on the annual PT/OT assessment, the annual PT/OT assessment did not document issues related to risk factors associated with possible future fractures. In this case, the Individual is being treated for osteoporosis and has a history of a fracture; the PT/OT assessment should address these risks, and as delineated by the medical provider, specify, develop and implement necessary precautions. Individual #483: The Medical provider documented osteoporosis as a risk factor for fracture, and delineated a specific action plan for this particular risk factor. The action plan was comprehensive and indicated that the IDT would address risk and develop specific plans to help minimize the risk of fracture, secondary to this particular risk. The Individual, however, has multiple risk factors for fractures, including seizure disorder, medications that can cause low bone density and affect balance, diagnosis of ataxia, a history of multiple fractures in the past, and degenerative joint disease of the knees and vertebrae. A comprehensive medical action plan should have been developed specific for fall and fracture prevention, based on all known risk factors. Summary: The Facility provides excellent medical care of reported and identified fractures, as based on the Monitoring Team's assessment of the initial medical triage and medical follow-up of fractures. In addition, the Facility ensures that appropriate diagnostics and consultations are obtained, as clinically indicated. The Facility should continue to enhance its identification of risk factors for fractures and falls, and ensure all necessary supports and services are in place. Medical providers, physical therapists, and occupational therapists must ensure that they identify all associated risks for falls and fractures, and develop an interdisciplinary approach to help minimize falls and fractures. <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 report • For all individuals diagnosed with intractable seizures (Individuals #475, #712, #130, #402, and #133): o Annual medical summary	

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		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 providers' 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 Monitoring Team specifically requested the above listed documents for individuals who experienced the following issues; however, the Monitoring Team was only provided one example, Individual #666: 1. From the list of all Individuals who have diagnosis of seizure disorder, the first five individuals who experienced episode of status epilepticus during this reporting period. If no individual experienced status epilepticus, then select from individuals who experienced at least one seizure event during the reporting period. 2. For the last five individuals on the list of individuals with VNS, please provide a. Most recent interrogation report for the VNS device The Facility reported that 123 individuals were diagnosed with a seizure disorder, one individual experienced an episode of status epileptics during the reporting period, six individuals were reported to have refractory epilepsy, and 11 individuals had a VNS implanted. The following is the Monitoring Team's summary of its document review of seizure management (Individual #666): • Zero out of one examples (0%) included an accurate diagnosis for the seizure disorder. • One out of one examples (100%) included a clinically appropriate medical action plan on the annual medical summary. • One out of the one examples (100%) 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. • For one out of one examples (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	

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		comprehensive SOAP note that included relevant subjective information, an assessment of the individual, a clinical assessment, and a clinically appropriate medical action plan. • There were no examples of interrogation reports provided for the 11 individuals who had a VNS implant. Individual #666: Review of the current annual medical summary indicated that the active problem list documented seizure disorder, and did not document the specific type of seizure disorder. In this example, the neurologist indicated that the diagnosis was Epilepsy, generalized, tonic/clinic. The Monitoring Team noted an exceptional medical action plan that was developed for the Individual's seizure condition. The action plan reviewed recent diagnostics, medication management, incidence of seizures, follow-up with neurologist, and indicated the need for the IDT to provide specific supports and services, such as monitoring for possible behavioral issues related to seizures, and the need to enhance fall risk assessment, as well as to enhance direct care staff training so they would better understand the Individual's seizure related condition. The Monitoring Team noted exceptional documentation of follow-up for seizure related issues. Although the IRRF did not address falls as a risk factor for seizures, and was not updated to include the medical provider's current recommendations, the IRRF did include an otherwise comprehensive and clinically meaningful list of necessary supports and services for seizure disorder. It would be advantageous if the medical provider would document the clinical rationale for continuing the Individual on Dilantin. The Monitoring Team clearly understand that some individuals require ongoing treatment with this drug, but there should be documentation as to why Dilantin is continued. In general, the medical provider demonstrated close and clinically appropriate follow-up to the Individual's seizure condition. Summary: The Monitoring Team was provided one, out of five examples requested, and was not provided with VNS interrogation reports. The one example provided for review did provided clinically appropriate level of medical follow-up, and medical action plan. The Monitoring Team does recommend that medical action plans include a review of fall risks associated with seizure disorder, assess efficacy of medications used to treat seizures, document the clinical rationale for the continued use of older anticonvulsants such as Dilantin and phenobarbital, and document a review of the seizure log. <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	

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		• The first five individuals on the list of all individuals who experienced five or more cases of pneumonia with in the past five years (Individual's #666, #523, #351, #192, and #84): o Most recent annual medical summary o All quarterly physician reviews for the reporting period 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 (Individual's #666, #523, #351, #192, and #84): • Assessment of the initial and follow-up acute care of pneumonia was not reviewed for this review period. • One out five examples (20%) indicated a specific, and clinically appropriate action plan for recurrent pneumonia. • Two out of five examples (40%) 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, such as review and assessment of efficacy of supports and services for recurrent pneumonia. • 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. Because of the incidence of recurrent pneumonia at the Facility, the Monitoring Team included a review of associated IRRFs, and PT/OT assessments: • One out of five (20%) PT/OT assessments reviewed, included a clinically appropriate, and comprehensive review of risks, and associated supports and services for aspiration pneumonia. • Zero out of five (0%) IRRF assessments included a clinically appropriate risk assessments for aspiration pneumonia. For example, the most recent IRRF for Individual #351 did not indicate risk factors for respiratory risks, despite the Individual having a diagnosis of a pulmonary nodule, which was identified by CT	

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		prior to the development of the IRRF, and underlying pulmonary fibrosis was also not listed as a risk factor. To help the Facility better appreciate the Monitoring Team's concern, the Monitoring Team offers the following comments, concerns, and suggestions, for the management of pneumonia, based on review of documents provided by the Facility: Individual #84: The most recent annual medical summary, dated 1/29/2014, did not list a past history of pneumonia for dates indicated on the Facility's tracking data of pneumonia. For example, a copy of the pneumonia database indicated diagnosis for pneumonia on 1/6/2011, 6/12/2011, 6/30/2011, and 8/1/2013; however the past medical diagnosis did not list these cases of pneumonia.. This discrepancy is significant, and the Facility must ensure accurate reporting of pneumonia. The Individual remains at significant risk for aspiration pneumonia, secondary to underlying medical conditions, including a large hiatal hernia and "failed fundoplication" procedure, cerebral palsy, enteric tube placement, and a statement listed in the medical action plan that the Individual "will continue to have appropriate positioning in an effort to avoid aspiration"; however, there was no diagnosis listed for recurrent aspiration pneumonia, and no specific medical action plan for this serious, life threatening condition. For example, the medical provider should have developed a medical action plan documenting all necessary supports and services necessary to help mitigate recurrent pneumonia, necessary monitoring and reporting parameters for staff to assess for pneumonia, necessary medical follow-up, and assessment of prescribed supports and services to help mitigate pneumonia. The Monitoring Team recognizes that at the time of the annual medical summary, the Individual did not have an active case of aspiration pneumonia; however, because of the significant known risk factors for aspiration pneumonia, and history of recurrent aspiration pneumonia, the diagnosis of recurrent aspiration pneumonia should be listed on the active problem list to ensure the medical provider regularly assesses the individual for this condition, and that an updated and efficacious medical plan is in place. The OT/PT evaluation, dated 3/15/2013, did not list a diagnosis of recurrent pneumonia on the pertinent history, and under the section of respiratory function, listed "did not exhibit signs/symptoms of hypoxia or respiratory distress during assessment". There was no statement about the history of recurrent pneumonias or risk factors for recurrent pneumonia. The OT/PT report indicated that the Individual had three episodes of possible pneumonia in 2012; however, these issues were not listed, or comment on in the annual medical summary; in fact, there were no diagnosis of pneumonia list for 2012 on the current medical summary, or the Facility's pneumonia database. Furthermore, there was no documentation in either of these reports that provided further exploration, or documentation as to the clinical rationale for the reported "possible pneumonia". The OT/PT evaluation also identified the Individual as having gastroparesis and constipation, both of which can manifest in aspiration, and	

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		these two conditions were not listed on the medical summary, or identified as risk factors. The OT/PT assessment did not effectively address all associated risk factors for aspiration pneumonia. For example, the OT/PT assessment should have had a section that identified the severity of aspiration pneumonia, all associated risks, specific supports and services in place, monitoring, and reporting parameters, and assessment of efficacy of supports and services. Following review of the physical nutritional management team (PNMT) note, dated 10/24/2013, which documented the recent incident of pneumonia on 8/1/2013, the Monitoring Team has significant concern over the Facility's management of pneumonia: • The PNMT did not question the diagnosis of "healthcare acquired pneumonia" (HCAP), despite the significant risk factors associated with the episode of pneumonia; in addition to the physician risk factors listed above, the Individual had experienced episodes of emesis prior to the diagnosis of pneumonia and sepsis. • The PNMT listed "recurrent healthcare acquired pneumonia" but did not provide clinical rationale for this diagnosis, and not indicating aspiration risks as at least contributing factors. The term healthcare acquired pneumonia can be misleading to the team, and minimize risks associated with aspiration pneumonia. For Individuals with known, significant risks for aspiration, and frequent recurrent cases of pneumonia, aspiration should always be a primary consideration, unless diagnostic evidence suggests otherwise. • The PNMT documented a series of medical issues, including the diagnosis of bowel ileus, and emesis on 7/13/2013, episode of hypoxia and emesis on 7/23/2013, and diagnosis of right lower lobe pneumonia on 8/1/2013, and did not comment on the probable association of the three issues and aspiration pneumonia • The PNMT analysis of findings did comment on the need to enhance supervision of all transfers, positioning changes, and enteric tube feeding. • The IRRF provided for review did not include a section for pneumonia, or respiratory issues. There were no medical provider IPNs provided to document initial triage or follow-up for the diagnosis of pneumonia, dated 8/1/2013. Individual #192: The Individual has had 8 episodes of diagnosed pneumonia in 2013. The OT/PT assessment, dated 4/30/2013 indicated that the Individual had "two episodes of aspiration pneumonia this year". Review of the Facility's pneumonia database indicated that during a one-year (12 month) time frame, as of the date of the OT/PT assessment, only one case of pneumonia was listed on the database; hence, a discrepancy between reports. The OT/PT assessment indicated various supports and	

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		services, and listed "hospital bed: to help keep head of bed elevated to 20 degrees during lying time, sleep hours. This position helps to reduce the risk of aspiration". There was no assessment documented about the efficacy of this support; furthermore, the OT/PT assessment did not effectively address all associated risk factors for aspiration pneumonia. This information is critical for the medical provider to review, as part of a medical assessment for recurrent pneumonia, in order to make an informed decision regarding medical care. As noted for Individual #84, the medical provider did not include a diagnosis of recurrent aspiration pneumonia, and did not develop a medical action plan for recurrent aspiration pneumonia. There were no progress notes provided for review of the medical provider's initial assessment and triage of the aspiration pneumonia diagnosed on 2/9/2014. The most recent IRRF indicate that the Individual's current status for respiratory compromise was "stable", and that "all supports appear to be effective". There was no evidence, by review of the annual medical summary, OT/PT annual assessment, or PMNT meeting minutes, to indicate a review of all supports and services to help mitigate aspiration pneumonia. The PNMT, dated 2/7/2014, listed that the Individual had a diagnosis of aspiration pneumonia on 11/22/2012; however, the Facility's pneumonia database did not list this episode of pneumonia; furthermore, the pneumonia database indicated a diagnosis of aspiration pneumonia on 12/27/12, which was not listed on the PNMT's review of pneumonia. The Monitoring Team was impressed with the PNMT's assessment of reported non-effective supports associated, under the heading of review of PNMP effectiveness, and noted improvement from previous compliance visit review's with the analysis of findings component of the PNMT assessment for this example. Individual #666: The Monitoring Team noted that the OT/PT assessment, dated 11/26/2013, documented a specific assessment of the efficacy of services and supports and identified recurrent pneumonia as an issue of concern. The assessment documented that current supports and services were ineffective; this is a significant improvement for the Facility. The Facility should continue to enhance this level of review, and ensure that the specific deficiencies identified are listed, and a plan developed to address this issue. The Monitoring Team was extremely impressed by the OT/PT nutritional assessment that clearly identified factors that could be associated with aspiration pneumonia that was diagnosed and listed as "bacterial pneumonia," on the Facility's pneumonia database for 2/14/2013. The OT/PT assessment also indicated a comprehensive review of incidences	

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		on 6/5/2013, and 10/6/2013. Individual #523: The Monitoring Team was pleased to see that the diagnosis of "aspiration syndrome" was listed as a diagnosis for the Individual's recurrent aspiration pneumonias. Also, the Medical provider documented a comprehensive review of aspiration pneumonia, and developed a medical action plan for this condition. The Monitoring Team recommends that the medical providers periodically assess the functionality of all prescribed supports and services, and comment on the efficacy. The IRRF, dated 9/4/2013, indicated that the individual's current status for aspiration was "stable" despite recent episode of pneumonia, and a comment within the text of the IRRF indicating possible aspiration risk. The IRRF had not been revised in response to recent incidences of pneumonia. There was no updated PNMT assessment provided for review for the 2/28/2014, and 1/17/2014, cases of reported aspiration pneumonia; in fact, the most recent PNMT assessment was from 10/17/2012, for a review of a 6/12/2012 referral for pneumonia. Summary. The Monitoring Team noted some improvement with the Facility's effort to help mitigate recurrent pneumonia. For example, some of the OT/PT assessments and PNMT assessments demonstrated a much better review of risks associated with pneumonia, and assessment of supports and services to help mitigate recurrent pneumonia. There was one example of an annual medical assessment documenting a comprehensive medical action plan for aspiration pneumonia, and listing aspiration syndrome as a diagnosis; however, the majority of examples reviewed did not demonstrate this level of management. The Facility must continue to enhance its efforts to help mitigate recurrent pneumonia. <u>Review of medical diagnoses</u> For treatment decisions to be made based on accurate information, both by clinicians and by the IDT, the information must be consistent both with assessments and history and across the record. The Monitoring Team, upon reviewing the most recent annual medical assessments, found numerous instances of inconsistencies among diagnoses and assessments. These included: • Individual #666: o Had cervical spinal fusion, but it was not listed as an active diagnosis on the active problem list. This condition requires regular assessment by the medical provider, and the development of a specific medical action plan, and an action plan was not evident. o Diagnosed by optometrist with Myopia and astigmatism, but this	

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		condition was not listed on active problem list. o Had testicle removed secondary to testicular torsion, but no diagnosis for monorchism was listed on the active problem list. • Individual #133: Diagnosed with seizure disorder, and the specific diagnosis, which the neurologist as determined epilepsy, tonic/clonic, was not listed on the active problem list. It is important to list the specific type of seizure disorder. • Individual #149 was reported to have had a DNR order in place. The order was not signed, and there was no evidence that a medical physician had assessed for a qualifying diagnosis for the DNR order. • Individual #351: A diagnostic study in 2012 indicated degenerative spine disease; however, there was no diagnosis listed for this condition on the active problem list. The medical provider must regularly assess degenerative spine disease, and a specific action plan must be developed and implemented. • Individual #192: o An optometrist diagnosed cataracts, however, this condition was not listed on the active problem list, and there was no medical action plan developed for this condition. o Cervical spine arthropathy was noted on CT scan of the spine, on 2012, during an emergency room evaluation. This condition was not listed on the active problem list. o The Individual has significant risks for aspiration pneumonia, and had been hospitalized for recurrent aspiration pneumonia; however, recurrent aspiration pneumonia was not listed on the active problem list. The Monitoring Team recognizes that at the time of the annual medical summary, the Individual did not have an active case of aspiration pneumonia; nevertheless, because of the significant known risk factors for aspiration pneumonia and history of recurrent aspiration pneumonia, the diagnosis of recurrent aspiration pneumonia, should be listed on the active problem list because the medical provider must regularly assess the individual for this condition, and ensure that an updated and efficacious medical plan is in place. • Individual #84: o A CT report in 2012 documented cervical osteophytes, and this diagnosis was not listed on the active problem list. o Pulmonary fibrosis was identified on 2012 CT, but this diagnosis was not listed on the active problem list, and there was no evidence to indicate resolution. Furthermore, pulmonary fibrosis of the lung is generally a chronic condition, secondary to underlying pathology, such as recurrent pneumonia and must be periodically assessed by the medical provider.	

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		o The Individual was diagnosed with a "large hiatal hernia" in 2004, but hiatal hernia was not listed on the active problem list. Furthermore, it was noted that the Individual had a history of a "failed fundoplication"; hence, the Individual remains at risk, secondary to the hiatal hernia. o The Individual had significant risks for aspiration pneumonia, and had been hospitalized for recurrent aspiration pneumonia, but recurrent aspiration pneumonia was not listed on the active problem list. The Monitoring Team recognizes that at the time of the annual medical summary, the Individual did not have an active case of aspiration pneumonia; nevertheless, as noted above for Individual #192, because of the significant known risk factors for aspiration pneumonia, and history of recurrent aspiration pneumonia, the diagnosis of recurrent aspiration pneumonia should be listed on the active problem list because the medical provider must regularly assess the individual for this condition, and ensure that an updated and efficacious medical plan is in place. o The medical assessment, as listed under the medical action plan for cerebral palsy, indicated a diagnosis of spasticity and contractures, however, neither of these conditions were listed on the active problem list. o The OT/PT assessment, dated 3/15/2013 indicated that the Individual had scoliosis, constipation, and gastroparesis, however, neither of these three conditions were listed on the active problem list, and there was no medical action plan developed such conditions. o The PNMT assessment, dated 2/28/2014, documented spina bifida as diagnosis; however, spina bifida was not listed on the active problem list. Summary: The Facility must ensure that the active problem list accurately reflects all known diagnoses, and conditions that require regular assessment by the medical provider. In addition, all medical diagnoses must have a clinically appropriate medical action plan. Conclusion: The Monitoring Team determined noncompliance with Section L.1. The Facility showed some improvements in the area of follow-up to acute care issues and medical provider documentation, must continue to enhance the management of chronic conditions, such as seizure disorder, and must ensure all medical conditions that are active, and/or require regular monitoring by the medical provider, are listed on the active problem list. Medical providers must also develop, implement and assess necessary supports and services for	

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		diagnosed medical conditions, and ensure that direct care and nurse staff are made aware of specific monitoring and reporting parameters for conditions that require specific, and/or close monitoring. Although the medical provider provides good medical triage and follow-up for acute fractures, medical providers must better identify risk factors for fractures.	
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 8 • Clinical pathway tools • Clinical pathway audits for round 8 • All QA/QI follow-up to action plans for the clinical performance audits, and the medical audits for round 8 <u>External medical review</u> A physician that was external to the Facility conducted round eight of the external medical reviews on 9/1/2013 through 9/13/2013. Specific clinical indicators assessed for this review included constipation, seizure, and UTI. The clinical records of 19 individuals were randomly selected by a computer software program, and used for the review process. For round 8, there were six practicing medical providers at the Facility, and all six 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: • Zero out of six medical providers (0%) received a score of 100% for essential elements. • Six out of six medical providers (100%) received a score of 80% or greater for	Noncompliance

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		non-essential elements. • Zero out of six medical providers (0%) received a score of 100% for medical management reviews. • For the three medical management reviews o Constipation had a cumulative score of 92% for all six medical providers. o Seizures had a cumulative score of 87% for all six medical providers. o UTI had a cumulative score of 87% for all six medical providers. These conditions differed from those reviewed in round seven (diabetes, osteoporosis, and pneumonia), so a direct comparison cannot be made. At the round seven review, cumulative scores for five medical providers were 94% for diabetes, 76% for osteoporosis, and 67% for pneumonia. 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 42 essential and non-essential action plans were developed for the six medical providers, and, at the time of the Monitoring Team's on-site compliance review, 36 out of 42 action plans (86%) were completed, per review of the Action Plan Follow-Up by QA report, found in the presentation book. • A total of five medical management action plans were developed; four out of five action plans (80%) were completed. Review of the 15 medical management elements, that covered all three diagnoses assessed for round eight of the medical audit process, indicated there were no examples of questions to determine if the provider assessed for the underlying etiology of a medical conditions, or documented efficacy of treatment. 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 assessed, by assessing the medical provider's treatment of a condition compared with current standard of care guidelines. Furthermore, the medical management component of the medical providers audit process consisted of 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. At the time of this review there was no documented evidence provided to demonstrate that the DADs medical audit process developed indicators for additional medical conditions. The summary report developed by the external physician who conducted round 8 of the external reviews, dated 9/16/2013, was not signed by the reviewing physician. The	

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		report was based solely on the findings of the medical review process. The external reviewing physician delineated 13 areas that needed improvement, including: o Better documentation of resolution of active medical problems o MMR documentation if status unknown o Abnormal lab results with chronic problems such as anemia or low anticonvulsant levels not addressed in IPN o Several acute conditions such as otitis media or conjunctivitis requiring antibiotic therapy not documented in IPN o Diagnosis on APL occasionally missing from discussion in annual plan of care o Several charts required a more complete plan of care for individuals' chronic conditions. o Physician's comment on IDT referral but their presence or signature was not present in IDT notes o Additional emphasis in younger residents on preserving functional status o Residents with cerebral palsy or Down syndrome deserve further attention to potential medical issues associated with these conditions. o Consultants recommended six month follow up for resident ongoing problems but no documentation of visit scheduled or occurring o Acknowledgement IPN by medical staff of nursing care for ongoing wounds or dietary issues o Medical staff required further comment on whether chronic conditions and imaging studies such as osteoporosis and DEXA scan are improving. Following the Monitoring Team's review of the external physician's list of areas that needed improvement, and its review of documents provided for Section L.1 of this report, the Monitoring Team concurs with the issues identified as needing improvement that were identified by the external physician reviewer, and strongly encourages the Facility to address these deficiencies prior to the next Compliance review. Summary: The Monitoring Team concurs with the external medical auditor's list of areas that need improvement. As with previous compliance visits, the Monitoring Team did not identify further development of the external medical management component of the medical audit process. The Facility must enhance the medical audit process by ensuring that additional 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. The Monitoring Team strongly recommends that the Facility address all areas needing improvement, as documented in the statement by the external physician who conducting the audit for round eight, prior to the next Compliance visit.	

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		Mortality Review Process: The Monitoring Team assessed the Facility process for conducting its mortality reviews of deaths that occurred at the Facility, by reviewing current policies and procedures, conducting a meeting with members of the mortality review committee, reviewing recommendations made by the mortality review committee to enhance system issues, and by reviewing the clinical record of Individual #99. Death Review Policies: • RSSLC Administration Policy A.7, Actions Following Death of Individual Served, Revised: 10/10/12 • RSSLC Policy: Addendum to the Death Review Policy (Draft), 12/11/13 Since the last compliance review, the Facility had developed an Addendum to the Death Review Policy that was still in draft pending approval. The purpose of the addendum was to provide an outline to guide the discussion during the Clinical Death review, Administrative Review, and Morbidity and Mortality Review in order to ensure that there was a comprehensive understanding of the cause of death, examine enhancements to support services that could improve the overall care of the individual, and conduct analysis of longitudinal data related to deaths in order to track and trend systemic issues and to develop corrective actions plans. It was positive to find, as was recommended in previous compliance reviews, the addendum included 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. In addition, the addendum included instructions for the Morbidity and Mortality Review Committee to meet every six months to review longitudinal data related to deaths to track and trend systemic issues, develop corrective action plans, and determine the efficacy of the corrective actions. The addendum included a required list of disciplines to attend the Clinical and Administrative Death Reviews and Morbidity and Mortality Committees. Medical Records will maintain the Death Review Database and provide data for discussion at the Morbidity and Mortality Review. The addendum was still in draft awaiting approval. The Monitoring Team will follow up on the approval and implementation of the Addendum to the Death Review Policy (Draft) at the next compliance review. Monitoring Team's Review of Death: Since the last compliance review, no deaths had occurred at the Facility. Mortality review for Individual #99, whose death occurred in the prior six months, had not been completed at the time of the last compliance review. On 3/6/14, the Monitoring Team	

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		met with the Medical Director, CNE, NOO, Hospital Liaison Nurse, QA Nurses, and Medical Records Director and reviewed the circumstance surrounding Individual #99's death, reviewed system improvement recommendations secondary to the mortality review, and reviewed the Individual's clinical record. The Monitoring Teams' review of supporting documentation of Individual #99's death showed that the Actions Following Death of Individual Served Policy's required procedures and timelines were followed. A review of the Death Review Investigation – Nursing Services conducted by the QA Nurse identified areas needed for improvement in Nursing and Residential Services and made appropriate recommendations. The QA Department provided a Clinical and Administrative Death Review Committee Recommendation Tracking Data and Follow-up Report from Individual #99's death review. A review of the recommendations found they were clearly stated in objective and measurable terms, identifying the responsible staff for carrying out the recommendation with specific timelines for completion. Of the thirteen recommendations, the report showed that ten of the thirteen (77%) recommendations had been completed according to the designated timelines. Three recommendations were not completed, i.e. two recommendations for Residential Services and one for Nursing Services. There was documentation that the QA Department followed-up and verified the ten recommendations were carried out as described. However, there was no documentation included related to the delinquent recommendations, of which two were due on 9/30/13 and one due on 10/3/13. The Facility should ensure these recommendations are completed as soon as possible. There were no recommendations made for Medical Services. Following review of the clinical record, and discussion with the members of the mortality review committee, the Monitoring Team noted several areas that should have been addressed by the mortality review. These issues were discussed with the members of the mortality review committee, including the medical director. The Monitoring Team's review of general findings for Individual #99's death on 7/22/13, included: • Individual #99 was a 48 year old male, diagnosed with profound mental retardation, osteoporosis, dyslipidemia, GERD, hypothyroidism, multi-infarct dementia, schizoaffective disorder, short gut syndrome, and osteoarthritis. The Texas Department of State Health Services Vital Statistics Unit listed the immediate cause of death as pneumonia with an underlying cause as sepsis shock. Individual #99 expired at the hospital. The Do Not Resuscitate (DNR) status prior to illness/incident was for full code. The DNR status at the time of death was for DNR. The manner of death was listed as natural. Individual #99 received enteral nourishment by gastrostomy tube. Review of the Individual's clinical record indicated several medical issues, included weight loss and abnormal laboratory	

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		findings, which were not assertively addressed within the context of the medical provider's IPNs. In addition, the Monitoring Team was concerned over the specific type of imaging diagnostics ordered, and members of the mortality review committee were unable to address the Monitoring Team's concerns by offering the clinical rationale for the diagnostics ordered. <u>Summary</u> The State had not yet revised the Death Review Policy. When the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care. The Facility did not develop system improvement action plans for issues related to medical care; thus, the Monitoring Team strongly recommends that the Facility conduct more detailed clinical reviews, that include retrospective review of clinical care provided for recent acute, and all chronic care issues, in addition to the circumstances at the time of death. The Monitoring Team is aware that the Facility has developed a clinical indicator that will be incorporated into the Facility medical QA process, and the Monitoring Team hopes that this new medical QA process will enhance future mortality reviews. <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. For these reasons, the Monitoring Team has determined that the Facility is not in compliance with Section L.2.	
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	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>Clinical performance audits</u> To enhance the Facility's assessment of medical providers' clinical performance, the Facility developed an additional assessment measure, called clinical performance audits;	Substantial Compliance

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	action; and monitors to ensure that remedies are achieved.	this 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 initiated for issues noted to be deficient; the Facility had evidence that they had followed up to ensure completion of developed actions for deficient areas. 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; the clinical performance audit policy, dated 9/27/2014, 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 The process follows the same format as the DADS central office internal and external medical audit, but the Facility developed clinical pathways to enhance the state's medical management indicators. Furthermore, the clinical performance audits are completed by	

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		the same reviewing physician, and at the same time, as the DADs internal and external medical audits. Each review period, three clinical indicators are chosen at random by a computer program, and each provider is assessed based on the same set of clinical indicators. Based on compliance, a score is generated. "Passing" scores have not been determined; however, medical providers are informed of the results, and action plans are developed, which requires each medical provider to rectify identified deficiencies. The Facility conducted an internal clinical performance audit, for each medical provider at the Facility on 12/16/2013. This audit assessed each of the medical providers on hypertension, management of GERD, and dyslipidemia. Each audit was conducted by an assigned Facility physician auditor, who completed a chart review for each of the three clinical pathways that were determined for this internal clinical performance audit. Each of the six medical providers was assessed and provided a score for each clinical pathway assessed. The medical providers generated a total score, known as a compliance rate per diagnosis of: o Hypertension: 63.9% o GERD: 63.9% o Dyslipidemia: 63.9% A total of 37 action plans were developed to address each deficient clinical pathway identified. At the time of this compliance review, 100% of the action plans were completed. <u>Internal medical reviews</u> Round eight of the internal medical reviews was conducted on 9/12/2013 and 9/13/2013, using the same format as the external medical reviews, as denoted in Section L.2, of this report. An assigned medical provider who worked at the Facility completed each clinical indicator. Specific medical management indicators assessed for this review, Round 8, included constipation, UTIs, and seizure disorder. The clinical records of 28 randomly selected individuals were randomly selected by a computer software program, and used for the review process. All six 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% 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	

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		The outcome of the internal medical reviews for round eight was as follows: • Four out of six medical providers (67%) received a score of 100% for essential elements. Although this is not consistent with the findings of the external medical review, two issues make it difficult to discern whether there was truly a discrepancy. First, the samples of individuals reviewed were different. Second, these reviews report the percent of medical providers who achieve a score of 100% but do not report the actual percentages; thus, a single deficiency on all the items for several sampled individuals could result in less than a 100% score. The Facility should identify when there is a possible discrepancy between internal and external reviews, and then review to determine the reasons for the possible discrepancy. • Six out of six medical providers (100%) received a score of 80% or greater for non-essential elements. • For the three medical management reviews o Constipation had a cumulative score of 75% for all seven medical providers. o UTIs had a cumulative score of 83% for all five medical providers. o Seizures had a cumulative score of 100% 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 29 action plans were assigned to the medical providers, and at the time of this compliance review 27 out of 29 (91%) had been completed. 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, and the reader is referred to external medical reviews, above, for details. The Facility's development of an independent process to enhance the DAD's medical audit process is advantageous because the process incorporates clinical indicators for many known and serious medical conditions that occur with in the developmental disability setting, and include an assessment of outcome data. The indicators assess actual efficacy of treatment by the medical provider. For example, the clinical indicator for diabetes assesses results of HgA1C, lipids, blood pressure, and urine protein levels, among many other such outcome data. <u>Data-based Quality Assurance Process</u> Provision L3 requires the Facility to implement a medical quality assurance (QA) process that collects data, assesses data for trends, initiates corrective action plans when necessary, and monitors to ensure that remedies are achieved. To assess the Facility's	

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		effort towards compliance for Provision L3, the Monitoring Team reviewed the following documentation: • Chronic Clinical Indicators Policy, revised 8/20/2013 • Healthcare Trend Report and action plans, that were presented to QA/QI Council Policy o Urinary tract infections, October 2013 and January 2014 o Medical follow-up, December 2013 o Diabetes, November 2013 o Pneumonia, October 2013 • Database elements for diabetes, osteoporosis, neuromotor and musculoskeletal conditions, UTIs, pneumonia, and medical follow-up. • RSSLC QA/QI Meeting Minutes for 11/26/2013 and 12/3/2013 • 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 audits 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 continued to develop clinically meaningful clinical indicators since the last compliance review, ensured tracking and trending of clinical indicator data, and developed efficacious action plans to address deficiencies. Each clinical indicator contain many different elements to help assess outcome of clinical care at the Facility. Specific indicators were developed for: • Diabetes Mellitus • Osteoporosis • Developmental Disability Healthcare Screening • Neuromotor/Musculoskeletal • UTI • Pneumonia • Medical Consultation Follow-up • Mortality Review • Chronic care	

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		Also, as reported in the last compliance report, the Facility enhanced its medical follow-up indicator to include assessment of the medical providers' participation at interdisciplinary team (IDT) meetings. All nine clinical indicators were reviewed by the Monitoring Team, and determined to be clinically relevant. Review of 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, and it was evident that the medical director had continued to develop two new indicators, including an indicator for developmental disability healthcare screening and a mortality review indicator, as well as enhanced the previously developed indicator for medical follow-up. 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 The newly developed disability healthcare screening indicator assesses if routine healthcare issues were appropriately evaluated by the medical provider, such as: • Vital signs • Vision/hearing/dental • Osteoporosis • Assessment for diabetes, osteoporosis, lipidemia • Immunizations, including Hepatitis, varicella, TDap, MMR, Pneumococcal, influenza, and polio • Colon, breast, testicular, and prostate cancer screening • Routine laboratory assessments In addition, the new clinical indicator for developmental disability healthcare indicator also assesses if the medical director provided specific screening for common developmental disabilities, including: • Cerebral palsy • Tuberous Sclerosis	

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		• Neurofibromatosis • Cri Du Chat Syndrome • Down's Syndrome • Prader-Willi Syndrome • Rett Syndrome The Monitoring Team is extremely impressed with the extensiveness of the clinical indicators and with the related databases. Clinical indicator trends analysis: The medical director reviews trends data for medical indicators monthly, and develops a report that is shared and discussed with the medical staff at regularly scheduled medical staff meetings; she also provides a healthcare trends report for review by the Facility's QA/QI department. A trends analysis, and review and report to the medical staff, and Facility's QA/QI department will occur regularly throughout the year: • Medical follow-up, diabetes, and pneumonia are scheduled to be assessed every six months. • Mortality review, developmental disabilities healthcare screening. neuromotor/musculoskeletal, osteoporosis, medical follow-up, and medical provider participation at IDT meetings are scheduled to be completed annually. • Current action plans are assessed for efficacy every six months, and are followed by the Facility's QA/QI department, as well as the medical director. During the reporting period, database elements and trends data were reviewed for five of the 10 clinical indicators: diabetes, urinary track infections, pneumonia, medical follow-up, and mortality review. The following is a summary of three trends analyses completed by the medical director, and reported on the healthcare trends report: • Review of data, and trends analysis for the newly developed mortality review indicator: Data, and trends analysis, was conducted for all deaths that occurred beginning January 2013 through December 2013. The data indicated a total of six deaths. On 2/28/2014, a trends analysis meeting was conducted; participants included medical, nursing, habilitation, residential, pharmacy, and medical QA staff. The Monitoring Team reviewed minutes of this meeting. The minutes reflected that there was a decrease from ten to six deaths between 2012 and 2013, and reflected that pneumonia and sepsis were the two etiologies resulting in all six reported deaths. The minutes reflected a review of age, living area, and underlying risk factors, and concluded that the deaths were associated with the medical fragile unit, all individuals were age 50 or over, and that enteral tube feeding was the primary risk factor associated with the deaths. The Facility developed three action plans to help reduce sepsis and pneumonia at the	

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		Facility, which included: o Installation of air scrubbers and UVC light coils to reduce airborne pathogens at the living area. o Enhance sterile technique for venipuncture. o Enhance habilitation services by assigning daily monitors to make observational assessments on specific units to check for proper positioning. Efficacy of the action plans will be assessed in six months, and a report to the Facility's QA/QI department will be issued at the next QA/QI meeting. • Review of data, and trends analysis for pneumonia: The Facility conducted a trends analysis meeting on 2/20/2014. Participants included medical, nursing, habilitation, residential, pharmacy, and medical QA staff. The Monitoring Team reviewed minutes of the meeting. The data included a review of all cases of pneumonia between February 2012 and February 2014. There were 44 incidences of pneumonia documented during this period. The data tracked pneumonia by type (aspiration 18, bacterial 22, viral 3, and unknown 1), as well as by each living area. The analysis also reviewed underlying etiology, such as diagnosis of dysphagia, the use of enteral feeding tubes, food texture, the method of enteral tube feeding such as bolus or continuous feeding, and monthly incidence rate of pneumonia. Following its review, the Facility determined that the following contributing factors may have placed individuals at risk for possible pneumonia: o Recent construction at a particular living area, which reduced the number of available bathrooms o The relationship of emesis to other medical conditions, such as to sepsis secondary to UTIs o Positioning issues associated with enteral tube feeding o Enteral tube migration, resulting in aspiration. Subsequently, the following action plans were developed: o Nursing staff to more assertively ensure appropriate placement of enteral tubes o Assertively address other causes of sepsis, including UTIs o Habilitation services to enhance observational assessment for proper positioning of individuals with enteral tubes. In addition, the Facility had followed up on previous action plans developed to help reduce the incidence of pneumonia: o The action plan for ensuring that appropriate administration of pneumococcal vaccination had demonstrated efficacy. During the past 12 months, 26 individuals known to have had recurrent pneumonia and who had been vaccinated in 2012, did not develop pneumonia in 2013. o The Facility's Vest therapy program, which was implemented in July	

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		2013, and piloted with 13 individuals who had high rates of respiratory infections, was assessed. Five individuals had experienced an episode of pneumonia during the past six months; the Facility, however, indicated that it will need to continue to evaluate this action plan for possible efficacy over the next six month period. Medical QA action plans: in collaboration with the Facility's QA/QI department, the medical department develops specific action plans for specific clinical indications and system issues, when necessary. During this reporting period, action plans were developed for the five medical indicators assessed (diabetes, urinary tract infections, pneumonia, medical follow-up, and mortality review), and follow-up of action plans was done. The following is a summary of action plans developed to help reduce urinary tract infections, and to reduce pneumonia, that occurred during this review period: • Action plan for urinary tract infections (UTIs): The healthcare trends report to the Facility's QA/QI report, dated February 2013, documented comprehensive review of database elements for UTIs. Incidence of UTIs for quarter three, 7/1/2013 through 9/30/2013, was compared to incidence of UTIs for quarter four, 10/2/2013 through 12/31/2013. Of the two units that had been identified at previous medical QA reviews, there was a marked decrease in the number of UTIs at these units: o Living area Trinity B: 13 incidences of UTIs in quarter 3, compared to 5 incidences of UTIs in quarter 4, which was a 62% reduction in UTIs. o Living area Trinity A: 7 incidences of UTIs in quarter 3, compared to 5 incidences of UTIs in quarter 4, which was a 29% reduction in UTIs. The Facility's QA department, in collaboration with the medical department, completed a corrective action plan summary report for UTIs, dated 2/19/2014, that indicated the completion status of each action plan, and reported that the overall reduction in UTIs was a result of the Facility's medical QA/QI process, and the use of the UTI indicator. The specific action plans used to address recurrent UTIs included: o Develop a work group to discuss factors associated with UTIs, and follow-up on UTI trends at the Facility. o Develop and implement a policy to promote reduction of UTIs at the Facility, which was completed on 11/2/2013. o Develop and implement a urinary incontinent brief check and change policy. This issue was completed by evidence of staff training sheets that were completed for the Trinity living area. o Enhanced identification and treatment of renal lithiasis. This issue was completed, by evidence consultation referrals to urologists for further evaluation and treatment of renal lithiasis. o Enhanced hygiene practice by staff. This issue was completed by	

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		evidence of staff training sheets from Trinity living area. In addition to assessing efficacy of previously developed action plans, the Facility developed additional new action plans, to help further reduce the incidence of UTIs: o Development of a pilot project to promote hydration o Enhance identification of causative organisms o Expand the incontinent brief check and change policy from Trinity living area, to all living areas. It should be noted that although the QA department worked collaboratively with the medical department, and helped to evaluate and report on the effectiveness of previous action plans for UTIs, as evident by the corrective action plans summary report by the QA department, dated 2/19/2014, the current findings have not yet been presented the QA/QI Council meeting, but are expected to be presented in late March 2014. • Medical QA review of action plans to address diabetes mellitus: The Monitoring Team reviewed the QA/QI meeting minutes dated 11/26/2013, which documented a review of health trends for diabetes. The minutes indicated that three individuals were diagnosed with Type I diabetes, and 18 individuals were diagnosed with Type II diabetes. The minutes also reflected the following monitoring parameters: o Hemoglobin A1C ▪ 15 out of the 21 individuals with diabetes had well-controlled hemoglobin A1C, of less than 7. o LDL cholesterol ▪ 2 of the 21 individuals with diabetes had an LDL cholesterol of greater than 100 o Blood pressure ▪ 21 of the 21 individuals with diabetes had normal targeted blood pressures. The QI/QI minutes indicated a review of the effectiveness of the previously developed diabetic education action plan, which was implemented in August 2013; the Facility developed a new action plan that will ensure similar educational venues will be offered every six months at the Facility. The Trends report for diabetes mellitus, dated 12/12/2013, which will be presented at the next QA/QI meeting, indicated the following: o The Facility had 22 individuals with diabetes at that time. o Average hemoglobin A1C level was 6.37 for quarter 3, and 6.57 for quarter 4 of 2014. Hemoglobin A1C levels continued to be well within American Diabetic Association (ADA) recommended level, and indicated excellent diabetic control of diabetes. The trends analysis indicated that	

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		the slight increase in A1C levels in November may be attributable to the possibility some individuals may have eaten additional sweets during home visits following Halloween; subsequently, the Facility had developed an action plan to enhance individual's family members understanding of diabetes, and will provide educational materials at the time of each home visit. o For five out of 22 individuals who had elevated hemoglobin A1C levels, the Facility conducted a clinical review, and based on the type of diabetes, and other clinical factors, determined that a clinically appropriate A1C level for each of the Individuals would be higher than the recommended ADA recommended A1C level, to prevent episodes of hypoglycemia. o The trends analysis report also reviewed other clinical indicators for diabetes: o 0 out of 22 had abnormal blood pressures o 2 out of 22 had abnormal LDL levels. For the two individuals with elevated LDL, the QA trends report documented the clinical issues, and an action plan help better control the LDL level. o 0 out of 22 had retinopathy, o 0 out of 22 had nephropathy o Also assessed by the trends analysis report was current medical treatment: o 22 out of 22 were prescribed prophylactic aspirin therapy. o 22 out of 22 were prescribed prophylactic ACE-I or ARB drugs for renal protection. o Appropriate use of antidiabetogenic drug usage was assessed. o The Trends analysis concluded that the action plan to enhance diabetic education had continued to be effective in the management of diabetes, at the Facility. <u>Conclusion</u> The Monitoring Team compliments the Facility for developing a comprehensive and clinically relevant quality assurance 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, utilizes clinical pathways that emphasize clinical performance issues, and specifically addresses medical providers' clinical performance against standardized clinical indicators.	

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		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, and development of meaningful corrective action plans, and assesses the action plans for efficacy. There were indications of follow-up on action plans to determine efficacy. Some, of the many action plans developed to enhance medical services, based on analysis of the Facility's medical QA analysis, include: • Strengthened the Facility's diabetic education program • Enhanced the interdisciplinary approach to the management of diabetes • Ensured that medical providers obtain all necessary diabetic screening assessments, such as HgA1C levels, LDL, urine protein, and other assessments • Developed a training venue for staff to be educated on the Facility UTI policy • Enhanced general hygiene measures at the living area • Developed a standardized approach to assess and change incontinent briefs • Implemented the use of a pulmonary vest for individuals with recurrent pneumonia • Developed a process to better ensure that staff assess for enteric tube migration • Implemented a new process to monitor and change air filtering systems at the living area • Developed a process to better ensure that enteral tube feeding issues are addressed prior to transfers, positioning issues, bathing, and before sleep. The Monitoring Team understands that this system will continue to grow and be refined with experience, and noted the development of two additional clinical indicators. The Monitoring Team noted that through the Facility's monthly trends analysis meetings, which included members of the Facility's QA/QI department, the Facility had assessed action plans for efficacy. In particular, the Monitoring Team comprehensively reviewed the Facility's trends analysis, action plans, and follow-up on action plans for pneumonia, and UTIs. In both cases, the Facility identified that action plans had a positive effect on reducing the number of cases of pneumonia and urinary tract infections. Because the Facility utilized a data-based system that identifies clinical indicators of care, further developed additional clinical indicators of care, identified the need for and developed clinical actions plans to address systems issues related to clinical care, and followed up on action plans to assess efficacy, the Monitoring Team determined substantial compliance for Section L.3.	

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L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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: • DADS Policy: IRRF Clinical Integration, dated 10/29/2013, no number • RSSLC Policy: Medical Services, number I.00a, revised 5/15/2013 • RSSLC Policy: Morning Report Policy, revised 11/4/2013 • RSSLC Policy: Clinical Performance Audit Policy, revised 9/27/2014 (this is the actual date listed on the policy) • RSSLC Policy: Chronic Clinical Indicators, revised 8/20/2013 • RSSLC: Policy: The Vest Policy, number 143, dated 6/21/2013 • RSSLC: Policy Providing Health Care Services, Clinical CLDP Review, number I.55, dated 11/25/2013 • RSSLC Policy: Addendum to The Death Review Policy, dated 12/11/2013 • RSSLC Policy: The Incontinence Brief Tracking Policy, number 146, dated 8/29/2013 <u>Review of the Medical Services Policy</u> This policy had not been updated since the last compliance visit. Following the Medical Providers review for Section L.1, of this report, the Monitoring Team determined that the Facility had not substantially implemented this policy. For example, medical providers did not document negative physical findings at the time of examining an individual, and did not consistently document the source of the subjective assessments; they also did not document an emphasis of prevention of acute and chronic care issues. Furthermore, the medical provider did not address many risk factors associated with certain medical conditions, such as recurrent aspiration pneumonia. <u>Review of the Providing Health Care Services, Clinical CLDP Review Policy</u> The Facility developed a health care policy to better ensure clinical follow-up at the CLDP. Per review of CLDPs for Individual's #35, #238, and #463, this policy had not been fully implemented. The Monitoring Team noted that the policy indicated the medical provider's requirement to identify and report on monitoring parameters for medical conditions; however, in order to ensure supports are provided, the policy should address the medical providers' involvement in reviewing findings from post move monitoring reports. <u>Review of the Addendum to The Death Review Policy, dated 12/11/2013</u> The Facility developed but had not yet fully implemented an addendum policy to the death review policy. The addendum policy elaborates on the medical provider's role in reviewing clinical care, and the clinical death review committee's review of the clinical	Noncompliance

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		issues that require follow-up by the medical provider. The policy also outlines the Facility's new database system that was developed to track and trend database elements associate with deaths at the Facility. <u>Review of the DADS IRRF Clinical Integration Policy, dated 10/29/2013</u> This new policy only addresses operational issues, such as timeliness, and format of completing the annual IRRF, and does not address other important issues, such as ensuring that all clinical issues, associated with a risk to the Individual are incorporated into the IRRF. Furthermore, the policy only indicated the need for primary care providers, case managers, and psychiatrist to be involved in this process, but, dentists and pharmacists must also ensure that clinical risks associated with their discipline are well addressed by the IRRF. In addition the policy did not address the format for updating risks, in the event of a significant medical issue that occurred during the interim of developing the annual IRRF. <u>Review of the Incontinence Brief Tracking Policy, number 146, dated 8/29/2013</u> Based on analysis form the medical QA analysis of UTIs, the Facility developed an action plan to enhance the assessment of incontinence briefs by direct care staff, and implemented this policy. Subsequent tracking of UTIs indicated that this practice demonstrated efficacy, and helped to reduce the number of UTIs. The Monitoring Team compliments to the Facility for its effort in addressing UTIs, and for developing, and implementing this policy. Conclusion: The Monitoring Team noted that the Facility had developed many new policies for medical services, and updated many older policies. The Monitoring Team determined that the Facility was not yet in substantial compliance with Section L.4, of the SA. Compliance will require that the Facility develop and implement policy and/or procedure for all major areas of clinical practice at the Facility, and ensure that the Facility has fully implemented and substantially follows its 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: 2/13/14 2. RSSLC Section M Action Plan, Updated: 2/13/14 3. RSSLC Section M Presentation Book 4. Texas Department of Aging and Disability (DADS), Policy: 053, Medication Variance Policy, Date: 9/23/11 5. DADS Policy, 044.2, Emergency Response, Date: 9/7/11 6. DADS Guidelines, Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Revised Date: 1/23/14 7. DADS Nursing Protocol: Enteral Nutrition, Revised Date: January 2014 8. DADS Nursing Protocol: Enteral Medication Administration, Revised Date: December 2013 9. DADS Procedure: Medication Administration Guidelines, Revised Date: January 2014 10. DADS Nursing Procedure: Management of the Foley or Supra-pubic Catheter, Dated: Revised Date: December 2013 11. DADS Nursing Procedure: Gastrostomy Tube: Insertion by a Nurse, Revised Date: December 2013 12. DADS Nursing Procedure: Injections (SQ, ID, ID), Dated: Revised Date: December 2013 13. DADS Procedure: Management of Acute Illness and Injury, Revised Date December 2013 14. DADS Procedure: Neurological Assessment, Revised Date: December 2013 15. DADS Procedure Nursing Competency Based Training Curriculum, Revised Date: December 2013 16. DADS Nursing Protocol: Pre-treatment and Post-Sedation Monitoring, Revised Date, December 2013 17. DADS Protocol: Seizure Management Guidelines, Revised Date, December 2013 18. DADS Nursing Protocol: Hospitalizations, Transfers, and Discharges, Dated: March 2013 19. DADS Guidelines: Care Plan Development, Revised Date: December 2013 20. DADS Nursing Protocol: Diastat AcuDial, Revised Date: December, 2013 21. DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Revised Date: January 2014 22. RSSLC Policy: I.6, Providing Health Care Services, Providing Acute Health Care, Revised Date: 9/23/13 23. RSSLC Policy : Sick Call, Dated: 10/18/13 24. RSSLC Policy: IRRF Clinical Integration, 10/29/13 25. RSSLC Policy: I.34, Providing Health Care Services, Medication Variances, Revised Date: 2/27/12 26. RSSLC Quality Assurance Department – Process for Creating, Submitting, Dissemination Corrective Action Plan, 2/3/14 27. RSSLC Policy: D.25,Safety and Environmental Management, Completing/Routing Fall Evaluation Form, (Draft) Revised Date: 10/14/13 28. RSSLC Policy: A-3, Nursing Services, Medication Administration Guidelines, Revised Date: 10/29/13 29. RSSLC Policy: I.01, Providing Health Care Services, Emergency Response, Reviewed Date: 1/29/14 30. RSSLC Guidelines for the Usage of Infirmary Beds, Date: 9/30/13 31. RSSLC Nursing Services Protocol: Process for Tracking Medical/Dental Restraint Checklist, 11/22/13

	32. RSSLC Nursing Organizational Chart 33. RSSLC List of New Policies, Procedures and/or Other Documents Addressing the Provision of Nursing Care Since the Last Compliance Review 34. RSSLC Standardized Nursing Abbreviations List, Revised Date: January 2014 35. DADS Hospital Transfer Form, Revised Date: December 2013 36. DADS Medication Administration Observation Form, Revised Date: 11/12/13 37. RSSLC Nursing Education Training Outline for All New and Ongoing Topics Since the Last Compliance Review 38. RSSLC Nursing Department Staffing Schedules and Staffing Patterns for last six month 39. RSSLC Nursing Department Meeting Schedule for Week of 3/3/14 40. RSSLC Nursing Staffing Patterns for Infirmary and Residential Units by Shifts 41. RSSLC Nursing Staffing Reports and Analysis for the last six months 42. RSSLC Nursing Overtime Hours by Nurse, August 2013 through December 2013 43. RSSLC Number of Filled and Unfilled Nursing Positions 44. RSSLC RN Case Managers' Caseload by Unit 45. RSSLC Nursing Department Administration and Nurse Managers Meeting Minutes for the last six months 46. RSSLC Quarterly Infection Control Committee Meeting Minutes, 8/27/13, 10/15/13, and 1/28/14 47. RSSLC Summary of Infection for the last six months 48. RSSLC Infection Control Database for all Types of Infection Report, August 2013 through January 2014 49. RSSLC Infection Control- Handwashing/Glove Use Analysis, August 2013 through January 2014 50. RSSLC Summary: Nursing Plan of Correction (POI) Committee Meeting Minutes, August 2013 through February 2014 51. RSSLC QA/QI Council Meeting Minutes, 10/22/13 and 1/14/14 52. RSSLC Quarterly Nursing Data Analysis Summary, July 2013 through September 2013 53. RSSLC Nursing Monitoring Sample for February 2014 54. RSSLC Internal Nursing Longitudinal Trends Report for Monthly Monitoring Tool Audits, August 2013 through January 2014 55. RSSLC Nursing Corrective Action Plans Summary Report, 2/18/14 56. RSSLC Nursing Medical/Dental Sedation Tracking Log, November, through February 2014 57. RSSLC Sedation/Pre-Sedation Log for November 2013 58. RSSLC Quarterly Pharmacy and Therapeutics Committee Meeting Minutes, 10/10/13 and 1/14/14 59. RSSLC Skin Integrity Committee Meeting Minutes for the last six months 60. RSSLC Medication Variance Reports for the last six months 61. RSSLC Medication Administration Observation Reports, for the last six months 62. RSSLC Summary of Emergency Equipment and Automated External Defibrillator (AED) Checklist Reports for the last six months 63. RSSLC Emergency Response Committee Membership 64. RSSLC Emergency Medical Response Committee Meeting Minutes, 10/6/13 and 1/15/14 65. RSSLC List of Location of Emergency Equipment and Automated and AEDs Campus-wide 66. RSSLC Mock Medical Emergency Drill Reports for the last six months 67. RSSLC List of Staff Responsible for Conducting Mock Medical Emergency Drills

	68. RSSLC List of Staff Responsible for Conducting, Reporting, Tracking and Analyzing Mock Medical Emergency Drills 69. RSSLC Monthly Mock Medical Emergency Drill Trend Analysis for last six months 70. RSSLC Curriculum for Implementation of Emergency Procedures and Training Materials 71. RSSLC Competency Training and Development (CTD) Due/Delinquent List for Cardiopulmonary Resuscitation (CPR) Basic and CPR for Healthcare Providers, Printed 3/5/14 72. RSSLC Infection Control Committee Meeting Minutes for Reviewing and Revising Infection Control Policies and Procedures for 2014 73. RSSLC Training Curricula for Infection Control with Training Material 74. RSSLC Monthly Antibiograms and Epidemiology Reports for last six months 75. RSSLC Competency Training and Development (CTD) Infection Control Due/Delinquent List, Printed: 2/28/14 76. RSSLC Percentage of Individuals Current with Tuberculosis Screening 77. RSSLC Percentage of Employees Current with Tuberculosis Screening 78. RSSLC Percentage of Individuals Current with Influenza Vaccinations 79. RSSLC Percentage of Employees Current with Influenza Vaccinations 80. RSSLC Percentage of Employees Current with Hepatitis B Vaccinations 81. RSSLC List of Infection Control Monitoring Tools 82. RSSLC List of Nursing Monitoring Tools and Procedures for Monitoring 83. RSSLC Nursing Monitoring Tools Analyses and Corrective Action Reports for the last six months 84. RSSLC Clinical Morning Report Minutes for the Week of 3/3/14 85. RSSLC List of Individuals Admitted to the Infirmary for the last year 86. RSSLC List of Hospital/Emergency Room Visits for the last six months 87. RSSLC List of Individuals' Health Risk Ratings 88. Sample Review of Comprehensive Records for 10 Individuals #723, #483, #503, #783, #585, #675, #13, #272, #417, and #72 89. Sample Review of Community Placement Nursing Summaries and Discharge Packets for Five Individuals #366, #35, #10, #219, and #555 90. Sample Review of Currently Active and/or Recent Skin Integrity Issues for Four Individuals #463, #544, #340, and #212 91. Sample Review of Ten Most Recent Reported Medication Variance Reports for Individuals #661, #379, #320, #203, #349, #314, #318, #413, #140, and #366 92. Sample Review of Records of Six Currently Active and/or Recent Urinary Tract Infections (UTIs) Individuals #51, #426, #701, #649, #388 and #503 93. Sample Review of Five Currently and/or Recent Hospitalized Individuals #154, #192, #402, #340, and #623 94. Sample Review Hospital Discharge Summaries of recently discharged individuals #340, #523, #364, #712, #515, and #558 95. Sample Review of Medical Restraint Records for Individual #387 96. Sample Review of Diabetic Teaching for Individual/Family Members Sheets and Integrated Progress Notes for Individual #680's. 97. Sample Review of Four Recently Admitted Individuals #13, #272, #417, and #72

	People Interviewed: 1. Sherene Green, BSN, RN. Chief Nurse Executive (CNE) 2. Reneda Simmons, BSN, RN, Nurse Operation Officer (NOO) 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, Nurse Educator 8. Rose Nnake, RN, RN Case Manager Supervisor 9. Wickliff Fawibe, RN, Skin Integrity Coordinator 10. Krista Bowers, RN, Infection Control Nurse 11. Antonio Crescini, RN, Assistant Infection Control Nurse 12. Deloris Milligan, RN Nurse Manager, Trinity 13. Irma Bernas, RN, Nurse Manager, San Antonio 14. Deborah Brewer, RN, Nurse Manager, Leon 15. Franca Uzuegbu, RN, Nurse Manager, Three Rivers 16. Amanda Hogan, RN, Nurse Manager, Four Rivers 17. Wilma Parker, RN, Quality Assurance Nurse 18. Robyn Partridge, RN, Quality Assurance Nurse 19. Joslyn McLean, Drill Instructor 20. Numerous RN Case Managers, Staff RNs and LVNs **Meetings Attended/Observations:** 1. Review of Section M with Nursing Administration and Management Staff, 3/3/14 2. Tour of Infirmary, Enteral Feeding Administration, Skin Integrity Dressing Change Observations, and Medication Room Survey, 3/3/14 3. Unit Nurse Managers Meeting to Review Acute Care Plans and Supporting Documentation, 3/3/14 4. Tour of Trinity A, B, C, D, 3/4/14 5. Meeting with Individual #463's RN Case Manager, Physical Therapist, Occupational Therapist, and Qualified Intellectual Disability Professional (QIDP), 3/4/14 6. Medication Administration Observations and Medication Room Survey in Nueces, 3/4/14 7. Meeting with RN Case Manager Supervisor and RN Case Managers, 3/5/14 8. Integrated Grand Rounds Meeting Regarding Individual #227, 3/5/14 9. ISP Meeting Regarding Individual #675, 3/5/14 10. Medication Administration Observations and Medication Room Survey in Nueces, 3/5/14 11. Medication Administration Variance Committee Meeting, 3/6/14 12. Pre-Hospital Discharge Meeting for Individual #169, 3/6/14 13. Impromptu Mock Medical Emergency Drill in San Antonio, 3/6/14 14. Numerous Impromptu Meetings with Nursing Administration and Management Staff throughout the Week
	Facility Self-Assessment: ▪ Nurse Educators, Specialty Nurses, Nurse Managers, and Quality Assurance Nurses that were

	responsible for conducting the audits/monitoring were programmatically competent in their relevant area(s) for Section M, in conducting the Facility Self-Assessment. ▪ 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 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. ▪ Sufficient inter-rater reliability process had been established between the Nursing Department and the Quality Assurance Department 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. ▪ Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop and implement a detailed sequential plan to accomplish the priorities. The Facility's Self-Assessment stated they were not in compliance with Provisions M.3 and M.5 and were in substantial compliance with Provisions M.1, M.2, M.4, and M.6; the Monitoring Team concurs with their findings for Provisions M.2, M.4 and M.6. While the entire Provision M.1 was not found in substantial compliance, most of the various requirements were close to substantial compliance or met substantial compliance. 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.2, M.4 and M.6 were found in substantial compliance. Provisions M,1, M.3 and M.5 were not found in substantial compliance. The Nursing Department continued

	to showed progress in Section M Provisions, more so in some than others. Provision M.3 showed significant improvement was made in the content and quality of Acute Care Plans and associated documentation in the Integrated Progress Notes. There was no significant improvement found in Provision M.5. Provision M.6 continued to maintain the positive practices found in previous reviews. Provision M.1 contained multiple requirements. Review of this Provision showed that all of the administrative, management, and leadership nursing positions vacated during the past six months were filled. Significant improvements were found in the assessment and documentation of acute change in health care status. This was no doubt attributed to the recent revision to the Acute Care template and continued daily Assessment and Documentation audits by the Nurse Managers and relevant Administrative/Management nursing staff. The Quality Assurance processes were well established, including inter-rater reliability processes. The Nursing Department worked collaboratively with other relevant disciplines and conducted a Diabetic Fair for individuals and their families/guardians to provide diabetic education. If the requirement for Infection Control was a standalone requirement it would be considered in substantial compliance. Although the incidences of pressure ulcers were low, the Skin Integrity Committee needs to continue to analyze underlying causes of skin breakdown and ensure that the all required committee members consistently attend the meetings. The Emergency Response Committee recently procured a full body mannequin to use in conducting realistic mock medical emergency drill scenarios. However, more practice with these scenarios is needed to ensure competency. Provision M.2 showed revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment Guidelines and Form were implemented and the RN Case Managers were trained on its use. It was apparent the recently hired RN Case Manager Supervisor had worked effectively with the RN Case Managers through additional training and auditing of nursing assessments to bring about substantial compliance with this Provision. The only constraint was, as reported by the RN Case Managers, that the new state Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment template could not be overridden. Therefore it limited the addition of information they wished to enter. This issue should be discussed with the State Office Nursing Coordinator. Provisions M.3 showed since the last compliance review the Acute Care Plan template had been revised to provide for more individualized care planning. The revised process included a bank of nursing interventions that could be used to assist in the development of the care plans. Significant improvement was found in review of Acute Care Plans regarding the individualization, content, and quality of the plans, as well as in the associated documentation in the Integrated Progress Notes. Relevant Nursing Protocols were incorporated into the Acute Care Plans. If the positive practices identified throughout the review of Acute Care Plans and associated documentation in the Integrated Progress Notes continue, at the next compliance review, this Provision will be close to achieving substantial compliance. Provision M.4 continued to maintained 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.5 showed minimal progress since the last compliance review. The RN Case Manager Supervisor was working collaboratively with the responsible Facility to make improvements. It was apparent the IRRF and IHCP processes were still evolving. Since this is an integrated process it will take Facility-wide improvement to achieve substantial compliance with this Provision. Provision M.6 continued to show substantial compliance 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 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.	<u>Monitoring Team's Findings:</u> 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 continued to make progress toward substantial compliance. 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. <u>Staffing:</u> At the time of the compliance review the census was reported as 335 individuals residing at the Facility. This represented a reduction of five individuals since the last compliance review when the Facility census was reported as 340. The Nursing Department reported there was a total of 158 allocated nursing positions, of which 88 Registered Nurses (RNs) and 60 Licensed Vocational Nurses (LVNs) were filled. There were six open RN positions and four open LVN positions. Not counted in the allotted nursing positions were 10 nursing positions on hold for deletion. The levels of RN or LVN nursing	Noncompliance

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		positions on hold were not identified. The number of Infirmary beds was reduced from 12 beds to four. The nursing positions on longer needed as a result of the reduction in bed capacity were redistributed across campus. The Facility did not use agency contract nurses to supplement staffing. The Monitoring Team's review of the summary/analysis of the Number of Overtime and Compensatory Hours by Nurses Report, August 2013 through December 2013, showed the Nursing Department continued to use a considerable amount of overtime and compensatory time hours for both administrative/management and direct care nurses. It was of concern that 10 nursing positions were on hold for deletion when so many hours of overtime and compensatory time were required in order to meet administrative/management and direct care nursing responsibilities. A review of Summary Addressing Minimum Staffing Patterns for Nursing Report for all units/Infirmary, daily by shifts, monthly, and longitudinally, August 2013 through January 2014, showed the Facility did not fall below the minimum established staffing patterns/ratios. The Facility used a pulling system if the minimum staffing/ratios were not met. Although the census had been reduced due to individuals' deaths and discharges to the community, the Facility continued to admit new individuals. This, coupled with the aging population and individuals with increasing acuity, requires 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. There was documentation that showed nursing recruitment efforts had continued; for example, in October 2013, RSSLC participated in the Job Fair in Sugarland, resulting in several LVN applications. The Monitoring Team found that the Nursing Department's Administrative and Management Nursing positions had experienced several changes since the last compliance review. The CNE had resigned in December 2013. The position was recently filled with a nurse hired from outside the Facility. The vacant Nursing Operations Officer noted at the last compliance review was filled in October 2013 by promoting the incumbent Infection Control Nurse. A new Infection Control Nurse was recently hired from outside the Facility and was in orientation. The vacant RN Case Manager Supervisor was filled in November 2013 by promoting an incumbent RN Case Manager. The Skin Integrity Coordinator resigned in December 2013 and was recently rehired and was in orientation. The CNE, Infection Control Nurse, and Skin Integrity Coordinator took out time from orientation to interview with the Monitoring Team. The other Nursing Administration/Management and Specialty Nursing positions remained stable. The Administrative/Management and Specialty Nurses remained motivated, and dedicated to providing high quality nursing services. 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 related to specialty areas of nursing practice. It was positive to find that the Nursing Department had developed and promoted qualified incumbent	

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		nursing staff to higher levels of responsibility. Promoting incumbent nursing staff has significant benefits because they know the individuals, have received the investment of training on the Facility's policies, procedures, protocols, and 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 often results when nurses are hired externally without IDD experience. <u>Quality Assurance Efforts:</u> It was impressive to find that the Program Compliance Nurse continued to prepare and provide an excellent and comprehensive summary of the quality assurance activities performed August 2013 through February 2014. The Monitoring Team's review of the Nursing POI Committee Meeting Minutes, August 2013 through February 2014, showed the committee met weekly and more often when indicated. The core membership consisted of the Program Compliance Nurse, Chair, NOO, Unit Nurse Managers, Infirmary Director, RN Case Manager, Nurse Educators, Hospital Liaison Nurse, Infection Control Nurse, Skin Integrity Coordinator, QA Nurses, Nursing Administrative Assistant, and Nursing Clerk. The committee reviewed, discussed, and took corrective action on the monitoring tools and/or items within the tools, for previously completed monitoring/audit tools that fell below 80% compliance, as well as reconciling and correcting any disparity found between the internal (Nurse Auditors)) and external (QA Nurse Auditors) results on the monitoring tools. For systemic trends identified, Corrective Action Plans (CAPs) were developed, implemented, and sent to the QA/QI Council for further review and disposition. The nursing POI Committee will continue to meet and discuss findings to identify areas of scores currently at 80% to increase compliance to 90% or greater. The committee meeting minutes and accompanying supporting documentation showed that continuous improvements were made in the quality assurance processes as a result of these efforts. <u>Facility Nursing Monitoring/Audit Results:</u> The procedure for Nursing Care Monitoring and Protocol Card Audit Tool audits continued to follow the QA Audit Process revised in April 2013. The Nursing Care Monitoring/Protocol Card Audit Tools were tracked and trended monthly by the internal auditors monthly. The Nursing Department had the prerogative of selecting the Nursing Monitoring Tools and Protocol Card Audit Tools they wished to audit based on areas of nursing practices that they identified in need of improvement. After a selected tool(s) achieved 90% or greater compliance for three consecutive months they may decide to discontinue monitoring/auditing the tool(s) and initiate other monitoring/audit tools. The Nursing Department reported that the internal nurses audited four Nursing Care Monitoring Tools and four or more Protocol Card Audit Tools with usually five samples per tool (44 samples per month August 2013 through September 2013) with a total of 88 samples and (45 samples October through January 2014) with a total of 180 samples. Overall, a total of 268 samples were audited for both Nursing Care Monitoring Tools and Protocol Cared Audit tools. The Monitoring Team reviewed the supporting documentation provided for nursing internal and	

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		external monitoring/audit tool results and a Summary of Nursing Monitoring Tools and Protocol Audit Tools results, August 2013 through January 2014, which showed: • Nursing staff responsible for conducting audits: Nursing Administrative staff including, Nurse Managers, Infection Control Nurses, Skin Integrity Coordinator, Nurse Educators, and Hospital Liaison Nurse. • Nursing Monitoring Tools: o Pain Management – August 2013 through September 2013, overall compliance was 93% o Skin Integrity – August 2013 through January 2014, overall compliance was 94% o Urgent Care/ER/Hospitalization – August 2013 through January 2014, overall compliance was 86% o Medication Observation and Documentation – August 2013 through January 2014, overall compliance was 99% o Annual Nursing Assessment – October 2013 through January 2014, overall compliance was 97% • Protocol Card Audit Tools: o Antibiotic Therapy – August 2013 through January 2014, overall compliance was 94% o Head Injury - August 2013 through January 2014, overall compliance was 91% o Pre-treatment/Post sedation - August 2013 through January 2014, overall compliance was 88% o Constipation – August 2013 through January 2014, overall compliance was 87% o PCP Notification – October 2013 through January 2014, overall compliance was 75% • Inter-rater Reliability Overall Level of Agreement Between Internal and External Nurse Auditors: Monthly the QA Nurses audited four Nursing Care Monitoring Tools and four Protocol Card Audit Tools for inter-rater reliability. o Pain Management – 100% agreement o Skin Integrity – 98% agreement o Urgent Care/ER/Hospitalization – 96% agreement o Medication Observation and Documentation – 98% agreement o Annual Nursing Assessment – 99% agreement o Protocol Card Tools: Antibiotic Therapy, Head Injury, Pretreatment/Post Sedation, Constipation and PCP Notification - 100% agreement • Pain Medication Review Process: o Nursing POI Committee o Pain Review Log (random audits) o Pain Management Monitoring Tool reached 93% compliance for three consecutive with 100% inter-rater reliability agreement in September 2013. This tool was discontinued. • Compliance for Entering Tools into Database by Date Assigned: o August 2013 through January 2014 the monitoring/audit tools were entered into the database with 100% compliance with the date assigned. • QA Compliance Data and CAP: o Pain Management CAP completed on 9/19/13 o Medication Maintenance and Storage/Medication Room Inspections CAP completed 9/19/13	

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		o Urgent Care/ER/Hospitalization CAP initiated on 9/1/13 and was ongoing with revisions o Medical/Dental Restraint Checklist CAP initiated on 1/13/14 o PCP Notification CAP initiated on 2/18/14 o Required reports regarding the status of the CAPs were submitted to QA Department for entry into the CAP database • Medication Room Surveys and Medication Administration Record (MAR) Audits: o Eight Medication Room Surveys and eight MAR Audits were conducted, August 2013 through January 2014, jointly by the internal and external nurse auditors. o MAR Audits – overall compliance by the internal nurse auditors was 83% o Medication Room Survey Audits – overall compliance by the internal nurse auditors was 91% o Inter-rater reliability level of agreement between the internal and external nurse auditors for Medication Room Surveys and MAR Audits overall was 97%. Other nursing Monitoring Tools used in addition to the tools listed above included the daily (Monday through Friday) Assessment and Documentation Audits completed by the Nurse Managers/Infirmary Director for a minimum of 10 random audits of records review from the previous days. Refer to Provision M.3 for the results of these audits. <u>Monitoring Team's Review for Safety during Medical Restraint:</u> The Monitoring Team found that the Medical/Dental Restraint Checklist CAP initiated on 1/13/14 to improve compliance with the Pre-treatment/Post Sedation Protocol appeared effective as evidenced by the documentation reported below: The Monitoring Team reviewed a sample of 15 individuals who received pretreatment sedation procedures on specified dates (Sample J3). The sample included four cases of pretreatment sedation for dental procedures and eleven cases of pretreatment sedation for medical procedures such as EKGs and imaging studies. Appropriate informed consent was provided for 13 of 15 (87%) individuals. During pretreatment sedation monitoring for safety was required, as specified by the physician or dentist. Such orders were provided for four of four (100%) individuals who received dental pretreatment sedation, and for zero of 11 (0%) individuals who received medical pretreatment sedation. Vital signs monitoring was provided for 15 of 15 (100%) individuals, and they followed nursing protocol guidelines. Those required vital signs to be monitored for 24 hours, starting with a baseline measure prior to administration of the pretreatment sedation. General nursing assessments were also provided for 24 hours, including examinations /observations for alertness, any breathing difficulties, and any constitutional symptoms such as nausea, vomiting, etc. At the end of the 24 hour period a final nursing summary was provided that established/confirmed ability to return to usual activities. Documentation was provided on Medical Restraint Checklists and IPNs. Overall, documentation of nurses monitoring for safety was much improved over the last visit. Forms such as the Medical Restraint Checklist were now used consistently. IPN notes that addressed post procedure monitoring were clearly labeled. Information entered used the Data-Assessment-Plan	

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		documentation method in a manner that was clear and easy to follow. That allowed nurses from different shifts to provide needed continuity of monitoring. The final nursing note provided assurances that the individuals could safely return to their usual activities without additional monitoring in 15 of 15 (100%) cases. For example, an IPN for Individual #387 on 12/11/13 stated "Medical monitoring completed. Report documented on 24 hour report, for oncoming nurse. Problem resolved." For additional information refer to Section C of the report. <u>Assessment and Documentation of Individuals with Acute Changes in Health Status:</u> The Facility continued the Clinical Morning Report meetings, which followed a formalized agenda for conducting the meetings. The Hospital Liaison Nurse continued to provide reports on all hospitalized individuals. The Infirmary Nurse provided reports on individuals admitted to the Infirmary. The Skin Integrity Nurse and Infection Control Nurse provided weekly reports for their respective areas of responsibility. A review of the Clinical Morning Report minutes on 3/4/14 found they were substantive and productive in ensuring communication and continuity for the individuals reviewed, as well as on other relevant clinical issues. The Hospital Liaison Nurse was responsible for following up on nursing issues with the responsible nursing staff. The Monitoring Team attended the Grand Rounds Meeting on 3/5/14, which was attended by relevant interdisciplinary team (IDT) members and other relevant Facility staff. There was an active participation by the team, particularly the Qualified Intellectual Disability Professional, Physical and Occupational Therapist, Clinical Pharmacist, RN Case Manager. The Medical Director led the meeting. The focus of the meeting centered on a thorough review of Individual #227's clinical course regarding recent falls. The team discussed potential underlying causes for the falls, current management plan, and elicited further strategies for management and treatment. The team will provide the recommended strategies for management and treatment to Individual #227's IDT for further review and disposition. 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 completed a comprehensive record review of a sample selected from across the units for individuals identified at high/medium risk health conditions, which included Individuals #661, #379, #320, #203, #349, #314, #318, #413, #140, and #366, and found: • The daily (Monday through Friday) comprehensive Assessment and Documentation Audits conducted by the Nurse Manager and other relevant Nursing Administrative/Management staff had significantly improved the quality and content of nursing assessments and documentation for acute changes in health status. The most significant improvements included: o The legibility of nursing documentation, signatures and titles. o Documentation entries for acute changes in health status were consistently completed: focus/comprehensive assessments for identified problems, including full sets of vital signs and oxygen saturation, adverse drug reactions, effectiveness of treatment, and documentation, mental/behavioral status, Wong Pain Scale Assessments, activity tolerance, and instructions to the Direct Support Professionals for their responsibilities related to the identified problems. In	

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		addition, the records reviewed showed that the SOAP method of charting was consistently used, there were no gaps found in documentation, documentation errors were properly corrected, and it was rare to find an entry that was not dated and timed. o Development and implementation of the Constipation Review Log to ensure bowel movements were tracked. The log included a list of individuals who had per necessary (PRN) medications/suppositories ordered for constipation, if the PRN medications were administered the effectiveness was assessed and documented in the Integrated Progress Notes within one hour after administration. o The consistent implementation of nursing protocols for assessing, documenting, and following through to resolution for acute illness and injuries that do 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. Examples of more frequently implemented nursing protocols included, but was not limited to the following: ▪ Individual #783: On 1/18/14 at 1145, Individual #783 had a 30 second seizure that required the administration of Diastat 10 mg per rectum per PRN order. The Seizure Protocol and 24 hour Nursing Monitoring was initiated and followed through to resolution on 1/19/14 at 1300. ▪ Individual #483: On 1/30/14 at 1330, Individual #483 had a 30 second seizure that required the administration of Diastat 10 mg per rectum per PRN order. The Seizure Protocol and 24 hour Nursing Monitoring was initiated and followed through to resolution on 1/31/14 at 2035. ▪ Individual #723: On 12/1/13 at 2100, the Direct Support Professional notified the nurse of drainage and redness of the eyes. The nurse performed a focused assessment of the problem and sent him to sick call the next morning on 12/2/13. He was diagnosed with Conjunctivitis and prescribed antibiotics. An Acute Care Plan for Conjunctivitis was initiated sufficient to meet his individualized needs. The Antibiotic Protocol was incorporated into the plan. As review of the Integrated Progress Notes showed, the plan was followed consistently as described and followed through to resolution on 12/9/13. ▪ Individual #13: On 12/18/13, Individual #13 was admitted to the Facility. The Medical Monitoring Protocol for new admissions was initiated for 72 hours. A review of the Integrated Progress Notes showed that the Medical Monitoring Protocol was consistently followed from 12/18/13 at 1400 through 12/22/13 at 1000. There were no incidences of maladjustment or health related problems reported during the 72 hour Medical Monitoring. ▪ Individual #417: On 1/21/14 at 1540, the Direct Support Professional reported that Individual #417 was brought back from the workshop for complaints of a headache. A focused assessment related to the headache was completed. The When Contacting the PCP protocol was followed and the PCP was notified of the assessment finding related to the headache. A one-time dose of Tylenol 650 mg orally was ordered and administered. The Pain Protocol was followed through to resolution of the headache. The nurse completed an	

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		assessment for pain relief at 1650 and documented the Tylenol was effective in relieving the headache. If the improvements and positive practices found throughout the above report are maintained and strengthened, substantial compliance with this requirement should be achieved at the next compliance review. Compliance with Urgent Care/ER/Hospitalization and PCP Notification protocols still needs improvement, as the Facility's data indicated. <u>Availability of Pertinent Medical Records:</u> There was no difficultly with the availability of records and documents for onsite review. However, there were two missing Physical Assessments that should have been included with the Comprehensive Record Review and a missing Hospital Transfer Record. Therefore, it could not be determined whether these documents were not completed or simply not copied for offsite review. The Nursing Department had an active Corrective Action Plan for ensuring hospital related information was filed according to policy. <u>Hospital Nurse Liaison Nurse Activities:</u> The Hospital Liaison Nurse continued to prepare and present the Monitoring Team with 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, documents supplied, and records reviewed validated that these activities were performed. The Hospital Liaison was readily knowledgeable of hospitalization activities and was able provided additional supporting documentation when requested. The Monitoring Team's interview with the Hospital Liaison Nurse and supporting documentation found the following activities were performed: o Conducted onsite visits and telephone updates to follow-up on individuals who were hospitalized in local acute care hospitals and Long Term Acute Care (LTAC) facilities Monday through Friday. Documented daily updates on the Hospital Liaison Reports and Integrated Progress Notes. o The Campus nurses maintained contact with the hospitals and/or LTAC facilities over the weekends and on holidays. o Daily updated the Hospital and Emergency Room Admission Logs in AVATAR, which included documentation regarding hospital transfers, admissions, and discharges. o Attended and participated at the integrated Clinical Morning Report Meetings and Grand Rounds Meetings. Updated the interdisciplinary team (IDT) on the status of individuals hospitalized and/or new hospital admissions. o Attended and participated at the daily Nurse Managers Morning Meetings. o Conducted orientation classes for newly hired nurses on the Protocol for Urgent Care/Emergency Room Visits and Hospitalizations. From August 2013 through February 2014 conducted orientation classes for seven nurses. o Participated and performed chart audits in collaboration with the Infirmary nurse on	

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		individuals' post hospital discharges who were admitted to the Infirmary to ensure the required assessments and documentation was completed and records were appropriately filed. From August 2013 through January 2014, charts of 46 individuals were audited. o Completed Hospital Discharge Summary Report on hospitalized individuals, which were presented at Post-Hospital Discharge Planning Meetings. The Monitoring Team verified the completion of these reports through review of a sample for recently discharged Individuals #340, #523, #364, #712, #515, and #558, and found they provided comprehensive and substantive information regarding the following information: Admitting Diagnoses, Discharge Diagnoses, Discharge Date, Hospital Course, Consultations, Lab Work, Radiographic Studies, Diagnostic Studies, Vital Signs, Feedings, Home Medications, Skin Integrity Issues, Health Status Change, and New Medications upon discharge. o Attended Facility Post-Hospital Discharge Planning Meetings held every Friday and prepared discharge summaries for all of those meetings. From September 2013 through February 2014, attended18 Post Hospital Discharge meetings and prepared summary reports of the meetings. o Served as a backup to the Physical Nutritional Management Team Nurse (PNMT) and completed the PNMT Nurse Post-Hospitalization Assessments/Evaluations. o Performed Medication Administration Record (MAR) reconciliation with the Medication Profile List on individuals admitted to the hospital. o Participated and coordinated with the Medical/Nursing team with the Locum Physician in facilitating sick calls and annual physical examination on assigned units/homes. o Ensured that nursing issues identified during the integrated Clinical Morning Meeting held on Tuesdays and Thursdays were carried out and follow-up as indicated, including preparation of summarized reports of issues discussed, followed with action plans, and recommendations made by the Medical Director and team at the end of each meeting. o Attended and participated in Clinical and Administrative Death Review Committee Meetings. Facility's Self-Assessment Urgent Care/ER/ Hospitalization Monitoring/Audit Reports: The results of the nursing monitoring/audit results, August 2013 through January 2014 showed: <table><tr><td>August 2013</td><td>September 2013</td><td>October 2013</td><td>November 2013</td><td>December 2013</td><td>January 2014</td><td>Overall Percentage</td></tr><tr><td>94%</td><td>69%</td><td>89%</td><td>95%</td><td>89%</td><td>83%</td><td>86%</td></tr></table> The Facility reported that in September 2013 the Urgent Care/ER/Hospitalization Monitoring Tool fell below 69% compliance. The factors contributing to less than 80% compliance included: • Unavailability of active records for timely filing of Hospital Liaison Nurse's Integrated Progress Notes and Hospital Liaison Reports. Active records for individuals admitted to the hospital must be taken to Medical Records. If the active records are sent to Medical Records when individuals are admitted to the hospital, the Hospital Liaison Nurse should b able to file hospital related documents timely. When the active records were not placed in Medical Records, it affected the timely filing of documents.	

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		• Inconsistent filing of pertinent documents such as, Hospital Transfer Forms and Post Hospital Assessment Forms, Hospital Discharge Summary, Lab, and Diagnostic Reports. The CAP for Urgent Care/ER/Hospitalization initiated on 4/12/13 was revised and continued on 9/1/13 and on 1/31/14, to show additional items on the tool that fell below 80% in the areas of completing the Hospital Transfer Forms and documentation in the Integrated Progress Notes for all hospitalizations. The Facility's Self-Assessment reported that the CAP was now showing improvement, following the drop in September 2013, for initial specific problems areas related to increased compliance for documentation in the record. However, compliance items for filing Hospital Discharge Summary, Labs, and Diagnostic Reports continued to fall below 80% compliance. Therefore, a CAP was continued until 90% or greater compliance was achieved and sustained longitudinally. The above information demonstrated to the Monitoring Team that the Nursing Department was analyzing monitoring tool data to make clinical decisions to improve compliance with Urgent Care/ER/Hospitalization nursing practices. The Monitoring Team reviewed five records on recently and/or currently hospitalized individuals: #623, #340, #402, #192, and #154, and found: • The Monitoring Team, using a comparable Urgent Care/ER/Hospitalization Monitoring Tool for reviewing required hospital related documentation of the above individuals, found an overall 89% compliance, which was comparable to the compliance scores reported in the Facility's Self-Assessment for this tool. The items on the tool that fell below 100% compliance were similar to those identified in the Facility Self-Assessment, for example: o Four of five (80%) individuals' records showed that a Hospital Transfer Form was completed. o Four of five (80%) individuals' records showed daily (Monday through Friday, except for holidays) Hospital Liaison Report and Integrated Progress Notes of hospital visits or telephone contacts with hospital personnel. o Four of five (80%) individuals' discharged showed acute care plans were initiated and carried out for diagnoses related to hospitalization. Of the four individuals who had acute care plans, two were carried out through to resolution and two acute care plans were still in process. o Four of five (80%) individuals' showed that Hospital Discharge Summaries were completed. o Four of five (80%) individuals' records showed that campus nurses contacted the hospital personnel when individuals were hospitalized over the weekend/holidays. Although the Monitoring Team found that most of the positive practices reported in the last compliance review continued, based on the above Urgent Care/ER/Hospitalization Monitoring Tool results, coupled with the Facility's Self-Assessment of the tool and the active CAP for Urgent Care/ER/Hospitalization, this section of the Provision was not considered in substantial compliance. It is essential that pertinent documentation is filed in the active record to ensure continuity of care, for making clinical decisions regarding support and services, and to meet compliance with record keeping guidelines. In order for substantial compliance, the active CAP must be resolved and the Facility's projected threshold of 90% or greater compliance must be achieved and sustained longitudinally. The Monitoring Team will follow-up on the status of this tool and the related CAP at the next compliance review.	

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		Refer to Provision M.3 for additional information regarding compliance with Post-Discharge Acute Care Plans and Protocols. The Monitoring Team Attended the Pre-Hospital Discharge Planning Meeting for Individual #169: On 3/6/14, the Monitoring Team attended the Pre-Hospital Discharge Planning Meeting for Individual #169 and reviewed the subsequent meeting minutes prepared by the Hospital Liaison Nurse. The Monitoring Team found that the meeting was integrated and well attended with active participation by all relevant disciplines responsible for Individual #169's supports and services. The discussion was substantive and appropriate for Individual #169's change of health status, as reported below. Staff attending the Pre-Hospital Discharge Planning Meeting included the Medical Director, Primary Care Providers, Hospital Liaison Nurse, Infection Control Nurse, Skin Integrity Coordinator, infirmary Director, RN Case Manager, Physical Nutritional Management Team (PNMT) Qualified Intellectual Disability Professional (QIDP), QIDP Coordinator, PNMT Nurse, PNMT Occupational Therapist, PNMT Physical Therapist, Trinity Physical Therapist, Licensed Medical Social Worker (LMSW), QA Nurse, DSPI, Clinical Pharmacist, Psychiatrist, RN Case Manager Supervisor, and Behavioral Services. The Hospital Liaison Nurse presented a comprehensive summary of Individuals #169's past health history, change in health status that lead to the necessity for hospitalization, hospital admitting diagnosis of Compartment Syndrome, as well as hospital course. Individual #169 had a very complicated medical history, which included a history of nephrolithiasis, hydronephrosis, and urinary tract infection. Individual #169 had a CT scan with contrast of the abdomen and pelvis to evaluate for kidney stones, which resulted in a severe iodine contrast extravasation in the left hand. On 2/28/14, Individual #169 was sent to the emergency room for marked swelling of the left hand with evidence of Compartment Syndrome. The individual was sent to the operating room on the evening of 2/14/14, where release of the swelling was performed on the left hand with a wound vac placed on the hand. Then, she was admitted to the Intensive Care Unit (ICU) for postoperative observation, where she was administered mild pain medication with low-dose morphine and started on intravenous (IV) antibiotic therapy. On 3/3/14, Individual #169 remained stable and was moved to the medical-surgery telemetry floor, where she continued to receive antibiotic therapy and pain medication. On 3/5/14, a revision of the wound with debridement was performed and wound vac reapplied. The date of discharge was pending. The group discussed the new diagnosis made during hospitalization for Compartmental Syndrome secondary to IV contrast infiltration, status post-surgical debridement, and Compartmental Syndrome Release. The group identified any new medications or medication changes Individual #160 will require upon discharge, which included potential for antibiotic therapy follow-up, wound care, and pain medication. The group identified any new treatment or equipment that Individual #169 will require after discharge, which included the Skin Integrity Coordinator going to the hospital to determine wound care needs, follow-up with the orthopedic/hand surgeon, follow-up with habilitation therapy, a new care plan on the home to prevent the wound from getting wet during bath time, and follow-up with infection	

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		control to prevent infection of the surgical would. The group discussed any outpatient workup or follow-up needed for Individual after discharge, which included the Skin Integrity Coordinator's follow-up with the hospital for Individual #169's wound care needs for outpatient care. The group discussed any deconditioning Individual #169 may have experienced that would require physical therapy or occupational therapy. The group identified infectious precaution for Individual #169 and the home staff post discharge. The group identified any other needs to anticipate for Individual #169 upon discharge. The group identified appropriate risk ratings base on the hospitalization. All risk ratings were reviewed and discussed for change of status. The risk ratings were changed as follows: Constipation/Bowel Obstruction changed from medium to high; Cardiac changed from low to high; Fluid Imbalance changed from low to high; Seizures changed from low to medium; Polypharmacy changed from low to medium; and Skin Integrity remained rated high. The group will submit the Pre-Hospital Discharge Planning Meeting results and recommendations to Individual #169's IDT for review and follow-up. <u>Skin Integrity</u> Skin Integrity Coordinator Activities: Since the last compliance review, the Skin Integrity Coordinator had resigned in December 2013, but he was recently rehired and was in orientation at the time of the compliance review. In the interim, one of the Nurse Educators had assumed the responsibility for overseeing skin integrity issues. A summary of improvements made in skin integrity activities were provided through interview with nursing administration/management staff and review of documents, which included: o Individuals' incontinent care was provided using wipes containing Dimethicone. The Skin Integrity Committee recommended the discontinuation of the use of towel wipes for incontinence. o Instructions to the Direct Support Professional for turning and repositioning individuals every two hours, or more often if included on their daily schedules, were reinforced. Individuals were repositioned from bed to chair as indicated on their Physical Nutritional Management Plans (PNMPs). The PNMPs were made available in each individual's Individual Notebooks. o Direct Support Professionals were instructed to check individuals for incontinence or wetness every two hours or more often if indicated/ordered on their PNMP and to report any reddened areas found to the nursing staff. o Nursing staff were instructed to report any identified skin breakdown or pressure areas on individuals to the Skin Integrity Coordinator to the unit RNs and/or RN Case Managers, who will notify the Skin Integrity Coordinator for follow-up. o The Hospital Liaison Nurse while making hospital rounds continued to immediately notify the Skin Integrity Coordinator of skin integrity issues. The Hospital Liaison Nurse and Skin Integrity Coordinator continued to make hospital rounds together when skin integrity issues were identified. The Facility team continued to work collaboratively with the Hospital Wound Care Center for a skin integrity problems found during hospitalization. Facility's Self-Assessment Skin Integrity Data: The Facility's Self-Assessment Skin Assessment Monitoring data, 8/1/13 through 1/31/14, reported that 30 internal audits were completed by the	

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nursing staff during the date range and six external audits were completed by the quality assurance staff during the date range. The data showed overall 94.38% compliance by the internal audits, overall 90.38% compliance by the external audits, with 98.48% level of agreement between the internal and external audits.

The chart below shows the Facility's Pressure Ulcer and No Pressure Ulcer/Wound Data Reports, August 2013 through December 2013:

Month*	Pressure Ulcers (unduplicated) Facility acquired	Pressure Ulcers (unduplicated) acquired outside Facility	Non-Pressure Ulcers(Active)	Total Number of all wounds for the month	Number of wounds healed	Individuals with new wounds for the month
August	1	1	8	10	0	2
September	0	0	3	3	0	0
October	0	1	26	27	4	1
November	0	0	8	8	5	3
December	0	0	2	2	1	2
Total	1	2	N/A	N/A	N/A	N/A

The Facility stated that in the absence of the Skin Integrity Coordinator for December 2013, the unit nurses collected the information concerning wounds. Primary Care Providers referred individuals with active wounds to off campus clinics at the local hospital for wound care. Unfortunately the data above did not include the stages of the pressure ulcers. Data for January 2014 and February 2014 was not available for review.

The above data continued to show low incidence of pressure ulcers considering the number of medically fragile individuals who have multiple high and medium risks rating. The Skin Integrity Coordinator in collaboration with the Skin Integrity Committee should continue to focus on more in-depth analyses and trends for underlying causes that contribute to pressure ulcers acquired at the Facility in the 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.

Skin Integrity Committee Meetings: The Facility's Self-Assessment stated that the Skin Integrity Committee met 11/1/13 to focus on more in-depth analysis and trending for underlying causes which contributed to pressure ulcers. The committee discussed prevention, positioning, and diet. Non-pressure ulcers were discussed and recommendations were given for reporting occurrence, immediate

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		notification, and aggressive treatment. The Skin Integrity Coordinator will include analysis of tracking and trending in the quarterly reports to the committee. However, the Monitoring Team was not provided a copy of this Skin Integrity Committee Meeting minutes to review. Therefore, the content of the committee's discussion and recommendations could not be determined. The Monitoring Team was only provided Skin Integrity Committee Meeting Minutes for 9/4/13, 9/18/3, 10/30/13, 11/6/13, and 11/20/13. Typically, in past reviews the Skin Integrity Committee met on a weekly basis. Therefore, the frequency of the meeting could not be determined. A review of committee meeting minutes' list of members attending showed that all required committee members were not consistently present at the meetings. This was of concern because the Skin Integrity Committee was supposed to be an integrated meeting. If relevant disciples do not attend the committee meetings, efforts to work collaboratively to prevent skin integrity/pressure ulcer cannot be adequately addressed/achieved. The Facility should ensure that all required members/disciplines consistently attend the Skin Integrity Committee Meetings and that the committee meetings are conducted as scheduled. In addition, a review of the content of the committee meeting minutes found that they were limited to a list of individuals with skin integrity issues/pressure ulcers/wounds, their treatment, and status of wound healing. There was no other substantive information included that described the discussions, recommendations, and disposition of measures taken to prevent skin integrity/ pressure ulcer/wound incidents. The documentation showed a regression of findings from prior in the Skin Integrity Committee Meeting Minutes. The Facility should ensure that the committee meeting include substantive information regarding efforts to prevent, analyze, track, and trend pressure ulcers/wounds and corrective action plans when indicated. Based on the Monitoring Team's findings, the Nursing Department needs to ensure the following issues are address: The Skin Integrity Committee should ensure that all required members attend the committee meetings consistently and that the committee analyze and trend skin integrity data for underlying cause for skin breakdown. <u>Infection Control</u> The Facility's Self-Assessment for Infection Control Activities provided the following data: • From 8/1/13 through 1/31/14, 262 Infection Control Forms (ICFs) and 261 Acute Care Plans (ACP) were reviewed that showed: o 262 of 262 (100%) ICFs were completed. o 261 of 262 (99.6%) ICFs had ACPs completed that include interventions for infection control. o One of 262 (.6%%) ICFs completed had infection control interventions included in an Integrated Health Care Plan. • The Antibiotic Protocol Audit results, August 2013 through January 2014, showed:	

Antibiotic Protocol Audit	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014	Overall percentage

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Tool *							
	89%	100%	100%	89%	100%	80%	94%

*Refer to above Quality Assurance Activities for the result of inter-rater reliability check for Nursing Care Monitoring Tools and Nursing Protocol Audits.

The Monitoring Team was provided supporting documentation that verified the Facility's Self-Assessment data.

Infection Control Nurse Activities: The Infection Control Nurses continued to prepare an excellent and comprehensive summary of the activities performed with supporting documentation 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 provided additional supporting documentation when requested. Activities included:

- Development and implementation of processes to improve the Handwashing Monitoring Tools and Infection Control by: Follow-up reminders for handwashing data was made to the department head for all areas for this information with 95% compliance. Infection Control Forms were being faxed as they are completed with 98% compliance, including after hours.
- Reviewed and reported Individuals' and employees' tuberculosis skin testing and influenza vaccination status:
  - Individuals' were reported to be 100% current with tuberculosis skin testing/screenings.
  - Individuals' who had received influenza vaccinations were reported as 100% complete.
  - Employees' tuberculosis skin testing and/or chest x-ray/screenings were reported at 99.46% completed.
  - Employees' who received influenza vaccinations were reported at 28% complete. Employees' who received Hepatitis B vaccination series were reported at 11.96%, August 2013 through January 2014.
- Prepared monthly Antibiograms and provided the information to the medical staff and to the Pharmacy and Therapeutics Committee.

Infection Control Policies and Procedures New/Reviewed:

- RSSLC Topic: Procedural Policy for Tracking Incontinence, 9/9/13. The Infection Control Manual policies and procedures were reviewed/revised by the Infection Control Committee on 2/11/14. The following Infection Control Manual policies and procedures were revised:
  - Policy D.4: Suction the Isolation Patient for a Sputum Specimen
  - Policy D.5: Administering Medication in Isolation
  - Policy D.6: Transporting the Isolation Individual
  - Policy D.8: Cleaning the Isolation Room

- Infection Control Nurse Training Activities:
  - The Infection Control Nurses continued to teach Infection Control Measures at New Employee Orientation and at annual refresher training in collaboration with CTD.

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		o The CTD Course Delinquency List, printed 3/5/14, indicated there were 11 delinquent employees for Infection Control annual refresher training. The Facility should ensure that all employees are current in Infection Control annual refresher training. o Additional in-service training was provided 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 Pinworm Prevention and Control training was provided to the San Antonio B and C on 9/4/13. o Seasonal Influenza: Flu Basics training was provided to the Infirmary staff on, 10/29/13, 10/30/13, and 11/1/13 staff. o Genital Herpes training was provided to the Infirmary and San Jacinto Unit in November 2013. o Signs and Symptoms of Conjunctivitis training was provided to Leon A and D staff in November 2013. o Hepatitis A, B, C and Standard Precautions training was provided to the Trinity Unit DSP staff 1/23/14. o Shingles Training was provided to Leon A Dorm staff on 1/27/14. o Blood Draw Procedure for Immunosuppressed Compromised Individuals training was provided to the RN staff on 1/21/14. o Universal Precautions training was provided to the San Antonio Unit staff on 2/21/14. o The Infection Control Nurses attended Bugs Among Us: Microbiology and the Infection Preventionist, Terri Goodman and Associates on 10/22/13; earning 5.5 contact hours of continuing education through the Texas Nurses Association. Infection Control Committee Meetings: Infection Control Committee Meetings continued to be 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 Monitoring Team reviewed the Infection Control Committee meeting minutes for 10/15/13 and 1/28/14, and 3/4/14. 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. A review of the Infection Control Committee Meeting minutes showed any old business was followed up	

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		on. There was substantive information presented, reviewed, discussed, and decisions made for improvement/corrective action on relevant topics. Infection Control data was presented regarding the incidences of each type of infection reported during the quarter. The Medical Director reported the incidences of Pneumonias and Urinary Tract Infections. At the 3/4/14 committee meeting the Medical Director reported that the cases of pneumonia had decreased since 2012 due to the following: Bed therapy, enteral nutrition, initialization of air scrubbers and Ultraviolet lighting, new action plans, and in order to prevent tube migration instructions were provided to all care givers to constantly check G-tubes to see if they had moved, especially during feeding, bathing or any time individuals were moved. In the case of UTIs, even though Trinity A and B have the most cases of UTIs, they have also decreased due to the following: More aggressive hydration, action plans, identifying type of bacteria, the use of UTI Stat was effective, and the Check and Change Policy. Infectious and/or Communicable Disease Data Reports: The Facility continued to maintain a comprehensive Infection Control Database, which represented data in bar and pie charts. The data included infections by type, overall number, number and percentage by home/unit. A summary of the infection control data, August 2013 through January 2014, continued to show a high rate of infections for: Soft Tissues/Cellulitis, Urinary Tract Infection (UTI), and Conjunctivitis. There were total of 83 Soft Tissue/Cellulitis Infections, 64 UTIs, and 23 Conjunctivitis Infections. All other infections were less 10 or less. There was one case of Methicillin-resistant Staphylococcus areus (MRSA) of the nares reported on 3/4/14 that required admission to the infirmary for isolation. The MRSA infection will be reported in the March 2014 infection control data. As reported in previous reviews, the Infection Control Committee was analyzing the high incidences of UTI data in an effort to identify underlying causes and to implement plans of actions to reduce/prevent their incidences. Monitoring Team's interview with the Infection Control Nurse and documentation showed the infection control measures put in place to reduce the incidences of UTIs appeared to be effective. The quarterly data provided showed: July 2013 through September 2013 there were 37 UTIs reported, October 2013 through December 2013 there were 30 UTIs reported, in January 2014 there were 12 UTIs reported, and in February 2014 there were six UTIs reported. The Action Plan implemented to reduce the incidences of UTIs included: • Tracking the check and change of disposable briefs for individuals who were incontinent. • Provide hydration, by giving extra fluids to individuals who were able to consume oral intake. The nurses will give extra fluids to individuals who receive enteral nutrition per physician orders. • Provide meticulous perineal hygiene by cleaning and wiping the perineal area from front to back after each urination and bowel movement to prevent ascending UTIs. • The Infection Control Nurse will follow-up on Urine Cultures results and identify the bacterial type causing the UTIs. • The staff will practice Standard Precaution, washing hands with soap and water and use gloves before and after individual contact and in between contact with individuals to prevent the spread of infection.	

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		The Monitoring Team was not provided with other action plans to reduce/prevent the incidences of Soft Tissue/Cellulitis and Conjunctivitis. This will be followed up at the next compliance review. Refer to Sections L and O for information regarding the incidences of aspiration pneumonias/pneumonias. <u>Summary of Infection Control Nurses Integration with other disciplines/departments included:</u> o Attended the Clinical Morning Meetings on Tuesdays and Thursdays. o Attended the Grand Rounds Meetings. o Attended the Skin Integrity Committee Meetings weekly. o Taught Infection Control Measures at New Employee Orientation in collaboration with CTD. o Attended IDT meetings when there was infection control issues that needed addressed. o Attended the Safety Committee Meetings monthly. o Attended Pharmacy and Therapeutics Committee Meetings Quarterly. o Attended the Environmental Readiness Team monthly meeting rounds on campus. o 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. Refer to Provision M.3 for reports on individuals' Acute Care Plans and associated documentation with recent and/or current active infections. <u>Diabetic Nurse Educator Activities:</u> It was positive to find since the last compliance review, even though the Facility did not have a dedicated Diabetic Nurse Educator, these activities were provided by the Nurse Educators. The Monitoring Team's review of documents and interview with the Nurse Educators showed the following diabetic activities were provided: o The Nursing Department, in collaboration with other disciplines, conducted their first Diabetic Health Fair on 1/15/14. o Diabetic Health Fair: On 1/15/14, the Nursing Department, in collaboration with other disciplines, conducted the first biannual Diabetic Health Fair for all individuals and family members. The target audience was the 22 individuals who have diabetes and their family members. The goal was to provide diabetic education to these individuals and their family members on what their expectations were especially for when they go on a pass outside the Facility. There were booth displays from other disciplines such as Dietary, Pharmacy, Dental, Habilitation Therapy, Residential/Recreational, and Nursing Departments. This was a significant improvement made by the Nursing Department over the past six months to	

#	Provision	Assessment of Status	Compliance
		accomplish the goals of optimal health status for individuals with diabetes through diabetic education training, as well as the integration of diabetic care with other disciplines, including Dietary, Occupational and Physical Therapies, Habilitation, Dental Services, and Primary Care Providers. o Individuals who have diabetes were monitored by the PCP, nurses, and staff, especially when individuals were out on pass. Diabetic education was provided to these individuals, staff, and family members by the RN Case Managers and unit nurses. The main goal was to educate individuals with diabetes, families, and Direct Support Professionals on signs and symptoms of hyperglycemia/hyperglycemia, making good food choices, exercise (stationary exercise bike) , and the effects of diabetes on teeth. An example of such teaching was verified through the Monitoring Team's review of Individual #680's Diabetic Teaching for Individual/Family Members Sheets and Integrated Progress Notes for outside passes on 11/27/13, 12/24/13, 1/5/14, and 1/11/14 and Individual #723 on 1/5/14. <u>Mock Medical Emergency Drills and Emergency Response Activities:</u> The Monitoring Team found since the last compliance review, the Facility continued to maintain the positive practices identified in previous reports. There was evidence found through staff interviews, direct observations, and supporting documentation supplied that prompt corrective action was taken on identified deficiencies identified, as well as identifying areas that needed continued improvements, as reported below: • As was suggested by the Monitoring Team on previous reviews, in November 2013, the Facility began conducting Mock Medical Emergency Drills consisting of a variety of scenarios and at various locations throughout the campus, except for the pool area, that might require emergency response. For example, in November 2013, it was documented that drills were conducted using the following scenarios: In San Antonio-A the victim was found in a chair, in San Antonio-D the victim was found lying on the sofa, in Leon C the victim was found lying on the sofa, and in the Workshop the victim was found in a wheelchair. In December 2013, it was documented that drills were conducted in TJ9 with the victim found in a chair in the dayroom, in TJ8 the victim was found setting in the Cushman in the parking lot, and in TJ5 the victim was found on the sofa in the living room. It was documented that in all of the drills the victims were moved to the floor before CPR was administered. All drills were documented as having passed. It was positive to find that in February 2014, the Facility had procured a full body mannequin to use in the various scenarios for the Mock Medical Emergency Drills. On 3/6/14, the Monitoring Team observed an impromptu drill in San Antonio-C where the mannequin was used, which was placed setting on the sofa in the living room. At the first drill attempt the staff were slow to respond and required much prompting. The staff initially laid the victim on the sofa; after prompting the victim was placed on the floor and CPR initiated. The drill was repeated a second time with rapid response and successfully completed with minor prompting. However, this demonstrated the need for continued improvement in response time and correct procedure for performing CPR using the full body mannequin.	

#	Provision	Assessment of Status	Compliance

- The Emergency Response Committee core membership was comprised of the Risk Management Director, Chair, Medical Director, Chief Nurse Executive, Competency Training and Development Director, Residential Services Director, Employee Injury Services Coordinator, Quality Assurance Nurses, and Nursing Administrative Assistant. The Emergency Medical Response Committee met quarterly.
- The Monitoring Team reviewed Emergency Medical Response Committee Meeting minutes for 10/16/13 and 1/15/14. The committee meetings were conducted quarterly as scheduled with core members or designee consistently present at the meetings. The minutes were substantive and issues identified in previous meetings that needed follow-up were addressed in following meetings. Newly identified emergency response issues were discussed along with corrective action to be taken. It was positive to find that the need for a full body mannequin to use for conducting Mock Medical Emergency Drills using various scenarios was discussed in October 2013 committee meeting. At the January 2014 committee meeting it was reported that the mannequin would be received by 2/1/14. The committee further discussed plans for conducting Mock Medical Emergency in different areas with the mannequin. There were no actual code events reported during the last six months that required the committee to conduct Emergency Medical Response Debriefing.
- The Monitoring Team's review of the monthly Mock Medical Emergency Drill Reports, August 2013 through January 2014, 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 that report no identified deficiencies. There was documentation that the Monthly Mock Medical Emergency Drill Reports were sent to Incident Management Meetings (IMM) after drills were completed. There was no documentation that IMM made any recommendations for improvement and/or corrective action. The data was also submitted quarterly to the Quality Assurance Department, as required by policy. No CAPs were reported.
- The Monitoring Team's review of internal nursing audits and longitudinal monthly Emergency Equipment/Automated External Defibrillators (AEDs) Emergency Walkthrough Checklist Report analysis for the Facility, August 2013 through January 2014, showed the following results:

Month	Signatures available daily for the month	Nurse Managers end of the month signatures	Missing entries	Zip ties number entered on the checklist	AEDs pads expiration dates checked	Oxygen Tanks available and checked	Suction machine available and checked
August	100%	100%	100%	100%	100%	100%	100%
September	100%	100%	75%	100%	755	100%	100%
October	100%	100%	100%	100%	100%	100%	100%
November	100%	100%	100%	100%	100%	100%	100%
December	100%	100%	100%	100%	100%	100%	100%
January	100%	100%	100%	100%	100%	100%	100%

Documentation of corrective action: In the month of September 2013, one of five units had missing entries and missing AED expiration dates. The Nurse Managers were re-trained to ensure that unit

#	Provision	Assessment of Status	Compliance
		nurses included the dates of AED expiration pads and missing entries. • The Monitoring Team's review of the monthly Emergency Walkthrough Checklist Report analysis for the Facility, August 2013 through January 2014, for the residential units, Infirmary, and other areas where emergency equipment and AEDs were located found these were checked 100% of the time by the Risk Manager and/or designee. There was documentation that any identified missing or not working equipment/AED was promptly replaced and/or repaired. • The Monitoring Team's observations of the AEDs and emergency equipment in Trinity Unit 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 was found completed as required by policy. A review of the Facility's List showed the location AED 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. • The Competency Training and Development (CTD) Due/Delinquency Training Lists, 3/5/14, indicated nine employees were delinquent in Basic CPR and no Health Care Providers were delinquent. The Facility should ensure that all required employees are current with Basic CPR training. It was positive to find that the Facility met the requirement of the Emergency Response Policy with the exceptions of failing to demonstrate competency with performing Mock Medical Emergency Drill using the full body mannequin to perform alternate scenarios (they had implemented use of alternate scenarios, but the drill observed by the Monitoring Team did not demonstrated competence) and the lack current Basic CPR training of all required employees. 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, under numerous environmental circumstances, and that all required employees are current in Basic CPR training. The Monitoring Team will follow-up at the next compliance review on the competency of realistic drill scenarios and Basic CPR training. A review of the various requirements found that most continued to maintain the positive practices identified at the last compliance review. However, there was a need for the Nurse Managers, Skin Integrity Nurse and Infection Control Nurse to provide more over-the-shoulder observations to ensure that proper techniques are followed for dressing changes and perineal care. The Emergency Response Committee recently procured a full body mannequin to use for conducting mock medical emergency drill using realistic scenarios. More drill practice is needed to ensure competency in completing the various scenarios.	
M2	Commencing within six months of the Effective Date hereof and with full implementation	<u>Facility's Self-Assessment for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessments:</u> <u>The Nursing Department had developed a monitoring tool for the recently revised Comprehensive Nursing Review/Quarterly Nursing Review/Quarterly Physical Assessments. The Self-Assessment provided the audit results of the monitoring tool for October 2013 through January 2013 as reported</u>	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>
<u>below:</u>
• Conducted monthly RN Case Manager Quality Peer Reviews on the revised Comprehensive Nursing Review/Quarterly Nursing Record/Review/Quarterly Physical Assessments. The results of the Nursing Department and QA Nurses audits, October 2013 through January 2014, showed the following percentage of compliance:
Nursing Department Audits
<table>
<tr><th>Annual Nursing Assessments</th><th>October 2013</th><th>November 2013</th><th>December 2013</th><th>January 2014</th><th>Overall Percentage of compliance</th></tr>
<tr><td></td><td>95%</td><td>98%</td><td>96%</td><td>98%</td><td>97%</td></tr>
</table>
Nursing Department and QA Nurses inter-rater reliability level of agreement showed:
<table>
<tr><th>Annual Nursing Assessments</th><th>October 2013</th><th>November 2013</th><th>December 2013</th><th>January 2014</th><th>Overall Percentage of compliance</th></tr>
<tr><td></td><td>98%</td><td>100%</td><td>100%</td><td>100%</td><td>99%</td></tr>
</table>
• Reviewed tracking of Annual and Quarterly Nursing Assessments for timely filing in the ISP folder. Tracking results showed the following percentage of compliance:
<table>
<tr><th>Units</th><th>October 2013</th><th>November 2013</th><th>December 2013</th><th>January 2014</th><th>Overall Percentage of compliance</th></tr>
<tr><td>Trinity</td><td>100%</td><td>100%</td><td>80%</td><td>100%</td><td>93%</td></tr>
<tr><td>Leon</td><td>75%</td><td>81%</td><td>100%</td><td>100%</td><td>85%</td></tr>
<tr><td>San Antonio</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Three Rivers</td><td>100%</td><td>75%</td><td>100%</td><td>100%</td><td>92%</td></tr>
<tr><td>Four Rivers</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>
The RN Case Manager Supervisor provided RN Case Managers coaching and retraining on proper filing Annual Nursing Assessment in the ISP folder within the mandated timeframe.

<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 Program Compliance Nurse, RN Case Manager Supervisor, RN Case Managers, Nurse Educators, QA Nurses; and review of medical records. 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.2 and the Monitoring Team concurs with their findings.

<u>New/Revised Policies, Procedures, and Processes:</u>
• DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Physical Assessment, January 2014 Refer to Provision M.4 for other related new/revised policies, procedures, protocols, and processes <u>RN Case Manager Training Activities:</u> • On 10/10/13, 17 of 20 (85%) RN Case Managers were trained on: o Revised Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment o Completing assessment ten days prior to the ISP o Changes on the Medical Consultation Database • On 10/14-29/13, 19 of 20 (95%) RN Case Managers were trained on: o Completing and reviewing Checklist for Medical/Dental Sedation o The process for tracking Checklist for Medical/Dental Sedation o Completing and submitting Sedation Log with accuracy • On 10/31/13, 19 of 20 (95%) RN Case Managers were trained on: o In-servicing individuals' guardians on diabetic diet for the individuals who are diabetic during the ISP meetings o Forms for the Unit Directors to sign for tracking Checklist for Medical/Dental Sedation o Places to file DSP Instruction Sheets o Completing IHCPs and review problems QA identified • On 11/7/13, 17 of 20 (85%) RN Case Managers were trained on: o Medical record documentation and filing o Restraint Checklist Process o Problems identified in the IHCP • On 12/12/13, 18 of 19 (94%) RN Case Managers were trained on: o The information missing on database for Medical Consultation o Reinforced teaching family/DSPs and individuals on diabetic diets • On 1/9/14, 19 of 19 (100%) RN Case Managers were trained on: o New policy on Acute Care Plans/Integrated Health Care Plans o Integrated Health Care Plan Monitoring Tool o Reviewed Trigger Sheet completion o Printing new Physician Order Sheet every time you are writing orders • On 1/4/14, 19 of 19 (100%) RN Case Managers were trained on: o DISCUS/MOSES – using Video • On 1/30/14, 17 of 19 (89%) RN Case Managers were trained on: o New Community Living Discharge Plan o Integrated Health Care Plan Action Plans for audit findings o Plan of Improvement o Physician coverage • On 2/13/14 18 of 19 (94%) RN Case Managers were trained on: o DISCUS/MOSES	

#	Provision	Assessment of Status	Compliance
		o New Enema Checklist Refer to Provision M.4 for a list of other training activities. <u>Monitoring Team's Meeting with the RN Case Managers:</u> On 3/5/14 the Monitoring Team met with the RN Case Manager Supervisor, RN Case Managers, Program Compliance Nurse, Nurse Educators, and QA Nurses and reviewed in detail the revised Guidelines for the Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessments. There was a general discussion regarding the fact that the state template for the revised Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment form was rigid and lacked the flexibility for data entries, which had the potential to contribute to lack of compliance. The nurses suggested that the required documentation should have areas that allow for elaboration on the areas that need further documentation. They explained this problem was due to their inability to override the template. The Facility should address this issue with the State Office Nursing Coordinator. The Monitoring Team reviewed the most recently completed Admission and/or Annual Comprehensive Nursing Reviews along with Physical 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 10 Individuals #661, #379, #320, #203, #349, #314, #318, #413, #140, and #366. These were all completed on the revised form; all in the sample were admission and annual nursing assessments, so the Monitoring Team cannot comment on quarterly assessment. The review found: • Ten of 10 (100%) Admission and/or Annual Comprehensive Nursing Reviews requested were available for offsite review. Eight of 10 (80%) Admission and/or Annual Comprehensive Nursing Reviews included the required Physical Assessment. • 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. The Monitoring Team reviewed 10 of the most recently completed Admission and/or Annual Comprehensive Nursing Reviews and Physical Assessments, which were completed on the revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment Forms. The Monitoring Team using an Annual Nursing Monitoring Tool comparable to the tool used by the Facility and found an overall compliance of 89%. However, two of the Comprehensive Nursing Reviews did not include the Physical Assessments (Individuals #783 and #585) required to be completed along with the admission and annual nursing assessments. Failure to have the Physical Assessments caused the overall compliance score to be lower. When eliminating those two records, the monitoring results of eight of eight nursing assessments showed 95% compliance. It could not be determined whether the Physical Assessments were not completed or simply not provided. In this case, the monitoring results were relatively consistent with the Facility's Self-Assessment for Annual Nursing	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Assessments data and the Monitoring Team findings of 95% compliance at the last compliance review. There continued to be significant improvement in the quality and content of the nursing assessments. The items on the tool that fell slightly below 90% compliance included:
o Current active medical problems were not totally consistent with those listed on the Annual Medical Assessments.
o Section VIII Summary: Summary of Current Health Status did not consistently include the health status for all identified high and/or medium risk conditions identified on the IRRFs that required nursing services. However, as mentioned above, this may have been due to the limitations on the Comprehensive Nursing Review Form and accompanying instructions. In addition, some of the missing summaries on admission assessments for high and/or medium risk ratings were attributable the fact that the nursing assessments were completed prior to the IRRFs and IHCPs and had not yet had time to assess health status in relation to effectiveness of the plans. The RN Case Manager Supervisor should ensure that the RN Case Managers include summaries on individuals' health status in relation to all identified high and/or medium risk conditions requiring nursing services at first Quarterly Nursing Record Review/Quarterly Physical Assessments and thereafter. These issues should not negate substantial compliance with this Provision.

The Facility's Self-Assessment, interviews with the Compliance Nurse and RN Case Manager, and review of documentation provided, showed that significant improvements had been made and were effective in improving the quality and content of the nursing assessments. The Facility stated they were in substantial compliance with this Provision and the Monitoring Team concurs with their findings. In order to maintain substantial compliance the Nursing Department must ensure that the positive practices identified in the report are continued.

Refer to Provision M.5 and Section I, Provision I.1 and I.2 for additional information regarding the IRRFs and IHCPs processes.</td><td></td></tr>
<tr><td>M3</td><td>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</td><td><u>Facility's Self-Assessment for Acute Care Plans:</u>
The newly hired Nursing Operations Officer, on 11/18/13, implemented a new process for the Nurse Managers to provide more oversight on monitoring acute care documentation. Each Nurse Manager reviewed records on a designated day for audits of the Integrated Progress Notes on their units weekly. The following audit data were provided for Acute Care Plans (ACPs) and Integrate Progress Notes (IPNs):
• The results of five audits for RNs using the newly revised template for ACPs, 12/1/13 through 1/31/14 showed the following percentage of compliance:
<table>
<tr><td>Acute Care Plans</td><td>December 2013</td><td>January 2014</td><td>Overall Percentage</td></tr>
<tr><td>Format/Components</td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>
• The results of five audits for IPNs documentation, November 2013 through January 2013, showed the following percentage of compliance:
<table>
<tr><td>IPN Documentation</td><td>November</td><td>December</td><td>January</td><td>Overall</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

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.

	2013	2013	2014	Percentage
Full Set of Vital Signs	100%	100%	100%	100%
Oxygen Saturation	100%	100%	100%	100%
Adverse Drug Reactions	90%	75%	75%	80%
Effectiveness of Treatments	100%	80%	90%	90%
Documentation of Resolution	100%	90%	90%	93%

- The process for tracking specific items was initiated as a result of a request on 11/5/13 from the Director of Medical Records to improve the legibility and gaps found during recordkeeping audits. Nurse Managers included tracking these items during the weekly reviews. This was an ongoing process. The results of five audits for IPNs documentation, December 2013 through January 2014, with tracking of specific items showed the following percentage of compliance:

INP and ACPs Reviewed	Legible Signatures Compliance	Printing Name (as needed) Compliance	Blanks/Gaps Corrections in INP	Overall Percentage of Compliance
December 2013	90%	100%	98%	96%
January 2014	96%	100%	97%	98%

Monitoring Team's Findings:
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, Program Compliance Nurse, Nurse Educators, Nurse Managers; RN Case Manager Supervisor, and RN Case 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.

New/Revised Policies, Procedures, and Processes:
- DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Revised January 2014

Refer to ProvisionM.4 for other new/revised policies, procedures, protocols, and processes

Training Activities:
- In December 99% of the RNs were trained on the newly revised Acute Care Plan template issued by the State Office.
- In January 2014, 100% of the RN Case Managers were trained on the new Community Living Discharge Plan,

Refer to Provision M.4 for additional training activities.

#	Provision	Assessment of Status	Compliance
		Monitoring Team's Meeting With the Unit Nurse Managers: On 3/3/14, The Monitoring Team met with all Unit Nurse Managers and discussed the changes to the newly revised Acute Care Plan template and bank of interventions. Then, each Nurse Manager brought one record and together the Monitoring Team and Nurse Manager critiqued each record's Acute Care Plans for infections and associated documentation in the Integrated Progress Notes. The collaborative review of ACPs for recent and/or infections, primarily Urinary Tract Infections, found that the recently implemented processes were beginning to be effective as reported below. The improvements showed in each shift entry: Significant improvement in the legibility of documentation and signatures and titles, full sets of vital signs and oxygen saturation, adverse drug reactions, effectiveness of treatment, and documentation. In addition, there was improvement in the consistency in documentation of focus/comprehensive assessments of identified problems, mental/behavioral status, Wong Pain Scale Assessments, activity tolerance, and instructions to the Direct Support Professionals for their responsibilities related to the identified problems. In the records reviewed there were no gaps found in documentation, documentation errors were properly corrected, and it was rare to find an entry that was not dated and timed. Monitoring Team's Review of Acute Care Plans and Associated Document for Active Pressure Ulcers: At the time of the compliance review, the Facility had three active pressure ulcers, of which two were hospital acquired and one was acquired at the Facility. Records were reviewed for Individuals: #340, #463, and #544, and the Monitoring Team found: • Two of three (67%) individuals had a Skin Integrity-Pressure Ulcer Acute Care Plan (ACP) provided for review. Individual #463 had neither an ACP and/or Integrated Health Care Plan (IHCP) for Skin Integrity. However, Individual #463 did have an Integrated Direct Support Professional Instruction Sheet sufficient for their responsibilities related to the management of the pressure ulcers. • Of the two individuals who had ACPs, two of two (100%) individuals' baseline data was sufficient to describe what led up to the necessity for a Skin Integrity-Pressure Ulcer ACP. • Two of two (100%) individuals had Skin Integrity-Pressure Ulcer ACPs initiated upon identification of the pressure ulcers. • Two of two (100%) individuals' goals to achieve the desired outcome of the plan were measurable and observable. • Two of two (100%) Skin Integrity-Pressure Ulcer ACPs were individualized sufficiently for nursing interventions and treatment orders to meet the individuals' health care needs. • Two of two (100%) Skin Integrity-Pressure Ulcer ACPs specified the frequency of the nursing interventions and treatment orders to be performed and documented. • Two of two (100%) Skin Integrity-Pressure Ulcer ACPs included infection control interventions. • One of two (50%) individuals' Skin Integrity-Pressure Ulcer ACPs included integration with the PNMT, Skin Integrity Nurse, and dietary. • Two of two (100%) individuals Skin Integrity-Pressure Ulcer ACP included instructions for the DSPs. • One of one (100%) individual who resided in TJ7 had Skin Integrity-Pressure Ulcer ACP's DSP Instruction Sheet signed by the Home Manager/Charge/DSPs. The other individual was being	

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		treated in the Infirmary as a result of a recent hospital discharge, which was not staffed with DSPs. • One of one (100%) individual's Skin Integrity-Pressure Ulcer ACP was revised when there were changes in nursing interventions and/or treatment orders for the pressure ulcer. The other individual's Skin Integrity-Pressure Ulcer ACP was very recently initiated and did not need revising. The Monitoring Team's review of Individuals #340, #463, and #544s' Integrated Progress Notes and associated documentation showed: • Individual #340 was discharged on 2/28/14 from the Long Term Acute Care (LTAC) Facility. He was initially admitted to the hospital on 2/2/14 for pneumonia/respiratory distress. On 2/6/14 Individual #340 was transferred to the LTAC Facility for continued IV therapy. While in the LTAC the Hospital Liaison Nurse reported that Individual had developed a Stage I pressure ulcer on the right ankle that was resolving. On 2/24/14, a redness and pressure area was reported on the sacral area. By 2/26/14 the pressure area on the sacral area had progressed to a Stage III pressure ulcer. There was documentation in the Hospital Liaison Reports and Integrated Progress Note that the Hospital Liaison Nurse worked collaboratively with the LTAC Wound Care Nurse for management of the wound. While in the LTAC Individual #340 had a gastrostomy tube inserted as a result of a barium swallow study that showed dysphagia. Individual #340 was admitted to the Infirmary upon discharge from the LTAC. An Acute Care Plan for Stage III Sacral Ulcer and Gastrostomy Tube Placement was initiated upon admission. The Integrated Progress Notes, 2/18/14 through 3/5/14, were reviewed; the care plans were carried out as described. The Stage III Sacral Ulcer Acute Care Plan's intervention for monitoring the wound included, "at least once a shift for color changes, redness, swelling warmth, pain, drainage, or other signs of infection and document in the Integrated Progress Notes." These assessments were consistently completed and documented on each shift. However, there were no instructions on the plan to for measure the size, depth, and stage of healing of the wound. Consequently, the size, depth, and stage of wound healing were not consistently documented at least daily in the shift reports, particularly when the wound dressings were changed. These assessments are essential to determine the status of wound healing in response to treatment regimens. There was documentation that a PNMT and Physical Therapist evaluation were completed on 3/3/14. On 3/3/14, there was documentation that the IDT was informed of Individual #340's return to the Infirmary on 2/28/14. On 3/4/14, at 1940 the nurse documented Individual #340's vital signs as blood pressure 125/77, temperature 100 axillary, pulse 115, respiration 30, and oxygen saturation 96% on room air. Individual #340 was using accessory muscles for breathing. The Nurse Practitioner was immediately notified of vital sign findings, who ordered one time Tylenol 650mg via G-tube for possible pain, scheduled for sick call in the morning, and to call her back if vital signs were still abnormal after the Tylenol. On 3/4/14 at 2250, the Nurse Practitioner was notified that Individual #340's vital signs continued to be elevated with rapid respirations with the use of accessory muscles and the oxygen saturation had dropped to 95%. The Nurse Practitioner advised the nurse to continue to monitor. On 3/5/14, Individual #340 was reassessed again at 0000, with vital signs documented as blood pressure 100/58, temperature axillary 95.7, pulse 94, respirations 30, and	

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		oxygen saturation 97% on room air and again at 0220, for which they were documented as blood pressure 134/70, temperature axillary 97.6, pulse 108, respirations 32 and oxygen saturation 82% on room air. Oxygen at 3 liters via nasal cannula was applied according to protocol. With the administration of oxygen the oxygen saturation came up to 92%. The Nurse Practitioner was notified again of findings. The nurse documented that she emphasized the fact that she did not feel comfortable about Individual #340's condition. The Nurse Practitioner instructed her to call the campus nurse to do an assessment. The nurse insisted again that she did not feel comfortable with Individual #340's condition. Then, the Nurse Practitioner gave an order to transfer Individual #340 to the emergency room via "regular" ambulance.. The campus nurse was notified, "regular" ambulance service was called but it was not available. The campus nurse arrived and agreed with the nurse that the Nurse Practitioner should be called to get an order to transfer Individual #340 via 911 Emergency Medical Services. The Nurse Practitioner was notified and an order was given to call 911. Emergency Medical Services arrived at 0300 and Individual #340 was sent to the emergency room for evaluation and treatment. The seeming reluctance of the Nurse Practitioner to send Individual #340 to the emergency room when the nurse notified her at the onset of the respiratory difficulties was of serious concern to the Monitoring Team based on his recent medical history. Individual #340 was admitted to the hospital on 1/15/14 and diagnosed and treated for pneumonia and sepsis. Individual #340 was discharged on 2/1/14 and was readmitted to the hospital on 2/2/14 diagnosed and treated for hypoxia and pneumonia. Further, it was of concern that initially the Nurse Practitioner gave the order to transfer Individual #340 who was experiencing respiratory distress via "regular" ambulance. It could not be discerned the difference between the "regular" ambulance services and 911 Emergency Medical Services.. It is important to ensure that the whatever ambulance services are used are fully equipped to manage a frank respiratory distress emergency; otherwise the Individual #340 and the Facility may be placed at risk of harm. On 3/3/14, the Monitoring Team observed Individual #340's sacral wound dressing change, accompanied by the Infirmary Director, Program Compliance Nurse, and QA Nurses. After Individual #340's incontinent briefs were removed it was discovered that he had a large bowel movement. The wound dressing was removed and the wound was irrigated with normal saline and covered with a Duoderm dressing. The nurse did not date, time, and initial the dressing. The bottom of the dressing was not properly sealed which if not corrected could allow bowel and bladder elimination to seep into to wound and cause infection. While providing perineal care for the bowel movement the nurse did wear gloves. However, the wipes and cleaning cream were laid directly on the bed. As the nurses went back and forth using the wipes and cream the gloves were not changed as she handled the cleaning products. Therefore, the cleaning products were cross-contaminated as well as the bed. The waste products for the dressing change and perineal care were disposed of in a clear plastic bag. After completing the perineal care the nurse set the cleaning products on the bedside table without placing them on a protective barrier. This resulted in cross-contamination of the bedside table. The nurse laid the dirty bed linens on a chair. The Infirmary Director immediately placed the linens in a plastic bag. After the dressing change the Monitoring Team met with the Infirmary Director, Program Compliance Nurse, and QA Nurses and reviewed the nurse's techniques for dressing change	

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		and perineal care. They agreed that the nurse failed to use clean technique as required. The Infirmary Director stated she would re-train all of the Infirmary nurses on correct clean wound care techniques and perineal care. On 3/3/14, the Infirmary Director re-trained all of the Infirmary nurses on clean wound care techniques and perineal care and provided the Monitoring Team with copies of the training material used and training sign-in sheets. This demonstrated the need for the Nurse Managers, Skin Integrity Coordinator, and Infection Control Nurse to provide more direct over the shoulder observations for wound and perineal care to ensure that these correct techniques are followed at all times to prevent cross-contamination and the spread of infections. • Individual #544: On 1/15/14 at 1945, the DSP reported to the nurse that while giving perineal care an abrasion and redness was discovered to the right and left buttocks. The nurse assessed the buttock and confirmed the redness and abrasion to the buttock. Individual #544 was referred to sick call. Individual was seen the following morning and assessed to have bilateral inner buttock cheek skin ulcerations with skin ulceration of the lower coccyx. Individual #544 toileted independently and the skin ulceration was thought due to poor perineal hygiene and sitting position. He refused to sleep in his bed and would only sleep on the chair in the dining room and on the sofa. It was puzzling how skin integrity had progressed to a stage of ulceration without staff detecting the problem during daily bathing and perineal care. In addition, it was puzzling that the bilateral inner buttock cheek skin ulcerations with skin ulceration of the lower coccyx was not documented on the Quarterly Physical Assessment completed on 1/16/14. If a physical assessment of the skin was completed it should have been identified since the pressure ulcers were identified and reported on 1/15/14. The BRADEN scale was scored as 23; with the development of the bilateral inner buttock cheek skin ulcerations with skin ulceration of the lower coccyx the BRADEN scale should have considered the increase in moisture due to the incontinence and poor perineal care that could have lowered the score. Once the skin ulcers were identified, treatment was ordered and an Acute Care Plan for Skin Ulcer to Bilateral Inner Buttocks and Coccyx Area was initiated on 1/16/14. A review of the Acute Care Plan and Integrated Progress Notes 1/15/14 through 3/2/14 found that the plan was sufficiently individualized to meet management of the skin ulcerations. There was documentation that the DSPs were trained on the plan on the 6-2 and 2-10 shift. The home did not have nurses staffed on the 10-6 shift. Nursing services were provided as needed on the 10-6 shift. A review of the Integrated Progress Notes found that the plan was consistently carried out as described on the 6-2 shifts and 2-10 shifts. As changes in treatment were made the plan was revised. As was mentioned earlier in the report, the wounds were assessed on each shift according to the plan for monitoring. However, the size, depth, and stage of wound healing were not consistently documented at least daily in the shift reports, particularly when the wound dressings were changed. The documentation showed that integrated services were provided in management of the wounds. Individual #544's sleep patterns were evaluated by Behavioral Services and a plan was developed to encourage sleeping in his bed. The PNMT and Physical Therapist assessed and developed a position plan to relieve pressure. As the wound to the coccyx persisted and progressed to a Stage II ulcer, Individual #544 was referred to the Wound Care Clinic for treatment and follow-up. The Monitoring Team discussed with the Nurse Managers the need to ensure that the DSPs on the 10-6 shifts were trained on the plan even though it was not staffed with nurses this does not negate the need for	

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		training on the plan. • Individual #463: On 1/15/14, Individual #463 was readmitted to the Facility from the LTAC facility. He moved to the community in April 2013. While in the community he developed significant changes in health status. Among the numerous health conditions identified at the time of admission was a Stage IV pressure ulcer. A review of Individual #463's records found that even though the Integrated Progress Notes documented that the Acute Care Plan for the Stage IV sacral ulcer was followed on each shift, the Acute Care Plan or Integrated Health Care Plan was not provided in response to a document request. Therefore, it could not be determined if such plans existed. Following the visit, the Facility reported it had provided the Acute Care Plan in the Presentation Book. For more information regarding Individual#463's health status and management refer to Section L. The Nurse Managers, Skin Integrity Coordinator, and Infection Control Nurse need to conduct more direct over the shoulder observations for wound and perineal care to ensure that these correct techniques are followed at all times to prevent cross-contamination and the spread of infections. The Acute Care Plans for pressure ulcers should include measurements of the size, depth, and stage of healing, and then ensure that the measurements are made and documented at least daily and/or when wound dressings are changed in order to accurately assess the status of healing. <u>Monitoring Team's Review of Acute Care Plans and Associated Documentation for Recent and/or Active Infections.</u> The Monitoring Team reviewed a sample of six individuals' Acute Care Plans (ACPs)and supporting documentation who had recent and/or current active infections for Individuals #51, #426, #701, #649, #388, and #503, and found: • Six of six (100%) ACPs had baseline data sufficient to identify the urinary tract infection that led up to the necessity for care plans. • Six of six (100%) ACPs had goals sufficient to identify the desired outcomes of the urinary tract issues for which the care plans were design to resolve. • Six of six (100%) ACPs that required antibiotic therapy included Individual Infection Control Forms completed and sent to the Infection Control Nurses. • Six of six (100%) ACPs were individualized care plans sufficient to meet the individuals' specific skin integrity issues. • Six of six (100%) ACPs incorporated relevant protocols in the plan, i.e., What to tell the PCP, Antibiotic Therapy, Urinary Tract Infections, and Pain. • Six of six (100%) ACPs included integration of care with other relevant disciplines. • Six of six (100%) plans included how frequently interventions were to be completed, by whom, and where documented. • Six of six (100%) plans included relevant preventative measures. • Six of six (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	

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		applicable to individuals' specific skin integrity issues. • Four of six (67%) ACPs had signature sheets verifying DSPs were trained on each shift. • Four of four (100%) plans that were resolved were followed through to resolution with an accompanying resolution note in the Integrated Progress Notes. Two plans were still in process. Individual #701's plan was resolved but not documented on ACP, but was documented in the Integrated Progress Notes Since the last compliance review and from a review of the above ACPs and accompanying Integrated Progress Notes for infections, it was evident the Nursing Administration and the Infection Control Nurses had continued to put forth significant effort to improve the quality and completeness of the ACPs related to infections. 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. The Integrated Progress Notes showed the ACPs were consistently carried out on all shifts according to the plans. The Nurse Managers need to ensure that that the DSPs are trained on the ACPs, even if nurses are not staffed on the 10-6 shifts. DSPs are staffed on all shifts and need to know how to carry out their responsibility for care as stated in the ACPs. <u>Nursing Discharge Summaries and Community Living Discharge Placement (CLDP)Packets:</u> Since the last compliance review, the Nursing Discharge Summary form was discontinued and replaced with the DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Revised January 2014, which included a section for CLDP. The RN Case Manager was in the process of developing a monitoring tool for CLDP. The Facility's Self-Assessment stated that from 9/30/13 through 12/31/13, there were five community living discharge placements, for which random samples of four CLDPs were audited for the completion of the Comprehensive Nursing Review/Nursing Physical Assessment within 45 days of CLDP. The audits of the CLDP showed the following areas of compliance: • High/Medium risk ratings – 100% • Special Instructions medication techniques - 100% • Health Status/Diagnosis/Problems – 100% • Triggers/signs and symptoms of illness – 100 • IRRFs and IHCPs – 100% • Discharge summaries completed per policy utilized the correct discharge form – 100% <u>The Monitoring Team's Review of Comprehensive Nursing Assessment Nursing and/or Nursing Discharge Summaries and Community Living Discharge Packets:</u> The Monitoring Team reviewed five Nursing Discharge Summaries and Community Living Discharge Placement (CLDP) Packets for Individuals #366, #35, #10, #219, and #555. Nursing assessments were completed on a combination of the Nursing Discharge Summary Form and/or the revised Comprehensive assessment. The Monitoring Team's findings were not consistent with the Facility's Self-	

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		Assessment: • Two of five (40%) CLDP Packets had a Comprehensive Nursing Assessment completed within 45 days of discharge. • Five of five (100%) Nursing Discharge Summaries and/or Comprehensive Nursing Assessments were completed for the individuals prior to discharge/transferring to the community. • Two of five (40%) Nursing Discharge Summaries and/or Comprehensive Nursing Assessments listed nursing diagnoses/problems for all high/medium risk ratings or other problems that required interventions. • One of five (20%) Nursing Discharge Summaries and/or Comprehensive Nursing Assessments 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. • Three of five (60%) Nursing Discharge Summaries and/or Comprehensive Nursing Assessments 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.)." • Zero of five (0%) Nursing Discharge Summaries and/or Comprehensive Nursing Assessments included Triggers/signs and symptoms of illness • Four of five (80%) CLDP Packets included a current list of medications. • Three of five (60%) CLDP Packets included a current Immunization Record. • One of five (20%) CLDP Packets included Integrated Risk Rating Forms (IRRFs). • Two of five (40%) CLDP Packets included Integrated Health Care Plans (IHCPs). • One of five (20%) CLDP Packets included Acute Care Plans/DSP Instruction Sheets. • Two of five (40%) CLPD Packets included a copy of the last MOSES/DISCUS assessment. • Zero of five (0%) provided documentation of training to the community agency nurse 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. There was no significant improvement found from the last compliance review. The revised Comprehensive Nursing Form did not include a section for listing nursing diagnoses/problems related to the high and/or medium risk ratings, nor did the form include a section for summarizing the health status of each identified high/medium risk ratings. There were general summaries included for the past year but they did not adequately summarize the health status for each identified high and/or medium risk rating that required nursing interventions. The RN Case Managers stated that the Comprehensive Nursing Assessment Form template could not be overridden to add additional information. This may attribute to the lack of adequate summaries. The Monitoring Team concurs with the Facility's Self-Assessment that they were not in substantial compliance with this Provision. Although it was positive to find that numerous processes had recently	

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		been put in place to improve the quality and content of the Acute Care Plans and associated documentation of care in the Integrated Progress Notes, more time is need to ensure that these processes are solidly in place. If they are maintained this Provision should move toward substantial compliance at the next compliance review. There needs to be improvement in the nursing assessments for Community Living Discharge placements to ensure that all identified high and/or medium risk ratings requiring interventions are identified with a cogent summary of the health status for each risk rating such that the community agencies are able to readily determine whether the individuals are making progress, maintaining or regressing toward the identified high and/or medium risk ratings. 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 Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	<u>Monitoring Team's Findings:</u> 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 Nurse Educators, and Program Compliance Nurse. Ample supporting documentation was provided in the Presentation Book for Provision M.4 with additional documentation provided onsite, which further validated compliance with training and monitoring activities for Provision M.4. 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 positive to find that the Nursing Department continued to have two Nurse Educators to provide nursing education/training. In order to ensure sufficient competency is achieved and maintained, it is important to have two Nurse Educators to ensure that all require training and re-training is provided to the nursing staff, as well as to assist CTD and other disciplines in providing education/training requiring the expertise of professional licensed nurses. In addition to providing the required formal and informal nursing education/training, the Nurse Educators divided the residential units to provide local identified training as opposed to relying solely on the Nurse Managers to provide the training. Such training on the units also provides the opportunity for onsite observations to ensure competency and to measure the effectiveness of the training. It was impressive to find that the Nurse Educators had prepared and presented an excellent and comprehensive summary with supporting documentation of activities performed since the last compliance review. The Monitoring Team's interview with the Nurse Educators demonstrated that they were readily knowledgeable of all education activities that had occurred over the past six months and were able to answer questions and provide additional supporting documentation when requested. The Nurse Educators also provided competency-based training materials used and training records for the trainings reported. <u>New and/or Reviewed/Revised Nursing Related Policies, Procedures, Protocols, Processes, Guidelines, and Forms:</u>	Substantial Compliance

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		DADS Policies, Procedures, Protocols, and Guidelines: • DADS Guidelines: Care Plan Development, Revised Date: December 2013 • DADS Acute Care Plan Form, Revised Date: December 2013 • DADS Nursing Protocol: DIASTAT AcuDial, Revised Date: December 2013 • DADS Nursing Protocol: Enteral Medication Administration, Revised Date: December 2013 • DADS Nursing Protocol: Enteral Nutrition, Revised Date: January 2014 • DADS Nursing Procedure: Management of the Foley or Supra-pubic Catheter, Revised Date: December 2013 • DADS Nursing Procedure: Gastrostomy Tube: Insertion by a Nurse, Revised Date: December 2013 • DADS Nursing Procedure: Injections (SQ, ID, IM), Revised Date: December 2013 • DADS Procedure: Management of Acute Illness and Injury, Revised Date: December 2013 • DADS Procedure: Medication Administration Guidelines, Revised Date: January 2014 • DADS Procedure: Medication Administration Observation Guidelines, Revised Date: December 2013 • DADS Medication Administration Observation Form • DADS Procedure: Neurological Assessment, Revised Date: December 2013 • DADS Procedure: Nurse Competency Based Training Curriculum, Revised Date: December 2013 • DADS Nursing Protocol: Pre-treatment and Post-Sedation Monitoring, Revised Date: December 2013 • DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Revised Date: January 2014 • DADS Nursing Abbreviation List RSSLC Local Nursing Related Policies, Procedures, Protocols, and Guidelines: • RSSLC Policy: Sick Call, Date: 10/18/13 • RSSLC Guidelines for the Usage of Infirmary Beds, Date: 9/30/13 • RSSLC Policy: I.6, Providing Health Care Services, Providing Acute Health Care, Revised Date: 9/23/13 • RSSLC Policy: D.25, Safety and Environmental Management, Completing/Routing Fall Evaluation Form, (Draft) Revised Date 10/14/13 • RSSLC Policy, A-1, Nursing Services, Medication Administration Guidelines, Revised Date: 10/29/13 <u>Nursing Education Training Activities:</u> In December 2013, revisions were made in the state's standardized Nursing Education Handbook for the New Nurse Orientation, Refresher Training and Annual Certification of Nursing Skill Competencies, which are listed below: • Intermediate Care Facility/Individual with Intellectual Disabilities (ICF/IID) Understanding the Survey Process • Social Media Use for Nurses • Tardive Dyskinesia, as part of new nurse orientation training	

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		• Nurse Competency Based Training Curriculum Policy was revised along with the nursing skill competencies Since the last compliance review, the Nurse Educators had conducted numerous training and re-training as listed below. New Nurse Orientation: A total of five New Nurse Orientations training were completed since the last compliance review. The dates are as follows: 9/3/13, 10/1/13, 12/4/13, 12/30/13, and 1/23/14. The trainings were competency based using the formalized lesson plans for the state standardized Nurse Educator Handbook. All New Nurse Orientations and Annual Competency Based trainings utilize the criteria contained in the Nursing Education Handbook. • 100% of the new nurses were trained on the following Nursing Related Policies, Procedures, Protocols, Processes, Guidelines, and Forms: o Nursing Services Policy o Nursing Documentation Guidelines o 24 Hour Clock o Nursing Standardized Abbreviation List 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 o Management of Acute Illness and Injury Policy o Nursing Protocol Cards (23 cards) o Emergency Response Policy o Hospitalization, Transfers, Discharge Protocol o Care Plan Development Policy o Skin Management and Wound Prevention o Neurological Assessment Protocol o Seizure Management Nursing Protocol o Vagal Nerve Stimulator Protocol o Pre-treatment and Post Sedation Nursing Protocol o Post Anesthesia Care Nursing Protocol o Weight Management Procedure o PICA o Physical Assessments Additional Trainings Conducted Since the Last Compliance Review: • 9/6/13 – 11/20/13: As part of a death review recommendation, the Nursing Department conducted competency based training for all campus Direct Support Professionals (DSPs) on Vagal Nerve	

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		Stimulator (VNS). The training included the names of individuals who currently had VNS implants, the location of the VNS Implantation in the body, procedure for using the magnet, and storage of the magnet for quick accessibility. • 9/9/13: 100% of all Three Rivers nursing staff and Infirmary nursing staff were trained on the importance of having two nurses or a nurse and another staff present for all physical examinations involving private body parts of the individuals served. The Nurse Educators also in-serviced 100% of the Infirmary Nurses on: Policy C.01: Incident Management, Policy C.02: Protections from Harm, Abuse, Neglect, and Exploitation. • 9/20/13: 99% of the nurses were trained on revised Policy: Medication Administration Guidelines, which included the procedure for Medication Administration Scoring of Tablets. Only tablets that are scored may be split. The tablet is to be split just prior to administration on the unit by the nurses and the unused half will be wasted. If the medication requiring splitting is a controlled substance, then two signatures are required to document the waste. This was rolled out in October 2013. • 10/3/13: 99% of all nursing staff were trained on Policy I.6: Providing Acute Health Care to reflect vital sign parameters to notified the PCP/on call Physician, Policy I.20: Changing Diet, Diet Texture and Desirable Weight Range. • 10/15/13: 100% of Infirmary nurses were re-trained on the job performance expectations regarding total patient care in the Infirmary, Infirmary rounds, check/change every 30 minutes, and having two nurses or a nurse and another staff present for all physical examinations involving private body parts of individuals served. • 10/22/13: The Nurse Educators continued to conduct training on the state mandated Physical Assessment Class for RNs only. This training was ongoing to include but not limited to newly hired RNs. • 11/4/13, 11/9/13, 11/18/13, and 11/22/13, and ongoing: 97% of the nurses were trained during the Annual Competency Based Health Fair for all nursing staff. The Fair included but was not limited to: Competency Skill lab, revised policies, Medication Administration Guidelines - Safe and Secure Practice, Enteral Medication, G-Tube Insertion, Fall Policy and Enteral Nutrition. Mosby's Physical Examination Video Chapter 10 Head and Neck, Nursing Protocol Cards, Medical/Dental Restraint Checklist, Medication Administration Math Test, Weight Management Procedure and Weight Machine, Guidelines for Usage of Infirmary Bed and Adverse Drug Reaction. • 12/16/13: 99% of the RNs received in-service training on the Development of Individualized Acute Care Plan using the new/revised Acute Care Plan Form. The in-service training also incorporated the use of the Nursing Protocol Cards. A new set of 23 Nursing Protocol Cards were issued to all RNs. • 1/13/14: 99% of the nursing staff received in-service training/re-training on Nursing Plan of Improvement (POI), which included but was not limited to: Nursing Protocol Cards with a new set of 23 Protocol Cards was issued to all LVNs, Documentation – Integrated Progress Notes, Focus Assessments/Follow-up Documentation, Medication Administration/MAR Documentation, Wound Assessment, DSP Instruction Signature Sheets for Acute Care Plans and Integrated Health Care Plans, Urgent Care/ER/Hospitalizations, Infirmary Admissions/Post Hospitalization Assessment Form/Filing, Mosby's Physical Examination Chapter 12: Ear Nose, and Throat, Revised Policies:	

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		Nursing Abbreviation List, Care Plan Development, Gastrostomy Tube Insertion, Management of Acute Illness and Injury, Blood Glucose Monitoring, Medication Administration Guidelines and Form, Neurological Assessment, Seizure Management Guidelines, Enteral Medication Administration, Enteral Nutrition, Diastat Protocol, Management of Foley and Suprapubic Catheter, Infections (SQ, ID, IM), Nursing Competency Based Curriculum, and Admitting to Infirmary for Acute Care. • Case Management: 100% of the RN Case Managers received annual MOSES and DISCUS Assessment training. Additional Case Management trainings provided to RN Case Managers is reported in Provisions M.2, M.3, and M.5. • Mosby's Physical Examination Course Training: The last two quarters of the Mosby's Physical Examination was for Chapter 10 – Head and Neck and Chapters 12 - Ear, Nose, and Throat. 99% and 99% of the RNs have been trained respectively. Training was ongoing until 100% completed. • State Mandated Health Physical Assessment Class: To date 99% of the RNs have completed the class. The Nurse Educators continued to conduct this class, which are provided only to newly hired RNs and/or other RNs who may require the class. • Infection Control: The Infection Control Nurses continued to conduct Infection Control training during New Employee Orientation and for annual refresher training. Additional training conducted by the Infection Control Nurses is reported in Provision M.1 Infection Control Activities section. • Skin Integrity: In the absence of the Skin Integrity Coordinator, the Nurse Educators continued to provide classes for Wound Care/Documentation of Wound to the newly hired nurses and incumbent nurses. Additional training provided on skin integrity issues is reported in Provision M.1 Skin Integrity Activities section. • Cardiopulmonary Resuscitation (CPR) • Currently 100% of the nurse staff were current in CPR training. <u>Nursing Education Database:</u> The Nurse Educators continued to maintain and track all required nursing training by each nurse through to completion in the Nursing Education Database in combination with the original nursing training sign-in sheets. The Nursing Education Database was used to track all trainings, nurses trained by role and responsibilities, by dates of trainings, training topics, names of nurses trained, percentage of nurses trained per course, percentage trained list, number of nurses on Family Medical Leave Act (FMLA), and delinquency reports indicating who is delinquent on any given course. Nurses on FMLA are required to complete delinquent trainings within two weeks of return to work. The Data Analyst continued to modify and improve the Nursing Education Database as need arises. <u>Nursing Education Integration with Other Disciplines:</u> • Diabetic Health Fair: On 1/15/14, the Nursing Department, in collaboration with other disciplines, conducted the first biannual Diabetic Health Fair for all individuals and family members. The target audience was the 22 individuals who have diabetes and their family members. The goal was to provide diabetic education to these individuals and their family members on what their expectations were especially for when they go on a pass outside the Facility. There were booth displays from	

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		other disciplines such as Dietary, Pharmacy, Dental, Habilitation Therapy, Residential/Recreational, and Nursing Departments. • 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, chaired by the QA Director, which meets regularly to oversee matters that impact the Facility's infrastructure and its ability to plan strategically and allocate resources effectively. • Bedrail Committee: The Assistant Nurse Educator participated in the Bedrail Committee meeting, which oversee 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 ensures 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 Committee for quality assurance review. • Competency Training and Development: The Nurse Educators continued to train the Incumbent and newly hired employees on the state mandated Observation and Reporting Clinical Indicators of Health Status Change of Individuals Served Class. Since the last compliance review, 80 new employees and 692 incumbent employees were trained on the class. The Nurse Educators continued to participate in CTD performance training meetings. • Nursing Responsibility/Documentation for Restraints: On 1/5/14, the Three Rivers nursing staff were provided re-training to on restraints to remind them to obtained Physician Orders, complete the assessment section of the Restraint Checklist, and on arriving to complete assessments following the application of restraints. Training was provided by the Behavioral Services staff. The Monitoring Team was provided with copies of training material and training sign-in sheets that verified the training was completed. • Adverse Drug Reaction (ADR) training was added to the Annual Competency for Nurses and was taught by the Pharmacist at the Annual Nursing Skills Fair in November 2013, which included the use of the newly revised ADR form. It was report that 98% of the incumbent nurses were trained. Two nurses were on leave and will be trained within two weeks of their return to work. The degree of adherence to the nursing protocols was reported in the other appropriately related Provisions. 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. 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	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>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.</td><td></td></tr>
<tr><td>M5</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and 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.</td><td>
<u>Facility Self-Assessment for Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs):</u>
• The Facility reported that nine of nine IRRFs and IHCPs were audited by RN Case Manager Supervisor, October 2013 through, January 2014, using the Section I – At Risk Individuals Monitoring Tool to ensure that risk ratings for high and medium risk ratings were included in the IHCP. The results of the audits showed:
<table>
<tr><th>Section I – At Risk Individual Monitoring Tool</th><th>October 2013</th><th>November 2013</th><th>December 2013</th><th>January 2014</th><th>Overall Percentage of Compliance</th></tr>
<tr><td>IRRFs/IHCPs</td><td>0%</td><td>77%%</td><td>22%</td><td>77%</td><td>44%</td></tr>
</table>
• On 10/31/13, the RN Case Manager Supervisor reviewed the October 2013 audit findings with the RN Case Managers and provided competency based training on audit findings.

<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 their IRRF and IHCP processes were still evolving. Through the Monitoring Team's review of Section M Self-Assessment, Section M Presentation Book, interviews with the Program Compliance Nurse, RN Case Manager Supervisors, and RN Case Managers; review of documents and individuals' records, there was evidence that the Nursing Department had continued to provide additional training and monitoring toward achieving compliance in this Provision. Minimal improvement was found from previous reviews. Further, the review of this Provision found evidence that validated the Facility's Self-Assessment activities, reported data, and findings upon which they based their status of noncompliance.

<u>Revised Policies and Procedures:</u>
• RSSLC Policy: IRRF Clinical Integration, 10/29/13. The purpose of this policy was to develop a procedure that ensures integration between the RN Case Managers, PCPs, and psychiatrists when completing the risk ratings for individuals using the IRRF. This process will ensure that clinical assessments along with action plans are accurate and consistent for chronic care conditions.

<u>Training Activities:</u>
• The RN Case Manager Supervisor met with the QIDP PNMP to discuss retraining the IDT and RN Case Managers on the IRRF and IHCP state mandated guidelines. A follow up meeting was conducted on 1/31/14 with the QIDPs, Nursing Administrative/Management staff, QA Nurses, and the Assistant Director of Programs, to discuss the Section I- Monitoring Tool.
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		<u>The Monitoring Team's Review of Individuals' IRRFs and IHCPs:</u> The Monitoring Team reviewed 10 of the most recently completed IRRFs and IHCPs for Individuals #783, #483, #723, #503, #585, #13, #675, #417, #272, and #72, and found: • Ten of ten (100%) individuals had a comprehensive interdisciplinary assessment completed. • Five of ten (50%) individuals' IRRFs assessments were adequate to support risk level determinations. • Five of ten (50%) individuals' IRRFs assessments provided information that helped plan how to address risks. • Nine of ten (90%)individuals had IHCPs developed to address risks. • Four of nine (44%) IHCPs met individuals' needs identified by the interdisciplinary assessments. • Five of nine (56%) IHCPs included preventative interventions sufficient to minimize the conditions of risk. • Two of nine (22%) IHCPs were integrated into individuals' ISPs. • Four of nine (44%) IHCPs showed adequate integration among all appropriate disciplines. o Example of an IHCP that did not show adequate integration among all appropriate disciplines included: Individual #503's risk factors included Choking, Aspiration Respiratory Compromise, Dental Gastrointestinal, and Constipation/Bowel Obstruction. His IHCP for these risk rating did not include the following relevant disciplines responsible for implementing the plan: PNMT, occupational/physical therapists, dietitian, primary care provider, or dentist. o Example of an IHCP that did show adequate integration among all appropriate disciplines included: Individual #483's risk factors included Choking, Aspiration Respiratory Compromise, Dental Gastrointestinal, and Constipation/Bowel Obstruction. His IHCP for these risk rating did include the following relevant disciplines responsible for implementing the plan: PNMT, occupational/physical therapists, dietitian, primary care provider and, dentist. • Four of nine (44%) IHCPs had appropriate functional and measurable objectives incorporated to measure the efficacy of the plans. • Four of nine (44%) IHCPs identified appropriate clinical indicators to be monitored and the frequency. The Monitoring Team found minimal improvement in the IRRF and IHCP Process since the last compliance review. The overall compliance of the above records reviewed found 54% compliance with completing individuals' IRRFs and IHCPs sufficient to identify individuals' risk conditions and to develop appropriate IHCPs to address the level of risks. These findings were relatively consistent with the Facility's Section I Monitoring Tool data for overall percentage of compliance. The area most notable missing in IRRFs and IHCPs and need improvement included: • According to review of the ISP sign-in sheets often the physician, psychiatrist, and dietitian did not	

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		attend. It was of concern that the dietician did not attend ISP meetings for individuals that were identified at high and/or medium risk for diabetes and weight. • Family histories of health conditions were rarely included for risk condition where family history was important. • Syndromes associated with intellectual disabilities were rarely included in the clinical data to consider for potential risks. • Often the current supports mentioned in the risk rating were not included in the IHCPs. • Functional and measureable objectives were combined into one statement in the group ratings. Therefore, they lacked specificity to accurately measure the objectives. Each risk should have a separate objective written. • The risk conditions that have the potential to have periodic acute episodes should include relevant Nursing Protocols in the IHCP for managing the acute episodes, such as but not limited to constipation, urinary tract infections, seizures activity/status epilepticus, respiratory distress/aspiration, vomiting, and diarrhea. It was positive to find that the recently hired RN Case Manager Supervisor worked collaboratively with the PNMT QIDP, QA Nurses, and Assistant Director of Programs to provide retraining to the IDT and RN Case Managers on the IRRF and IHCPs state mandated guidelines. In addition, the IRRF Clinical Integration Policy, if adhered to, should further improve these processes. 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 to complete and accurately conduct risk ratings for all risk categories and groups. The IRRF and IHCP must be integrated with all disciplines and cannot be the sole responsibility of the RN Case Managers. The Facility stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. Refer to Provision M.3 for information on compliance with Acute Care Plans and documentation.	
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	<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 both offsite and onsite; attendance at the Medication Variance Committee Meeting; inspections/observations of Medication Administration Observation and Medication Rooms surveys; The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6 and the Monitoring Team concurs with their findings. <u>New/Revised/Reviewed Medication Administration Policies, Procedures, and Guidelines:</u> • DADS Procedure: Medication Administration Guidelines, Revised Date: January 2014 • DADS Procedure: Medication Administration Observation Guidelines, Revised Date: December 2013	Substantial Compliance

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	accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	• DADS Medication Administration Observation Form, Revised Date: 11/12/13 • DADS Nursing Protocol: Enteral Nutrition, Revised Date: January 2014 • DADS Nursing Protocol: Enteral Medication Administration, Revised Date: December 2013 • DADS Nursing Protocol: Diastat AcuDial, Revised Date: December, 2013 • DADS Nursing Procedure: Injections (SQ, ID, IM), Revised Date: December 2013 • RSSLC Policy: A-3, Nursing Services: Medication Variance Guidelines, Revised Date: 10/29/13 • RSSLC Policy I.34, Providing Health Care Services: Medication Variances, Revised: 2/27/12 <u>Medication Administration Training Activities:</u> • 100% of the nurses were trained on the above policies, procedures, guidelines, and protocols. Refer to Provision M.4 for details of the training. • 100% of the nurses were trained on Medication Administration for Individuals with Intellectual and Developmental Disabilities, which was jointly taught by Habilitation Therapy, Physical Nutritional Management Team (PNMT) Nurse, and the Nurse Educators. This training was included in the New Nurse Orientation training. • Adverse Drug Reaction (ADR) training was added to the Annual Competency for Nurses and was taught by the Pharmacist at the Annual Nursing Skills Fair in November 2013, which included the use of the newly revised ADR form. It was reported that 98% of the incumbent nurses were trained. Two nurses were on leave and will be trained within two weeks of their return to work. • AVATAR Medication Variance Entry Training presented by the Data Analyst on 12/10/13 to the Program Compliance Nurse, all Unit Nurse Managers, and QA Nurses • Case Management: 100% of the RN Case Managers received annual MOSES and DISCUS Assessment training. This training is provided to new RN Case Managers in New Nurse Orientation. Additional Case Management trainings provided to RN Case Managers is reported in Provisions M.2, M.3, and M.5. <u>Medication Variance Committee Meetings:</u> The Monitoring Team reviewed the monthly Medication Variance Committee meeting minutes August 2013 through January 2014, which showed 100% of the meetings were conducted as scheduled. The Committee was chaired by the Chief Pharmacist. The required core committee members consistently attended the committee meetings. Prior to the committee meetings 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 corrective action 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 issues were followed through to resolution. Each disciplines' monthly medication variance data analysis were presented at the Committee meetings for review, discussion, and when indicated, local and/or systemic recommendations were made for improvement in mitigating the incidences of medication variances. Nursing also reported on the monthly results of Medication Administration Observation Audits, Medication Room Survey Audits, and Medication Administration	

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		Record (MAR) 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 3/6/14. The meeting was attended by 100% of relevant members. The meeting was substantive and informative. Old business was reviewed and discussed from the January 2014 meeting. The QA Nurse stated all of the old business issues were resolved with the exception of two issues that had to do with orders that were written in the Neurology and Dental clinics where the charts were not returned timely to the nurses on the units. The QA Nurse reminded the Nurse Manager and RN Case Managers to make sure to inform the DSPs they were to take the charts to the nurses instead of putting them the medication rooms. There was also an ongoing issue where physicians wrote orders and then several hours later a stack of records with orders were given to the nurses to transcribe. The delay in providing the nurses with charts with physician Orders caused the nurses to be out of compliance with transcribing the orders timely, according to policy. The Medical Director will continue to follow-up on this this. Each discipline, i.e., Nursing, Pharmacy, Medical, and Dental presented their medication variance data for the number and type of medication variances, as well as for any local and/or systemic variances, and recommendations to mitigate medication variances. There were no systemic issues identified that required CAPs, neither were there any active CAPs for medication administration practices. After the meeting the Monitoring Team met with the Chief Pharmacist, CNE, NOO, and QA Nurse and discussed the concern that the number of medication variances reported by this Facility was consistently lower than other facilities monitored. They were asked if they reported each single medication variance identified. The Chief Pharmacist adamantly insisted that the Facility followed the state and local Medication Variance Policies, which stated, "When multiple doses are involved in the variance, such as a transcription variance that leads to multiple missed or extra doses or an individual receives another individual's medications, these are considered a single event/variance rather than multiple variances." This may account in the disparity found in the number of medication variances reported between RSSLC and the other sister facilities. For example, one of the 10 most recent Medication Variance Reports reviewed by the Monitoring Team for Individual #320 found on 12/31/13 that nine Depakote 500 mg doses were short. A Mediation Excess/Shortage was Form was completed and submitted to the Pharmacy on 12/31/13. The reason documented on the form was "unknown shortage". The nine short medications were considered as one event; therefore only one Medication Variance Report was completed. This may explain the reason for a lower number of medication variances reported by the Facility. However, since the Medication Variance Policies included a limited number of examples that could be considered as one event, this will not be considered sufficient to result in a finding of noncompliance. There should be further clarification with the state office regarding the interpretation of this policy statement. <u>Pharmacy and Therapeutics Committee Meetings:</u>	

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		The Monitoring Team's review of the quarterly Pharmacy and Therapeutic Committee meeting minutes, 10/10/13 and 1/14/14, showed that 100% of the committee meetings were conducted as scheduled. The committee was chaired by the Chief Pharmacist. The required core committee members consistently attended the committee meetings. Minutes from the previous committee meetings were reviewed and approved. The minutes showed that the disciplines responsible for medication variances provided a quarterly summary of medication variance data analysis for the number and type of medication variances, as well as for systemic variances, developed strategies, and corrective action to mitigate medication variances for review, discussion and disposition. Nursing also reported on the monthly results of Medication Administration Observation Audits, Medication Room Survey Audits, and Medication Administration Record (MAR) Audits and any corrective action taken to correct deficiencies found on these audits. There were no systemic trends identified by the committee that required a CAP. The Infection Control Nurse provided the committee quarterly summaries of all identified infections on campus for review, discussion, and disposition, with emphasis on pneumonias and urinary tract infections. However, there were no recommendations provided by the committee to mitigate the incidence of infections. <u>Medication Variance Database 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, apartment, 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 January 2014 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 department, reported for the past rolling 13 months, which showed:	

Month	Medical	Nursing	Pharmacy	Dental	Other	Pharmacy Other**	Nursing Medical***	Total*
January 2013	1	9	8	0	0	0	0	18
February 2013	3	2	3	0	0	0	0	8
March 2013	2	22	9	0	0	0	0	33

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April 2013	0	18	7	0	0	0	0	25
May 2013	1	2	10	0	0	0	0	13
June 2013	0	6	4	1	0	0	0	11
July 2013	0	9	11	0	0	0	0	20
August 2013	1	15	9	0	0	0	0	25
September 2013	0	25	5	0	6	1	0	37
October 2013	5	38	11	0	8	0	2	64
November 2013	10	5	9	2	0	0	0	26
December 2013	7	3	14	1	0	0	0	25
January 2014	5	22	10	2	0	0	0	39
Total	35	176	110	6	14	1	2	344

*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. **Medication Variance involved Oak Bend Medical Center (OBMC) prescribing a medication that had been discontinued while at RSSLC. ***Medication variance involved shared responsibility of Nursing and Medical Departments.

The Monitoring Team found since the last compliance review, that the Facility had continued to make significant improvements in reporting, analyzing, trending, and corrective actions taken to mitigate medication variances. This was evidenced through review of the Medication Variance and Pharmacy and Therapeutics Committee meeting minutes and supporting documentation, Medication Variance Database, and Monitoring Team's attendance at the Medication Variance Committee meeting on 3/6/14, which found that the Pharmacy, Medical, Nursing, and Dental Departments were reporting, tracking, analyzing, trending, and taking local and systemic corrective action on identified 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 reported across all responsible disciplines compared to the last compliance review report. As system improvements were made in reporting all types of medication variances committed by responsible disciplines, there was a steady increase in the number of medication variances reported. This was a positive finding because it demonstrated the Facility was critically analyzing and trending medication variance data and using the data to make clinical decisions to ensure that all actual and/or potential medication variances were reported.

<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 continued to conduct inter-rater

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		reliability checks on Medication Administration Observations and Documentation, Medication Room Survey, and Medication Administration Record Audits. The Nursing Department was following the DADS Procedures: Medication Administration Guidelines, revised January 2014 and Medication Administration Observation Guidelines, revised December 2013, and Medication Administration Observation Form, revised 11/12/13. This was evidenced by the Monitoring Team's review of the Medication Administration Observation data completed by the Nurse Managers and the inter-rater reliability checks performed by the QA Nurse, August 2013 through January 2014. The data below shows the overall monthly percentage of compliance with the observation tool and level of agreement between the Nurse Managers and the QA Nurse, August 2013 through January 2014:	

Month	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014	Overall Total*
Internal Percentage of Compliance	99%**	99%**	99%**	97%**	99%**	100%**	98%**

*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. ** During this reporting period there was an overall 98% level of agreement of between the internal nurse auditor and the external QA nurse auditors.

Medication Room Surveys and Medication Administration Record (MAR) Audits:

- Eight Medication Room Surveys and eight MAR Audits were conducted, August 2013 through January 2014, jointly by the internal and external nurse auditors.
- MAR Audits – overall compliance by the internal nurse auditors was 83%.
- Medication Room Survey Audits – overall compliance by the internal nurse auditors was 91%.
- Inter-rater reliability level of agreement between the internal and external nurse auditors for Medication Room Surveys and MAR Audits overall was 97%.

Monitoring Team's Review of the Ten Most Recent Medication Variance Reports:

The Monitoring Team's review 10 of the most recent Medication Variance Reports and supporting documentation provided by the Facility for Individuals #661, #379, #320, #203, #349, #314, #318, #413, #140, and #366 found significant improvement in the completeness and accuracy of the reports completed by all respective disciplines, i.e., nursing, pharmacy, medical, and dental departments:

- 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 notification to the physician was not applicable for notification due to a filling variance by the

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		pharmacy. The nurse found medication for Individual #661 placed in another individual's medication drawer. The medication was not administered and the pharmacy was notified and the variance was corrected placing the medication in the correct drawer. The nurse discovered a shortage of nine Depakote 500 mg doses in Individual #320's medication drawn. The reason for the shortage was undetermined. Consequently, a Medication Variance Report was completed as one event. Both Nursing and Pharmacy were listed as responsible for the medication variance. • Six of 10 (60%) Medication Variance Reports were for Medical Services, one of 10 (10%) was for Pharmacy Services, one of 10 (10%) was for Nursing Services, one of 10 (10%) was for Dental Services, and one of 10 (10%) was for a combination of Pharmacy Services and Nursing Services. • 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 were effective in improving the completeness and accuracy found in the above Medication Variance Reports. <u>Monitoring Team's Medication Room Surveys:</u> • The Monitoring Team conducted Medication Room Survey Audits in the medication rooms in the Infirmary, Nueces, and Leon C, using the state's standardized Medication Room Audit Tool. The findings were consistent with the Facility's findings reported above. However, the medication room is Nueces was very small. Medications were stored in antiquated individual plastic bins. Oral and topical medications were stored in separate bins. When the nurses were asked about the use of a medication cart, they stated the room was too small to accommodate a medication cart. However, a small medication cart like the one used in the in the Infirmary might fit in the small space. This would provide more security for the medications because the bins were not behind double locks. Medications are required to be secured behind double locks. The door into the medication room only serves as one lock between the door and the medication bins. The Facility should consider procuring a small medication cart for the Nueces medication room to ensure medications are secured behind double locks. • 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. <u>Monitoring Team's Review of Medication Administration Records and PNMPs:</u> The Monitoring Team reviewed the MARs and PNMPs for all the individuals for which Medication Administration Observations were conducted, using a standardized Medication Administration Record (MAR) Audit Tool. It was positive to find that no deficiencies were identified. <u>Monitoring Team's Medication Administration Observations:</u> • The Monitoring Team conducted Enteral Nutrition Administration Observation in the Infirmary on 3/3/14 at the 12:00 p.m., for Individual #340, accompanied by the Infirmary Director, QA Nurses,	

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		Program Compliance Nurse, and Nurse Educators, and found: o Enteral nourishment was administered via G-Tube as a bolus feeding. Individual #340 was administered enteral nutrition in a private room in bed with the head of the bed in a semi-fowlers position. Prior to the administration of enteral nutrition the nurse reviewed Individual #340's PNMP/MAR and explained that she was going to administer his enteral nutrition. The nurse performed the correct Enteral Nutrition Administration in accordance with the Nursing Procedure. After the enteral nutrition administration observation was completed the Monitoring Team observed Individual #340's Stage II sacral pressure ulcer and dressing change. Refer to Provision M.1 in the Skin Integrity Activities section of the report for additional information. • The Monitoring Team conducted Medication Administration Observation in Nueces on 3/4/14 at the 4:00 p.m. med pass, accompanied by the Nurse Manager and QA Nurses, and found: o Individuals were administered medications through a Dutch door. As mentioned above, the medication room was very small and there was lack of a medication cart. Medications were taken from individuals' plastic bins and prepared on the counter top and cross-checked with individuals' PNMPs and MARs. o The DSP assisted the nurse by bringing one individual at a time to received medication. o The nurse administering medications followed the generally accepted professional standards of safe medication administration, including performing the required three checks for each medication administered to ensure the correct medications were administered and charted. o The nurse referred to each individual's 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 nurses 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 swallowed. The nurse followed any other special strategies and the use of adapted equipment contained on individuals' PNMPs. o One individual's medication required splitting. The nurse used the correct technique with the pill splitter to split the pill. However, the pill crumbled and had to be wasted. The nurse wore gloves and was able to successfully split the pill in the package without damage or contamination. o The nurse talked to individuals during the medication pass telling them what medications they were receiving and their purpose. Self-Administration of Medication (SAM) Programs were reinforced during the med pass for individuals with programs. o Individual #523: The nurse was observed administering medications and enteral nutrition via bolus through G-tube. Medications and enteral nutrition and supplies were prepared and placed in a plastic container for administration. The nurse hand carried the medication and supplies first to Individual #523's bedroom for administration, but she preferred to	

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		receive the medication and enteral nutrition in the living room setting in a recliner. The nurse performed the correct Enteral Nutrition Administration in accordance with the Nursing Procedure, with the exception that in the living room the MAR was not available and there was a failure to have a container available to dispose of waste products. The QA Nurse brought the nurse a plastic bag, in which the waste material was disposed. This pointed out another reason/need to have a medication cart available for the nurse to place the MAR on and to dispose of waste material when medications and/or enteral nutrition is provided out on the units. The MARs should always be present with the nurses when medications and/or enteral nutrition are being administered to ensure the correct medications and/or nutrition is administered. • The Monitoring Team conducted Medication Administration Observation in Leon's dedicated medication administration room on 3/5/14 at the noon med pass, accompanied by the Nurse Manager, QA Nurses, and Nurse Educator, and found: o Individuals were administered medication in a room to ensure privacy. o The DSPs assisted the nurse during the med pass by bringing one individual at a time to receive medications. 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 administering medications followed the generally accepted professional standards of safe medication administration, including performing the required three checks for each medication administered to ensure the correct medications were administered and charted. 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 was reinforced during the med pass. o It was positive to find that the medication cart was stocked with maroon spoons for medication administration and all of the necessary adaptive equipment to use for individuals who required such equipment. o Individual #723, who was a brittle diabetic, required blood glucose finger sticks before administering the 11:30 a.m. (before meal). The nurse followed correct procedure for performing the blood glucose finger stick. The individual's blood sugar glucose results were 46; therefore, no sliding scale insulin was required. The nurse gave him a can of prune juice to drink and informed the DSP to take him to eat. After eating the nurse stated she would recheck the blood glucose and determine whether sliding scale insulin administration was	

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		indicated based on the results of the repeated blood glucose check. The Nurse Manager reminded the nurse to ensure that if sliding scale insulin administration was necessary, she needed to have another nurse check with her the dose of insulin drawn up in the syringe and for both nurses to sign the MAR after administration. The nurse stated that was what she always does. o There was one instance when the nurse returned to start administering medication after she open the door to allow an individual to enter and momentarily neglected to use hand sanitizer. The Nurse Manager immediately promptly the nurse to use the hand sanitizer. From the Monitoring Team's observations of this nurse she appeared experienced and competent. The momentarily lapse in using the hand sanitizer may have been attributed to the numerous observers in the room. While it is important for Facility nursing administrative/management staff and QA nurses to accompany the Monitoring Team during medication administration observations, in the future consideration should be given to limiting the number of staff observing to avoid distracting the nurses administering medication and the individuals receiving medications. o The nurse reported to the Nurse Manager that Leon was having difficulty receiving an adequate supply of fluids to use for medication administration. The Nurse Manager assured the nurse she would see to supplying Leon with an adequate supply of fluids for medication administration. o The medications administered were checked against Physician's Orders by the Monitoring Team and were found to be administered as ordered. With the exception of an occasional minor prompting by the Nurse Manager, the nurses observed continued to administer medication in accordance with generally accepted safe medication administration practices, as well as consistently following individuals' PNMPs' prescribed strategies for safe administration of medication. Refer to Section O for additional information regarding the Monitoring Team's medication administration observations. The Facility's Self-Assessment stated they were in substantial compliance with this Provision and the Monitoring Team concurs. Based on the findings of this compliance review, this Provision was found in substantial compliance. The Monitoring Team found that the Facility continued to maintain the positive medication administration practices previously found for all aspects of this Provision. In order for this Provision to continue to maintain substantial compliance the Facility must continue to maintain the positive administration of medication practices identified and to continue to monitor and take corrective action for any future identified deficiencies.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-Assessment 2/13/14 2. RSSLC Action Plans 2/13/14 3. RSSLC Presentation Book 4. RSSLC Pharmacy Policy and Procedure Manual, Adverse Drug Reactions, revised on 8/28/2013 5. RSSLC medication variance committee minutes 6. Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties 7. Alpha list of individuals who are prescribed anticholinergic drugs 8. For the first five individuals on the list of individuals prescribed anticholinergic drugs (Individuals #447, #9, #320, #529, and #711): a. Most recent two Quarterly Drug Regimen Reviews (QDRRs) b. Current medical list c. Most recent medical and psychiatric annual reviews d. Most recent MOSES and DISCUS assessments 9. Pharmacy and Therapeutic Committee (P&TC) Meeting Minutes for October 2013, and January 2014. 10. QDRR schedule for past six months and pending six months 11. List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date 12. Average daily census 13. Alpha list of individuals who were prescribed a neuroleptic and have diabetes 14. Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension 15. Alpha list of individuals who were prescribed a benzodiazepine 16. Alpha list of all individuals with diagnosis of osteoporosis 17. For individuals #142, #149, #130, #133, #330, #645, #109, and #787: a. Most recent two QDRRs b. Past six months MOSES and DISCUS assessments c. Most recent 12 months of lab results d. Most recent two EKG reports e. Most recent annual physician summary f. Most recent psychiatric assessment g. Most recent Integrated Risk Rating Form (IRRF) 18. Past six months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties 19. For the first five individuals on a list of benzodiazepines used for psychiatric indication (Individuals #513, #368, #475, #330, and #155): a. Most recent two QDRRs

	b. Most recent IRRF c. Current medication list d. Most recent psychiatric assessment e. Most recent annual medical assessment 20. For Individuals #351, #151, #747, #672, and #363: a. Most recent QDRR b. Most recent IRRF c. Current medication list d. Most recent six months laboratory data e. Most recent annual medical assessment f. Most recent psychiatric assessment g. Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome 21. Monthly Polypharmacy Panel Meeting minutes for August 2013, through January 2014 22. List of all individuals on polypharmacy 23. For the first, individual on the list of polypharmacy (Individuals #19, #155, #238, #787, and #66) a. Most recent two QDRRs b. Most recent psychiatric assessment c. Current medication list d. Most recent ISP, or related document the use of polypharmacy 24. For Individuals #447, #140, #74, and #561: a. Emergency Medication Monitoring database printouts, documenting the pharmacists' review of the stat chemical restraint usage b. QDRRs c. Post chemical restraint IPN by the psychiatrist d. Post chemical restraint documentation by the pharmacist 25. Graph of all chemical restraints used during the reporting period 26. Past six months MOSES and DISCUS side effects scale results for Individuals #142, #149, #130, #133, #330, #645, #109, #787, #72, #561, #80, and #714 27. List of all individuals who were prescribed a new antipsychotic, or who had an increase or decrease in the dosage of an antipsychotic drug 28. Adverse Drug Reaction (ADR) report form, and IPNs related to the ADR, that occurred during the reporting period for Individuals #68, #726, and #537 29. Past six months data, trends analysis, and committee meeting minutes related to a system review of ADRs at the Facility 30. Medication Variance Committee meeting minutes August 2013 through January 2014 31. All graphs, data tables, and data analysis for medication variances used by the Facility for a systems review of medication variances during the reporting period 32. List of all medication variances that occurred during the reporting period 33. For Individuals #239, #66, #475, #10 #379, #273, #751, #551, #465, and #508: a. Copy of completed medication variance report form b. All physician IPNs associated with the medication variance c. All nursing IPNs associated with the medication variance

	d. All pharmacy documentation, and communication related to the mediation variance **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 **Meetings Attended/Observations:** 1. Medication Variance Committee Meeting
	Facility Self-Assessment: The Facility reported a self-assessment of substantial compliance for all eight Sections of Provision N; however, the Monitoring Team determined substantial compliance for Sections N.1, N4. N6, N7, and N8, and non-compliance for Sections N.2, N.3, and N.5. For Section N.2, the Facility determined substantial compliance "Based on the findings of this self-assessment, this provision is in compliance". Although the Monitoring Team concurs with the self-assessment for completion of QDRRs within 90 day period, and that the PCP, and psychiatrists review an sign the QDRR, the Monitoring Team disagrees with the 100% rating of recommendations made on the QDRR, were outstanding from the narrative component of the QDRR. For example, as documented in the body of this report, Individual #424, #645, and #142, among others, were noted to have recommendations within the narrative (body) of the QDRR, but did not include the recommendations under the heading of recommendations. Furthermore, the self-assessment did not assess if the QDRR reflected a review of all pharmacotherapy prescribed. For Section N.3, the Facility determined substantial compliance because "Based on the findings of this self-assessment, this provision is in compliance, because there is a proven system to monitor 100% of all the emergency/stat medication orders for appropriateness and the metabolic syndrome is monitored according to the policy." The self-assessment did no assess many issues related to this provision. For example, the self-assessment did not assess if the pharmacists and psychiatrists review of stat medications included an effective clinical review of the use of stat chemical restraint, and there was no review of the Facility's systems review of benzodiazepines, anticholinergic, and stat medication usage. The Facility should assess to ensure that systems review for the usage of such agents is regularly conducted, and are meaningful to the Facility, in helping to identify potential systems issues, and remedial actions to help reduce the use of these medications, Facility wide, when clinically indicated. The Facility indicated substantial compliance for Section N.5, stating "Based on the findings of

	this self-assessment, this provision is in substantial compliance, because there is a system in place at RSSLC to verify that a valid instrument (MOSES and DISCUS) is completed 100%." The Monitoring Team determined noncompliance because the majority of MOSES and DISCUS assessments provided for review, did not have a physician assessment component documented for each of the MOSES and DISCUS reviewed, and because more frequent monitoring of dyskinesia was not assessed as clinically necessary. The self-assessment for Section N.5 did not address these issues.
	Summary of Monitor's Assessment: The Monitoring Team noted significant improvement in the pharmacy's progress towards substantial compliance and concurs with the Facility's self-assessment of substantial compliance with Sections N.1, N.4 and N6 through N.8, but disagrees with the Facility's assessment of substantial compliance with Sections N.2, N.3, and N.5. Although progress had been made with Sections N2 and N.3, additional enhancements will be necessary for substantial compliance. The Facility must significantly improve its process for monitoring dyskinesia and other side effects associated psychotropic medications. The following are some additional concerns, for each Section. **Section N.1**: The parties agreed that the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. **Section N.2:** The Monitoring Team noted significant improvement with the QDRRs provided for review. The majority of the QDRRs were noted to be more coherent, addressed relevant clinical issues, and provided more structured recommendations. Per the examples reviewed, none of the QDRRs included a section for the medical providers to document if they agreed or disagreed with the pharmacist's recommendations. Substantial compliance will require the Facility to enhance its QDRR process by ensuring that all MOSES and DISCUS assessments utilized for the QDRR reviews have been completed by the prescriber; ensure that there is a section documenting the medical provider's agreement or disagreement with recommendations; document efficacy of prescribed medication; document agreement or disagreement with current pharmacotherapy, and when disagreeing with the medical provider, document clinical recommendations for alternate pharmacotherapy. **Section N.3:** The Facility conducted a clinically appropriate systems review for polypharmacy, but did not conduct a clinically meaningful system review for stat medication usage. Also, there was no indication that a systems review was conducted for benzodiazepine or anticholinergic usage. The Facility had made significant improvements with individual reviews for metabolic syndrome, benzodiazepine, anticholinergic and polypharmacy usage; however, the Facility did not conduct clinically meaningful individual reviews for stat psychotropic medication usage. As noted in previous Monitoring Team reports the Facility must continue to enhance its systems review for benzodiazepines, anticholinergic, and stat medication usage. Also, the Facility must enhance its individual reviews of stat medication usage. For these reasons, the Monitoring Team determined noncompliance with Section N.3.

	Section N.4: The parties agreed that the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. **Section N.5:** As a result of not completing a physician review section on the MOSES and DISCUS forms, and because there was not more frequent monitoring for dyskinesia and other side effects that can be associated with a change in dose of a dopaminergic drug, the Monitoring Team determined that the Facility is not in compliance with Section N.5. **Section N.6:** The Monitoring Team noted significant improvements with the Facility's ADR process. The Facility had enhanced its training for all relevant staff on the ADR identification and reporting process, revised its ADR reporting form to include a section for pharmacists comments, ensured that pharmacists and medical providers document on the ADR, and ensured that there was clinical follow-up by the medical provider for all reported ADRs. For these reasons, the Monitoring Team determined substantial compliance for Section N.6. **Section N.7**: The parties agreed that the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. **Section N.8:** The Facility had continued to enhance its medication variance process by ensuring a robust reporting process, conducting efficacious medication variances committee meetings, and addressing medication variances once identified. Also, the Facility had a reporting process for documenting medication variances made by medical providers and pharmacy staff. Therefore the Monitoring Team determined that the Facility is in substantial compliance with Section N.8.

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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	The parties agreed that the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	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.		
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 were 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 • The following examples from the alpha lists above (Individuals #142, #149, #130, #133, #330, #645, #109, and #787) 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;	Noncompliance

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		indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale <u>Timely Completion of QDRRs</u> Per review of the past two QDRRs completed for Individual's #142, #149, #130, #133, #330, #645, #109, and #787, the most recent QDRR's were completed within the designated completion date, according to the QDRR schedule. <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 #142, #149, #130, #133, #330, #645, #109, and #787): • Of the eight example reviewed, five examples included psychotropic polypharmacy, and of the five examples, two examples (40%) included a specific pharmacy review of the prescribed polypharmacy that include the pharmacist documenting concurrence or disagreement with the current polypharmacy. • For the three individuals treated with benzodiazepines, three out of three (100%) examples indicated a specific assessment for the use of benzodiazepine by the pharmacist. • The pharmacist assessed Laboratory tests in eight out of eight examples (100%). • Metabolic syndrome was appropriately assessed in eight out of the eight examples (100%) that required a review for metabolic syndrome. • The QDRR indicated review by the medical provider in eight out of eight examples (100%); however, only two out of eight examples (25%) included documentation by the medical provider of either accepting or rejecting the pharmacist's recommendation. The Monitoring Team noted that in most of the QDRRs reviewed, only two of three pages were provided for review, and questions whether such documentation might have been on page three. • The QDRR indicated review by the psychiatrist in eight out of the eight examples (100%); however, only two out of eight examples (25%) included documentation by the psychiatrist of either accepting or rejecting the pharmacist's recommendation. The Monitoring Team noted that in most of the QDRRs reviewed, only two of three pages were provided for review, and questions whether such documentation might have been on page three. • The MOSES and DISCUS included as part of the assessments for the QDRRs indicated significant deficiencies. Only three out of 12 MOSES assessments (25%) included a review and assessment section for the prescriber to complete, and only 3 out of 13 DISCUS assessments (23%) included a section for the prescriber to complete. Both assessments require a specific review and conclusion by the prescriber. • For the two individuals reviewed by Monitoring Team who had a diagnosis of osteoporosis, the pharmacist completed a comprehensive assessment of associated pharmacotherapy, and efficacy of therapy, in zero out of two examples (0%).	

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		• The QDRR clearly delineated the appropriateness for all drugs prescribed in two out of eight examples (25%). • The QDRR clearly delineated effectiveness of all drugs prescribed in zero out of eight examples (0%). • The QDRR clearly delineated potential drug-drug interactions for all of the prescribed medications in four out of eight examples (40%). The following are the Monitoring Team's specific comments and concerns, upon review of the QDRRs, and supporting documents for Individuals #142, #149, #130, #133, #330, #645, #109, #787: Individual #424: The pharmacist documented several recommendations, within the context of the QDRR, however, did not document them in the section for recommendations at the bottom of the QDRR.; hence, this could be misleading, and the medical provider may not appreciate the many valid recommendations per the pharmacist. It was noted that the pharmacist indicated that a previous recommendation to reduce paroxetine dosage had not been addressed by the medical provider. There was excellent review for metabolic syndrome and anticholinergic usage. The pharmacist did not document concurrence or disagreement with the current polypharmacy usage. Although the psychiatrist and the primary medical provider signed and dated the QDRR, there was no indication of their acceptance or disagreement with the pharmacist's recommendations. The MOSES side effect scale, dated 12/6/2013 and 12/11/2013, did not include an area for the medical provider to document review. The DISCUS form, dated 12/6/2013, did not include a component for the medical provider to indicate the presence or absence of tardive dyskinesia (TD). Individual #787: Although the psychiatrist and the primary medical provider signed and dated the 1/30/2014 QDRR, there was no indication of their acceptance or disagreement with the pharmacist's recommendations. The provided MOSES assessment for 11/1/2013, and the DISCUS assessments for 2/4/2014 and 11/1/2013 were not completed by the prescriber, as there was no area for the prescriber to document their findings. Individual #330: This Individual was on the list of individuals who were prescribed an anticholinergic medication, and review of the drug regimen review profile medication list indicated the Individual was on metoclopramide, which has known anticholinergic properties; however, the QDRR dated 1/14/2014 stated "The patient is not receiving treatment with any medication which appears on the ACB scale. Therefore it is presumed that the current patient medication regimen is not presenting any anticholinergic burden effects which could have negative cognitive effect". The QDRR should indicate that the Individual is prescribed a medication that does have anticholinergic properties, and to monitor closely for anticholinergic side effects. Furthermore, it is well known that the drug-drug interaction between metoclopramide and lorazepam may hasten cognitive side effects, and this potential interaction was not commented on. The most recent QDRR, dated	

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		1/14/2014, was signed by both a primary medical provider and a psychiatrist; however, there was no indication whether either agreed or disagreed with the pharmacist's recommendations. Both the MOSES and DISCUS assessments for 11/27/2013 were not signed, nor was there a section on either for the prescriber to complete. Individual #645: The DISCUS assessment, dated 2/4/2014, did not have a section for the prescriber to complete. The pharmacist documented an important recommendation for the addition of guanfacine, and to re-evaluate the use of lorazepam, among other recommendations within the body of the QDRR; however, there was no area listed on the QDRR form specifically for recommendations. It is essential that the QDRR list specific recommendations for the medical providers to address, so that the pharmacy department can efficaciously track recommendations. Despite being included with the document request for Individuals prescribed anticholinergic drugs, the QDRR indicated that the individual was not prescribed anticholinergic drugs; review of the medication list indicated that the Individual was prescribed diphenhydramine cream, which would not result in systemic anticholinergic effects. The medical provider and psychiatrist signed the QDRR, and although the psychiatrist concurred with the pharmacist's recommendations, the medical provider indicated that he did not agree, and there was no supporting documentation to indicate what the medical prescriber did not agree with, or an alternative plan to address the pharmacist's concern. There was a physician quarterly review integrated progress note provided for review by the Monitoring Team; however, the document was not signed by the pharmacist or by the medical providers. Individual #142: The QDRR, dated 12/23/2013, provided excellent review of laboratory results, meaningful review for the use of psychotropic medications, and assessing efficacy. Although documenting a review for osteoporosis and the use of alendronate, the pharmacist did not document efficacy, and there was no review of bone mineral density results; there was no indication noted by the Monitoring Team when DEXA evaluation had been completed in the past, as test results were not provided for review. Also, despite the QDRR indicating that the Individual would continue on alendronate, the most recent IRRF dated 2/7/2013, indicated that the Individual was to remain off alendronate for off campus dental surgery. It would be advantageous if the excellent recommendations, documented within the body of the QDRR, would be delineated in a section specific for the pharmacist's recommendations; this process would better ensure that all recommendations would be reviewed by the medical provider, and would provide an effective mechanism for the pharmacy to follow-up and ensure compliance by the medical provider. Both the medical provider and psychiatrist signed and concurred with the pharmacist's recommendations. The MOSES and DISCUS assessments provided for review did not include a section for the prescribers review. Individual #109: The 12/27/2013 QDRR did not include a review for osteoporosis, despite the Individual having a diagnosis of osteoporosis, and per the most recent annual medical summary, dated 3/6/2013 that stated the individual was noted to have osteoporosis prior to 2012, was	

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		prescribed both Calcium and Vitamin D supplementation for osteoporosis, and was to have a "repeat DEXA scan in one year, after starting Reclast". There was no documentation that the Individual had a follow-up DEXA scan. The IRRF, dated 3/20/2013 indicated a high risk secondary to osteoporosis, documented that i.v. Reclast was administered in 2012, but did not comment on follow up therapy, or assessment for the management of osteoporosis. The MOSES, dated 8/26/2013, did not include a section for the medical provider to complete. The physician and psychiatrist signed their review of the QDRR,.. The QDRR did not include a specific section for pharmacist's recommendations. Individual #133: The 2/7/2014 QDRR provided a clinically rational and meaningful review of the Individual's prescribed benzodiazepine. Also noted was clinically relevant and meaningful review of potential drug-drug interactions and side effects. The pharmacist followed up on previous recommendations that were not addressed by the medical provider, and the QDRR included a section for pharmacist's recommendations. Although the medical provider and psychiatrist signed the QDRR, there was no section for either to agree or disagree. Individual #130: The QDRR, dated 2/18/2014, provided cohesive documentation for a pharmacotherapy review. The pharmacist provided a meaningful and clinically rational review for the proscribed benzodiazepine, included a good review for side effects and drug-drug interactions, and assessed metabolic syndrome. The pharmacist followed up on previous recommendations that were not addressed by the medical provider. There was a section specific for the pharmacist's recommendation. Although signed by the medical provider and psychiatrist, there was no space for either to agree or disagree with the recommendations. The MOSES assessment, dated 12/4/2013, did not include a prescriber's review. <u>Summary</u> The Monitoring Team noted significant improvement with the QDRRs provided for review. The majority of the QDRRs were noted to be more coherent, and addressed relevant clinical issues, and provided more structured recommendations. Per the examples reviewed, none of the QDRRs included a section for the medical providers to document if they agreed or disagreed with the pharmacist's recommendations. The Monitoring Team determined noncompliance of Section N.2; substantial compliance will require the Facility to enhance its QDRR process by ensuring that all MOSES and DISCUS assessments utilized for the QDRR reviews have been completed by the prescriber; ensure that there is a section documenting the medical provider's agreement or disagreement with recommendations; document efficacy of prescribed medication; document agreement or disagreement with current pharmacotherapy; and when disagreeing the medical provider, document clinical recommendations for alternate pharmacotherapy.	
N3	Commencing within six months of the Effective Date hereof and with full	Section N.3 requires that the Monitoring Team's assess the pharmacy's ability to review and address metabolic syndrome, stat chemical restraints, and anticholinergic, benzodiazepine, and polypharmacy usage. The following is a summary of the Monitoring Team's review of each issue:	Noncompliance

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	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.	<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 five individuals on the list of individuals prescribed anticholinergic drugs (Individuals #447, #9, #320, #529, and #711): o Most recent two QDRRs o Current medical list o Most recent medical, and psychiatric annual reviews o Most recent MOSES and DISCUS assessments • Pharmacy and Therapeutic Committee Meeting Minutes for October 2013 and January 2014 Review of clinical documents above (Individuals #447, #9, #320, #529, and #711) indicated: • In five out of five cases (100%) the QDRR documented the indication for the use of all anticholinergics prescribed. • In five out of five cases (100%), the QDRR documented risks associated with the use of anticholinergics. • In four out of five cases (80%), the QDRR documented whether the dose of the anticholinergics drugs was clinically justifiable. • In four out of five cases (80%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. • In four out of five cases (80%), the pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics. There was no evidence provided indicating that the Facility conducted a systems review of the usage of anticholinergic usage at the Facility. Review of the October 2013 and January 2014 P&TC meeting minutes did not indicate that anticholinergic usage was presented and reviewed by the committee. The lack of a systems review for the usage of anticholinergic usage was commented on in previous Monitoring Team reports. <u>Benzodiazepine usage:</u> The Monitoring Team reviewed the following documents to assess the Facility's review of benzodiazepine use:	

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		• Alpha list of all individuals on benzodiazepines • For the first five individuals on a list of benzodiazepines used for psychiatric indication (Individuals #513, #368, #475, #330, #155): 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 Monitoring Team made the following determination, for Individuals #513, #368, #475, #330, and #155: • In five out of five cases (100%), the QDRR documented the use and indication for the use of the benzodiazepine. • In five out of five cases (100%), the QDRR documented risks associated with the use of the benzodiazepine. • In two out of five cases (40%), the QDRR documented efficacy or lack of efficacy of the benzodiazepine. • In five out of five cases (100%), the QDRR documented whether the dose of the benzodiazepine was clinically justifiable. • In five out of five cases (100%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. It should be noted that there was no specific statement documenting continuation; however, the Monitoring Team could infer the intent of the pharmacist, based on recommendations. There was no evidence provided indicating that the Facility conducted a systems review of the usage of benzodiazepines at the Facility. Review of the October 2013,and January 2014 P&TC meeting minutes did not indicate that benzodiazepine usage was presented and reviewed by the committee. The lack of a system review for the usage of benzodiazepine was commented on in previous Monitoring Team reports. <u>Assessment of Metabolic Syndrome Monitoring:</u> The Monitoring Team selected the first five individuals on a list of all individuals who are on a neuroleptic and had a diagnosis of diabetes or hypertension, and reviewed the following documents to assess the Facility's monitoring of metabolic syndrome (Individuals #351, #151, #747, #672, and #363). • Most recent QDRR • Most recent IRRF • Current medication list • Most recent six months laboratory data	

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		• Most recent annual medical assessment • Most recent psychiatric assessment • Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome The Facility reported a total of 72 individuals being assessed as having the diagnosis of metabolic syndrome; 35 of the 72 (49%) of those diagnosed with metabolic syndrome were prescribed an antipsychotic drug. The following is a summary of the documents reviewed for metabolic syndrome, for the five examples provided (Individuals #351, #151, #747, #672, and #363): • Five of five QDRRs (100%) indicated specific review for metabolic syndrome on the QDRR report. • Five out of five QDRRs (100%) assessed clinically appropriate risk factors to evaluate for metabolic syndrome. • There were two examples of an individual meeting risk criteria for metabolic syndrome, and the IRRF for one out of the two examples (50%) documented metabolic syndrome as a specific risk factor. • Of the two examples of an individual meeting risk criteria for metabolic syndrome, the pharmacists documented the risk versus benefits on the QDRR in zero out of two examples (0%). <u>Review of polypharmacy usage</u>: To review the pharmacists' participation with assessing the appropriateness of polypharmacy, the Monitoring Team reviewed the following documents: • Monthly Polypharmacy Panel Meeting minutes for August 2013 through January 2014 • Pharmacy and Therapeutic Committee (P&TC) meeting minutes for 10/2013 and 1/2014 • List of all individuals on polypharmacy • For the first five individuals on the list of polypharmacy (Individuals #19, #155, #238, #787, and #66) 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 the appropriateness of polypharmacy usage of four individuals each month, at the monthly polypharmacy review panel meeting. The review consists of a pharmacist, medical provider, psychiatrist, psychologist, and nursing representatives. As part of a systems review each quarter, polypharmacy usage is presented, and reviewed at the Facility's P&TC. The polypharmacy review panel members had met each month during this review period and did review four individuals each month; review of the meeting	

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		minutes for August 2013 through January 2014 indicated a robust clinical review of individuals that were prescribed polypharmacy. Issues such as appropriate diagnosis, appropriate indication for polypharmacy, adverse effects, and strategies to help minimize the use of polypharmacy were documented. The Facility conducted P&TC meetings on 10/10/2013 and 1/14/2014 during this reporting period. Review of the meeting minutes indicated a report on polypharmacy usage that included a trends analysis, documented the total usage of polypharmacy each month, and indicated a rational explanation for the increase from 55 individuals who received psychotropic polypharmacy in May 2013 to 62 individuals in February 2014. The following is a summary of the documents reviewed for polypharmacy (Individuals #19, #155, #238, #787, and #66): • In four out of five examples (80%) the QDRR documented the indication for the use of each polypharmacy agent. • In four of five examples (80%), the QDRR documented the serious risks for the use the polypharmacy combination. • In four out of five cases (80%), the QDRR documented whether the dose for the specific polypharmacy agents was appropriate or not appropriate. • In four out of five cases (80%), the QDRR documented clinically justifiable recommendations for continued use, along with the clinical rationale for continued use or consideration for alternative treatments. • In four out of five cases (80%), the pharmacist documented the efficacy, or lack of efficacy, for the use of polypharmacy. The Monitoring Team noted significant improvement with the review of polypharmacy on the QDRR. In the five examples reviewed, only one example (Individual #19) did not include a specific review of polypharmacy related issues on the QDRR, and in this particular example, the QDRR appeared to have been completed prior to the pharmacy department implementing its updated review process for polypharmacy issues. <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. For the first ten individuals who were administered a stat chemical restraint during the reporting period, the Monitoring Team, was provided the following documentation (Individuals #447, #140, #74, and #561): • Emergency Medication Monitoring database printouts, documenting the pharmacist's review of the stat chemical restraint usage. • QDRRs	

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		• Post chemical restraint IPN by the psychiatrist • Post chemical restraint documentation by the pharmacist In addition, the Monitoring Team reviewed: • Pharmacy and Therapeutic Meeting minutes for October 10, 2013 and January 14, 2014 • Graph of all chemical restraints used during the reporting period To assess the Facility's review of stat chemical restraint usage, the Monitoring Team review the pharmacist's review which was documented on the Facility's Stat Chemical Restraint Database, and the psychiatrist's review which was documented on a post chemical restraint IPN. Pharmacist's review of Stat Chemical Restraints (Emergency Medication Monitoring database): • In zero out of four examples (0%), the pharmacist documented a review of scheduled psychotropic medications, and if the scheduled medication dose, formula, or schedule should be changed to help minimize the need for stat chemical restraint. • In zero out of four examples (0%), the pharmacist documented if side effects occurred following the stat chemical restraint. • In four out of four examples (100%), the pharmacist documented if the indication for the stat chemical restraint was appropriate. • In three out of four examples (75%), the pharmacist documented if drug and dose used for the stat chemical restraint were clinically appropriate. • In zero out of four examples (0%), the pharmacist documented if currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint. Psychiatrist's review of Stat Chemical Restraints: • In four out of four examples (100%), the psychiatrist documented the clinical rationale for the use of the stat chemical restraint, and if the stat chemical restraint was appropriate or not appropriate. • In four out of four examples (100%), the psychiatrist documented if side effects occurred following the stat chemical restraint. • In four out of four examples (100%), the psychiatrist documented if drug and dose used for the stat chemical restraint were clinically appropriate. • In 0 out of four examples (0%), the psychiatrist documented if currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint. • In one out of four examples (25%), the psychiatrist documented a review of scheduled psychotropic medications, and if the scheduled medication dose, formula, or schedule should be changed to help minimize the need for stat chemical restraint. • In zero out of four examples (0%), the psychiatrist documented review and determination if the behavioral support plan was effective or not effective.	

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		Individual #140 was administered ten stat chemical restraints between 8/1/2013 and 1/31/2014. Review of the most recent QDRR, dated 1/6/2014, did not comment on the total number or severity of the behavioral exacerbations and did not comment on the usage of Geodon and Haldol which, in addition to a benzodiazepine, were used as a stat chemical restraints. The QDRR indicated that several attempts had been made to reduce the usage of scheduled benzodiazepine, but that each attempt was followed by an increase in behavioral issues; however, the QDRR did not provide pharmacologic recommendation to help minimize the need for stat medication for recurrent behavioral exacerbation, or recommendations for alternative scheduled baseline medications. Furthermore, the Emergency Medication Monitoring database that was completed by the pharmacist, as a review of the stat chemical restraint, did not document an attempt to adjust the Individual's baseline psychotropic medication, benzodiazepine, which resulted in increased behavioral exacerbation. Systems review of stat chemical restraint: The Facility indicated on the document request form that there was no committee that presided over stat chemical restraint usage, and provided no documents as part of the document request for the review of stat chemical restraint that indicated a systems review was done that included a trends analysis of stat chemical restraint usage. Despite the document request indicating that the Facility did not conduct a committee review of stat chemical restraint usage, while reviewing documents on polypharmacy, the Monitoring Team did identify that stat chemical restraint usage was commented on at the P&TC meetings in October 2013 and January 2014 that documented the total number of stat chemical restraint uses per month; however, there was not a detailed analysis documenting the number of stat chemical restraints administered to each of the individuals who required a stat chemical restraint. For example, several individuals, such as Individual #140, had multiple stat chemical restraints, and this information was not reviewed within the context of the committee. In fact, the only data graph provided was of total stat chemical restraint usage each month, and there was no data provided indicating the number of stat chemical restraints administered to each individual who required a stat chemical restraint. The Facility should conduct a comprehensive systems review of the usage of stat chemical restraints, that includes a review of the number of stat chemical restraints administered to each individual who required a stat chemical restraint; the committee should also address all incidences of uses of stat chemical restraint, such as in the example for Individual #140, who was administered ten stat chemical restraints during the reporting period. Summary: The Facility conducted a clinically appropriate systems review for polypharmacy, but did not conduct a clinically meaningful system review for stat medication usage. Also, there was no indication that a systems review was conducted for benzodiazepine or anticholinergic usage. The Facility had made significant improvements with individual reviews for metabolic syndrome, benzodiazepine, anticholinergic and polypharmacy usage; however, the Facility did not conduct	

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		clinically meaningful individual reviews for stat psychotropic medication usage. As noted in previous Monitoring Team reports, the Facility must continue to enhance its systems review for benzodiazepines, anticholinergic, and stat medication usage at the Facility. Also, the Facility must enhance its individual reviews of stat medication usage. For these reasons, the Monitoring Team determined noncompliance with Section N.3.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The parties agreed that the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	To assess if the Facility completed clinically appropriate monitoring for side effects caused by dopaminergic drugs, such as the emergence of dyskinesia, the Monitoring Team reviewed the past six months MOSES and DISCUS side effects scale results for Individuals #142, #149, #130, #133, #330, #645, #109, and #787. In addition, the Monitoring Team requested a list of all individuals who had either a dose increase, discontinuation, or dose decrease with a currently prescribed neuroleptic, and requested the past six months MOSES and DISCUS side effects scale results for the four Individuals who were reported to have had a dose increase, decrease or discontinuation of a neuroleptic (Individuals #72, #561, #80, and #714) Review for More Frequent Monitoring of Dyskinesia: For the four Individuals who were reported to have had a dose increase, decrease or discontinuation of a neuroleptic: • Individual #72 was reported to have had risperidone discontinued on 11/26/2013. There was no increased monitoring by the MOSES or DISCUS assessment tools, as the follow-up DISCUS and MOSES assessments were completed on 2/13/2013, which was seven weeks following discontinuation of the drug. • Individual #561 was reported to have had a reduction in risperidone dosage on 10/29/2013. Follow-up MOSES and DISCUS assessments were not obtained until 1/24/2014. The 1/24/2014 DISCUS indicated a score of three for lip smacking, which was a new finding, but the DISCUS report did not provide a comment on this potential side	Noncompliance

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		effect. Furthermore, a follow-up DISCUS was not completed until 2/4/2014, which reported a score of zero for lip smacking, and again there was no comment denoted on the DISCUS form as to the clinical nature of the emergence and remission of lip smacking. • Individual #80 was reported to have had a decrease in Zyprexa dosage on 11/26/2013. Only one additional DISCUS scale was completed during the reporting period, on 1/10/2014; which was reported to be a scheduled "3-Month" examination. • Individual #714 was reported to have had a decrease in Mellaril on 10/29/2013, followed by a discontinuation of Mellaril on 11/19/2013 and initiation of Seroquel on 12/31/2013. A follow-up DISCUS assessment following the Mellaril dose reduction on 10/29/2013 did not occur until 12/10/2013, which was six weeks following the dose reduction. Review of Completed MOSES and DISCUS Assessments: • Of the 24 MOSES assessments reviewed for Individuals #142, #149, #130, #133, #330, #645, #109, #787 #72, #561, #80, and #714, five out of 24 (21%) included a completed physician review section on the MOSES assessment report form. • Of the 25 DISCUS assessments reviewed for Individuals #142, #149, #130, #133, #330, #645, #109, #787#72, #561, #80, and #714, three out of 25 (12%) included a completed physician review section on the DISCUS assessment report form. Summary: Many individuals with intellectual disabilities cannot effectively identify and report signs and symptoms of side effects to medications. Changes in neuroleptic medications, such as with an increase, discontinuation, or decrease in dosage can result in acute side effects including dyskinesia, among other conditions. Because of such challenges and the seriousness of dyskinesia, and other conditions associated with these medications, more frequent monitoring for side effects is required when dose changes are made. Six weeks following a neuroleptic dosage change is excessive, and more frequent monitoring by a standardized instrument, such as the DISCUS, should be completed shortly after the medication dose change, and more close monitoring should continue for at least four weeks following the dose change. Signs and symptoms of acute dyskinesia can be subtle and requires monitoring by a trained professional who utilizes a standardized assessment tool. Furthermore, the Monitoring Team was concerned that Individual #561 developed lip smacking, which is a characteristic sign of dyskinesia, following the discontinuation of risperidone on 10/29/2013 and initiation of Seroquel on 11/14/2013, with no clinical explanation documented on the DISCUS assessment form. The Monitoring Team is also concerned that the MOSES and DISCUS assessments provided to the Monitoring Team for review did not include a physician assessment section on the assessment forms. As a result of not completing a physician review section on the MOSES and DISCUS forms, and because more frequent monitoring for dyskinesia and other side effects that can be associated with a change in dose of a dopaminergic drug was not done, the Monitoring Team determined that the Facility is not in compliance with Section N.5.	

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N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	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 during the reporting period; 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. In addition the Pharmacy Policy and Procedure Manual, Adverse Drug Reactions, 01.05.25, revised on 8/28/2013 was reviewed. <u>ADR Policy</u> The Facility's Pharmacy Policy and Procedure Manual, Adverse Drug Reactions revised on 8/28/2013 was reviewed. The policy indicates that 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. The Policy include the process for identifying, and reporting ADRs, and specifics on staff training venues for 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, pharmacists, nurses, and direct care staff. All medical providers, pharmacists, nurses, and direct care staff had participated at the Facility's annual training that includes specific training on ADRs. <u>Data analysis of ADRs</u> The Facility provided a bar graph entitled "Adverse Drug Reactions – Counts By Month", dated 8/1/2013 through 2/28/2014, indicated a total of 27 ADRs; however, an additional bar graph that was dated 8/1/2013 through 2/28/2014, entitled "counts by home," indicated 28 ADRs had been reported. A list of all reported ADRs during this same time period was provided to the Monitoring Team and indicated that a total of 28 ADR had been reported during the reporting period. This is an increase of 12 ADRs from the16 ADRs that were reported for previous Compliance visit . The Pharmacy department generated trends analysis of ADRs that occurred during each quarter and reported relevant clinical and systems information at the 10/10/2013 and 1/14/2014 P&TC meetings, as reflected in the P&TC meeting minutes. Review of Reported ADRs: The Monitoring Team requested the ADR reporting form and relevant IPNs, for the first, and then every second ADR that occurred during the reporting period. Upon reviewing the documents requested, the Monitoring Team was provided a document by the pharmacy director indicating that the Facility had updated its practices based on the last compliance report and that such improvements were made beginning in November 2013. For this reason, the Monitoring Team only reviewed the documents provided subsequent to October 31, 2013; hence, three ADR reports were reviewed (individuals #68, #726, #537)	Substantial Compliance

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		The following is a summary of the Monitoring Team's findings of its review of reported ADRs: • The ADR reporting form was fully completed in zero out of three examples (0%). The Monitoring Team recognized that only minor, and non-clinical information, such as indicating if the legal authorized representative (LAR) was notified, was missing from the forms. • The ADR form was fully completed in ten three of three examples (100%). • The medical provider component of the ADR reporting form was completed in three out of three examples (100%). • The medical provider signed the ADR report form in three out of three examples (100%). • The pharmacist provided comments regarding the ADR in three out of three examples (100%). • Three out of three ADR reports (100%) indicated that the pharmacist identified the ADR. However, upon review of the list of all 28 ADRs that occurred during the review period, the Monitoring Team noted that seven out of 28 (25%) were reported by the pharmacists, and 21 out of 28 (75%) were reported by other staff. This increase in reported by non-pharmacy staff, is an improvement from previous compliance reviews, and may be a result to the Facility's enhanced training on the ADR process. • There was evidence to indicate medical follow-up by the medical provider for three of the three ADRs reviewed (100%). Summary: The Monitoring Team noted significant improvements with the Facility's ADR process. The Facility had enhanced its training for all relevant staff on the ADR identification and reporting process, revised its ADR reporting form to include a section for pharmacists' comments, ensured that pharmacists and medical providers document on the ADR, and ensured that there was clinical follow-up by the medical provider for all reported ADRs. For these reasons, the Monitoring Team determined substantial compliance for Section N.6.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly	The parties agreed that the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	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.		
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 August 2013 through January 2014 • All graphs, data tables, and data analysis for medication variances used by the Facility for a systems review of medication variances during the reporting period • 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 (Individuals #239, #66, #475, #10 #379, #273, #751, #551, #465, and #508): o Copy of completed medication variance report form o All physician IPNs associated with the medication variance o All nursing IPNs associated with the medication variance o All pharmacy documentation, and communication related to the mediation variance <u>Completion of Medication Variance Report Forms:</u> The Facility provided nine of the ten requested completed medication variance report forms (one page of the scanned document was blurred and could not be read). Review of the medication variance report forms indicated the following (Individuals #239, #66, #475, #10 #379, #273, #751, #551, #465, #508): • The Medication Variance forms were fully completed, and indicated the type of variance, severity index, physician notification, and review by the department supervisor, in ten out of ten (100%) examples. • The department supervisor documented appropriate corrective action in ten out of ten (100%) examples. • Medication variances were incorporated into the medication variance database, and after analysis was presented to the medication variance committee for review in ten out of ten (100%) examples. <u>Medication Variance Committee Meetings:</u> The Monitoring Team reviewed the monthly Medication Variance Committee meeting minutes August 2013 through January 2014, which showed 100% of the meetings were conducted as	Substantial Compliance

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		scheduled. The Committee was chaired by the Chief Pharmacist. The required core committee members consistently attended the committee meetings. Prior to the committee meetings 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 corrective action to mitigate medication variances. The Quality Assurance (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 issues were followed through to resolution. Each discipline's monthly medication variance data analysis was presented at the Committee meetings for review and discussion; when indicated, local and/or systemic recommendations were made for improvement in mitigating the incidences of medication variances. Nursing also reported on the monthly results of Medication Administration Observation Audits, Medication Room Survey Audits, and Medication Administration Record (MAR) 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 3/6/14. The meeting was attended by 100% of relevant members. The meeting was substantive and informative. Old business was reviewed and discussed from the January 2014 medication variance meeting. The QA Nurse stated all of the old business issues were resolved with the exception of two issues that had to do with orders that were written in the Neurology and Dental clinics where the charts were not returned timely to the nurses on the units. The QA Nurse reminded the Nurse Manager and RN Case Managers to make sure to inform the DSPs they were to take the charts to the nurses instead of putting them in the medication rooms. There was also an ongoing issue where physicians wrote orders and then several hours later a stack of records with orders were given to the nurses to transcribe. The delay in providing the nurses with charts with physician orders caused the nurses to be out of compliance with transcribing the orders timely, according to policy. The Medical Director will continue to follow-up on this this. Each discipline, i.e., Nursing, Pharmacy, Medical, and Dental presented their medication variance data for the number and type of medication variances, as well as for any local and/or systemic variances, and recommendations to mitigate medication variances. There were no systemic issues identified that required corrective action plans (CAPs), nor were there any active CAPs for medication administration practices. After the meeting the Monitoring Team met with the Chief Pharmacist, CNE, NOO, and QA Nurse and discussed the concern that the number of medication variances reported by this Facility was consistently lower than other facilities monitored. They were asked if they reported each single medication variance identified. The Chief Pharmacist insisted that the Facility followed the state and local Medication Variance Policies, which stated, "When multiple doses are involved in the	

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		variance, such as a transcription variance that leads to multiple missed or extra doses or an individual receives another individual's medications, these are considered a single event/variance rather than multiple variances." This may account for the disparity found in the number of medication variances reported between RSSLC and the other sister facilities. For example, one of the 10 most recent Medication Variance Reports reviewed by the Monitoring Team, for Individual #320, found on 12/31/13 that nine Depakote 500 mg doses were short. A Medication Excess/Shortage Form was completed and submitted to the Pharmacy on 12/31/13. The reason documented on the form was "unknown shortage". The nine short medications were considered as one event; therefore only one Medication Variance Report was completed. This may explain the reason for a lower number of medication variances reported by the Facility. However, since the Medication Variance Policies included a limited number of examples that could be considered as one event, this will not be considered sufficient to result in a finding of noncompliance. There should be further clarification with the state office regarding the interpretation of this policy statement. <u>Pharmacy and Therapeutics Committee Meetings:</u> The Monitoring Team's review of the quarterly Pharmacy and Therapeutic Committee meeting minutes, 10/10/13 and 1/14/14, demonstrated quarterly reporting and review of medication variances. <u>Medication Variance Database 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, apartment, campus-wide, shift, number of variances by type and node, severity index by Categories A though I, nurses who committed the variances, individuals for whom 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. These 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 January 2014 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 department, reported for the past rolling 13 months, which showed:	

Month	Medical	Nursing	Pharmacy	Dental	Other	Pharmacy Other**	Nursing Medical***	Total*

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January 2013	1	9	8	0	0	0	0	18
February 2013	3	2	3	0	0	0	0	8
March 2013	2	22	9	0	0	0	0	33
April 2013	0	18	7	0	0	0	0	25
May 2013	1	2	10	0	0	0	0	13
June 2013	0	6	4	1	0	0	0	11
July 2013	0	9	11	0	0	0	0	20
August 2013	1	15	9	0	0	0	0	25
September 2013	0	25	5	0	6	1	0	37
October 2013	5	38	11	0	8	0	2	64
November 2013	10	5	9	2	0	0	0	26
December 2013	7	3	14	1	0	0	0	25
January 2014	5	22	10	2	0	0	0	39
Total	35	176	110	6	14	1	2	344

*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. **Medication Variance involved Oak Bend Medical Center (OBMC) prescribing a medication that had been discontinued while at RSSLC. ***Medication variance involved shared responsibility of Nursing and Medical Departments.

The Monitoring Team found since the last compliance review, that the Facility had continued to make significant improvements in reporting, analyzing, trending, and corrective actions taken to mitigate medication variances. This was evidenced through review of the Medication Variance and Pharmacy and Therapeutics Committee meeting minutes and supporting documentation, Medication Variance Database, and Monitoring Team's attendance at the Medication Variance Committee meeting on 3/6/14, which found that the Pharmacy, Medical, Nursing, and Dental Departments were reporting, tracking, analyzing, trending, and taking local and systemic corrective action on identified 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 reported across all responsible disciplines compared to the last

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		compliance review report. As system improvements were made in reporting all types of medication variances committed by responsible disciplines, there was a steady increase in the number of medication variances reported. This was a positive finding because it demonstrated the Facility was critically analyzing and trending medication variance data and using the data to make clinical decisions to ensure that all actual and/or potential medication variances were reported. Summary: The Facility had continued to enhance its medication variance process by ensuring a robust reporting process, conducting efficacious medication variances committee meetings, and addressing medication variances once identified. Also, the Facility had its reporting process for documenting medication variances made by medical providers, and pharmacy staff. In addition, the Facility included a comprehensive trends analysis for its medication variance process. Therefore the Monitoring Team determined that the Facility is in substantial compliance with Section N.8.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Self-Assessment-Sections O and P 2/13/14 2. RSSLC Action Plan-Sections O and P 2/13/14 3. Presentation Books for Sections O and P 4. RSSLC Policy K.01 Physical and Nutritional Management (rev: 10/21/13) 5. RSSLC Policy K.04 Developing and Revising PNMP (rev 10/21/13) 6. RSSLC Policy K.05.2 Occupational Therapy/Physical Therapy (rev: 7/3/13) 7. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 1/15/14) 8. RSSLC Policy K.08 Developing Pathways to Oral Intake (rev: 10/31/13) 9. RSSLC Policy K.09 Wheelchair and Accessories Maintenance (7/17/13) 10. RSSLC Policy K.12 Departmental Quality Assurance Plan (11/1/13) 11. RSSLC Policy E.11 Mealtime Procedure (rev. 1/10/14) 12. Record or partial record review: • Sample O.1: Individuals #84, #192, #351, #364, #477, #523, #558, and #783 • Sample O.2: Individuals #31, #84, #159, #360, #500, and #558 • Sample O.3: Individuals #77, #106, #192, #535, #558, #666, and #675 • Sample O.4: Individuals #27, #73, #125, #159, #160, #173, #227, #248, #256, #284, #309, #364, #399, #413, #484, #512, #558, #589, #612, #678, #701, #716, #765, #773, #776, #783, and 798 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. Brandie Rabe PNMT SLP 4. Jean Cuevo PNMT PT 5. Dana Hatter QIDP/PNMT Lead 6. Sally Eastwood PNMT RN 7. Ten DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meetings Attended/Observations:** 5. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon) 6. PNMT meeting (3/5/14) 7. PNMT/IDT meeting, 3/5/14 (Individuals #324 and #284)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 2/13/14 and Action Plan dated 2/13/14. 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: the PNMT Assessment Audit and Outcome Audit, PNMP/Dining Plan Audit, and PNMP Outcome Audit. 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 stated the staff/positions who were responsible for completing the audit tools, such as Facility therapists (i.e., OTs, PTs, and SLPs); therefore, there was 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. This reflects the current overall review of this section, in which many components were present but lacked review of quality. The Facility rated itself as being in compliance with Provision O.1 and Provision O.5. This was not consistent with the Monitoring Team's findings of noncompliance with Provision O.1 but consistent with the finding of substantial compliance with Provision O.5. The Action Plan was well thought out and was felt to lead RSSLC towards improvement. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	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. Staff knowledge improved but proper implementation continued to be a concern of the Monitoring Team. A serious issue was an apparent lack of accuracy in monitoring; unless monitoring accurately identifies problems with implementation of PNMPs, there is little likelihood that implementation will improve and individuals will remain safe. The need to provide comprehensive assessment should continue to remain a focus of RSSLC, as should completion of all recommendations in a timely manner by the IDT in response to a timely exchange of information between the PNMT and the IDT. Provision O.1: This provision was determined to be not in compliance. A PNMT existed that contained all the required participants with the needed training. The PNMT met consistently and received the proper continuing education to expand their knowledge of PNM issues. The issues were that the Facility PNMT did not have a sustainable system that was fully implemented for resolution of systemic issues/concerns. All areas related to PNM were not effectively tracked and analyzed. Per interview with the PNMT, it was reported that Falls were tracked from review of the campus coordinator notes but that the notes were not consistently accurate. This information was brought to the clinical meetings in the morning and shared with the PCPs as well as the QIDPs but missing from the process was a method for accumulating this data for trending and analysis. Provision O.2: This provision was determined to be not in compliance. Measurable outcomes were missing related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. The referral criteria identified a part of the PNMT assessment were general and focused primarily on if pneumonia reoccurred, and did not utilize baseline data to help develop indicators of change. Additionally, while the essential components of the PNMT were improving, there was some concern regarding the comprehensiveness and quality of the assessment. 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. PNMPs were mostly 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 ISP Addendum (ISPA) and/or PNMT minutes as well as training and implementation of the PNMP in a timely manner. While the ISPs contained review of the PNMP, the ISPs did not contain evidence of review as it relates to the effectiveness of the PNMP and if the individual had any related PNM issues since the previous ISP was implemented. 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 had improved their knowledge of the plans and why the proposed strategies were relevant to the individuals' well being but, as stated, this had not resulted in improved implementation.

	Provision O.5: This provision was found to be in Substantial Compliance. All staff, new and existing, received both foundational as well as individual-specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Individual specific training was provided in a timely manner and was competency based as indicated by the change in the plan. The provided trainings resulted in improved staff knowledge as identified in Provision O.4. 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. The form had been revised in October 2013 to include focus areas, which included communication, offering of drinks and following the positioning plan. Additionally, the weight of the scoring was altered so that "implementation of the plan" was weighted more heavily and was worth 30 points while the others were scored as 10 points each. This resulted in staff being unable to obtain the necessary score for compliance if they were observed not implementing the plan, and therefore training was needed and provided by the monitor. The concern was that monitoring lacked accuracy, which calls into question the validity of the process and whether or not there is a true system in place to provide the monitoring needed to ensure implementation of the PNMP. The Monitoring Team was conducting an observation on Leon during lunch in which a therapist and two PNMP coordinators were present providing monitoring. During this time, the three staff were observing the same tables and individuals as the Monitoring Team but failed to identify any of the concerns that were seen by the Monitoring Team. 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 QIDP monthly reviews if completed 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. Individuals were not provided with an overall treatment plan that included all of the needed components.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of eight 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	Noncompliance

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	shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional	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). Sample O.2 consisted of six individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of seven individuals at RSSLC who received enteral nutrition. Sample O.4 consisted of 27 individuals observed in homes and day programs throughout the 24-hour day. <u>PNM Policy and Role of the PNMT:</u> The Facility did have evidence of a comprehensive PNM Policy that included 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;	

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	management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	▪ 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 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. Below in section O.6, an issue identified was lack of accuracy regarding monitoring. This is an area that would benefit from increased inter-rater reliability and a set schedule in which this would be provided.	

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		Core PNMT Membership: 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. Evidence that systemic review and/or analysis continued to be noted during this visit. Also noted was improved information sharing between the IDT and the PNMT. 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 Muneer RD • Adriano Soria RN back up • Ping Law, PNMT Lead back up • Tran Quan DO, PNMT Medical Consultant Consultation with Medical Providers and IDT Members For five of six individuals in Sample 0.2 (83%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. Dr Quan was the PNMT primary physician and served as the liaison between the PNMT and medical providers. For five of six individuals in Sample 0.2 (83%), 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 Six of six core and three of three back up/non-designated/consultant PNMT members (100%) were licensed to practice in the state of Texas. Nine of nine PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Continuing Education Nine of nine PNMT staff (100%) had completed continuing education hours ranging from six to 34.5 in the last year. Many of these classes were 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	

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		▪ The SLP and the OT attended: Dysphagia: From Assessment to Discharge ▪ RD attended: Chronic Kidney Disease ▪ RN attended: Clinical Indicators of Health Status Change <u>PNMT Meetings</u> From 8/1/2013 to 1/29/2014, of the 25 weeks, the PNMT met 23 of 25 weeks (92%). Meetings were consistently held as evidenced by the two weeks missed being during a shortened labor Day week and the week of Christmas. All core members of the PNMT were present for at least 80% of the meetings. This was an improvement over the previous review in which the Dietitian and PNMT Lead were absent for greater than 20% of the meetings. A back up PNMT lead had been identified to assist with administrative issues when lead was not available. This resulted in 100% attendance by the PNMT lead/Back up. Twenty-three of the 23 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. The Facility PNMT did not have a sustainable system that was fully implemented for resolution of systemic issues/concerns. A new system did exist that included; ▪ 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). The new system had begun to track pneumonia and skin breakdown. It had not yet been in place long enough to evaluate data from one quarter to a prior quarter. The concern was that not all areas related to PNM were effectively tracked and analyzed. Per interview with the PNMT, it was reported that Falls were tracked from review of the campus coordinator notes but that the notes were not consistently accurate. This information was brought to the clinical meetings in the morning and shared with the PCPs as well as the QIDPs. Missing from the process was a method for accumulating this data for trending and analysis. Per review of the PNMT minutes, it was noted that there was an increased tracking of falls as part of the 1/22/14 and 1/29/14 PNMT Meeting Minutes. As mentioned, the concern was that there did not appear to be any analysis of the falls occurring on a facility basis. Per request of evidence	

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		of trending, tracking, and analysis for falls, the Facility provided evidence of injury trending and those injuries that resulted from falls but did not have a system in place that actually tracked the occurrence of falls, the location of falls, and the precipitating factors. Falls resulting in injury or no injury at all should be tracked as a method to determine if positive outcomes are resulting from provided interventions. In order for the Facility to move towards substantial compliance, RSSLC must develop a system for tracking, trending and analyzing all PNM related areas including falls and emesis.	
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 thirteen out of 335 Individuals were identified as having PNM related issues. Three hundred thirteen of 313 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"). Eleven of 12 individuals in Samples O.1 and O.2 (92%) 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). <u>Physical and Nutritional Management Team Referral Process</u> Eight of eight individuals from Sample O.1 were appropriately referred to the PNMT based on the criteria included in the Facility policy. The previous concern regarding the Facility policy reflecting the state policy, which allows for multiple choking events or aspiration pneumonia without requiring an automatic referral to the PNMT, had been rectified and now any choking event or aspiration Pneumonia led to automatic referral as stated in policy K.01 "Physical and Nutritional Management" rev: 10/21/13. In eight of eight 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 continued to conduct assessments in response to all changes in status and discussed these results during the PNMT meeting. Eight of eight individuals (100%) were seen	Noncompliance

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		within five days of their change in status or by the PNMT Nurse within five days of their return from the hospital. 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 the weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. 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> Six of six 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 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 Six of six 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 PNMT then makes the determination of whether a comprehensive assessment was needed. When a full assessment was not warranted, all 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: • Six of six (100%) contained date of referral by the IDT. This information was contained within the PNMT assessment. • Six of six (100%) contained date assessment was initiated. This information was contained within the PNMT assessment, and PNMT minutes. • Five of six (83%) contained evidence of review and analysis of the individual's medical	

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		history. This information was contained as part of the PNMT RN Assessment as well as the PNMT assessment. • Six of six (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. • Six of six (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. • Five of six (83%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition. • Six of six (100%) contained assessment of current physical status. This information was contained within the PNMT minutes, PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Six of six (100%) contained assessment of musculoskeletal status as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Six of six (100%) contained evaluation of motor skills as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Six of six (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Five of six (83%) 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. • Six of six (100%) contained evaluation of current adaptive equipment. This information was contained within the PNMT Assessment, Habilitation Assessment as well as the PNMT minutes. • Six of six (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. • Six of six (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. • Zero of one (0%) who received enteral nutrition had identified residual thresholds, for return to the PNMT. Although residual thresholds were identified as part of the IHCP, there was no clear referral indicator back to the PNMT. • Five of five (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. One Individual was NPO and therefore this	

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		indicator was not applicable. • Six of six (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting • Five of six (83%) 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. Individual #192 had labs that were suggestive of dehydration (lab values in which there were elevated BUN/Creatinine ratio greater than 20) but there was no evidence that this was identified. • Six of six (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. • Six of six (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. • Six of six (100%) contained oral hygiene status. This information was contained within the Habilitation Assessment, and PNMT evaluation. • Six of six (100%) contained evidence of observation of the individuals' supports at their home and day/work programs. • Six of six (100%) contained evidence that the PNMT conducted hands-on assessment and/or review. • Five of six (83%) identified the potential causes of the individual's physical 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. • Five of six (83%) 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. • Six of six (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. • Zero of six (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. The referral criteria identified as part of the PNMT assessment were general and focused primarily on if pneumonia reoccurred and did not utilize baseline data to help develop indicators of change. • Six of six (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (e.g. revision of the individual's PNMP). • Six of six (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT/IDT. As stated, in the bullet point above, the criteria for referral were general	

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		and not based on clinical indicators. • Six of six (100%) contained signatures with dates. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u> For zero of six individuals (0%) 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 #159 had a recommendation to check residuals and for impaction post seizure activity but this was not included as part of the IHCP. • Individual #558 had a recommendation to bring the O2 concentrator available during oral care and bathing. This was not included as part of the IHCP. • Individual #500's criteria for referral back to the PNMT were not included as part of the IHCP. • Individual #558's IHCP still had her listed as receiving oral intake when the Individual was to have nothing by mouth. Other concerns noted included: • The IHCP was not consistently updated when there was a change in status. For example: o Individual #192's IHCP still stated the individual was on a ground diet when the Individual was actually NPO and enterally fed. o Individual #192's IHCP was not updated to reflect change in Bowel Movement criteria. Individual has a significant history of constipation and is high risk but the IHCP was not updated to reflect "notify if no BM in two days". o Individual #558's IHCP still stated the individual ate by mouth when then individual has been enterally fed since 11/2013. In order to move towards substantial compliance, RSSLC must ensure that IHCPs are updated in a timely manner and that staff are notified of any changes to the IHCP as part of their training. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In six of six individuals' plans reviewed (100%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. • In four of four individuals (100%) for whom Head of Bed Elevation (HOBE) assessments were conducted or reviewed, the HOBE recommendations were integrated into individuals' plans. • In three of six individuals' plans reviewed (50%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. The IDT did not clearly develop or respond to 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. The PNMT had developed a form titled	

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		the "PNMT/IDT Discharge Plan". This form contained recommendations, needed action plans, person responsible and due dates. The issue was that the IDT failed to consistently meet the due dates or identify a follow up date to ensure all recommendations were completed and therefore the Monitoring Team was unable to determine if completion of recommendations were timely. For example: o Individuals #159, #500, and #360 did not have follow-up meetings planned by the IDT to ensure completion of all PNMT recommendations. • In six of six 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 six 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. Measurable objectives were included as part of the IHCP but were not necessarily relevant to the PNMT recommendations and/or issues. • In six of six individuals' plans reviewed (100%), the plans defined triggers. • In six of six individuals' plans reviewed (100%), the frequency of monitoring was included in the plans. The PNMT included as part of their assessment, a monitoring schedule that outlined what the PNMT would review and the length in which it would be reviewed. In order to move towards substantial compliance, The PNMT must do a better job at identifying thresholds for return to the PNMT as well as clinical indicators that will help the PNMT determine the effectiveness of the proposed recommendations. 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 six 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. As stated previously, the PNMT had developed a form that would help outline responsibilities and due dates but there remained little evidence that the IDT reconvened in a timely manner to discuss the results and/or status of the recommendations • In zero of six individuals' plans reviewed (0%), documentation was provided to show	

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		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. In order for the Facility to move toward substantial compliance, the Monitoring Team recommends the IDT meets 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: ▪ Six of six individuals (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ Six of six individuals' (100%) discharge summaries/action plans provided objective clinical data to justify the discharge. ▪ Zero of six individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. ▪ Zero of six 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. While criteria for referral were included as part of the PNMT assessment, the criteria were primarily based upon reoccurrence of pneumonias and not objective clinical data that will proactively help the PNMT address concerns before they become a risk to one's health. Additionally, the criteria that were identified were not integrated into the IHCP. There was not a clear, consistent process that documented a collaborative discharge summary/action plan that included key clinical indicators, individualized triggers, evidence that discharge recommendations were integrated into the IHPC, and criteria for referral back to the PNMT integrated as part of the IHCP. A more thorough review was provided of Individual #192. There was a concern as to the comprehensiveness of the overall review of Individual #192. Individual #192 has a significant history of pneumonia (eight in the past 12 months). The individual was seen by the PNMT in August 2013 and again in February 2014. Multiple recommendations were provided but there was limited evidence that these recommendations were followed up on in a timely manner. There was also conflicting information provided between assessments, tests and meetings. Some of the concerns noted included: • Lack of comprehensive review regarding lab data that suggested possible dehydration secondary to elevated BUN/Creatinine levels greater than twenty. • Conflicting information between ISPA (2/20/14) and ISPA (11/26/13) and ISPA (11/21/13). ISPA dated 2/20/14 stated that the individual silently aspirated. ISPA dated 11/26/13 references an MBSS 8/2013(which was the last one provided) in which there	

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		was no aspiration and only minimal penetration and an ISPA dated 11/21/13 in which it was stated that the individual had major swallowing problems. Again, this was not substantiated by the MBSS in 2013 or one provided in 2011. • Lack of clear clinical logic when determining/developing plans of care. For example, the IDT stated that enteral nutrition would help reduce aspiration but then stated the reason for the aspiration is due to poor positioning and/or compliance with positioning. Providing a G-tube will not decrease the risk of aspiration when positioning is the believed root cause of the aspiration. By inserting a g-tube, the risk was potentially increased as now the need for proper positioning has increased significantly. • Assessments/evaluations not completed in a timely manner. The ISPA dated 1/13/14 requested a Head of Bed Evaluation and in May 2013, an Endocrinology referral was suggested. As of the compliance visit, neither had been provided. Behavior assessment was recommended as part of the 2/7/14 PNMT evaluation but there was no evidence that this was initiated. • Lack of updates to the PNMP. The PNMP as of 10/23/13 still reflected that the individual was on a ground diet when their diet texture had been changed to puree on 10/18/13. • Lack of updates to the IHCP. The IHCP as of 3/6/14 still stated the individual is on a ground diet when the individual is tube fed. Also, the IHCP still reflected to notify the nurse if no BM in 3 days when this directive was changed on 8/12/13 to notify the nurse if no BM in 2 days. Another concern noted through review of the PNMT minutes was that the discharge process was often delayed and not completed. Examples included Individuals #84, #296, #500, #558, and #570's discharge process, which consisted of the PNMT attempting to meet with the IDT multiple times without response. In greater detail: • The PNMT attempted to contact Individual #296's QIDP from 8/1/14 to 8/21/14 before possibly getting a meeting on 8/22/14. The Monitoring Team was unable to confirm the meeting occurred, as this was not reflected in the PNMT minutes. • Individual 570's PNMT/IDT meeting was delayed for a month resulting in the individual not getting the review of services that was needed. • Individual #500 had a PNMT assessment completed. The PNMT and IDT did not meet for 18 days to discuss PNMT assessment findings. • Individual #558's PNMT assessment was completed on 12/20/13 but was not reviewed with the IDT until 1/10/14. • Individual #84's PNMT assessment was completed on 10/24/13 but was not shared with the IDT until 11/6/13. Due dates for completion of this task were often changed and delayed on a weekly basis due to lack of a timely PNMT/IDT meeting. Failure to meet with the IDT resulted in the delay in implementing many strategies/recommendations identified as part of the PNMT assessment.	

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		It should be noted that per PNMT minutes, in all cases listed above, the PNMT attempted to notify the IDT multiple times. In order for the Facility to move towards substantial compliance, there must be timely information sharing between the IDT and the PNMT as well as well documented and timely follow up by the IDT in reviewing and implementing PNMT recommendations as indicated.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>Identification of Individuals Requiring a PNMP</u> For the eight individuals in Sample O.1, eight of their annual ISPs (100%) noted that the 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 90% consistency at the annual IDTs in which the PNMP was reviewed and revised. A member of the Habitation Department was present at 100% of the meetings. Seven of twelve PNMPs (58%) were reviewed by the individual's IDT in the annual ISP meeting. The ISPs contained evidence of review, update/revision, and specified the changes required to the PNMP. While the ISPs contained review of the PNMP, the ISPs did not contain evidence of review as it relates to the effectiveness of the PNMP and if the individual had any related PNM issues since the previous ISP was implemented. In order to achieve substantial compliance, RSSLC must ensure that the PNMPs are consistently reviewed for their effectiveness as part of the ISP. <u>PNMP Format and Content</u> A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 12 of 12 individuals (100%) were current within the last 12 months. • PNMPs for 12 of 12 individuals (100%) included a list of high-risk levels and individual triggers as indicated. • In 12 of 12 most current PNMPs (100%), there were large and clear color photographs with instructions. • In 12 of 12 PNMPs (100%) the adaptive equipment required by the individual was listed. 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. • In 10 of 10 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 12 of 12 PNMPs (100%), positioning was adequately described per the individuals'	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessments. Pictures were present and instructions were clearly linked to the assessment. • In 12 of 12 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 12 of 12 PNMPs (100%), bathing instructions were provided. • In 12 of 12 (100%) PNMPs, toileting-related instructions were provided, including check and change. • In 12 of 12 (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 12 of 12 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • Twelve of 12 individuals' (100%) Dining Plans were current within the last 12 months. • Two individuals had feeding tubes with no oral intake. Two of two (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 12 of 12 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 10 of 10 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 10 of 10 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 10 of 10 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 12 of 12 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 12 of 12 PNMPs (100%) information related to communication was included (how individual communicated, how staff should communicate with individual). <u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u> For four of five individuals (80%) in Sample O.1 for whom the IDT identified changes needed to be made to the PNMP, ISPA meeting documentations or PNMT meeting documentation noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. Individual #192 was the exception; the PNMP still stated on 10/23/13 the individual was on a ground diet when the diet had been downgraded. For Individuals for whom the PNMP was revised, there was supporting documentation that five of five individuals' (Sample O.1) revised PNMPs (100%) had been implemented and trained.	
O4	Commencing within six	<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u>	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>Staff did not engage in safe mealtime practices, as indicated by the following: Per observations conducted by the Monitoring Team, nine of 27 individuals' (33%) dining plans/PNMPs in sample O.4 were implemented as written.

Examples of dining plans not implemented included but were not limited to:
• Individual #701 was not encouraged to take sips between bites to help clear oral cavity, resulting in an increased risk of aspiration and/or choking.
• Individual #248 was overstuffing his mouth and eating at a fast rate with no cues from staff to slow down. This individual ate an entire meal in fourteen bites.
• Individuals #678, #309, #364, and #256 were not provided with the right amount of liquids. Individuals required ¼ or 1/3 cup of liquids but were supplied with full cups which resulted in chugging.

Based on observations by the Monitoring Team, examples of positioning plans not being implemented included:
• Individual #783 was lying supine when the plan called for left side lying.
• Individual #512 was in right side lying with a collapsed trunk resulting in increased abdominal compression and therefore increasing risk of reflux aspiration.
• Individual #125's plan called for him to be in left side lying but was observed lying on his stomach.

Transfers were improved and observations noted:
• Four of four 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.

Two of two (100%) individuals' (Sample O.4) oral hygiene plans were implemented as written.

<u>Knowledge of Staff Regarding PNMPs</u>
Based upon interviews with six staff from Three/Four Rivers, San Antonio, Trinity and Leon, staff knowledge of the individuals' PNMPs showed improvement since the previous visit. Following are the numbers of staff who answered correctly and the number asked the question:

<table>
<tr><td></td><td># Asked</td><td># Correct</td><td>% Correct</td></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>5</td><td>4</td><td>80%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Mealtimes:</td><td></td><td></td><td></td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>For what reason does the individual have thickened liquids?</td><td>10</td><td>8</td><td>80%</td><td></td></tr>
<tr><td>For what reason does the individual eat a modified texture?</td><td>10</td><td>10</td><td>100%</td><td></td></tr>
<tr><td>What is the reason for the individual using a specific utensil?</td><td>10</td><td>8</td><td>80%</td><td></td></tr>
<tr><td>If the individual receives enteral nutrition, how do you determine if he/she is in the correct position?</td><td>6</td><td>5</td><td>83%</td><td></td></tr>
</table>

There was an increase in knowledge exhibited by staff but this increase did not result in an increase in the implementation of the PNMP. In order to move towards substantial compliance, RSSLC must ensure staff is consistently following the plans as indicated.</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>This provision was found to be in Substantial Compliance. All staff, new and existing received both foundational as well as individual specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Individual specific training was provided in a timely manner and was competency based as indicated by the change in the plan. The provided trainings resulted in improved staff knowledge as identified in Provision O.4.

<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 (Body Mechanics)
Positioning
Adaptive Equipment
PNMP Orientation
Safe Mealtime Strategies
Basics of Dysphagia
Beginning in October 2013, the topic of dysphagia was expanded to focus on the rationale for implementing the PNMP.

The large majority of staff successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs. As of March 3, 2014, 99% of staff had competed the Core Competency training.

Per RSSLC training records, 41 of 41 (100%) new staff recently participated in the trainings and</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		completed the core competency NEO trainings on 2/28/14. <u>PNM Core Competencies for Current Staff</u> Six hundred ten of 617 current staff that require training (99%) successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. Seventy-eight of 78 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 ▪ 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	

#	Provision	Assessment of Status	Compliance
		• 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). As mentioned above, status of the training was as follows: • As of 3/3/14, 610 of 617 (99%) had received PNM core competency trai.ning <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: 922 staff (97%) had completed their annual lifting class. ▪ Preventing Aspiration: 956 staff (99%) had completed their annual aspiration class Per PNM policy, training will be provided at least annually and as indicated by monitoring. <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 two 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, the Monitoring Team determined the Facility did not have a clear process in place. For two of two individual's (Sample O.1) staff (100%) assigned to individuals #523 and #477, there was evidence of exchange of the information included in the PNMP prior to the provision of services. For Individuals #477 and #523, two of two (100%) Individual's staff assigned had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. Two of two individuals' staff (100%) 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. This information was contained at the top of the training form.	

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		An extended review was drawn from Samples O.1 and O.2 to verify the results of individual specific training and the results were as follows: • Individuals #351, #360, #500, and #666's staff (100%) had received the necessary individual specific training as indicated by their plans of care. The Facility did have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. The process including the primary therapist training the staff responsible for training others and then certifying thorough observation that the training is adequate to proceed. 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.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<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 concern noted during the previous review over lack of clarity regarding the monitoring schedule for those outside of "high risk" had been rectified and the policy now clearly included the schedule for those who were not "high risk." 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	Noncompliance

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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. The form had been revised in October 2013 to include focus areas, which included communication, offering of drinks and following the positioning plan. Additionally, the weight of the scoring was altered so that "implementation of the plan" was weighted more heavily and was worth 30 points while the others were scored as 10 points each. This resulted in staff being unable to obtain the necessary score for compliance if they were observed not implementing the plan, and therefore training was needed and provided by the monitor.

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

Forty-four of 44 staff (100%) responsible for conducting the monitoring were provided with the training needed to successfully complete the forms in a consistent and comprehensive manner.

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 continued to:

- Track and trend the monitoring data
- Identify staff who are unable to implement the PNMP
- Report results to QA/QI Council
- Develop corrective action plan

A graph showing the approximate percentage of areas monitored for PNM during the months of August 2013 to January 2014 on first shift (the other shifts had just begun to provide these data) provided information as follows:

	Bathing	Lifting/Transfer	Meal	Med Admin	Oral Care	Positioning	Snack	Assistive Equipment	Commu
8/13	10%	11%	25 %	10%	7%	24%	5%		
9/13	20%	10%	28 %	14%	12%	15%	6%		
10/1	8%	10%	32	9%	5%	23%	9%		

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3			%								
11/13	7%	3%	38%	17%	10%	21%	1%			3%	
12/13	7%	5%	33%	18%	8.9%	20%	1%	5%		2%	
1/14	9%	6%	28%	17%	11%	17%	1%	6%		4%	

The above graph demonstrates a proportionate number of monitors being focused on all areas in which PNM difficulties are likely to be provoked. A total of 2380 monitoring forms were completed from August 2013 to January 2014. Also noted upon review of the monitoring data was the inclusion of all three shifts in the monitoring process. Beginning in December 2013, there was evidenced that monitoring occurred in all applicable areas on all applicable shifts. During the months of September 2013 to November 2013, some monitoring was provided during second shift but there was no evidence included in the monitoring summary provided that detailed what the second shift monitoring covered. As stated, this was addressed in December 2013.

In order to obtain substantial compliance, RSSLC must ensure the monitoring continues to occur according to schedule identified as part of policy K.07. The Monitoring Team was unable to determine substantial compliance at this time due to the new monitoring process being relatively new in its implementation.

Monitoring for Individuals in Samples

For individuals in Sample O.1, PNM compliance monitoring over the past three months for eight of eight individuals (100%), occurred at the frequency of monitoring 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 six of six individuals (100%), occurred at the frequency of monitoring 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
- Moderate risk: Monitored once monthly

Additionally, the PNMT provided a level of monitoring for identified indicators (e.g., vomiting) for a period of two months post discharge. This monitoring by the PNMT assisted the PNMT in determining if strategies/recommendations resulting from the PNMT assessment were effective in mitigating risk.

For the three months prior to the review, 75 of the expected 144 monitoring sessions per policy or

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		the individuals' assessments and/or plans (52%) were completed timely. Individuals were not consistently provided with the monitors as identified by the schedule, which was once weekly for high risk and once monthly for moderate risk. For the past three months, problems were noted on two of the 75 monitoring forms. Of these, documentation of adequate follow-up was provided on the form for two (100%). The concern was that monitoring accuracy was lacking and therefore calls into question the validity of the process and whether or not there is a true system in place to provide the monitoring needed to ensure implementation of the PNMP. The Monitoring Team was conducting an observation on Leon during lunch in which a therapist and two PNMP coordinators were present providing monitoring. During this time, three staff were observing the same individuals as the Monitoring Team but failed to identify any of the concerns that were seen by the Monitoring Team. These issues focused on Individuals #678, #309, #364, and #256 not being provided with the right amount of liquids. The issues observed such as not providing the right amount of liquid were very easy issues to identify; for no one monitoring the meal to recognize the issue worries the Monitoring Team and questions the relevance of the monitoring system at all in identifying issues and providing solutions to those issues. Failure to provide such basic interventions unnecessarily increases the risk to individuals. In order to achieve substantial compliance, the Facility must not only have the data to support the monitoring but have the needed accuracy and reliability of the completed monitors to ensure implementation of the PNMP. The number of completed monitors will also need to meet the schedule identified as part of policy K.07.	
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 six 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). Zero of the 12 individuals' records in Samples O.1 and O.2 (0%) 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. QIDP monthly reviews 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. Twelve of 12 individuals' records (100%) 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.	Noncompliance

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		Two of 12 Trigger sheets (17%) were completed correctly. Three of 12 Trigger sheets (25%) 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. Seven of seven 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. Seven of seven 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> Four of seven individuals (57%) 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 appropriate. This information was contained within the PNMT assessment. It appeared that if the Individual had not received a PNMT assessment then the path/return to oral intake was not well discussed or assessed by the IDT. 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. As stated previously above, this information was only contained if the Individual had received a PNMT assessment.	Noncompliance

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		RSSLC did not consistently provide treatments or strategies to help move the individual along the pathway to oral intake. Examples included: • Individual #106 and #675 were identified as having poor oral motor ability but no plan was in place to improve oral musculature was recommended. Zero of four individuals from Sample O.3 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. Four of four individuals' plans to return to oral eating or improve oral eating were based on the results of the IDT's discussion (100%), but zero of four (0%) were integrated in the IHCP, ISP, and/or an ISPA. In determining compliance with this metric, the SLP notes representing acceptance of the referral and the initial treatment note represented the plan. Four of four individual's plans to return to oral eating (100%) were implemented in a timely manner. In determining compliance with this metric, the SLP notes representing acceptance of the referral and the initial treatment note represented the plan. The SLP documented in the IPNs four out of four (100%) individuals' current status but did not provide an overall treatment plan that included all of the following components: • Staff training required prior to implementation; • 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. There were no clear Oral intake plans; therefore, the Monitoring Team was unable to determine if the individuals' plans (%) were monitored as outlined in the plan or if staff responsible for implementation was properly trained.. No modifications resulting from Oral Motor Therapy were recommended, therefore the Monitoring Team was unable to determine if the individuals' plans were modified by the IDT or if needed, the IDT met and interventions were reviewed and changed, as appropriate, in a timely manner.	

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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 2/13/14 2. RSSLC Action Plan-Section O and P 2/13/14 3. Presentation Books for Sections O and P 4. Record or Partial Record Reviews: • Sample P.1: Individuals #84, #192, #351, #364, #477, #523, #558, and #783 • Sample P.2: Individuals #195, #391, #468, #470, #478, #529, and #700 5. RSSLC Policy K.01 Physical and Nutritional Management (rev: 10/21/13) 6. RSSLC Policy K.04 Developing and Revising PNMP (rev 10/21/13) 7. RSSLC Policy K.05.2 Occupational Therapy/Physical Therapy (rev: 7/3/13) 8. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 1/15/14) 9. RSSLC Policy K.08 Developing Pathways to Oral Intake 10. RSSLC Policy K.09 Wheelchair and Accessories Maintenance 11. RSSLC Policy K.0.9.1 Wheelchair Clinic and Ordering 12. RSSLC Policy K.12 Departmental Quality Assurance Plan 13. RSSLC Policy E.11 Mealtime Procedure (rev. 1/10/14) 14. List of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 15. Current lists of individuals: • Who use wheelchair as primary mobility; • With transport wheelchairs; • With other ambulation assistive devices, including the name of the device; • With orthotics and/or braces; • Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution; • 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 16. OT/PT assessments template 17. Wheelchair seating, PNM clinic assessment templates and related documentation OT/PT-related spreadsheets 18. 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 19. List of individuals receiving direct OT and/or PT services and focus of intervention 20. Last five assessments completed by OT/PT **People Interviewed:** 1. Ping Law OTR Habilitation Therapies Director 2. David Taylor OTR, PNMT OT

	3. Jean Cuevo PNMT PT 4. Dana Hatter QIDP/PNMT Lead 5. Sally Eastwood PNMT RN **Meeting Attended/Observations:** 1. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon) 2. PNMT meeting (3/5/14) 3. PNMT/IDT meeting, 3/5/14 (Individuals #324 and #284)
	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: OT/PT Assessment Audit & Outcome Audit. 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 not consistent with the Monitoring Team's findings of compliance with both Provisions P.1 and P.3 Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	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. It appeared the plan to improve skill acquisition was working as evidenced by improvements from 56% to 75% regarding expansion of the individual's current abilities and 25% to 50% regarding the individual's potential to develop new functional skills. 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 found to be in Substantial Compliance. All staff, new and existing, received both foundational as well as individual specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Individual specific training was provided in a timely manner and was competency based as indicated when there was change in the plan. 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 had been expanded to include monitoring for those who were moderate risk. This process was relatively new and had only been in effect for approximately 2 months. This will be further reviewed once the new process has had an opportunity to be fully implemented. Another concern noted was the accuracy and reliability of the completed monitors. This concern came from the Monitoring Team identifying several issues in which observations at the same time as Monitoring Team observations were missed by the PNMP coordinators and therapists.

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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	This provision was determined to remain 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 or develop functional skills. Although there is still a need to improve the development of skill acquisition, improvement continues to be noted and a system was in place to ensure continued growth. 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 eight 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	Substantial Compliance

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	consider significant medical issues and health risk indicators in a clinically justified manner.	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** Seven of seven 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. Fifteen of 15 individuals' OT/PT assessments in sample P.1 and P.2 (100%) were dated as having been completed at least 10 days prior to the annual ISP. Fifteen of 15 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** Fourteen of 15 assessments (93%) (Samples P.1 and P.2) were completed consistent with the established schedule, or the individuals' need. Individual #192 was recommended to have a Head of Bed (HOB) evaluation on 1/13/14 but there was no evidence this was done. It should be noted that this individual has had multiple hospitalizations over the past 6 months. 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: • Fifteen of 15 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. • Fifteen of 15 assessments (100%) included diagnoses and relevance to functional status. • Fifteen of 15 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. • Fourteen of 15 assessments (93%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years	

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		or assessments. • Fourteen of 15 individuals' OT/PT assessments (93%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • Fifteen of 15 assessments (100%) included medical history and relevance to functional status. • Fifteen of 15 assessments (100%) addressed health status over the last year • Fifteen of 15 assessments (100%) listed medications and potential side effects relevant to functional status • Fifteen of 15 assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills • Fifteen of 15 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work) • Fifteen of 15 assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings • Twelve of 15 assessments (80%) included discussion of the expansion of the individual's current abilities. An example of an individual whose assessment did not include this discussion was Individual #468, who requires total assistance with wheelchair mobility but there was no plan in place to improve her skill although she has the fine motor skills needed to perform such a task. This represented an improvement of 24% since the last compliance review. • Eight of 15 assessments (53%) included discussion of the individual's potential to develop new functional skills. For example, Individual ##84 was totally dependent with grooming, bathing, and dressing yet no skill acquisition opportunities were identified through the OT/PT assessment. This represented an improvement of 28% since the previous compliance review. • Fifteen of 15 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 • Fifteen of 15 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions. • Fifteen of 15 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. • Fifteen of 15 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. • Fifteen of 15 individuals' OT/PT assessments (100%) made a determination	

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		about the appropriateness of transition to a more integrated setting. This information continued to improve 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. • Fifteen of 15 assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Fifteen of 15 assessments (100%) included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature. • Fifteen of 15 assessments (100%) include recommendations for services and supports in the community. This information was present as part of the "Factors for Community Placement." • Fifteen of 15 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 Monitoring Team has recognized significant improvement in the comprehensiveness of the OT/PT assessments including the identification of skill acquisition programs as it relates to Activities of Daily Living (ADLs). While improvement was noted, there remained a need to further improve the development of ADL skill acquisition as a part of the overall OT/PT assessment process. Overall, Individuals continued to be identified as being totally dependent for many ADLs without being provided any goals/programs to expand existing skills or develop new skills. Per review of documentation and interview with Habilitation Director, the assessment audit that is conducted on a monthly basis reviews this component and has resulted in improvement. The Monitoring Team agreed with this statement. Per review of the assessments provided as part of Samples P.1 and P.2, the presence of skill acquisition programs had improved from 56% to 80% and 25% to 53% respectively. This improvement must continue so that development of skill acquisition is part of the overall assessment and support planning process.	
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	**OT/PT Interventions** For individuals receiving OT/PT supports and services, 15 of 15 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 15 of 15 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.	Noncompliance

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	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.	**Direct OT/PT Interventions** The records of individuals in Sample P.2 were reviewed resulting in the following findings: • Three of seven individuals' direct intervention plans (38%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. The Monitoring Team was unable to determine if the remaining four individuals were implemented timely as there were no OT/PT progress notes available for review. • For three of seven individuals' records (38%) reviewed, the current OT/PT assessment/note identified the need for direct intervention with rationale. The Monitoring Team was unable to determine if the remaining four individuals were implemented timely as there were no notes available for review. • For three of seven individuals' records (38%) 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. The Monitoring Team was unable to determine if the remaining four individuals were provided with measurable objectives as no OT/PT progress notes were available for review • For one of one individual's 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 provided in the Pre-ISP meeting documentation. Fifteen of 15 ISP annual meetings (100%) had a member from either OT or PT present to represent the disciplines. Fifteen of 15 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 seven of the eight ISPs or ISPAs reviewed (88%), skill acquisition programs that had	

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		been recommended in the OT/PT assessment were present. The problem noted with this area was that although improved, skill acquisition programs needed to increase their presence 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 consistently identify potential areas in which skills such as ADLs could be addressed. Three of seven individuals receiving direct OT/PT Services (Sample P.2) (43%) 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 15 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 QIDP 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 indicated in reference to the individual's progress or lack of progress. In order for the Facility to move towards substantial compliance, the PNMP review conducted by the QIDP should include a statement, based on clinical information and measurable indicators, 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	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	Substantial Compliance

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	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.	PNMP. As with Provision O.5, this provision was found to be in Substantial Compliance. All staff, new and existing, received both foundational as well as individual specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Individual specific training was provided in a timely manner and was competency based as indicated by the change in the plan. The provided trainings resulted in improved staff knowledge as identified in Provision O.4. As reported in that provision, 99% of direct support staff had received core competency training on physical and nutritional management.	
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 appears to have implemented a system for the adequate monitoring of PNMPs but the process has only been implemented for a little over two months and will need to be reviewed at the next compliance visit for full implementation. Revision of the monitoring process included addition of the monitoring for moderate risk individuals, monitoring during all shifts, and revision of the scoring method. PNMP Training and Monitoring Policy K.07 (revised 1/15/14) 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 were provided with a set schedule that ensured review of their OT/PT related plans at least once monthly. The Monitoring Team reviewed the following policies and procedures: o RSSLC Policy K.01 Physical and Nutritional Management (rev: 10/21/13) o RSSLC Policy K.04 Developing and Revising PNMP (rev 10/21/13) o RSSLC Policy K.05.2 Occupational Therapy/Physical Therapy (rev: 7/3/13) o RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 1/15/14) o RSSLC Policy K.08 Developing Pathways to Oral Intake o RSSLC Policy K.09 Wheelchair and Accessories Maintenance o RSSLC Policy K.0.9.1 Wheelchair Clinic and Ordering o RSSLC Policy K.12 Departmental Quality Assurance Plan o RSSLC Policy E.11 Mealtime Procedure (rev. 1/10/14) The Facility did have OT/PT policies that substantially included the needed components. The policies included the following elements: • Define the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment;	Noncompliance

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		• 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 • Define a formal schedule for monitoring to occur. In order to move towards substantial compliance, RSSLC should ensure the monthly review conducted by the QIDP includes a statement regarding the effectiveness of the supports provided as evidenced by health and functional status. Additionally, there were concerns regarding the reliability of the data acquired by the PNMPCs. The concern was that monitoring accuracy was lacking and therefore calls into question the validity of the process and whether or not there is a true system in place to provide the monitoring needed to ensure implementation of the PNMP. The Monitoring Team was conducting an observation on Leon during lunch in which a therapist and two PNMP coordinators were present providing monitoring. During this time, three staff were observing the same individuals as the Monitoring Team but failed to identify any of the concerns that were seen by the Monitoring Team. Additional information regarding these issues may be found under Section O.6. For 15 of 15 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 quarterly basis. If issues were noted outside of the scheduled checks, a work	

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		order/consult was sent to the home therapist. For 15 of 15 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 67 of 67 (100%) individuals for whom adaptive equipment was noted to be in disrepair or needing replacement between the dates of 1/1/14 to 2/4/14, 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, 03/18/1014 2. RSSLC Action Plan, (need to add date) 3. RSSLC Presentation Book, March 2014 4. RSSLC Policy: Dental Desensitization Policy, 8/1/2013, unnumbered 5. RSSLC Policy: Dental Procedure, Radiation Policy, dated 12/20/2013 6. Document indicating dental office staffing 7. List of continuing education for dentists 8. List of all policies/procedures specific for "dental emergencies" 9. Alpha list for all dental emergencies during past six months, including: a. Name b. Description of dental emergency c. Date, and time dental emergency was first identified 10. For Individuals #316, #184, and #181: a. Progress notes documenting initial triage of the dental emergency (medical/or dental note) b. 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) c. All documentation of IDT review/s, and recommendations, specific for the dental emergency 11. Number TIVA hours per month available at the Facility 12. Number of individuals who have been provided Total Intravenous Anesthesia (TIVA) services each month, for this reporting period 13. Alpha list of all individuals who require TIVA for dental services

	14. Alpha list of all individuals who were provided TIVA for dental services during the past 12 months 15. For the first five individuals who were provided TIVA anesthesia (Individuals #77, #436, #596, #678, and #508): a. Copy of TIVA records associated with the most recent use of TIVA anesthesia b. Copy of all nursing notes associated with post anesthesia monitoring of the individual, following TIVA once back at the living area (or infirmary) 16. List of 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). a. Date that TIVA was provided b. Date pneumonia was diagnosed/treated/or person hospitalized 17. 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 18. Alpha list of all individuals who the Facility has identified as not being current with dental radiography 19. Alpha list of all individuals who have <u>not</u> had preventive dental x-rays (or alternative to bitewings) within the past 24 months 20. Policy and/or procedure specific to dental radiography 21. For individuals #678, #508, #155, #596, and #600: a. Type and date of dental imaging studies completed during the past 24 months b. Copy of the most recent ISP, or IDT minutes, documenting the clinical rationale for not obtaining preventive dental health imaging studies, if imaging studies were not obtained within 24 months c. Copy of documentation of the dental imaging results, such as an dental IPN or x-ray report 22. Copy of last six months and next six months appointment schedule for annual dental examinations 23. As of the day prior to this compliance 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, including the following information: a. Name b. Date of previous year's annual dental examination c. Scheduled date for most recent dental examination 24. For individuals #16, #238, #155, #678, and #551: a. Copy of past two completed annual dental reports, and associated dental IPNs b. Copy of dental hygiene records for past six months c. Copy of most recent ISP or IDT minutes specific to comments and recommendations for dental issues, and services d. Copy of dental record indicating most recent dental x-rays 25. List of individuals who were not current with scheduled dental hygiene 26. Alpha list of all individuals who are provided suction toothbrushing 27. Alpha list of all individuals identified as needing suction toothbrushing, but not currently receiving suction toothbrushing. 28. For the last five individuals on the list of those who are provided suction toothbrushing (Individuals

	#235, #402, #585, and #729) please provide: a. Copy of the most recent assessment results used to evaluate efficacy of suction toothbrushing for the individual b. Copy of most recent oral health rating scale c. Copy of the most recent ISP, and/or IDT minutes specific to the use of suction toothbrushing d. Documentation assessing the efficacy of the use of suction toothbrush 29. List of all pending restorative treatments that indicates: • 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 IDT's awareness of the need for restorative treatment 30. Policies and procedures for oral health care at the living area 31. Oral health care plans for individuals #678, #16, #155, #238, #1, #463, #551, #67, #273, #694. 32. Evidence that oral health care treatments were routinely assessed at the living area, such as oral hygiene spot checks 33. Newly developed dental database monitoring guidelines (undated) 34. Blank copy of newly developed data collection sheet (undated) 35. Screen shots of newly developed dental database: a. Current dental schedule b. Tracking and trending of pneumonia c. Dental x-rays **People Interviewed:** 1. Carol Heath, Dental Director 2. Laurena Moore DDS **Meetings Attended/Observations:** None
	Facility Self-Assessment: The self-assessment reported that Facility was not in substantial compliance "due to a need to have a facility wide process for desensitization." The Monitoring Team concurs with the self-assessment of non-compliance for Section Q.2, however, the Monitoring Team found that in addition to not having a Facility wide process for desensitization, the Facility must also develop a specific medical quality assurance process to assess efficacy of dental services, and potential adverse outcome secondary to dental services. The Monitoring Team would like to comment on the Facility's assessment of having "adequate" level of dental services because oral hygiene ratings were fair in 69.35% of "data from 8/1/2013 to 1/15/2013. Oral hygiene is only one clinical indicator of efficacy of dental services. Issues such as periodontal disease, carries, the need for extractions, and assessment of restorative

	treatments are essential elements that require regular assessment. Furthermore, the Monitoring Team noted a significant discrepancy between data reported for its oral hygiene ratings for the self-assessment of Sections Q.1 and Q.2. For Section Q.1, the Facility indicated that the most recent oral hygiene rating indicated 31.85% had good oral hygiene ratings, but for the self-assessment for section Q.2, the Facility reported that 69.35 hand good oral hygiene. Furthermore, the self-assessment should not only rely on reviewing dental records to assess oral hygiene, but should also conduct spot checks of Individuals for gross debris, glistening plaque, and bleeding gums, and compare those findings to the findings of oral hygiene identified at the time of a dental examination.
	Summary of Monitor's Assessment: The Monitoring Team noted substantial improvements in the area of dental services, and the Facility is moving closer to substantial compliance with Sections Q.1, and Q.2. Noted improvements included ensuring that oral healthcare programs were developed, providing timely and comprehensive annual dental examinations, ensuring efficacious monitoring during and following dental anesthesia, and the initial development of an electronic mechanism to track and trend dental related services. The Facility must continue to improve programs and services to gain substantial compliance with Sections Q.1 and Q.2. The following is a outline of some addition comments, and concerns specific for each section. Section Q.1: The Facility had made significant improvement moving closer to substantial compliance for Section Q.1. The Facility provides close monitoring of individuals during and after TIVA anesthesia for dental services, and the Monitoring Team especially compliments the nursing staff for their diligent assessment, and documentation of their assessment, through the monitoring period following TIVA anesthesia. The Facility had ensured that oral health care plans were up to date and that they included all necessary instructions for living area staff. Annual dental examinations were completed within a 12-month period, and were available to the IDT for review prior to the ISP meeting. In addition, the annual dental examinations were comprehensive and included assessment of periodontal disease, carries, oral hygiene, and behavior related issues. The Facility had ensured that the Integrated Risk Rating Form (IRRF) included issues related to suction toothbrushing, and revised its policy to ensure that there is a mechanism to help ensure on-going assessment of individuals for the possible need for suction toothbrushing in the future. However, the Monitoring Team determined that the Facility is not in substantial compliance with Section Q.1; the Facility must continue to enhance dental services, especially in areas such as tracking and trending restorative treatments as well as ensuring that dental IPNs are written in a language that can be interpreted by living area staff and include documentation informing the living area staff of the reason for the dental visit, assessment, treatments provided and pending, follow-up date, and monitoring parameters. The Facility must also ensure a standardized approach to obtaining preventive dental health imaging studies, per recommendations by the American Dental Association, and in cases when such standards were not followed, or cannot be followed, ensure that the clinical rationale is documented in the dental record and the IDT is informed. The Facility should also ensure that nursing staff complete a medical or nursing assessment documenting vital signs and general condition of the individual prior receiving anesthesia for dental services.

	Section Q.2: The Facility had redeveloped its dental QA process but had not yet implemented data collection or analysis. The Monitoring Team is concerned that the newly developed program is not designed to evaluate the effectiveness of dental services, and to track adverse outcomes secondary to dental services. The Facility had yet to fully implement its newly developed project to help minimize the need for dental restraint. The Facility had made significant improvements with its ability to track and trend dental related services, and the Monitoring Team looks forward to evaluating this at the next compliance visit. Because of the need to continue development and implementation phases for dental QA, dental scheduling, and programs to minimize the need for dental restraint, the Monitoring Team determined noncompliance for Section Q.2 but encourages the Facility to continue its efforts to complete development, implementation, and evaluation of effects of these initiatives.

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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, including the use of suction toothbrushing; 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 five hours of direct care each week. • The full time staff dentist provides an average of 35 hours of direct care each week. • The Facility has two full time dental hygienists. The Facility did not provide documentation of the number of hours each hygienist provided direct care. • The Facility indicated that dental director and dentist attended one hour of continuing education specific to special needs dentistry, and six hours for continuing education on periodontal health, during this reporting period. In	Noncompliance

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		addition, the dental director participated in an additional 12 hours of continuing education on general dentistry related conditions and techniques. • The Facility documented that it has two-full-time dental assistants; however, it did not indicate the number of hours of direct clinical care and non-direct clinical care hours. Summary: The Facility maintained adequate dental staffing, and ensured that dentists were provided continuing education. <u>Dental Emergencies</u> 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 iii. Date, and time dental emergency was first identified 3. For Individuals # individuals #316, #184, 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 The Facility did not provide documented evidence that the interdisciplinary team (IDT) reviewed dental emergencies. Issues such as the need for dental extractions, changes made to dentures, and other dental issues should be reviewed by the IDT. Review of documents indicated that a total of three dental emergencies were reported to the dental office for treatment (Individuals #316, #184, and #181). Review of the three examples requested (Individuals ##316, #184, and #181) indicated the following: • In three out of three cases (100%), the dental emergency was provided prompt clinical attention by living area staff and the dental office staff. • In zero out of three cases (0%), the integrated dental progress note (IPN)	

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		documented an action plan that included further monitoring parameters and necessary follow-up for the dental emergency. • In zero out of three cases (0%), the dental IPN reflected the dental progress note's report of assessment and treatment of the dental emergency. In all cases, the assessment was documented in language that used dental abbreviations and other language that could not easily be interpreted by staff who were not dental professionals, such as direct support professionals (DSPs), who provide daily support and care, and QIDPs. For example, the IPN dated 8/8/2013 documented "PA-Large radiolucency #5-#7, Possible decay #7, May need PCT #7, Will Rx antibiotics re eval in 7 days to F/U". The IPNs must be written in language that will enable living area staff to interpret the dental issues, assessment, treatment provided, pending treatments, specific monitoring parameters, and expected follow-up. • IPNs did not provide specific monitoring, and follow-up instructions. • In zero out of three 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 as, or contributing to, severe behavioral exacerbation. Summary: As per previous Monitoring Team concerns, the Facility continued not to involve the IDT for review of dental emergencies, document dental IPNs in language that can be easily interpreted by living area staff, or document specific monitoring and follow-up instructions for living area staff. The Facility did, however, provide emergency care promptly. <u>Total Intravenous Anesthesia (TIVA), and Monitoring of Anesthesia</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 this reporting period • 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 individuals who were provided TIVA anesthesia (Individuals #77, #436, #596, #678, #508): o Copy of TIVA records associated with the most recent use of TIVA	

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		anesthesia o Copy of all nursing notes associated with post anesthesia monitoring of the individual, following TIVA, 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 TIVA 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 examples that were provided during the reporting period: Documentation provided by the dental director indicated that during the reporting period a total of 86 individuals received TIVA and an average of 11.3 TIVA opportunities were provided each month. The Facility documented that 120 individuals are known to require TIVA for all invasive dental procedures and to complete their annual dental examination; therefore, the Facility must enable at least 240 TIVA opportunities each year, to provide an annual examination and at least two dental hygiene appointments. The average 11.3 TIVA opportunities per month during the reporting period would extrapolate to only 136 TIVA opportunities per year, instead of the necessary 240 TIVA opportunities. The dental director provided a signed document indicating that the Facility had ample TIVA opportunities, and that "individuals receive TIVA according to clinical indications and clinical judgment". At the next compliance review, the Monitoring Team will request a list of all TIVA opportunities, along with specific examinations and treatments completed during the previous 12 month period; for all individuals who had not received an annual dental examination and two completed dental hygiene treatments, the dental professional will need to indicate the clinical rationale for not providing dental care, as recommended by the American Dental Associations, which recommends two dental hygiene treatments per year. The Monitoring Team recognizes that in some instances individuals may not be appropriate for traditional standard of care treatments, but such instances must be well documented, and information must be provided to the IDT. 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 #77, #436, #596, #678, and #508)	

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		• In five out of five cases (100%), the anesthesiology records were completed, and documented all necessary monitoring parameters, during the dental procedure. • In five out of five cases (100%), there was documentation of necessary post anesthesia monitoring parameters, until the individual reached a REACT score of greater than or equal to eight. • The Living Area nurse continued post anesthesia monitoring, until fully cleared from signs and symptoms of anesthesia in five out of five (100%) examples. • In one out of five cases (20%), the nurse performed, and documented, pre-sedation assessment • In one out of five cases (20%), the dental office provided post-sedation orders, or other specific documentation that delineated monitoring parameters. The Monitoring Team noted that the Facility had a specific Post Anesthesia Recovery (TIVA) instruction list for direct care staff; however, this form was only provided for example #426. Summary The Monitoring Team compliments the nursing department for exceptional documentation of post anesthesia monitoring, through resolution of anesthesia; however, the Monitoring Team was provided only one example of pre-anesthesia evaluation by nursing, or medical staff, on the day of anesthesia. Although there was an example of specific and individualized instructions for the direct care staff for the monitoring of the individual following TIVA, it was provided for only one of the five examples. <u>Dental Imaging</u> 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 <u>not</u> had preventive dental x-rays (or alternative to bitewings) within the past 24 months • Policy and/or procedure specific to dental radiography • For individuals #678, #508, #155, #596, #600: o Type and date of dental imaging studies completed during the past 24 months o Copy of the most recent ISP, or IDT minutes, documenting the clinical rationale for not obtaining preventive dental health imaging studies, if imaging studies were not obtained within 24 months o Copy of documentation of the dental imaging results, such as an dental IPN or x-ray report	

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		The Monitoring Team was provided a document stating that a report on the type of dental x-rays, and dates when dental x-rays were completed could not be provided because the database had been found to be corrupted. The document also stated that the dental office did not "write x-ray reports", and that the dental office did not notify the IDT in the event of individuals not being current with dental x-rays. The Facility must have an efficient mechanism in place to determine if dental x-rays had been obtained, as necessary, and it is necessary that the IDT be well informed in the event an individual is not current with dental x-rays. In the event that an individual is not current with dental x-rays, the IDT should assist the dental office in developing strategies to help ensure that necessary dental imagine studies are obtained as necessary. A document, dated 3/12/2014, was provided that was labeled X-Rays Individual Plan, which listed all of the individuals at the Facility, and the following categories: date of last, interval, and next due. The interval category included three options; 18-24 Months, Not Clinically Indicated, and 24-36 Months. The Monitoring Team was conflicted with this report, because it indicated specific interval ranges for dental imaging studies; however, during the on-site discussion with the dental director, the Monitoring Team was informed that the Facility did not follow a specific or standardized schedule, but only ordered dental imaging studies when clinically necessary. Also, the document listed specific dates of previous dental x-rays; however, the document provided as part of the document request indicated that the date of previous dental x-rays was not accurate, as the database was corrupted. Review of Dental Procedure, Radiation Policy, dated 12/20/2013: The policy indicated the following: • "Dental radiographs and retakes may be ordered by either the dentist or physician when there is clinical evidence or suspicion of dental pathology. • Dental radiographs may be exposed prior to restorative and surgical treatments when possible and necessary. • Dental radiographs may be take on a routine basis as part of the annual examination when possible. • The frequency of radiographic exposure will be in accordance with the American Dental Associations recommendations. The majority of the individuals at the Lubbock (sic) State Supported Living Center will be in the category: Recall patient with periodontal disease." The Monitoring Team is concerned that the Facility provided a copy of the dental procedure that was specific for Lubbock State Supported Living Center, and not Richmond Supported Living center. Also, the Monitoring Team disagrees that the	

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		majority of the individuals should fall only under the category of periodontal disease, and suggests that other categories are also applicable to many of the individuals at the Facility, especially the category for who are at risk for dental caries, and therefore be recommended for dental imaging studies at 6 to 18 month intervals. Regardless, during the on-site interview with the dental director, the Monitoring Team was specifically informed that the Facility does not provide dental radiographs based on a specific interval, but only when clinically indicated. In situations when individuals do not receive dental imaging studies, per recommendations by the American Dental Association, the the dentist should provide clinical documentation as to the rationale for not obtaining the imaging studies.. Review of documentation of x-rays for first five individuals on the list of all individuals who have had dental x-rays (individuals #678, #508, #155, #596, and #600) showed: • Zero out of five examples (0%) documented the results from the dental x-ray. • Two out of five examples (40%) indicated the specific type of dental x-ray obtained. • Zero out of five examples (0%) indicated the type and date of the last set of x-rays for preventive dental care. Summary: The Facility must enhance its process of documenting imaging studies obtained for preventative care, and x-rays obtained for specific dental conditions such as follow-up to dental pain, and pre or post treatment x-rays. The Facility must also ensure documentation when not obtaining dental imaging studies, as recommended by the American Dental Association, and inform the IDT when dental imaging studies were not obtained as scheduled, and the reason why the imaging studies were not obtained. The Monitoring Team is aware that the Facility is currently enhancing its database system to better track dental imaging studies. <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, including the following information: o Name o Date of previous year's annual dental examination	

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		o Scheduled date for most recent dental examination • For the first and then every fifth individual listed on the current Monitoring Team's name key, for a total of five examples, provide the following information (Individuals #16, #238, #155, #678, #551): o Copy of past two completed annual dental reports, and associated dental IPNs o Copy of dental hygiene records for past six months o Copy of most recent ISP or IDT minutes specific to comments and recommendations for dental issues, and services o Copy of dental record indicating most recent dental x-rays. • List of individuals who were not current with scheduled dental hygiene The Facility provided a document indicating that 326 out of 335 individuals (99%) were current with their annual dental examination. Review of the four examples of annual dental reports indicated that four out of four (100%) were obtained at least 14 days prior to the annual ISP meeting. The Facility provided examples for five of the five examples requested (Individuals #16, #238, #155, #678, #551). The following is a summary of the Monitoring Team's findings: • Five out of five (100%) examples included a current oral hygiene care plan that delineated the individual's oral health support needs. • Five out of five (100%) examples included a clinically appropriate behavioral note associated with the individual's most recent dental visit. • Dental x-rays were obtained with in the past 12 months in four out of five (80%) examples. • A complete annual dental examination was provided within 12 months from the previous complete dental examination in five out of the five examples (100%). • There was a dental IPN associated with the annual dental examination in four out of the five examples (80%); however, in zero out of five examples (0%), was the IPN written in language that could be understood by staff who were not dental professionals.. • A cancer screening was completed in five out of five examples (100%). • Periodontal assessment was documented in three out of the five examples (60%). For Individual #16, the dentist did not document periodontal disease assessment for the 5/29/2013 examination, and Individual #238 did not have periodontal disease assessment or an assessment for dental caries for the 8/28/2013 annual examination. • Four out of five annual dental examination reports (80%) indicated poor oral hygiene, at the time of the examination, indicating lack of efficacious oral	

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		hygiene at the living area. Summary: The Facility ensured that individuals were provided a completed annual dental examination at least annually. The Facility should enhance its dental IPNs to better enable direct care and other living area staff an understanding of supports and services provided by the dental office and of oral health care issues. <u>Suction Toothbrushing</u> To assess the Facility's process for providing suction toothbrushing, the Facility requested the following documentation: • Alpha list of all individuals who are provided suction toothbrushing • Alpha list of all individuals identified as needing suction toothbrushing, but not currently receiving suction toothbrushing. • For the last five individuals on the list of those who are provided suction toothbrushing (Individuals #235, #402, #585, #729): o Copy of the most recent assessment results used to evaluate efficacy of suction toothbrushing 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 toothbrushing o Documentation assessing the efficacy of the use of suction toothbrush Individuals identified as requiring suction toothbrushing but not provided suction toothbrushing: The Facility provided the Monitoring Team with a document titled "Suction Toothbrushing" that stated 81 individuals were provided suction toothbrushing. In addition, the Facility provided a document stating that there were no individuals who required suction toothbrushing but were not provided suction toothbrushing. The information on the list, however, was not complete. None of the data field for the date when suction toothbrushing was initiated was completed. Most data fields for diet texture were not completed. The Monitoring Team requested documentation that periodic assessment of the efficacy of suction toothbrushing was being completed. The Monitoring Team was provided a document called Oral Hygiene Spot Checks. This document listed a total of nine individuals who received suction toothbrushing and had their oral hygiene assessed by spot checks from June 2012 through August 2013. 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.	

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		• 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 toothbrushing (Individuals #235, #402, #585, and #729) indicated: • The individual support plans (ISPs) for three out of five examples (60%) indicated the use of suction toothbrushing. • The ISP documented the rationale and associated risks of suction toothbrushing in in zero out of five examples (0%). • The annual dental examination documented oral health care as good or better in one out of five examples (20%), indicating that the provision of oral health care at the living area was suboptimal. • The Facility conducted a total of 11 spot checks for oral health care at the living area, out of the 81 individuals who were provided suction toothbrushing (14%), during the reporting period. Of the 11 examples, two out of 11 documented good or better oral health care (18%), indicating that the provision of oral health care at the living area was suboptimal. • There was an oral health care plan documenting the use of a suction toothbrush in five out of five (100%) examples. • There were zero out of five (0%) examples documenting an assessment of the provision of suction toothbrushing at the living area. • Of the 81 individuals provided suction toothbrushing, there were 13 individuals (16%) who developed pneumonia during the reporting period. Furthermore, the 13 individuals experienced a total of 22 cases of pneumonia, with some individuals experiencing more than two episodes of pneumonia during the reporting period. Review of the RSSLC Dental Procedure, Process for Enrollment in Suction Toothbrushing Program, dated 1/1/2014, indicated that the Facility has an effective mechanism to provide on-going evaluation for individuals who may require suction toothbrushing in the future. Summary: The Facility maintained a process to provide suction toothbrushing, and implemented a policy that helps to ensure that individuals will be provided suction toothbrushing, if needed in the future. The Facility incorporated suction toothbrushing as part of oral health care plans, and as part of the IRRF assessments. Oral health care ratings for individual's who were provided suction toothbrushing less then clinically acceptable, and the Facility should enhance oral health care opportunities for this population. <u>Restorative dental care:</u>	

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		To assess effectiveness of the Facility's provision of restorative dental care, the Monitoring Team requested 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 For this document request the Monitoring Team was provided two datasheets: Future Restorative Dental Appointments. This document listed the names, reason for appointment, and a date. Handwritten on the datasheet were the dates that the condition was first diagnosed, hence, the diagnoses date is not a component of the database. It is important for the Facility to be able to track and trend delinquent restorative treatments. Also handwritten on the datasheet were the reason why the restorative appointment was delayed. Restorative Dental Care Reporting Dates: 9/1/2013 – 3/5/2014. This report indicated that 37 unique individuals underwent a total of 58 restorative treatments; however, the Monitoring Team noted that for eight out of the 37 individuals, more than one restorative appointment was documented for the same date, and for the same procedure. For example Individual #677 was noted to have had three restorative appointments on 12/16/2013, with the same treatments listed for each of the same three dates. Furthermore, the list of treatment did not include a restorative treatment, but indicated that the individual was provided "TIVA, Exam Annual; Brushing; Fluoride Treatment; Oral Ri". In fact, for the 58 appointments for treatments, only 25 out of the 58 appointments (43%) indicated that the treatment included a restorative treatment. There was no document provided to indicate that the IDT had been informed of necessary restorative treatments. Summary. The Monitoring Team was not able to determine the Facility's management of restorative dental treatments. The Facility did not have a efficient mechanism to track and trend delays in restorative treatment, and the data provided to the Monitoring Team did not clearly include the type of restorative treatments; included treatments that were not restorative, on the datasheet listed for Restorative Dental Care; and included multiple examples of duplicate appointment dates for the same individuals, and for the same treatments. The Monitoring Team strongly recommends that the Facility enhance its	

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		ability to track and trend restorative dental treatments. The Facility should also ensure that the IDT is informed of necessary restorative treatments. <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: • Policies and procedures for oral health care at the living area • Oral health care plans for the first and than every fifth individuals listed on the current name key, for a total of ten examples (Individuals #678, #16, #155, #238, #1, #463, #551, #67, #273, and #694). • Evidence that oral health care treatments were routinely assessed at the living area, such as oral hygiene spot checks. Review of the oral healthcare plan, and documentation of oral healthcare assessments (Individuals #678, #16, #155, #238, #1, #463, #551, #67, #273, and #694) indicated: • In ten out of ten examples (100%) there was evidence of a completed oral healthcare plan. • The most recent dental examination indicated that oral healthcare was at the level of good in one out of ten (10%) examples. • The Facility provided documentation of spot checks for oral hygiene at the living area for a total of five individuals during this reporting period. Since 1/26/2012, the Facility provided a total of 18 spot checks for oral hygiene at the living area. Furthermore, the spot checks only assessed oral hygiene ratings, and did not document if oral hygiene was provided as instructed by the oral health care plan. Summary. The Facility must continue to enhance its oral hygiene process at the living area by better ensuring that individuals and staff are providing oral health care as recommended by the oral health care plan, and by improving the efficacy of oral healthcare at the living area. The Monitoring Team is concerned that during the reporting period, only five spot checks at the living area were completed, and in no examples was there documented evidence of assessing if oral healthcare was provided as instructed by the oral healthcare plan. <u>Conclusion</u> The Facility had made significant improvement moving and moving forward closer to substantial compliance for Section Q.1. The Facility provides close monitoring of individuals during, and after TIVA anesthesia for dental services, and the Monitoring Team compliments the nursing staff for their diligent assessment and documentation of	

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		their assessment through the monitoring period following TIVA. The Facility had ensured that oral health care plans were up to date and that they included all necessary instructions for living area staff. Annual dental examinations were completed within a 12-month period, and were available to the IDT for review, prior to the ISP meeting. In addition, the annual dental examinations were comprehensive and included assessment of periodontal disease, carries, oral hygiene, and behavior related issues. The Facility had ensured that the IRRF included issues related to suction toothbrushing, and revised its policy to ensure that there is a mechanism to help ensure on-going assessment of individuals for the possible need for suction toothbrushing in the future. At this time the Monitoring Team determined that the Facility is not in substantial compliance with Section Q.1, and the Facility must continue to enhance dental services, especially in areas such as tracking and trending restorative treatments; ensuring that dental IPNs are written in a language that can be interpreted by living area staff, and include documentation informing the living area staff of the reason for the dental visit, assessment, treatments provided and pending, follow-up date, and monitoring parameters. The Facility must also ensure a standardized approach to obtaining preventive dental health imaging studies, per recommendations by the American Dental Association, and in cases when such standards were not followed, or cannot be followed, ensure that the clinical rationale is documented in the dental record, and informed to the IDT. The Facility should also ensure that nursing staff complete a nursing assessment, documenting vital signs, and general condition of the individual, prior to an individual receiving anesthesia for dental services.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints;	To assess compliance issues for section Q.2, the Monitoring Team reviewed the Facility's processes related to dental Quality Assurance, issues related to scheduling of dental services, and programs to reduce the need for dental pre-treatment sedation. <u>Review of Programs to Reduce Need for Pre-treatment sedation</u> During the on-site interview with the dental director, the Monitoring Team was made aware that the Facility was continuing to enhance its process for reducing the need the restraint use associated with dental services, and is working with the psychology department to enhance this process. The Facility's presentation book indicated that the Facility continues to develop and implement a process to help reduce the need restraint when providing dental services, and that a policy and procedure is currently not available. As reported in Provision J4, the Facility had begun a pilot program at one home to consider actions to reduce need for pre-treatment sedation, but plans had not yet been created. The Monitoring Team will evaluate this program at future compliance visits, when a definitive policy was been developed and trends data is available for review.	Noncompliance

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	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.	<u>Dental quality assurance:</u> To assess the Facility's process to monitor the quality of dental services, and develop strategies to enhance oral health care at the Facility, the Monitoring Team requested the following documents: • List of all dental QA indicators used to assess efficacy of dental treatment, and potential adverse outcome secondary to dental services. • 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 During the on-site interview with the dental director, the Monitoring Team was informed that the Facility had yet to develop a dental QA process to assess the efficacy of dental treatments, and potential adverse outcome following dental treatments. Furthermore, the Facility's presentation book for dental services indicated, "The old Q tool has been discontinued. State Office has provided a new Q tool. QA nurses have been assigned to assist with collecting and analyzing data for dental services. This will commence in March, 2014." The Facility's presentation book included the new dental database monitoring guidelines. Review of the guidelines for the newly developed, but not yet implemented, dental QA process raised the following concerns by the Monitoring Team by not including assessments for: • Efficacy of dental treatments, including evaluation of dental hygiene, and restorative treatments. • Monitoring and assessing potential adverse outcomes secondary to dental services, such as pneumonia, behavioral exacerbation, and injuries. • Spot checks of oral hygiene at the living area, and to ensure that oral hygiene is being practices at the living area as delineated by the oral healthcare plan. • Effectiveness of programs to help minimize the need for sedation. During the onsite meeting with the dental director, the Monitoring Team was informed that the Facility develop an effective electronic database system that will better enable the tracking and trending of dental services, including the collection and reporting of database elements specific to adverse outcomes of dental services, as well as of behavioral issues related to the effectiveness of behavioral programs to help minimize the need for pre-treatment sedation for dental services. The Monitoring Team was impressed by the initial presentation of this new system and looks forward to evaluating the completed programs, and its full implementation. Summary:	

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		The Facility has revised its dental service QA process, with a new process that will be implemented in the future. The Monitoring Team looks forward to evaluating the Facility's new process at future compliance visits; however, the Monitoring Team strongly recommends that the new dental QA process include a process to evaluate the effectiveness of dental services, and to monitor for potential adverse outcome following dental services. <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. Summary: The Monitoring Team refers the reader to Provision J.4 of this report for a detailed summary of the usage of oral sedation. <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 ▪ Evidence of the Facility's efforts to help mitigate future missed appointments. • Total number of missed dental appointments during that past six months • 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	

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		The Facility was not yet able to provide all of the scheduling-related information requested by the Monitoring Team. During the on-site meeting with the dental director, the Monitoring Team was informed of, and was shown screen shots of, the newly updated electronic database system that will enable better tracking and trending of all dental services related issues. However, at the time of this report, the Facility was unable to effectively document issues such pending appointments for the next six months, specific list of missed appointments including the reason why the appointments were missed, and detailed scheduling issues related to TIVA appointments. Furthermore, as delineated in Section Q.1 of this report, the Facility was unable to provide meaningful data related to restorative treatments and dental imaging studies. Summary: The Facility had made significant improvements with scheduling of dental services, As informed by the dental director, additional enhancements are needed prior to fully implementing the Facility's newly developed dental database scheduling system. It is essential that the Facility maintain an efficient and effective mechanism to track and trends dental appointments and dental services. <u>Conclusion</u> The Facility had developed a dental QA process but had not yet implemented data collection or analysis. The Monitoring Team is concerned that the newly developed program is not designed to evaluate the effectiveness of dental services and adverse outcomes secondary to dental services. The Facility had yet to fully implement its newly developed project to help minimize the need for dental restraint. The Facility had made significant improvements with its ability to track and trend dental services, and the Monitoring Team looks forward to evaluating its effectiveness at the next compliance visit. Following its review for Section Q.2, because of the need for continued development and implementation phases for dental QA, dental scheduling, and programs to minimize the need for dental restraint, the Monitoring Team determined non-compliance for Section 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 2/13/14 2. RSSLC Action Plan 2/13/14 3. RSSLC Policy K.06.1 Staffing Effectiveness (rev: 10/30/13) 4. RSSLC Policy K.06.2 Speech-Language Pathology Services policy (rev: 10/30/13) 5. RSSLC PolicyK.11 Skill Acquisition Planning (10/1/13) 6. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 1/15/14) 7. RSSLC Policy J.O6 Behavior Intervention (rev: 1/8/14) 8. Record reviews for the following samples: a. Sample R.1: Individuals #8, #76, #140, #223, #264, #440, #603 and #709 b. Sample R.2: Individuals #8, #264, #452, #552, and #651 c. Sample R.3: Individuals #80, #448, #695, and #736 d. Sample R.4: Individuals #149, #232, #497, and #552 e. Sample R.5: Individuals #159, #264, #358, and #399 9. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 10. A list of people with Alternative and Augmentative Communication (AAC) devices 11. AAC evaluation and Speech Language assessment template 12. Monitoring tools template for AAC and SLP programs 13. List of individuals receiving direct speech services, and focus of intervention 14. Positive Behavior Support Plans (PBSPs) for sample individuals 15. Communication assessments for sample individuals 16. Communication programs for sample individuals **People Interviewed:** 1. Brandie Rabe MS, CCC-SLP 2. Ping Law PT Director of Habilitation Therapies 3. Seven 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 2/13/14 and Action Plan dated 2/13/14. 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: Speech/Communication Assessment Audit & Outcome Audit • 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. • 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 sample sizes appeared to be adequate for the data available. For example, sample size was smaller for newly implemented processes. • 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 being in compliance with Provision R.1 and not in compliance with Provisions R.2, R.3, and R.4. This was consistent with the Monitoring Team's findings of substantial compliance with Provision R.1 and noncompliance with Provisions R.2, R.3, and R.4. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: RSSLC showed overall improvement with Provision R. Assessments continued to become 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, as there was only one occurrence in which

	the Monitoring Team observed use of augmentative communication or environmental control. 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 in Substantial Compliance. The Facility has 6 full time professional speech positions. As of 01/31/2014, all positions were filled with permanent staff and there were no vacancies. Among six full time speech professionals, five are licensed Speech-Language Pathologists (SLP) and one is a certified Speech-Language Pathology Assistant (SLP Assistant). Among them, four SLPs and the SLP Assistant are dedicated to communication and one SLP is dedicated to dysphagia. Additionally, a comprehensive Speech Policy existed that included but was not limited to information regarding staffing effectiveness, assessment schedule, IDT attendance expectations, and monitoring guidelines. 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 if there was not an indirect direct treatment plan in place. . Programs were not developed and many of the ones in place were not being consistently implemented or monitored. Also, a pilot had recently been implemented that was designed to enhance SLP/BA interaction; this process will need to be reviewed during the next visit. 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. Additionally, as with Provision O.6, there were concerns over the validity of the monitoring results.

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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	Samples for this section are as follows: Sample R.1: Consisted of eight 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 five Individuals receiving direct speech services.	Substantial Compliance

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	training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Sample R.3: Consisted of four Individuals with a PBSP and communication deficits. Sample R.4: Consisted of four Individuals with AAC systems Sample R.5: Consisted of five individuals who received indirect Speech Services/Supports. This provision was found to be in substantial compliance secondary to RSSLC having sufficient and well-trained staff to develop and implement the services needed by the individuals. Additionally, a comprehensive Speech Policy existed that included but was not limited to information regarding staffing effectiveness, assessment schedule, IDT attendance expectations, and monitoring guidelines. **Staffing** The Facility has 6 full time professional speech positions. As of 01/31/2014, all positions were filled with permanent staff and there were no vacancies. Among six full time speech professionals, five are licensed Speech-Language Pathologists (SLP) and one is certified Speech-Language Pathology Assistant (SLP Assistant). Among them, four SLPs and the SLP Assistant are dedicated to communication and one SLP is dedicated to dysphagia Per policy K.6.1 Staffing Effectiveness which was revised on 10/30/2013. The effectiveness of staffing is based on the following criteria, not by the Facility individual census: • Meeting assessment schedule; • Timely implementation of approved communication supports and services program; • Timely response to status change; • Attendance in ISP *I* ISPA when speech-language pathologist attendance is required; and • Timeliness of effectiveness monitoring **Qualifications:** Five of five positions for SLPs (100%) for which documents were provided to the Monitoring Team were filled by licensed SLPs. • Five of five SLPs (100%) were licensed to practice in the state of Texas. • Five of five SLPs (100%) had evidence of ASHA certification.	

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		Continuing Education: Based on a review of continuing education completed in the last 12 months, five of five 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: • Implementation Strategies for AAC • AAC Apps: Finding the right one for your patient **Facility Policy** A local policy/process did exist that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlines minimum components of communication supports and services. RSSLC had a localized Speech-Language Pathology Services policy (K.06.2-rev: 10/3013). 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. • 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	**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**	Noncompliance

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	involving behavioral supports or interventions.	Eleven of 11 individuals in Sample R.1 (100%) were provided a communication assessment per policy and/or Master Plan. Seven of seven individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission. For ten of 11 individuals in Sample R.1 (91%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. Eleven of 11 individuals in Samples R.1 and R.2 (100%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. **Communication Assessment:** Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows: • Four of 11 individuals' Communication assessments (36%) 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. • Eleven of 11 individuals' Communication assessments (100%) were dated as completed at least 10 working days prior to the annual ISP; • Nine of 11 individuals' Communication assessments (82%) included diagnoses and relevance of impact on communication; • Eleven of 11 individuals' Communication assessments (100%) included individual preferences, strengths, and needs • Ten of 11 individuals' Communication assessments (91%) included medical history and relevance to communication • Ten of 11 individuals' Communication assessments (91%) listed medications and discussed side effects relevant to communication; • Seven of 11 individuals' Communication assessments (64%) provided documentation of how the individual's communication abilities impacted his/her risk levels; • Nine of 11 individuals' Communication assessments (82%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; • Eleven of 11 individuals' Communication assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Ten of 11 individuals' Communication assessments (91%) contained evidence	

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		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; • Nine of 11 individuals' Communication assessments (82%) included discussion of the expansion of the individuals' current abilities. • Eleven of 11 individuals' Communication assessments (100%) provided a discussion of the individuals' potential to develop new communication skills; • Nine of 11 individuals' Communication assessments (82%) 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. • Nine of 11 individuals' Communication assessments (82%) offered a comparative analysis of health and functional status from the previous year • Ten of 11 individuals' Communication assessments (91%) gave a comparative analysis of current communication function with previous assessments. • Ten of 11 individuals' Communication assessments (91%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. • Seven of 11 individuals' Communication assessment (64%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; • Eleven of 11 individuals' Communication assessments (100%) had a reassessment schedule; • Eight of the 11 individuals' Communication assessments (73%) supplied a monitoring schedule. • Eleven of 11 individuals' Communication assessments (100%) 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. • Ten of 11 individuals' Communication assessments (91%) made a recommendation about the appropriateness for community transition. • Seven of 11 individuals' Communication assessments (64%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. There was a system of assessment audits implemented and outlined per policy. Per facility policy K.06.2, Speech-Language Therapy, staff participated in monthly quality assurance (QA) activities. The SLP and QA program monitor participated in monthly assessment audit peer review. The assessment audit was discontinued when the therapist reached the score of 80% or above in 3 consecutive audits.	

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		SLP and Psychology Collaboration: Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans (PBSPs), the following was noted: • Four of four 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 four individuals (100%) communication strategies identified in the assessment were included in the PBSP. • For four of four 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, the SLP participated in 0% of the meetings. Although he SLP did not participate in the meetings, the process for information sharing between the SLP and the Behavior Analyst was clearly defined as part of Policies J.06 and K.06.2. Additionally, a pilot had recently been started that included the following process: 1. Before updating or revising a Behavioral assessment, the SLP will be notified. 2. A conference will be set up between the BA and the SLP 3. During the conference, behavioral and speech assessments will be reviewed and discussed as well as any current strategies or supports that are related to either discipline 4. As part of the review, communication strengths, deficits and barriers to communication will be discussed 5. Communication deficits or barriers that could contribute to the challenging behavior will documented on the collaboration sheet and will include general recommendations that could help address the barrier and/or deficit As stated, this was recently initiated and is in a pilot phase. The Monitoring Team will review implementation of this process at subsequent visits.	
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	**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: • In 11 of 11 ISPs reviewed (100%) for individuals with communication needs an SLP attended the annual ISP planning meeting, or the team provided adequate justification. • Nine of 11 ISPs reviewed (82%) included a description of how the individual communicated and how staff should communicate with the individual, including	Noncompliance

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	communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	the AAC system if he/she had one. • Communication Dictionaries for four of eight individuals (50%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. • Two of eleven ISPs reviewed (18%) included how communication interventions were to be integrated into the individual's daily routine. • Seven of 11 ISPs reviewed (64%) 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. Per habilitation director, RSSLC has 39 individuals with communication dictionaries and 42 individuals with low/high tech AAC. Observations were conducted in homes with AAC systems in Sample R.4 Findings included the following: • For two of four individuals (50%), AAC devices were present in each observed setting and readily available to the individual. • AAC systems for zero of four individuals (0%) were noted to be in use in each observed setting. • AAC systems for four of four individuals (100%) were portable. • AAC systems for four of four individuals (100%) were functional. • For one of four individuals (25%), staff instructions/skill acquisition plans related to the AAC system were available. • For zero of four 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 five homes and to determine the presence and use of general AAC devices. Findings included the following: • Five of five homes (100%) had general use AAC devices present in the common areas. In three of five homes, (60%), general use AAC devices were operational. The devices at the door San Antonio and Angelina were nonfunctional. • Fifteen of 16 general use AAC devices (94%) noted contained clear directives on how staff should use these devices. • Sixteen of 16 general use AAC devices (100%) noted had a clear function within	

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		that setting/situation. • Zero of 16 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. During multiple mealtimes and times of transition, staff and Individuals were observed passing by numerous boards and devices without any cues or encouragement to utilize. Overall, the presence and functionality of General area devices had improved as well as the instructions for using them. The concerns were as follows: • Although the function and instructions had improved, implementation had not shown the same level of improvement. • Opportunities for the presence of AAC/Environmental Control remained not fully integrated. For example, the sensory room would be an ideal place for the use of environmental control switches for those who are more severely challenged as a way to form a path to the potential use of AAC. In order to move towards substantial compliance, RSSLC must develop a consistent monitoring process that will ensure all devices are utilized and staff is provided consistent modeling on how to use the devices. **<u>Direct Communication Interventions</u>** Review of the individuals' records from Sample R.2 showed the following: • Two of five individual's direct intervention plans (40%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For five of five individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. It also should be noted that Individual # 223 from Sample R.1 was recommended to have direct treatment but there was no evidence that this support were provided. Individuals receiving direct Speech Services (Sample #R.3) were not provided with comprehensive progress notes that contained each of the indicators listed below. • For zero of five individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For one of five individuals (20%), information was present regarding whether the individual showed progress with the stated goal. • For zero of five individuals (0%), a description was found of the benefit of the	

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		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 five individuals (40%), a report was found regarding the consistency of implementation. • For four of five individuals (80%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • For four of five individuals (80%) progress notes occurred at a minimum monthly. **Indirect Communication Supports:** Programs for individuals in Sample R.5 who received indirect communication supports were reviewed and found: • Two of four individuals' indirect plans (50%) (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; Individual #358's communication SAP was to be implemented by 9/30/13 but as of 12/9/13 had still not been implemented. • For four of four individuals' records (100%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For two of four individuals in Sample R.4 (50%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. It should be noted that Individual #158 was recommended as part of the Speech Assessment to receive indirect supports in the form a skill acquisition plan to improve attention to task. There was no evidence that this was developed or implemented. This type of issue also was noted through review of Individual #440 and #223 in Sample R.1 who were recommended to have communication dictionaries but were not provided with one. Providing description of behaviors and other nonverbal means of communication and identify their intent is an integral part of providing total care and better understanding the individual to help determine wants and needs. 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	

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		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 seven staff interviewed (43%) 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 titled "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. Ninety-nine of 99 new employees since August 2013 (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 three individuals in Samples R.4 and R.5 had received training related to Communication SAPs and programs.	

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		Two of three (67%) individual's staff assigned had completed competency check-offs regarding the individuals' communication programs. The one staff responsible for training other staff was a Speech Therapist and was competent to train other staff regarding implementation of the device. Through review of the training sheets, there was evidence that any additional staff that provided the training had received the necessary training prior to training others.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**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 1/15/14) 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). • The frequency of monitoring. • The process for identification, training, and validation for monitors. • The process of inter-rater reliability. In addition to the monitoring of the working condition and presence of AAC devices, to be conducted by non-clinicians, there was also effectiveness monitoring that was to be provided by the Speech Pathologist. This type of monitoring occurred 30 days post implementation of communication plan. The presence of monitoring that focused on the use of the equipment was recently implemented and included as part of the PNMP monitoring process. The Monitoring Team will need to review this process during subsequent review visits for implementation and effectiveness on increasing the usage of devices on campus. Since communication monitoring was now integrated into the PNMP monitoring, a schedule for monitoring existed as well as a process for validation and inter-rater reliability. **Monitoring of Implementation of Communication Supports** 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:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• For four of four individuals (100%), monitoring of communication supports was outlined in the assessment. • For zero of four individuals (0%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. For example, Individual #149 was not provided with effectiveness monitoring and Individual #497 was not provided with monthly monitoring by the QIDP.	

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 (2/13/2014) 2. RSSLC Action Plan (2/13/2014) 3. RSSLC Presentation Book for Section S (3/7/2014) 4. Documents that were used as part of the document review process included the following. **a.** For Provision S.1, ISPs, related assessments, and Skill Acquisition Plans (SAPs) were reviewed for Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799. b. For Provision S.1, the content and composition of SAPs were reviewed for Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799. **c.** For Provision S.2, the facility tracking spreadsheets for assessment report submissions was reviewed. d. For Provisions S.1 and S.3.a, SAPs and data collection forms were reviewed for Individuals #19, #56, #68, #235, #284, #417, #515, #526, #569, #576, #600, #669, and #729. 5. For Provision S.3.b, Facility summary data for community outings and SAP training sessions were reviewed. **People Interviewed:** 1. Davondra Brown – Director of Education and Training 2. Angela Hernandez – QIDP Educator 3. Douglas Cameron – Vocational Director 4. Approximately 25 direct care staff in the following residences and day treatment areas: Lavaca, Leon, Nueces, Sabine, San Antonio, and Trinity. **Meeting Attended/Observations:** 1. Education and Training Meeting 2. The following residences and day treatment areas: Lavaca, Leon, Nueces, Sabine, San Antonio, and Trinity.
	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. For Section S, in conducting its self-assessment, the Facility: ▪ Did not indicate the use of specific monitoring/auditing tools. The Facility did demonstrate the following: o Assessment included report indicators from the Monitoring Team's report relevant to making compliance determinations.

	o Did conduct observations, interviews, and record reviews. o The Self-Assessment identified the sample 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 Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Did use an additional relevant data source. For Provision S.3.b, the Facility utilized the database of off-campus activities. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on indicators used in the Monitoring Team reports o Consistently stated but did not measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with no provisions of Section S. 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 Not Started. ▪ The Facility data did not identify areas of need/improvement in the Action Plans. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Although the Facility did provide a number of actions to be implemented, these actions were discrete tasks that did not necessarily provide for a sequential plan to achieve substantial compliance. In addition, these actions in many cases were quantitative rather than qualitative and therefore of limited benefit in achieving substantial compliance.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 3/3/2014 through 3/7/2014. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that that no Provisions of Section S were in substantial compliance with the Settlement Agreement. Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved. • The percentage of individuals provided functional engagement continued to increase, with observations from the current sit visit reflecting the highest percentage of individuals actively engaged since the beginning of the Settlement Agreement monitoring process. Although the percentage of locations with at least 50% engagement declined slightly, the observed percentage remained well above baseline levels. • The Facility had substantially expanded the number of skill acquisition programs implemented in community settings, initiated a staggered approach to diversifying community training, and

	expanded the ability to track community activities. Despite the areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas. • There was little evidence to indicate that the Facility made effective use of skill assessments when developing skill acquisition training programs. Few of the reviewed training programs were supported by assessment results, and assessment reports were frequently no available for the ISP meetings. • Skill acquisition programs continued to lack several components essential to effective teaching. Behavioral Objectives seldom included objectively defined and measureable goals. Staff instructions were unlikely to result in correct and consistent program implementation. In many circumstances, training opportunities were inadequate, scheduled to occur once per day or less. Plans also lacked strategies for expanding the individual's ability to use the targeted skills outside of the specific training exercise. • Data from skill acquisition training continued to be recorded inconsistently and incorrectly. • Opportunities for competitive employment in the community were very limited. In the six months prior to the current site visit, one individual was provided a job in the community. This individual represented the only person living at RSSLC who had community employment. Based upon the information obtained as part of the current site visit, it was suggested that the Facility had not provided the assessments and training opportunities necessary for the individuals living at RSSLC. As a result, the Facility was determined to have not achieved substantial compliance with the Settlement Agreement.

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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	<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 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 the display of skills, 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 reveal only very modest improvement in limited areas. In May 2012, a sample of 26 ISPs and corresponding SAPs reflected no indication that the Facility used assessment information in the development of skill acquisition programs. Additionally, none of the ISPs included in the sample involved formal assessment of	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td>
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.

During the August 2013 site visit, a limited sample reflecting new procedures suggested improvement in the SAP development process.

<u>Current Site Visit</u>
During the current site visit, the Facility provided one recent ISP with associated assessment reports and SAPs from 10 residences. From these, the first SAP presented in the submitted documents for each ISP was selected as the sample. This allowed for a sample of 10 SAPs. The individuals for whom SAPs were reviewed included Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799.

<u>Use of Assessment Information in Planning Skill Acquisition</u>
Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training.

The table below reflects the status of assessments in relation to the sampled SAPs. Information in the table reflects modest improvement in relation to the use of assessments.

<table>
<tr><td></td><td>5/2010</td><td>8/2013</td><td>3/2014</td></tr>
<tr><td>Skill acquisition plans are implemented to address needs identified in:</td><td></td><td></td><td></td></tr>
<tr><td>ISP</td><td>0%</td><td>25%</td><td>20%</td></tr>
<tr><td>Adaptive skill or habilitative assessment</td><td>0%</td><td>0%</td><td>20%</td></tr>
<tr><td>Psychological assessment</td><td>0%</td><td>0%</td><td>20%</td></tr>
<tr><td>Skill acquisition plans are chosen in an individualized manner.</td><td>0%</td><td>50%</td><td>20%</td></tr>
<tr><td>Skill acquisition plans are related to the individual's preferences.</td><td>0%</td><td>50%</td><td>0%</td></tr>
</table>

Records submitted by the Facility reflected that five of the 10 individuals included in the sample (50%) were provided a task analysis as a part of SAP development. Even though a task
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#	Provision	Assessment of Status	Compliance
		analysis was included in the documentation provided for five of 10 SAPs, those task analyses did not address or provide support for the skills targeted by the reviewed SAPs. Therefore, none of 10 SAPs (0%) were supported by a task analysis. Not all teaching procedures require a task analysis. Because the Facility used described chaining procedures in essentially all of the SAPs, a formal task analysis would be an essential assessment. Records submitted by the Facility included a Functional Skill Assessment (FSA) for eight of the 10 individuals in the sample (80%). Only two of 10 SAPs (20%, Individuals #760 and #787)) were supported by the FSA. It was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training or other sources. • Individual #111 had a SAP for showering. The FSA indicated that "manipulation" was required for all aspects of bathing. The task analysis, however, reflected that only verbal prompts were required for many elements of bathing. • The SAP for Individual #72 targeted swallowing pills upon request by the nurse. Although the FSA indicated the individual already was able to follow multiple step requests independently, the pill-swallowing skill as presented in the SAP was essentially a multi-step request. No self-administration of medication assessment was provided by the Facility. Therefore, there was no documented need for an SAP to teach the pill-swallowing skill. The development of SAPs requires a comprehensive and precise understanding of numerous facets of an individual's abilities and limitations. The FSA alone lacks the ability to provide such assessment and understanding. The FSA, however, could serve as the initial component to a more comprehensive assessment, helping to focus attention upon general skill areas in which the individual experienced limitations. It would then be necessary to supplement the SFA with assessments specific to the areas where skill deficits were suggested. This approach could lead to a more comprehensive understanding of the individual and lead to specific and individualized training. There was no indication in the records reviewed that such supplemental assessments were used in developing skill acquisitions programs at the Facility. Records for seven of the 10 individuals included in the sample (70%) included a preference assessment using the Preferences and Strengths Inventory (PSI). This tool provides a subjective measure that relies upon self-report and staff observation regarding what the individual prefers in relation to residence, leisure, employment, diet, and numerous other areas. A large number of individuals living at the Facility experienced substantial deficits in communication skills. It was not evident from the preference assessments that vocal, gestural or other non-language-based communication was considered when identifying personal preferences. Furthermore, it was not evident that the Facility had made use of other means to identify personal preference with people experiencing communication limitations, such as	

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		systematic observations by neutral staff or providing the individual systematic opportunities to select or indicate preferred items. Rather, the preference assessments for individuals with limited communication routinely consisted of general, anecdotal statements of undocumented origin that could not be verified or validated. Based upon the materials submitted by the Facility, it was evident that other assessments frequently were not available at the time of the ISP meeting. For the 10 individuals included in the sample, none (0%) was provided with all necessary assessments. The table below presents trends regarding the availability of assessments.	

Area	Percentage of Individuals provided with assessment
Communication	10%
Functional Skills Assessment	80%
Integrated Risk Rating Form	40%
Medical	30%
Nursing	30%
Occupational/Physical Therapy	30%
Preferences and Strengths Inventory	70%
Psychiatric	70%
Psychological	80%
Rights	40%
Self-Administration of Medication	30%
Structural Functional Assessment	60%
Task Analysis	50%
Vocational	80%

Based upon the available information, despite some improvement, there was little to indicate that the Facility systematically and comprehensively integrated assessments into the development of Skill Acquisition Programs.

Teaching New Skills

In order to assess the components of the SAPs, a total of nine skill acquisition programs were reviewed. This sample included the same 10 individuals presented immediately above minus Individual #787. This Individual had an ISP developed in February 2014, only four months following the previous ISP. No information was provided from the earlier ISP, and sufficient time had not elapsed for SAPs resulting from the second ISP to be developed.

	5/2010	8/2013	3/2014

#	Provision	Assessment of Status	Compliance

Plan reflects development based upon a task analysis	0%	0%	0%
Behavioral objective(s)	0%	50%	0%
Operational definitions of target behavior	0%	25%	44%
Description of teaching conditions	0%	75%	11%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%
Relevant discriminative stimuli	0%	50%	33%
Specific instructions	0%	0%	11%
Opportunity for the target behavior to occur	0%	100%	56%
Specific consequences for correct response	0%	75%	100%
Specific consequences for incorrect response	0%	25%	89%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%
Documentation methodology	0%	0%	0%

Based upon the information obtained from the sample, there were no clear trends regarding compliance with the requirements of the Settlement Agreement. Some elements reflected sizable increases in performance, while others indicated substantial regression. Specific issues regarding the SAPs are presented below.

Behavioral objectives

None of the nine reviewed SAPs (0%) reflected adequate behavioral objectives. Objectives should define the conditions under which the skill will be performed, the actions that constitute successful performance of the skill, and the criteria for measuring success. In addition, the objective should define a timeframe for success that reflects an understanding of the individual's potential, allowing adequate time for success without perpetuating training indefinitely. Of the nine SAPs in the sample, all (100%) required the individual to demonstrate mastery for at least 90 days before moving to the next step of the program; requiring such a long period of mastery may actually slow down progress through the steps and learning of the whole skill. Behavioral objectives in all nine SAPs (100%) also included success criteria that did not match data collection practices. For example, Individual #155 had a SAP for showering. The objective stated the requirement that the individual must complete the current step of the SAP in four of five trials per month for three months. Data were collected five days per week, which provided in excess of 20 trials per month. It was not indicated, nor was it evident, which five of those 20 or more trials were to be used in determining success. To address the issues of excessive durations for training as well as unclear performance criteria, the objective could be revised to include a statement such as, "The current step of the program will be considered mastered when the individual demonstrates success on 80% of

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		the 10 most recent trials." <u>Operational definitions</u> Four of the nine reviewed SAPs (44%) reflected adequate operational definitions. The remaining five SAPs included no operational definitions. An operational definition identifies the components of the behavior in objective and measurable terms, provides sufficient clarity so that a naïve observer could recognize the behavior, and is sufficiently thorough so that the behavior and other similar yet different behaviors can easily be differentiated. <u>Description of teaching conditions</u> One of the nine reviewed SAPs (11%) reflected an adequate description of teaching conditions. For a SAP to be implemented correctly there should be a description of where teaching will be conducted, how to arrange and present teaching materials, and how to provide an environment that is conducive to learning. The remaining eight SAPs included no description of teaching conditions. <u>Sufficient trials</u> None of the nine reviewed SAPs (0%) reflected sufficient trials for learning to take place. It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities for reinforcement. Often, lower frequencies of reinforcement result in slower rates of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not compete effectively and efficiently with other reinforcement in the environment. In the majority of skill acquisition programs reviewed at RSSLC, the teaching trials were provided at a rate of one per day or less. A single trial per day is not usually sufficient to develop a new behavior or skill. <u>Relevant discriminative stimuli</u> In order for training to be effective, there must be a cue or indication for the learner that reinforcement is available for the completion of a specific task. In three of the nine SAPs (33%), a specific prompt was to be delivered at the beginning of training that could have served as a discriminative stimulus. For the remaining SAPs, either no prompt was required or the instructions for prompting were not sufficiently clear to allow for an adequate discriminative stimulus. For example, for Individual #417 instructions called for an initial verbal prompt for washing face, as well as an "initial prompt" for the lathering step and up to three additional verbal prompts. The discriminative stimulus would typically involve the prompt at the beginning of the trial that indicated training was starting and reinforcement was available for a specific behavior. That prompt was not defined in the SAP, so different staff would be likely to give different prompts rather than a consistent prompt. The prompt at the beginning of the lathering step could serve as a discriminative stimulus for that step. The	

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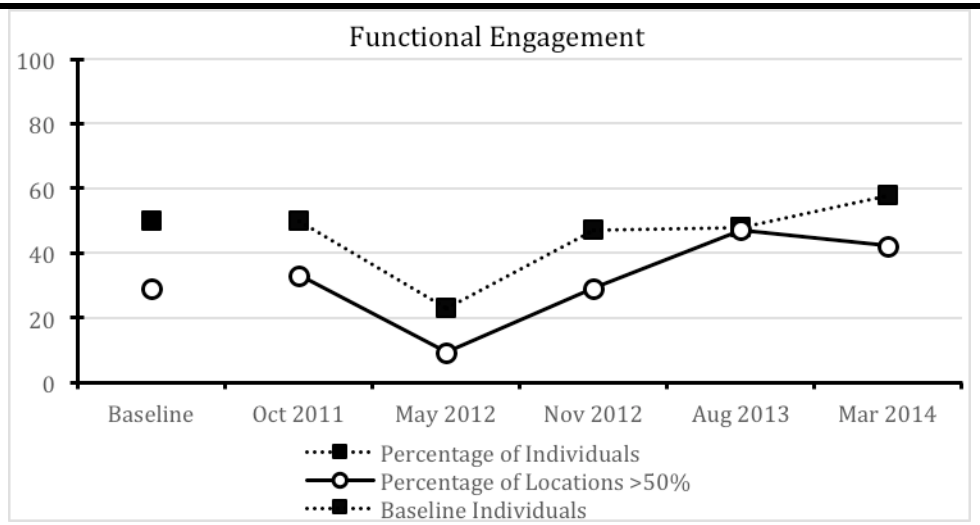
		"initial prompt" was also not defined, making it likely there would not be a consistent prompt. When a skill is being learned, consistent prompts are more likely to be effective. Furthermore, using a prompt for the step without giving the individual an opportunity to do the step independently may slow progress toward learning the steps in the chain; the prompt to wash face should be the discriminative stimulus, and corrective prompts could be provided if the individual does not initiate the step. <u>Specific instructions</u> As with the teaching conditions, it is necessary that training be conducted in a consistent and specific manner. Without specific instructions, the trainer may use a different prompt than was intended, offer reinforcement in a different way, or strengthen a behavior other than the behavior to be learned. Only one of the nine SAPs (11%) included adequate instructions for staff. <u>Opportunity for the target behavior to occur</u> Five of the nine reviewed SAPs (56%) reflected the opportunity for the target skill to be performed. The four SAPs that lacked this involved Individuals #19, #272, #760, and #799. It must be noted, that the opportunity for a behavior to be performed does not ensure that the behavior will be performed or that the opportunity will occur in the context of a teaching program; instead, actual training would need to occur and be documented. A person could have a SAP to teach appropriate greeting skills. Through the course of a day, the person might experience a dozen circumstances in which the targeted greeting skills could be used, but training might not be provided. If staff does not implement the program according to instructions and document the training according to specific data collection procedures, there is no way to know if the program was implemented or if the targeted greeting skills were exhibited. Therefore, circumstances could allow for ample opportunities for the behavior to be displayed and yet training not be done frequently enough for learning to take place. Furthermore, in such a case, the individual might exhibit (and even be reinforced for) behaviors that interfere with the behavior to be learned; for example, avoiding individuals who they might greet, or hitting such individuals, might result in attention or escape that could be reinforcing. In the majority of skill acquisition programs reviewed at RSSLC, the teaching trials were provided at a rate of one per day or less, regardless of the opportunities for display. A single trial per day is not usually sufficient to develop a new behavior or skill. <u>Specific consequences</u> Nine of the nine reviewed SAPs (100%) reflected specific consequences for correct responses, while eight of the nine reviewed SAPs (89%) reflected specific consequences for incorrect responses. The SAP that did not include adequate consequences had no consequence listed for an incorrect response. <u>Documentation methodology</u>	

#	Provision	Assessment of Status	Compliance
		None of the nine reviewed SAPs (0%) reflected a potentially adequate documentation methodology. In order to determine if a skill acquisition program was successful, there must be a valid and reliable method of measuring and documenting the performance of the person being taught. The data collection process must provide specific instructions for when to document performance, how to record the data, and the forms or tools that are to be used. In addition, an adequate data collection system must involve collecting data with sufficient frequency to ensure that a valid estimate of individual performance is achieved. All reviewed SAPs provided only generic instructions for data collection. Documentation provided by the Facility also reflected numerous lapses in ensuring that data were consistently recorded, tracked, and monitored. Of the nine individuals included in the sample, five (56%) had at least one monthly data sheet missing. Additionally, five of nine individuals (56%) had at least one IDT Monthly Review report missing. To further assess whether the documentation methodologies were sufficient to produce adequate data collection, 13 current SAP data collection forms located in the residences were selected by choosing the top or first data collection book from the storage location in each residence visited and reviewing the current form for the first SAP listed. These 13 data forms included Individuals #19, #56, #68, #235, #284, #417, #515, #526, #569, #576, #600, #669, and #729. Of the 13 data forms reviewed, two (#235 and #515, 15%) reflected correctly recorded and complete data. This appeared to substantiate concerns about the adequacy of SAP data collection instructions. <u>Plan for maintenance and generalization</u> Skill acquisition programs have the ultimate goal of increasing skills in situations outside of the teaching setting. If an individual learns to differentiate colors in the classroom, but does not exhibit that same skill at home, at work or as part of a new and more complex task being learned, then the training has not been fully successful. In order to determine if skills are being used beyond the training setting, it is important that a specific method for monitoring the skill be in place. None of the nine skill acquisition programs reviewed at the Facility (0%) included specific plans for generalization. <u>Promotion of growth, development, and independence</u> Despite some noted improvement, due to the limitations presented above, none of the nine reviewed SAPs (0%) was likely to promote growth, development and independence. | | 5/2010 | 8/2013 | 3/2014 | | Overall, the set of skill acquisition programs promote growth, development, and independence | 0% | 0% | 0% |	

#	Provision	Assessment of Status	Compliance
		Engagement, activities, and informal skill acquisition training In addition to substantial weaknesses relating to skill assessment and SAP development, the Facility also demonstrated substantial limitations regarding the provision of active treatment. The Facility did have in place a system for monitoring active treatment or engagement. Despite a considerable investment of time by the Facility, however, evidence did not reflect that this system produced accurate information or resulted in adequate levels of engagement. The Monitoring Team conducted observations in a variety of settings across the Facility. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior.	

	Staff Present	Individuals Present	Individuals Functionally Engaged	Percent Functionally Engaged
Triniity	10	8	8	100%
Leon	11	12	8	67%
Leon B	4	9	4	44%
San Antonio	13	10	9	90%
Lavaca	1	2	1	50%
Nueces	2	2	1	50%
Nueces	4	5	5	100%
Trinity D	1	6	2	33%
Trinity D	2	8	3	38%
Leon D	3	11	3	27%
Leon A	1	2	1	50%
Leon A	2	7	4	57%
Sabine	0	3	0	0%
Trinity	10	8	8	100%
Total percentage of individuals functionally engaged				58%
Percentage of locations with 50% or greater functional engagement				42%

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

#	Provision	Assessment of Status	Compliance
		 Observations revealed that across all settings 58% of observed individuals were functionally engaged. Furthermore, less than half (42%) of all environments observed reflected at least 50% engagement. Specific concerns noted during observations included the following. • Individual #248 was observed sitting with no meal or interaction in the dining room for his residence. While seated, he exhibited multiple movements that resulted in contact with his neck and back. Abrasions and callouses were noted on these two areas, suggesting chronic self-injurious behavior. Staff did not interrupt the behavior or attempt to engage the individual in activities that could be more functional. • Observations shortly after 9:00AM in the Sabine residence revealed one individual watching television and two others asleep in a bedroom adjacent to the living room. The only staff person noted in the area was a male DSP who was observed outside smoking. Not all observations conducted at the Facility reflected low levels of functional engagement. In a few settings, staff attempted to provide the materials and attention necessary to maintain reasonable levels of functional engagement. • In the Nueces residence living room, a variety of educational and leisure materials were available. Four staff was observed actively engaged with the five individuals present. • In the Trinity D activity room, two staff was engaged in attempts to increase the tolerance for touch in one individual while prompting and encouraging non-verbal communication from a second individual.	

#	Provision	Assessment of Status	Compliance
		Based upon information obtained from the Facility, as well as observations and document reviews, it was suggested that individual interaction had improved in some locations although weaknesses continued in much of the Facility. Despite the decrease in ratings, the percentage of locations with at least 50% engagement remained well above baseline levels.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Based upon a review of assessment practices in Provisions K.5, K.6, and K.7, as well as S.1, of this report, it was evident that the Facility displayed difficulty in ensuring that individuals received complete and comprehensive assessment as part of the ISP process and training program development. Specific issues related to psychological assessments are presented in Section K of this report. Assessment problems in addition to psychological and behavior assessment were also noted. None of the 10 individuals included in the Provision S.1 sample (Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799) had been provided with all necessary assessments at the time of the most recent ISP. Materials provided by the Facility reflected that the provision of necessary assessments ranged from 21% (Individual #760) to 93% (Individual #155) with an average of 50% of assessments submitted. Because of the broad weaknesses in assessment practices at the Facility, it was not evident that the assessments provided adequate measurement of individual abilities or were likely to facilitate the skill acquisition process. Based upon this information, it was not possible to identify any areas of substantial progress in skill or preference assessment at the Facility.	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, 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	Due to the limitations noted in Provisions S1 and S2, it was frequently not possible to determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that the Facility did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>the most integrated setting consistent with the individual's needs, and</td><td>In very few locations was it possible to observe the implementation of formal skill acquisition programs. To obtain some measure of how well SAPs were implemented and documented, 13 SAPs and the latest data recording form for each were reviewed in individuals' residences. Each SAP and data form was selected by choosing the top or first data collection book from the storage location in each residence visited and reviewing the current form for the first SAP listed. The 13 individuals included in the sample were Individuals #19, #56, #68, #235, #284, #417, #515, #526, #569, #576, #600, #669, and #729.

The table below reflects the results of the review.

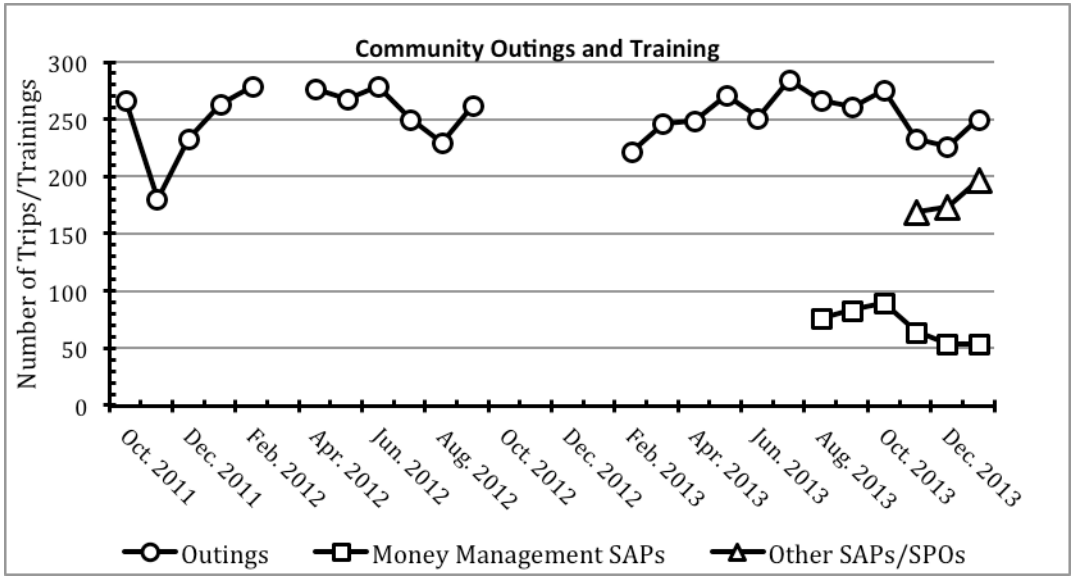
<table>
<tr><th>Element</th><th>Percent Correct</th></tr>
<tr><td>Data recording forms present</td><td>85%</td></tr>
<tr><td>Individual information is correct</td><td>85%</td></tr>
<tr><td>Data current</td><td>54%</td></tr>
<tr><td>Plan is implemented according to the specified schedule.</td><td>54%</td></tr>
<tr><td>Data recorded correctly</td><td>15%</td></tr>
</table>

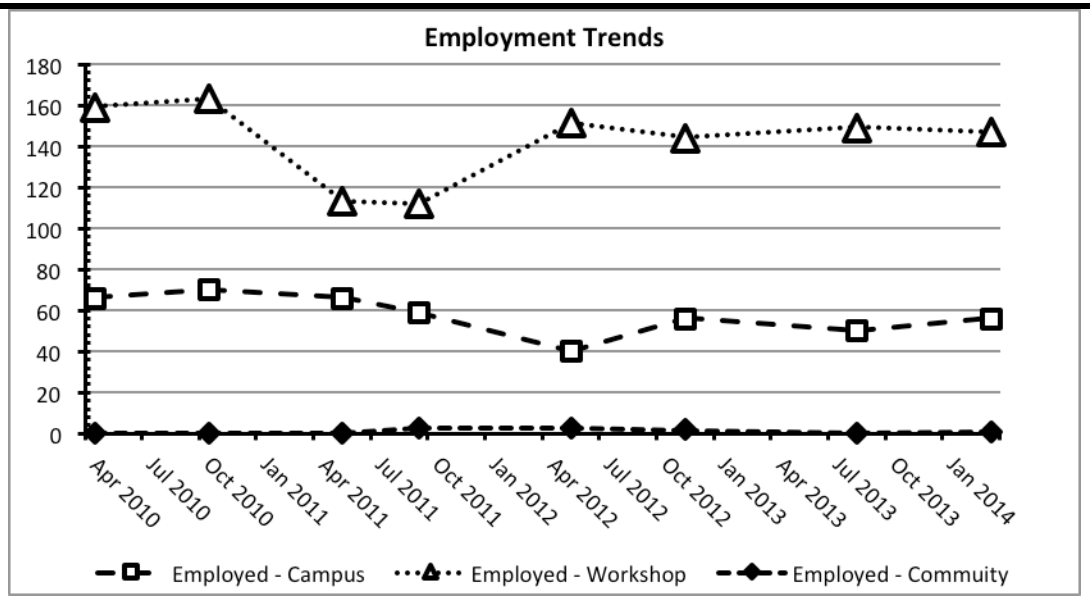
It is suggested that a SAP would be practical and functional if it a) could be implemented in locations where the individual was likely to live and work, and b) was likely to strengthen the basic set of skills the individual would need to succeed. In order to obtain a measure of practical and functional qualities of the SAPs at the Facility, the nine ISPs and SAPs in the sample for Provision S.1 (Individuals #19, #72, #111, #155, #272, #302, #417, #760, #787, and #799) were rated on five questions. Those questions and the ratings are presented below.

<table>
<tr><th>Practical</th><th>Percentage of SAPs</th></tr>
<tr><td>SAP does not require excessive resources, time or staff.</td><td>67%</td></tr>
<tr><td>SAP is not excessively difficult or technical.</td><td>67%</td></tr>
<tr><td>SAP can be implemented in relevant environments.</td><td>67%</td></tr>
<tr><td>Functional</td><td></td></tr>
<tr><td>SAP addresses specific needs from formal assessment.</td><td>11%</td></tr>
<tr><td>SAP targets skills useful for the individual.</td><td>44%</td></tr>
</table>

Specific issues noted regarding functionality included the following.
• Only one of the 13 sampled SAPs (11%) addressed specific needs reflected in formal assessments.
• Four of the 13 sampled SAPs (44%) targeted skills that would likely be useful for the individual.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Examples in which a SAP was not functional are presented below. • Individual #19 was provided a SAP designed to teach appropriate work-related behaviors. Although the SAP was arranged in steps common to a forward or backward chaining procedure, each step consisted of a rule or requirement that was not related to other steps in the SAP. The current step at the time of the site visit was to use an appropriate tone and volume in speaking. There was no indication that the individually experienced difficulties with the tone or volume of her speech. Furthermore, there was no definition for appropriate tone or volume of speech. As a result, it did not appear that the SAP was targeting skills that would be of benefit to the individual or assist in increasing independence and success. • Individual #272 was noted to have difficulty in identifying the appropriate change to receive when making a purchase. The ISP indicated that he was to be provided with a SAP to teach subtraction so that the individual could identify the correct amount of change he was to receive. The SAP implemented for the Individual consisted of asking him to state that he would receive $.55 in change when purchasing an item valued at $1.45 with $2.00. Rather than teaching subtraction, the provided SAP only required the individual to memorize the amount of change in a single, specific transaction. In most purchases, the skill targeted by the SAP would be of no benefit to the individual. Concerning practicality, none of the reviewed SAPs was overly sophisticated or required expertise a DSP was unlikely to possess. In all cases, the determination of a SAP to be impractical resulted from weaknesses in assessment or instructions. Based upon information presented by the Facility, it was evident that progress had been made toward providing training that was practical and functional for the individual. At the time of the site visit, however, considerable weaknesses remained. As a result, the Facility continued to fall short of substantial compliance with the Settlement Agreement.	
	(b) Include to the degree practicable training opportunities in community settings.	Of the 10 SAPs submitted by the Facility, one (#799, 10%) included indications of potential implementation in the community. For the remaining nine SAPs, there was nothing in the submitted documentation to indicate the SAP was targeted for community implementation. It therefore did not appear that the Facility had a comprehensive plan for providing community instruction when developing the SAPs. There were other indications, however, that the Facility was attempting to enhance skill acquisition training in the community. In October 2013, a database was developed to capture and track the implementation of SAPs in the community. Although data entry had begun only in November 2013 and remained incomplete at the time of the site visit, an initial review suggested the new database to be a powerful and helpful tool. Data obtained from the	Noncompliance

#	Provision	Assessment of Status	Compliance
		database is presented in the graph below.  Based upon available documentation, it was suggested that substantial efforts toward providing training in the community were underway. The Facility is to be commended for these efforts. Due to the weaknesses noted in Provisions S.1 and S.2 of this report regarding assessment and SAP development, however, it was improbable that the majority of the SAPs implemented in the community were likely to result in substantive skill development. During the current site visit, information provided by the Facility indicated that employment both on and off campus remain relatively stable. Although stable, employment in the community remained low, as only one individual was provided community employment.	

#	Provision	Assessment of Status	Compliance
		 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 02/13/2014 2. Richmond State Supported Living Center Action Plans, updated 02/13/2014 3. Richmond State Supported Living Center Settlement Agreement Presentation 4. Section T Presentation Book materials 5. DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013 6. RSSLC Policy G.6 Admitting/Moving Individuals: Most Integrated Setting Practices, Effective 10/13/2013 7. RSSLC Policy G.6 Admitting/Moving Individuals: Community Movement, Revised 8/11/11 8. RSSLC Policy G.05 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement, Revised 01/31/14 9. RSSLC Policy G.06 Admitting/Moving Individuals: Community Movement, Revised 01/31/14 10. RSSLC Policy G.6.1 Admitting/Moving Individuals: Post Move Monitoring, Revised 01/31/14 11. RSSLC Policy G.14 Admitting/Moving Individuals: CLDP Grand Rounds, effective 08/30/2013 12. DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 13. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 14. Since last on-site review, a list of all individuals who have been referred for placement 15. Since last on-site review, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge" 16. Since last on-site review, a list of all individuals who have died after moving to community living 17. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 18. For the last twelve months, a list of individuals who were reported to have been assessed for placement 19. Individual Support Plans (ISPs) including assessments for 12 Individuals #86, #144, #149, #184, #302, #324, #349, #487, #503, #582, #723 and #758 20. ISP Addenda (ISPA) to rescind referrals for Individuals #529 and #791 21. Community Placement Report, dated Monday, March 03, 2014 22. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 23. Minutes of Self-Advocacy meetings for the last six months 24. Community Transition Process from a SSLC, dated June 2013 25. RSSLC Annual Report: Obstacles to Community Transition, Fiscal Year 2013, dated November 2013 26. DADS Annual Report: Obstacles to Transition Statewide Summary, issued 2/26/13 27. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan

	(CLDP) developed 28. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #48, #142, #175, #256, #415, #512, #603, #641, #765, and #787 29. Completed CLDPs for Individuals #10, #35, #164, #165, #219, #366, #555, #711, #746, #748, and #764 30. CLDP Grand Rounds minutes for Individuals #35, #366, #711, #746,and #748 31. Partial CLDPs (in progress) for Individuals #19, #302, #600 and #625 32. Pre Move Site Reviews for Individuals #10, #35, #164, #165, #219, #366, #555, #711, #746, #748, and #764 33. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #10, #35, #164, #165, #219, #366, #555, #711, #746, #748, and #764 34. Completed Post Move Monitoring (PMM) checklists for Individuals #10, #35, #81, #164, #165, #219, #267, #366, #459, #511, #555, #711, #746, #748, and #764 35. Timelines of events and Contact Notes related to Individual #463 **People Interviewed:** 1. Terri Carter, Acting Admission/Placement Coordinator (APC) and Post Move Monitor 2. Andrea Lewis, Transition Specialist 3. Latonya Akorede, Transition Specialist 4. Corneshia Fowler, Transition QIDP 5. Georgette Brown, QA Director 6. Mallory Hagger, Post-Move Monitor 7. Sherita Flowers, QA Auditor **Meetings Attended/Observations:** 1. ISP annual planning meetings for Individuals #675 and #718 2. Pre-ISP meeting for Individual #501 3. PMM visit for Individual #35
	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 the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The self-assessment rating did not substantially rely on data collected through the Facility's QA/QI processes, as these were not yet fully implemented. In order to improve its Self-Assessment for use in achieving compliance, the Facility should review the criteria by which it assesses that compliance. The Facility's criteria did not always fully address the noncompliant findings from the Monitoring Team. The Facility also 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 should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. Overall, a comprehensive strategic plan that identifies all requirements and the measurable indicators for each would allow the Facility to not only better prioritize its activities, but would also allow it to better monitor its overall progress toward substantial compliance. At least, the Facility should determine the priorities for action for the next six months, complete an analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. Sections of the Self-Assessment could reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could 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. This would also allow the Facility to appropriately update or modify its Action Steps based on an evaluation of outcome data. As an example of how the Self-Assessment and Action Steps were not yet integrated into a cohesive plan, for Provision T2a, the Facility reported the activity engaged in for the self-assessment was review Post-Move Monitoring Checklists to ensure they were completed within the 7, 45 and 90 day timeline. The results were that 100% indicated the revised Post-Move Monitoring Checklists were completed on the required timeframes. Based upon the results of the self-assessment, the Facility then concluded the provision was in substantial compliance. However, timeliness is only one criterion by which the Monitoring Team assesses compliance for this provision. It also reviews indicators related to thoroughness of the process, including in assessing the presence and implementation of supports. Performing a function on a timely basis is important, but the process must also be completed thoroughly. The only current Action Step for Provision T2a was to reference the Section F Action Steps for identification of supports, as PMM was being completed according to timelines. While it was true that the adequate identification of services and supports by the IDTs was a critical foundation for the development of what was to be monitored, and how, the Monitoring Team has consistently found deficiencies in the thoroughness of the PMM process as described above that also contributed to noncompliance. There were no Action Steps in this regard. If the Facility intends to use its Self-Assessment to conclude whether it is in substantial compliance, it must identify and factor in all of the criteria upon which compliance is to be based. It may choose to prioritize only certain components in its Action Plan, but it should be aware that the prioritized activity may not be sufficient in achieving substantial 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; and T1h, the issuance of the Community Placement Report. The Monitoring Team concurred with Facility findings of substantial compliance for Provisions T1c2, T1c3

	and T1h, but did not concur with self-assessment of compliance with T1c1. The Monitoring Team found substantial compliance with Provision T1c, which involves timeliness of development of the CLDP as well as participation by the IDT in development and implementation of the CLDP and the transition planning process, and coordination with the Local Authority. The Monitoring Team agreed with the findings of noncompliance with the remaining provisions. 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 provided no rating as no Alternate Discharges had occurred.
	Summary of Monitor's Assessment: The Monitoring Team continued to find noncompliance for this Section. More work remained to ensure transitions were effectively planned and successfully implemented. Positive developments noted included the development of a Grand Rounds process for reviewing CLDP assessments in advance of the actual CLDP meeting in order to identify any questions, concerns, or discrepancies that might need to be addressed. The Monitoring Team was also particularly pleased to see the Facility's increased in-service training and competency testing for provider staff. This was an important step forward that could be further enhanced in terms of content. Other specific findings are detailed below: For Provision T1, 11 individuals had transitioned to community living and there were 12 active referrals. The Department of Admissions and Placements staff, including two Transition Specialists and a Transition QIDP, were working collaboratively with individuals, IDTs and families to foster encouragement of community living exploration and to effect transitions on a reasonable pace. RSSLC still needed to improve its processes to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. Continuing deficits in assessments also translated to many instances in which the IDT failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits were apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living. The Monitoring Team did find substantial compliance for Provisions T1c2. T1c3 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; the involvement of the individual and, as appropriate, the LAR in transition planning; and, the issuance of the Community Placement Report. 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 continued to be completed in a timely manner, but RSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDPs, nor did the CLDPs yet provide adequate monitoring parameters for the Post-Move Monitor to reference. A newly hired Post Move Monitor was in orientation at the time of the monitoring visit and would be taking over these responsibilities soon. A Program Auditor had been assigned to Section T and was making her first audit during the PMM reviewed during this monitoring visit. The Facility should continue to ensure implementation of this formalized review and scrutiny of PMM over the course of the next six months, particularly as a new Post Move Monitor undertakes the responsibilities. For Provision T3, no rating is required. For Provision T4, the Facility was not rated. The Facility reported no Alternate Discharges during the past six months.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a 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	<u>Transition Outcomes During Last Six Months:</u> • Community Transitions: The number of community transitions showed a relatively stable trend. o There were 11 transitions to community living in the last six months. With 336 individuals currently living at RSSLC, this represents approximately three percent of the population. This number of transitions was an increase over the last previous monitoring period for which nine individuals had transitioned, but still fewer than the 15 individuals who had transitioned in the period before that. o The transition process took more than 180 days for six of the 11 (55%) individuals. This was improved from 78% in the previous six month period and recent referrals appeared to be progressing more quickly. • Referrals for Community Transitions: o The number of community referrals indicated an increasing trend. Eleven had been made in the past six months, according to the Community Placement Report, as compared to eight in the six month period preceding it. o Twelve individuals were on the active referral list (approximately four	Noncompliance

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	accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	percent of the current population at RSSLC). o Only one of the 12 (8%) individuals had been on the referral list more than 180 days. • Individuals requesting placement, but were not referred: Of the four individuals who requested placement during this six months, but were not referred, four (100%) had an LAR who made this decision. • Rescinded Referrals: o There were two 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%). Both were rescinded due to LAR choice. • Returns from Community Placement o One individual had returned from a community placement. This number of individuals who returned to the SSLC after a failed community placement indicated a slightly increased trend over the previous two monitoring site visits. The Monitoring Team had significant concerns regarding the sequence of events leading to the individual's return, which are further detailed in Provisions T1d and T2a. • Deaths Following Community Placement o Since the last onsite review, there had been one death of an individual who had moved from RSSLC to the community. This death did not occur within the 90-Day PMM period, but was approximately 18 months following transition. • Other Adverse or Unexpected Outcomes o Two of 11 individuals (18%) individuals who transitioned in the past six months experienced a psychiatric hospitalization. The Facility did provide documentation of IDT review of both of these hospitalizations. <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: • The Facility had developed a Grand Rounds process for reviewing CLDP assessments in advance of the actual CLDP meeting in order to identify any questions, concerns or discrepancies that might need to be addressed. See Provision T1f. <u>Conclusion:</u>	

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		This provision was found to be not in compliance. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 and F2ab); education for community awareness (see Provision T1b2); and transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not yet be said to be effectively assisting and encouraging individuals to move to the most integrated setting.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	<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 T1b3 would be considered stand-alone provisions that require implementation independent of T1b or any of the other cells under T1b. Since the previous visit, DADS had issued DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013. The Monitoring Team will comment at the next compliance review as to whether the state policy adequately addressed all of the items in section T of the Settlement Agreement. The Facility had issued RSSLC Policy G.6 Admitting/Moving Individuals: Most Integrated Setting Practices, Effective 10/13/2013, which was virtually identical to the DADS policy and had not been operationalized/localized with facility-specific details. However, Policy G.6 was part of a more comprehensive set of policies related to the Most Integrated Setting that expanded on and localized DADS Policy 018.2. The Facility had reviewed and made minor terminology revisions to several of these, including: • RSSLC Policy G.05 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement, Revised 01/31/14 • RSSLC Policy G.06 Admitting/Moving Individuals: Community Movement, Revised 01/31/14 • RSSLC Policy G.6.1 Admitting/Moving Individuals: Post Move Monitoring, Revised 01/31/14 These latter policies provided substantially more process explanation, which was commendable, but continued in some cases to need additional detail and/or clarification. Examples included: • There was not a sufficient description of the process used to assess individuals for transition. • RSSLC Policy G.6.1 Admitting/Moving Individuals: Post Move Monitoring, Revised 01/31/14 provided a much more extensive description of expectations for PMM, including a process for determining if PMM should be extended past 90 days. The policy was not clear about the expectations for IDT review of each PMM visit, however; the wording was such that it could be read to require IDT	Noncompliance

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		review either as a routine or only "as necessary." • RSSLC Policy G.06 Admitting/Moving Individuals: Community Movement, Revised 01/31/14, documented a requirement for the LA to complete a pre-move site visit prior to movement, but did not reference the Facility's own Pre-Move Site Review process. The Facility had also issued new RSSLC Policy G.14 Admitting/Moving Individuals: CLDP Grand Rounds, effective 08/30/2013. This policy is discussed in Provisions T1d and T1f. <u>Conclusion:</u> This provision was not in compliance.	
	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 examples reflected some 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 remained 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. It was also concerning to the Monitoring Team that even when individualized strategies had been developed, as in the previous visit, the Facility had failed to implement them on a consistent basis. <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. <u>Identification of and Plans to Overcome Obstacles to Transition:</u> RSSLC gathered obstacle information through the ISP process, and categorized these using a list of DADS-approved obstacles. These included: • Individual's reluctance for alternate placement	Noncompliance

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		• 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, for this visit the Monitoring Team found that obstacles to transition were still not yet consistently addressed by the IDTs in the ISPs. The Monitoring Team reviewed 12 recent ISPs. No referrals were made at the time of the ISP, although for one individual a referral was generated several months after the ISP was held. None (0%) of the twelve ISPs reviewed evidenced proficiency in identification and addressing of obstacles. The obstacles cited were often LAR and/or Individual choice, but in no case was a comprehensive and individualized plan developed to address the concerns. Action Plans found were almost always generic. Of the twelve ISPs in this sample, none (0%) included an action plan to address/overcome obstacles identified that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles.) A review of each of the ISPs revealed the following findings: • For Individual #302, the facility discipline members determined the individual could be served in a more integrated setting, but did not make a referral due to the individual needing more community living options experience and stabilization of target behaviors. LAR Choice and Behavioral Health/Psychiatric Needs were chosen as the major obstacles; individual lack of understanding was not checked. The narrative also indicated the LAR would like to revisit living options in six months. The Action Plans included inviting the family to group home tours on a quarterly basis and to the Provider Fairs and for the individual to attend group home tours quarterly. While the construction of these were still generic, the IDT was to be applauded for following up on the LAR's receptiveness, resulting in a referral three months after the ISP was held. • For Individual #503, the facility discipline members determined the individual could not be served in a more integrated setting because of a lack of understanding of community living options and lack of community exposure. The entire IDT determination was also documented as such in the narrative. The major obstacle selected was LAR Choice, but the individual did not have an LAR. The only Action Plans were for generic activities, to wit: to be given the opportunity to attend community events and to be scheduled to tour a Provider	

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		Fair. There were no individualized plans or measurable outcomes defined. • For Individual #349, the facility discipline members determined the individual could be served in a more integrated setting, but did not make a referral because the individual and mother lacked understanding about community options. Major obstacles checked included Individual Choice, LAR Choice and Behavioral Health/Psychiatric Needs. The latter was not referenced as an obstacle in the narrative of the Living Option Recommendation, which states the individual could be served in the community with 24 hour staff and PICA protocols. The Behavioral Health Assessment stated the individual was behaviorally stable and that problematic behaviors were not demonstrated frequently, and recommended that the team consider future placement outside of RSSLC. Action Plans included attending tours quarterly and Provider Fairs. There was no discussion documented of the individual's specific learning needs, desired measurable outcomes, or monitoring of results. • For Individual #149, facility discipline members determined the individual could be served in a more integrated setting but did not make a referral due to individual choice and lack of community awareness. Both Individual and LAR Choice were checked as major obstacles. The narrative of the Community Awareness and Education Discussion indicated the LAR was opposed in part due to the individual's health and not being able to verbally communicate if a hazardous situation were to occur. It was also documented the LAR declined to participate in tours and declined the individual's participation in group home tours and Provider Fairs. Action Plans included community group home tours "as scheduled" and the Provider Fair, so it was unclear whether these plans could be implemented. In any event, there was no discussion of the individual's specific learning needs, desired measurable outcomes or monitoring of results documented, nor was there any Action Plan to address the LAR-identified obstacle of being able to communicate the occurrence of hazardous conditions. • For Individual #184, the ISP indicated facility discipline members determined the individual could be served in a more integrated setting, but then provided two reasons for the determination that appeared to contradict the overall opinion. These were the individual's choice to remain at RSSLC and a requirement for 24 hour nursing care. The entire IDT did not recommend a referral due to LAR Choice, Individual Choice and Medical Issues. Living Options Action Plans were service objectives to participate in recreation trips, having the opportunity to attend Provider Fairs and receiving the CLOIP information. There was no discussion of the individual's specific learning needs, desired measurable outcomes or monitoring of results documented. • For Individual #324, the narrative of the Community Awareness and Education Discussion reflected a discussion of the individual's needs in a more integrated	

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		setting, but also indicated the correspondent was opposed to transition. There was no discussion of the individual's community awareness or educational needs. The Living Options Recommendation did not provide a determination by the facility discipline members or any narrative regarding the entire team's determination. Individual Choice (lack of understanding of options) was checked as major obstacle, but no specific rationale for this selection was provided. Living Options Action Plans did not include any community living education or awareness for either the individual or the correspondent. Medical Issues was also checked, but again without any specific rationale. The Annual Medical Summary did not support this selection as it stated the individual would be a candidate for community placement as in the last year the individual had done very well from a medical standpoint. • For Individual #144, facility discipline members did not provide an independent determination of whether the individual could be served in a more integrated setting. The entire IDT did not recommend a referral due to LAR Choice. It was noted in the Community Awareness and Education Discussion narrative that the LAR would allow the individual to participate in group home tours; however, the Action Plans stated only the opportunity to participate in community excursions and for the individual and LAR to be provided with updated community awareness information at least annually. There was no discussion of the individual's specific learning needs in this regard, desired measurable outcomes, or monitoring of results documented. • For Individual #487, the Community Awareness and Education Discussion provided conflicting information as to whether the individual participated in group home tours over the past year. It then further stated the individual would "continue" to participate in group home tours "as needed." It was unclear what "as needed" would mean as there was no discussion of the individual's specific learning needs in this regard or desired measurable outcomes documented. The facility discipline members determined the individual could be served in a more integrated setting, but the entire IDT did not recommend a referral. This was documented in the narrative as due to LAR Choice, but no major obstacle was checked. The Living Options Action Plans were generic, such as continuing to enhance awareness through various preferred activities on and off campus and continuing to educate the LAR. No details as to how these would be implemented were provided. An Action Plan to provide opportunities to participate in group home tours had an implementation date, but no one was assigned responsibility and no outcome criteria were indicated. • For Individual #86, the Community Awareness and Education Discussion narrative stated the team recommendation was unanimous that transition would not be suitable for maintaining the individual's best optimal health,	

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		stability or in the individual's best interests overall, as was stated in the Annual Behavioral Health Assessment, but this was not consistent with the recommendation in all discipline assessments. There was no discussion of how these were reconciled. The only major obstacle chosen was LAR Choice; Behavioral Health/Psychiatric Needs was not selected. • For Individual #723, the Community Awareness and Education Discussion indicated that the individual's preferences were unknown due to not having any information on community living or attending any group home tours. There was no LAR. The Living Option Recommendation stated facility discipline members determined the individual could be served in a more integrated setting, but did not recommend a referral due to Medical Issues, noted as being 24 hour nursing care. The Annual Medical Summary and Nursing Review both stated the individual could be served in the community, however, and there was no narrative in the ISP that contradicted this. Individual Choice was not selected as a major obstacle despite the discussion of the lack of experience and awareness. Living Options Action Plans indicated the individual would "continue" to participate in community group home tours, although he had not been attending those, and attend Provider Fairs. The frequency of implementation was to be "bi-yearly" which was unlikely to result in significant learning given his lack of current experience and his learning needs. There was also no specific requirement set for the type of homes he should tour that would meet any perceived 24 hour nursing needs he might have. • For Individual #582, facility discipline members did not provide an independent determination of whether the individual could be served in a more integrated setting. The Community Awareness and Education Discussion narrative indicated the individual could continue to attend community group home tours, and that this was allowed by the LAR as a part of the individual's leisure activity, but there was no discussion of any tours he may have made. According to the CLOIP Worksheet, the individual had not made any tours as the LAR did not see any point in doing so. The major obstacle chosen was LAR Choice, but the only Action Plan to address this was the annual CLOIP packet being provided to the LAR. An Action Plan for the individual to have the opportunity to attend Provider Fairs and tours had a frequency of implementation designated as "upon scheduled." • For Individual #758, facility discipline members determined the individual could be served in a more integrated setting, but the entire team did not recommend a referral due to Individual Choice (lack of understanding of community living options) and LAR Choice (lack of understanding of community living options.) No Action Plans were described in the narrative and the Action Plans provided in the packet for review were blank.	

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		At the time of the last monitoring visit, the Monitoring Team had noted there was some improvement in the creativity and integration of the IDT strategies that could serve as the basis for an adequate plan to address obstacles, but found these were not being implemented. For example, the Monitoring Team had attended the ISP annual planning meeting for Individual #120 at the time of the last monitoring visit, on 8/27/13, and reviewed the individual's record for evidence of its implementation since that time. The ISP called for the individual to make monthly tours of community living options. No tours had yet been completed. There was also a Service Objective (SO) for developing a Community Living Options binder that would be reviewed with the individual on an ongoing basis in order to increase familiarization with those options. The Monitoring Team asked to review the binder and was provided with a copy of the CLOIP Making Informed Choices Workbook. It had not been individualized. The Monitoring Team also requested data related to implementation of this SO. While SO Progress Notes indicated the level of assistance was usually V, I (Verbal, Independent), the actual data sheets indicated Individual #120 almost always refused to participate, rendering this an ineffective approach. There was no evidence that the IDT assessed this or took any action. <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's review of the twelve completed ISPs found that 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 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	<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:	Noncompliance

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	individuals and their families or guardians to enable them to make informed choices.	An Individualized Plan For Each Individual: In twelve sample ISPs, 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 twelve (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, as described in ProvisionT1b1. The Facility did not yet succeed in developing individualized plans for community education and awareness. An Annual Provider Fair: The Facility had held its most recent semiannual provider fair on November 23, 2013. Attendance sheets were not provided for review, but the Self-Assessment indicated attendance included 49 individuals, three staff and 27 family members. Inclement weather was reported to have been a factor in attendance. Regular SSLC Meeting With Local LAs: The Admissions and Placement staff continued to meet jointly with local LAs and transition staff from Brenham State Supported Living Center on a regular basis. The Facility provided documentation that indicated its staff had attended regional LA and Provider Network meetings in September, October and November 2013. The agenda included status updates regarding community services. A Transition Specialist from RSSLC also spoke at one of the meetings to share an overview of the SSLC transition processes with providers in attendance. 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. • CLOIP: As indicated in previous reports, the annual LA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals. The Monitoring Team reviewed a sample of ten CLOIP Worksheets selected at random from ISPs held in February 2014. For these individuals, eight of ten (80%) were visited by the CLOIP Service Coordinator. The other two were not visited per LAR request. For two of the eight (25%) in which the LA was permitted to engage the individual, the LA Service Coordinator was able to document the individual had any interest in or	

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		meaningful response to the materials or information being offered. This continued to indicate DADS needs to assess how the process, materials and/or information might be modified to more effectively meet the needs of the individuals. <u>Tours Of Community Providers:</u> 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: • <u>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):</u> Since the time of the last monitoring visit, the Facility reported seven CLOIP tours had been scheduled or held. The Monitoring Team requested attendance documentation for these tours, but the Facility was able to provide such documentation for only 15 individuals. Another six individuals may have participated, but the documentation provided did not clearly indicate the individuals had made the tour or were simply expected to make the tour. The Facility should address its record-keeping in this area to ensure it is able to track the participation of each individual, as this should be a factor in evaluating the implementation and success of each individual's education and awareness plan. The Monitoring Team was concerned that individuals were not being offered opportunities to explore community options, except on a very minimal basis, resulting in their having no experience with which to form any preferences. This did not appear to provide sufficient opportunities for the 336 individuals residing at the Facility to obtain enough experience about community living to form an opinion or participate in informed decision-making. • <u>Places chosen to visit are based on individual's specific preferences, needs, etc.:</u> 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. • <u>Size of tours:</u> 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	

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		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. The Transition QIDP was now completing a form entitled Community Tour Documentation that asked how the individual reacted to the tour and for any staff comments about the program. This process had not yet been implemented to any significant extent, but the examples provided for review appeared to have usefulness for the IDTs in assessing individuals' reactions and preferences. 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, including attending a birthday party for a friend who had moved and attending a BBQ at the home of another. Education Provided In Various Venues: The Facility continued to hold monthly self-advocacy meetings for adults and youth, although no meetings had been held in November and December 2013 due to a vacancy in the HRO position. The meeting minutes provided for review did not indicate any agenda items related to the most integrated setting or community living options. 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 Fair, with 44 staff who attended in November 2013, and the annual LA In-service Training held on February 11, 2014, with 92 staff in attendance. The Facility noted another LA In-service Training was held on February 7, 2014, but no attendance documentation was provided for that date. The Facility also continued to include 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. However, during the PMM review for Individual #35 observed during the monitoring	

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		visit, the Transition QIDP did ask the sister of the individual if she would be willing to speak with at least one reluctant family. The sister agreed to do so enthusiastically. 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 Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	Assessment Practices Pursuant to Transition and Discharge Policies and Procedures: 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. This was unchanged since the previous monitoring visit. The Monitoring Team also reviewed DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013 and RSSLC Policy G.06 Admitting/Moving Individuals: Community Movement, Revised 01/31/14. The Facility also provided a list that indicated 323 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 held during the annual ISP meeting, which did not suffice as an assessment for community living, as evidenced by the lack of a thorough discussion of living options observed in 12 sample ISPs. See below for a description of the deficiencies found in the process. Percentage of Individuals Assessed as Required: The process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement; therefore, the Monitoring Team found that no individuals (0%) had been adequately assessed for placement. Issues that affected the adequacy of the assessment included:	Noncompliance

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		• As described in Provision T1b1 and Section F, 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. • None (0%) of the twelve ISPs reviewed evidenced proficiency in identification and addressing of obstacles. • The Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements as described in Provisions T1b1, 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. In twelve sample ISPs, 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 twelve (0%) recently completed ISPs was there an individualized plan for increasing awareness of community living options that took into account the learning needs of the individual, The Monitoring Team was also concerned that individuals were not being offered opportunities to explore community options, except on a very minimal basis. • As described in Provision F1e, each discipline's ISP assessment needed to include an opinion/recommendation regarding community living. For twelve recently completed ISPs, there were a total of 121 discipline-specific assessments reviewed. Of these, 57 (47%) included a determination of whether the individual could be served in a less restrictive setting. 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. • As described in Provisions T1d and T1e, the CLDP process did not adequately assess community living needs nor adequately identify needed pre and post move supports. These findings are discussed further in Provision F1e. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team 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	<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	Substantial Compliance

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	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:	basis as circumstances required. The Monitoring Team reviewed a sample of four completed CLDPs (Individuals #35, #165, #711, and #748) and four CLDPs in progress (Individuals #19, #302, #600 and #625) for referrals made during the past six months. Overall, the Monitoring Team found that documentation of ongoing implementation continued to be more frequent and detailed since the Transition Specialists were designated to maintain the referral status updates, so this appeared to be a successful modification to the process: • For eight completed CLDPs and CLDPs in progress, eight (100%) were initiated within 14 calendar days of referral. • For eight completed CLDPs and CLDPs in progress, seven (88%) included adequate documentation to show that they were updated throughout the transition planning process over the past six months. o Four of the four (100%) completed CLDPs included adequate documentation to show that they were updated throughout the transition planning process over the past six months. o Three of four (75%) CLDPs in progress included adequate documentation to show that they were being updated throughout the transition planning process. For Individual #302, it was not clear the IDT acted in a sufficiently timely manner. The individual's LAR had requested a referral to a specific community living option where the individual's brother also resided. The Living Options meeting occurred on 12/05/13, but there was no documentation provided the IDT took action to visit the home until two months after the referral was made, on February 6, 2014. Further, the IDT provided in-service training on that date, but the trial visit was not then scheduled until March 10, 2014. No rationale was provided for this additional lapse of more than 30 days; this was of particular concern because the in-service training was so far removed from the actual visit. • For two of two (100%) individuals whose referrals had been rescinded in the past six months, the Facility provided documents which demonstrated an appropriate level of activity had been undertaken to achieve a transition during the active referral period. The Monitoring Team reviewed an updated Community Placement Report, updated on Monday, March 03, 2014 covering the previous six months. Eleven of the 12 (92%) current referrals were within the 180 days allowed in the current policy. Six of the 11 (55%) transitions that had occurred exceeded 180 days, however. The two Transition Specialists had been assigned to work with the 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	

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		continued to appear to be appeared to a successful approach in achieving transitions in a timely manner. Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180-day timeframe will appropriately be exceeded. DAD's policy also acknowledges this and provides a process for the IDT to meet and review when the 180-day threshold has been reached. 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 018.2 that required the IDT to meet every 30 days once the initial 180 days has expired. <u>IDT Member Participation in Transition Planning Process:</u> Seven of the eight (88%) CLDPs reviewed, including four completed CLDPs and three in progress, included documentation to show that IDT members actively participated in the transition planning process. Documentation included evidence of good IDT participation in the referral meetings and frequent participation of IDT members in visiting potential homes and day providers. The Facility did not routinely provide evidence of IDT review of each trial visit, but did typically reference such review in the CLDP document. The Facility should ensure that it routinely documents ongoing reviews as required. The Monitoring Team noted that IDT members were typically responsive to issues that arose during the pre-move planning process, but also found evidence that this was not consistently sustained during the post move period; in one egregious instance, an individual with significant health care concerns did not receive adequate IDT attention and eventually returned to the Facility. See Provision T1a. <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 in substantial 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. The Department of Admission and Placement was making use of the two Transition Specialist positions in a manner that was contributing to a timelier outcome for most individuals.	

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		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. The Monitoring Team notes this finding of substantial compliance is based largely on pre-move development and implementation of the CLDP, as there were concerns regarding IDT involvement post-move. In order to maintain substantial compliance in future visits, the Facility should ensure it can document adequate and continuing IDT participation in ongoing planning as required throughout the pre and post move implementation of the CLDP.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	<u>Actions that Need to be taken by the Facility Are Specified:</u> 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. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). . • 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 The CLDP itself did not typically specify the level of training that would be provided or the competency achieved by those trained, but there were materials and in-service signature sheets provided for each of the four CLDPs reviewed. The Facility had recently begun an initiative to enhance its pre-move in-service training, including competency-based written tests, which was a significant improvement the Monitoring Team commends. The Facility should continue to expand upon this initiative and may even want to consider some return demonstration competency testing in certain circumstances, such as the use of equipment or assisting individuals with complex dining and/or positioning techniques. Collaboration with community providers continued to be largely 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. Certain day of move activities were listed in the CLDP, but responsible staff were not	Noncompliance

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		consistently identified. No day of move documentation was provided with the CLDP, so a full evaluation could not be completed. In some instances, the 7-Day Post-Move Monitoring did make note these activities had occurred. Coordination of CLDP with provider staff: 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. The Monitoring Team was again particularly pleased to see the Facility's increased in-service training and competency testing for provider staff. This was an important step forward that could be further enhanced in terms of content. In addition, provider staff participated in the CLDP for Individual#238 observed by teleconference as a part this monitoring visit. Conclusion: This provision was found to be not yet in compliance, but progress was noted, particularly in terms of provider staff training.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The Facility requested reduced monitoring due to history of compliance ratings and the Monitoring Team agreed. A brief review of four CLDPs indicated the following: • Responsible staff identified for needed actions: For four of four (100%) of CLDPs the Facility consistently identified Facility staff responsible for each of the essential and non-essential supports by name. • Completion timeframes for needed actions identified: For four of four (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. Conclusion: This provision was found to be in substantial compliance.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Review of CLDP with Individual and, as appropriate, the LAR: The Monitoring Team reviewed the documentation for four completed CLDPs and four CLDPs in process, for a total of eight to assess compliance with this provision. For eight of eight (100%), there was ample documentation of the level of involvement by the individual and/or the LAR in the decision-making process prior to the move. Conclusion: This provision was found to be in substantial compliance.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive	Timeliness of Assessments: The Facility had initiated a new RSSLC Policy G.14 Admitting/Moving Individuals: CLDP Grand Rounds, effective 08/30/2013 for the review of assessments and to make assignments for any updates, revisions or Action Plans that needed to be made to an	Noncompliance

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	assessment of needs and supports within 45 days prior to the individual's leaving.	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, but despite this improved process, the Monitoring Team found RSSLC continued to need to focus its attention on whether these assessments were adequately prepared, as described in Provision T1c1 and below. <u>Adequacy and Comprehensiveness of Assessments:</u> 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. The Monitoring Team found that the assessments did not consistently address the services and supports needed for each an individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. In addition, few of the assessments reviewed placed any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. Examples of concerns related to the adequacy of assessments included the following: • The Monitoring Team attended the CLDP for Individual #238 by teleconference having reviewed the draft CLDP and assessments, as well as ISP materials in the record. 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: o The individual had a significant psychiatric history, including behavioral challenges that had led to institutionalization on several occasions, including the two most recent instances in 2011. These behaviors were reported to have included physical aggression and unauthorized departure. These were not adequately discussed in terms of assuring the provider was aware of potential behavioral issues. RSSLC staff reported that all behaviors had been at a very low level since the individual was admitted from a state hospital in January 2013. It was further reported that a current Positive Behavior Support Plan was in place and focused only on verbally disruptive behavior. Staff noted that there were some other behaviors noted on occasion, but not deemed to be significant. This latter discussion was not specific; for example, it	

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		was noted the individual had engaged in "some property destruction," but no details as to the nature, severity, precursors or effective interventions was provided. The Monitoring Team appreciated the effort by the IDT to refrain from having a negative reputation follow the individual unnecessarily, but was concerned that potential risks were not adequately identified to ensure safety. For example, the potential risk of unauthorized departure should have been discussed and precautions developed. This behavior had not been seen since admission to RSSLC, but the Facility likely provided a more controlled environment than found in most community settings. This behavior was, in fact, one of the primary precipitating factors in the individual's most recent re-institutionalization. There was no discussion nor were any risk mitigation strategies developed as pre or post move supports. There was a note on the profile page that there should be "door chimes to prevent any episodes of elopement," but this was not in the required supports, nor was it discussed during the CLDP. Even when the LA noted there were open windows and missing screens in the home, this did not prompt any discussion as to how this might be especially significant related to the unauthorized departure history. o It should be noted the Monitoring Team's concerns in this matter were compounded by not having been able to find a current PBSP in the record while on site on March 6, 2014. It was unclear when the PBSP mentioned in the CLDP may have been developed, as the most current reference in the record was an ISPA indicating an intent to develop the plan by 1/31/2014. The Behavioral Health Assessment provided for the CLDP was dated 1/24/2014, but was not in the record when it was viewed by the Monitoring Team. This assessment was very short on details as to the individual's behavioral history and provided no recommendations for behavioral supports in a community setting. The Behavioral Health Specialist did not participate in the entire meeting, leaving after about 30 minutes. Given the individual's history, in particular, this clinician should have participated in the entire meeting. o In terms of preparation for serving the individual at the Facility and ensuring adequate supports were developed for community living, the Monitoring Team was concerned the Facility recommended the provider get in touch with the mother to get a better understanding of how the individual's seizures were manifested. It was appropriate that the Transition QIDP tasked the facility Social Worker for following up on that with the mother prior to the transition date, but it called into question why the Facility had not already taken such action as it provided ongoing care and treatment.	

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		o The individual receives medication for extrapyramidal symptoms (EPS) related to psychotropic medications, but there was no specific discussion of the indications for which this was prescribed. There was considerable discussion about appropriate instruments to be used for monitoring EPS, and a discussion of the recent scores on the MOSES and DISCUS scales of side effects, but no references as to the specific symptoms experienced by this individual. This information is important for the provider's direct care staff to be aware of and monitor for. See Provision L1 for additional details. o The individual had a diagnosis of Bipolar Disorder Type I with psychotic features and a support was established for provider staff to monitor for exacerbation or decompensation of certain symptomology, including increases or decreases in certain activities. In some instances, adequate monitoring parameters and baseline data were provided, but in many other cases were not. For example, decreased sleep was to be an indicator, but there were no data provided about current sleeping habits from which to ascertain a decrease. There was also some concern the individual was noted by staff to have poor social skills, including laughing loudly to himself for no apparent reason. This may also have been a symptom of psychosis, but no consideration of this possibility was discussed. See Provision L1 for additional details. o The narrative in the CLDP indicated the individual had some targeted behaviors including spending an "exorbitant" amount of time trying to flush the toilet or washing his hands. These behaviors were not further discussed, mentioned in the Behavioral Health Assessment or included in the behavioral supports. A review should be undertaken by the IDT to clarify the extent/frequency/severity of these behaviors and document whether any specific behavioral strategies may be needed by the provider. If these are behaviors that have resolved in the past year since the individual's admission to RSSLC, it would be advisable to share the successful interventions with provider staff as well. o The individual did not have a current PSI or vocational assessment and there was conflicting information within the ISP and CLDP about preferences related to work. Most references indicated the individual was not interested in work, but in the discussion related to the ADHD diagnosis, it stated it would be important to find community activity that interested the individual and noted one of the individual's specific preferences was office work. There was no discussion of this and the post-move support indicated only that the individual would attend day programming to increase recreational, leisure and independence skills. • As described in Provision L1, a review of the 12/2/2013 medical summary	

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		included as part of the CLDP for Individual #35 indicated a clinically appropriate summary of the medical action plan for documented diagnoses; however, there were no diagnoses, or action plans, for noted small vessel disease of the brain, and cerebellar atrophy, which the Monitoring Team identified by review of neuroimaging results in the active clinical record. The CLDP Grand Rounds for this individual did not identify this discrepancy. There was also no consideration undertaken if this could be a factor in persistent and recurrent dizziness. • Individual #463 was readmitted to the Facility following a failed community placement. Discussion with the medical director, meeting with living area staff, review of the active clinical record, and the CLDP dated 3/20/2013, indicated that the individual had significantly decompensated following transition to the community agency, developed an extensive stage IV decubitus ulcer, and required emergency resection of the Individual's intestine. Following its clinical review, the Monitoring Team identified several significant concerns regarding medical care, as further detailed in Provision L1. The Monitoring Team is concerned that underlying medical conditions, including history of intestinal ileus in 2012, history of gastroperesis, history of C. difficile colitis, history of chronic constipation requiring daily medications, including Golytely, the need to prescribe daily lactase, and a history of anorexia requiring an enteral tube placement for nutritional support, did not result in a more assertive evaluation of the Individual's gastrointestinal condition, prior to transfer from the Facility. <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 continue 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.	
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	<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 #238 observed as a part of this monitoring visit. 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:	Noncompliance

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	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.	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. The Monitoring Team was encouraged to observe a new emphasis placed on the identification of clinical indicators in the medical summaries to be used as monitoring parameters to be included in the CLDP and used for PMM. This was an important step and represented progress, but there remained significant concerns about the thoroughness of the assessment process as a whole and the impact of this on the adequacy of the monitoring parameters identified. Other significant deficiencies remained as to the above criteria in the CLDPs reviewed, and none of the criteria were consistently present in the CLDPs reviewed. Examples included:	

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		• None of four CLDPs (0%) reviewed consistently provided sufficient descriptions or adequately defined criteria as a whole. The CLDP still did not consistently specify what observation or staff interview should reveal. Sometimes this appeared to be self-evident, but in many cases it was not. For example, the CLDPs frequently indicated the provider staff were to be knowledgeable of a list of the individual's health care needs, but did not consistently provide the indicators the Post Move Monitor could use as the benchmarks for confirming staff were indeed knowledgeable . 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 Provision T1d regarding the need for careful identification of monitoring indicators. • For Individual #238, whose CLDP was observed by teleconference as a part of this monitoring visit, there were a number of supports that were not adequately described. As reported in Provision T1d and Provision L1, documentation in the individual's record clearly indicated behavioral, psychiatric and health care needs that were not adequately addressed in the CLDP. • For Individual #35, the post move monitoring checklist was rendered deficient by not including specific monitoring and reporting parameters for important clinical conditions, such as: osteoarthritis of the knee, degenerative disease of the vertebra, glaucoma, small vessel disease of the brain and associated cerebellar atrophy, constipation, and seizure disorder, among other conditions that were diagnosed, or otherwise indicated by review of the active clinical record. • Also for Individual #35, the post-move supports indicated the provider staff were to document any auditory hallucinations, but there was not an adequate 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 indicators to be documented. As reported in T2b, the Post-Move Monitor asked the provider staff if there had been any hallucinations. She described these as "seeing things that are not there," but the individual's hallucinations were reported to be auditory in nature, not visual, indicating the support was not even well-defined enough for the Post Move Monitor to comprehend. <u>LA Continuity of Care Process:</u> The Monitoring Team reviewed documentation for four individuals who had transitioned to the community in the last six months and was able to find three of four (75%) LA Continuity of Care Pre-Move Site Review Instruments in the packets provided. Each of these three was completed within the required timeframe and included the required	

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		DADS QRS report as an attachment. One was not available for review (Individual #748). <u>Pre-Move Site Visit Completed by Facility:</u> The APC designated one of the various Admissions and Placement Departmental 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 11 individuals who had transitioned in the past six months. Ten of eleven (91%) were provided for review. These ten each appeared to have been completed in a timely manner and included a visit to each service provision site. The Monitoring Team had selected a sample of four CLDPS to review more extensively to assess thoroughness in addition to timeliness, including the Pre-Move Site Reviews, for Individuals #35, #165, #711, and #748. The Pre Move Site Review for Individual #748 was not made available for review. The findings for the remaining three included: • The Pre-Move Site Review did specifically document if it included a visit to each service provision site as required. • 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. 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 of those supports that will be due prior to the 7-Day visit. • 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 three (0%) was any such documentation found. Each CLDP 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. For example, for Individual #711, the CLDP indicated the evidence for pre-move in-service training supports would be the training materials, sign-in sheets and staff interviews. None of these were documented in the Pre-Move Site Review; rather the staff person completing the review indicated only that the RSSLC IDT had completed the in-services on 10/30/13. This was not adequate to satisfy the evidentiary requirements for these pre-move supports. It also raised additional concerns, in that the transition took place on 1/30/14, some three months after the documented in-service. It would have been even more critical to test staff retention of knowledge following such a lapse. In fact,	

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		however, there was documentation included with the CLDP that indicated in-services had been completed variously on more recent dates of 11-20-13 and 12-10-13, with some level of competency testing completed for the provider staff in the in-services. This would not have relieved the RSSLC staff from abiding by the CLDP evidentiary requirements to confirm adequate provider staff knowledge of the supports and services in the CLDP, however, and the lack of awareness of the actual in-service dates called into question the accuracy of the information contained in the Pre-Move Site Review. <u>Conclusion:</u> This provision was found to be not in compliance. The Pre-Move Site Review process did not consistently document the CLDP-required evidence of the presence of all pre-move supports nor adequately assess the presence of supports that would be due before the 7-Day visit or obtain plans for them. This provision also 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. The CLDP Grand Rounds process described in Provision T1d and below in Provision T1f represented progress in providing heightened scrutiny, but needed to be seen as one part of an overall quality assurance plan for transition activities.	
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.	<u>Quality Assurance Processes to Ensure Development of CLDPs:</u> At the time of the last monitoring visit, the Monitoring Team had recommended the Facility undertake a focused initiative within the Quality Assurance Department and in conjunction with the Department of Admissions and Placement, 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. QA procedures related to ensuring the development of CLDPs had been enhanced since the last monitoring visit. The Facility continued tracking the timeliness of the 45-Day assessments from the various disciplines using a revised Transition Checklist. It had also developed a new policy, RSSLC Policy G.14 Admitting/Moving Individuals: CLDP Grand Rounds, effective 08/30/2013, as described above. This policy called for a two-step review of the contents of an individual's record and current assessments to identify any issues or discrepancies and develop action plans to resolve these prior to the actual CLDP meeting. The first step was an internal review held by the Department of Admissions/Placements, with a full IDT review to follow. Action Plans developed were to be tracked by the Transition QIDP, who was responsible for the facilitation of the CLDP. The Monitoring Team commends	Noncompliance

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		the Facility for implementing this quality assurance process. See also Provision T1e. <u>Quality Assurance Processes to Ensure Implementation of CLDPs:</u> 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. See also ProvisionT1e The Section T Monitoring Tools had undergone some minor revisions since the last monitoring visit. These tools included the CLDP tool, the PMM tool and the Alternate Discharge tool. The Facility had initiated implementation of the CLDP tool, with only one having been completed thus far. The other two had not yet been implemented. It is essential the Facility develop a comprehensive and coordinated quality assurance process that is implemented on an ongoing basis. There are many components to the CLDP that should be monitored in addition to the continuing concern about the quality of assessments noted above. For example: • The Monitoring Team reviewed a CLDP in progress for Individual #302 and was concerned regarding the rigor with which its implementation was proceeding. As described above in Provision T1c, the timeliness of implementation appeared to be unduly delayed, as the individual's LAR had requested a referral to a specific community living option where the individual's brother resided and there was no evidence provided the IDT took action to visit the home until two months after the referral was made, on February 6, 2014. The packet of documentation provided to the Monitoring Team included in-service training materials used on that date to prepare provider staff for an upcoming trial visit. The Monitoring Team was pleased to observe that, in some areas such as vocational, physical and nutritional supports and medical/nursing needs, IDT members had developed in-service summaries and post-tests. This was an improved process. Unfortunately, however, the in-service training provided for review did not appear to adequately address the individual's significant behavioral health needs. As background, the individual had a diagnosis of intermittent explosive disorder and the IRRF included in the packet indicated the risk rating in this area was high. Behaviors which were documented in the ISP and in an ISPA dated 12/05/13 included self-injurious behaviors, physical aggression and throwing body onto the floor or other hard surfaces. The Monitoring Team could find no documentation that these specific issues were addressed in the in-service and no behavior support plan was included in the packet. The only references in any of the in-service summaries or the post-tests that related to behaviors were indications in the vocational materials that the	

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		individual would engage in "inappropriate behaviors" in certain environmental conditions. While this information would be helpful for provider staff in terms of developing a supportive environment, this was not sufficient to ensure provider staff were knowledgeable of the individual's significant behavioral health needs and how to effectively support them. On a positive note, the Monitoring Team did find that a similar set of documents for Individual #19 did include specific in-service training and post-testing for behavior support needs and recommended interventions. Such inconsistencies in CLDP development and implementation can be minimized with adequate monitoring and appropriate corrective action. <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: • 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.	
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,	<u>Facility Annual Obstacles Report:</u> The Facility provided an updated Annual Report: Obstacles to Community Transition, Richmond State Supported Living Center, Fiscal Year 2013 for review. The report was dated November 2013. The report noted that LAR reluctance continued to be the greatest obstacle to referral for community transition at RSSLC and the most difficult one to overcome. It also noted individuals' reluctance for community placement appeared to be due largely to a lack of understanding of community living options. For the most part, the report described the Facility's current efforts to address these obstacles, such as its reliance on the efforts of the Transition Specialists in educating individuals and family members, and cited its progress as evidence that these were effective approaches. It was not clear the data were universally positive, however. The RSSLC-specific data provided at the outset of the report did appear to show an overall trend in increasing referrals, but the data for actual transitions appeared to be trending downward. The Monitoring Team did appreciate the work of the Transition Specialists in this area, and believed it was likely an important strategy for educating individuals and families and facilitating transition activity, but encourages the Facility to objectively analyze the trends as it continues to develop and refine its strategies for overcoming obstacles. <u>DADS Annual Obstacles Report:</u>	Noncompliance

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	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.	DADS had not yet issued an update to the Annual Report: Obstacles to Transition Statewide Summary as described in the previous monitoring report. The 2012 report included data as of 8/31/12 from all 13 Facilities. This report had been issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of that 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: • Definitions: 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. • Referrals: 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.	

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		• Transitions: Adequate methodologies were not in place to collect data on 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.	

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T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing 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.	Issuance of the Community Placement Report: No monitoring was requested for this Provision due to findings of substantial compliance for more than three rounds and this was accepted by the Monitoring Team. The Facility did provide a Community Placement Report, dated Monday, March 03, 2014, for six months ending on 2/28/2014 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: The finding of substantial compliance stands. The Monitoring Team did note that the Meeting Date for one referral, for Individual #19, did not coincide with the actual date of the referral meeting and this should be corrected in the system.	Substantial 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	Policies and Procedures related to Post-Move Monitoring: As noted in Provision T1b, DADS had issued DADS Policy 018.2: Most Integrated Setting	Noncompliance

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	full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Practices, dated 10/18/2013. The Monitoring Team will comment at the next compliance review as to whether the state policy adequately addressed all of the items in section T of the Settlement Agreement. The Facility reported there had been only some minor revisions to its policy related to Post-Move Monitoring. It reported it had begun using a PMM Checklist as revised in December 2013. This version of the Checklist was condensed from a previous version. Staffing: There was a single Post-Move Monitor at RSSLC, who had recently been hired and was in orientation at the time of the monitoring visit. In the interim, several members of the Department of Admissions/Placements staff had been completing the PMM responsibilities. Review of PMM Checklists: The Monitoring Team reviewed PMM Checklists for 16 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%) due during this time period 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). It was noted that in one case, for Individual #711, the Post-Move Monitor documented she had not visited the day program because the individual had not yet started attending, although this support was due to have begun. See below. • 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 2013 or, more recently the checklist as revised in December 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 generally 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	

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		Monitoring Team found the PMM process was not yet as vigilant in this regard as necessary. In the most concerning case, the Facility completed a 90-Day PMM visit for Individual #463, who was hospitalized at the time, having had bowel surgery. See Provision L1, T1d and T1e for additional details. In terms of the PMM process, the Monitoring Team found the following deficiencies: • The 90-Day PMM Checklist indicated the individual continued on a lactose free diet, but other provider documentation, including the Medication Administration Record (MAR), indicated the provider was not administering this support due to Medicare unwillingness to reimburse. • The 90-day PMM Checklist indicated a number of supports were in place that would have been unobservable and/or subject to change given the individual's hospitalization at the time. One example of this would be the assertion that staff continued to provide for the individual's appropriate positioning needs, as his surgery may well have resulted in changes. The individual did develop a significant decubitus following the surgery, which likely was an indication that his positioning needs were not adequately managed. See also next section. <u>Facility's Efforts to Ensure Supports are Implemented:</u> The Post Move Monitor maintained a file with materials to verify the implementation of supports as well as to document follow-up. The Monitoring Team appreciated the work of the Post Move Monitor in maintaining supporting documentation in some instances, but the process was not yet consistently implemented nor was it sufficient to ensure supports were implemented. Also see Provision T2b below. Examples included: • For Individual #463, the 90-Day PMM Checklist indicated the IDT should follow up with the provider and monitor the individual's recovery, but there was no consideration apparently given to extending the PMM period due to these events. The IDT did not meet to review the 90-Day PMM Checklist, nor was the Facility able to document any visits to the home to observe the individual or assist the provider in adjusting his services and supports from the time of transition until the individual returned to the Facility. The APC and IDT Social Worker did have some contact with the provider over this period of several months, but the IDT did not document any meeting or action until after the individual's mother contacted the Facility to express her alarm over the individual's condition. See also next section. • For Individual #711, the Post-Move Monitor documented she had not visited the day program because the individual had not yet started attending although this support was due to have begun. There was no documentation of the reason this support had not been implemented nor any evidence that suggested the Facility	

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		had taken any action to ensure its implementation before the 45-Day PMM visit. <u>ISPA meetings following PMM visits</u>: The IDT did not routinely complete review of each PMM Checklist, which would assist the Post-Move Monitor in evaluating any emerging issues. It was reported such review was no longer required as a matter of routine, but was to occur only if there was a concern. The Monitoring Team noted that while neither the statewide MIS Policy 018.2 nor the broad RSSLC MIS Policy G.00 required this review, RSSLC Post Move Monitoring Policy G06.1, revision date 01/31/14, was not clear about the expectation and needed to be clarified. In any event, there was not a clear process in place to determine what might constitute a special concern that would require IDT review; it was reported this relied primarily upon the Post-Move Monitor, perhaps in consultation with other departmental staff, to identify such a need. The Monitoring Team found the actual practice at the Facility was inconsistent. There were instances in which the IDT appeared to review PMM visits in which no concerns were identified, but also instances in which it did not review PMM visits that did indicate reasons for concern. Examples of the former, which demonstrate how routine review of the PMM visits may support successful transitions even when the PMM Checklists themselves identify no special concerns, included: • The Monitoring Team was particularly impressed with the initiative of the IDT for Individual #219. While the 7-Day PMM indicated there were no issues or concerns, the IDT responded promptly when concerns were raised by a representative of Disability Rights Texas shortly thereafter about the individual's supports in the day program. IDT members met and then sent representatives out to assist the provider in making adjustments. The ensuing 45-Day and 90-Day PMM visits were also reviewed by the IDT to ensure continued success. • The IDT for Individual #480 reviewed the 45-Day PMM as a matter of routine and found there were behavioral concerns that, while not unexpected, may have jeopardized the success of the transition. This IDT also worked with the provider to assist in resolution. There were instances identified in which PMM review should have taken place, but did not. In the most concerning of these, for Individual #463, the individual was hospitalized at the time of the 90-Day PMM visit after undergoing intestinal surgery. This PMM visit, as further described above, was not reviewed by the IDT, even though it was the final one and the individual's status was somewhat uncertain. 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	

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		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 supports 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 observed by teleconference as a part of this monitoring visit, the IDT failed to consistently specify the evidence that would be required for the pre or post-move supports. The Monitoring Team was impressed with certain assessments that did provide specific monitoring parameters and encourages the Facility to expand this across all CLDP assessments as a foundation for the IDT to use in developing the final monitoring evidence. <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.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before	<u>Observation of Post-Move Monitoring Visit:</u> The Facility had indicated it was achieving some level of compliance in the area of PMM. In order to assess the Facility's assertion that it had achieved compliance in this provision, the Monitoring Team accompanied the Post-Move Monitor on the 7-day PMM visit for Individual #35. The CLDP and accompanying assessments were also reviewed. One of the Transition Specialists served as the Post-Move Monitor. The Transition QIDP and the QA Program Auditor assigned to Section T also attended. There were again some 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. The Post Move Monitor received word just moments before arriving at the day habilitation program that the individual had experienced a lengthy seizure and been transported to the hospital for evaluation. While the	Noncompliance

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	the 90th day following the move date.	Monitoring Team cannot comment with certainty whether the Post-Move Monitor would have observed all supports as required under normal circumstances, it did observe some issues of concern that should have been identified or addressed by the Post-Move Monitor, but were not. These included: • At the day habilitation program, the Post-Move Monitor did not test staff knowledge as to the individual's seizure diagnosis or as to the availability and use of the Vagus Nerve Stimulator (VNS), which was a critical intervention prescribed for seizure activity. • It was also unclear the residential staff understood the protocol for use of the VNS, as she provided a description of swiping it "over and over" when the protocol indicated swiping may be repeated every 75 seconds if seizure activity continued. The Post Move Monitor did not test the knowledge of the protocol. • The CLDP called for the implementation of the Facility's behavior support program at the home and day program. While there was discussion with both the home and day program staff about how they were addressing behaviors, there was no reference made to the behavior support program or the strategies included in it. The day habilitation program staff indicated he thought the provider's consulting psychologist was developing one. • The Post-Move Monitor did not observe the outside patio area in the backyard of the individual's home for safety. • As reported in Provision T1e above, there were also issues related to the adequacy of identification of pre or post move supports in the CLDP, which hampered the ability of the Post-Move Monitor to thoroughly assess whether the individual's needs were being addressed. For example: o The Post-Move Monitor asked staff if the individual was exhibiting any hallucinations, but as noted in Provision T1e, the CLDP did not provide adequate information as to the individual's specific symptoms or manifestations. The Post-Move Monitor appeared not to be knowledgeable the individual's hallucinations were auditory in nature, at one point describing this as seeing things that aren't there rather than as hearing things internally that were not actually occurring. This was of particular concern because the day habilitation staff did indicate the individual would sometimes talk about things that didn't seem to be relevant, and there was not adequate probing to assess whether this reflected auditory hallucination activity. The lack of specificity in the assessments and monitoring parameters prevented the Post Move Monitor and the provider staff from accurately assessing whether hallucinations were occurring. o There was no probing regarding side effects to psychiatric medications and insufficient monitoring parameters were provided.	

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		o The individual had persistent and recurrent episodes of dizziness, for which a protocol was prescribed for staff to carry out. The Post Move Monitor did not question staff as to this protocol. There were also no parameters as to monitoring the frequency of these episodes or expectation of action to be taken if frequency increased. <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. • 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.	
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-	<u>Number and Categories of Alternate Discharges:</u> In response to the document request, RSSLC reported there were no alternate discharges during the past six months.	Not Rated

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	required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

SECTION U: Consent	
	Steps Taken to Assess Compliance: The parties agreed the Monitoring Team would not monitor this Section, as the Facility was awaiting development of a process for assessing capacity of individuals to provide consent.
	Facility Self-Assessment: The Facility did provide a self-assessment. Because the parties agreed this Section would not be monitored at this visit, the Monitoring Team did not review the self-assessment.
	Summary of Monitor's Assessment: NA

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The parties agreed the Monitoring Team would not monitor this Section, as the Facility was awaiting development of a process for assessing capacity of individuals to provide consent.	Not Rated
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those	The parties agreed the Monitoring Team would not monitor this Section, as the Facility was awaiting development of a process for assessing capacity of individuals to provide consent.	Not Rated

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	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.		

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment 2/13/14 2. RSSLC Action Plans 2/13/14 3. Presentation Book for Section V 4. Provision Action Information 2/20/14 5. DADS Policy 020.1 Recordkeeping Practices 3/5/10 6. List of DADS Policies revised since last visit, including a. DADS Policy 002 Incident Management 11/5/13 b. DADS Policy 004 ISP Policy 11/21/13 c. DADS Policy 008 Behavioral Health Services Department 11/5/13 d. DADS Policy 018.2 Most Integrated Setting Practices 10/18/13 e. DADS Policy 021.3 Protection from Harm-Abuse, Neglect, and Exploitation 11/13/13 (in DSSC Policy as CMGMT 01A) 7. List of RSSLC Policies revised since last visit, including a. RSSLC Policy A.1 Developing/Revising/Reviewing a Policy or Procedure 1/10/14 b. RSSLC Policy A.6 Recordkeeping 1/29/14 c. RSSLC Policy A06.1 Individual Notebook 1/29/14 d. RSSLC Policy A.28 Quality Assurance 1/29/14 e. RSSLC Policy A.29 Discipline Department Head Monthly Quality Assurance (QA) 1/29/14 f. RSSLC Policy A.30 Unit Quality Assurance Monthly Meeting 1/29/14 g. RSSLC Policy A.31 Database Request 1/29/14 h. RSSLC Policy C.01 Incident Management 11/25/13 i. RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 11/25/13 j. RSSLC Policy C.5 Initial Actions Regarding Sexual Abuse, Neglect, Exploitation, and Other Sexual Incidents 1/8/14 k. RSSLC Policy F.21 Engagement Monitoring 1/17/14 l. RSSLC Policy F.04 Individual Support Plan Process 1/29/14 m. RSSLC Policy F.17 Skilled Acquisition Plan Evaluation Process 2/21/14 n. RSSLC Policy F.22 Habilitation, Training, Education, and Skill Acquisition Programs (undated) o. RSSLC Policy G.01 Admitting/Moving Individuals: Admission Request 1/31/14 p. RSSLC Policy G.02 Admitting/Moving Individuals: Admission Request 1/31/14 q. RSSLC Policy G.03 Admitting/Moving Individuals: Moving within the Unit 1/31/14 r. RSSLC Policy G.04 Admitting/Moving Individuals: Moving to Another Unit 1/31/14 s. RSSLC Policy G.05 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement 1/31/14 t. RSSLC Policy G.05.1 Admitting/Moving Individuals: Community Exposure u. RSSLC Policy G.06 Admitting/Moving Individuals: Community Movement 1/31/14

	v. RSSLC Policy G.06.1 Admitting/Moving Individuals: Post Move Monitoring w. RSSLC Policy G.08 Admitting/Moving Individuals: Withdrawal of Referral for Community Movement 2/6/14 x. RSSLC Policy G.09 Admitting/Moving Individuals: Placement/Program Review Team (PRT) 2/6/14 y. RSSLC Policy G.13 Admitting/Moving Individuals: High Risk Individuals 2/6/14 z. RSSLC Policy I.00e Pharmacy Services 1/24/14 aa. RSSLC Policy I.06 Providing Acute Health Care 9/23/13 bb. RSSLC Policy I.08 At Risk Individuals 11/26/13 cc. RSSLC Policy I.12 Routing of Off-Campus Consultations 9/9/13 dd. RSSLC Policy J.06 Psychological and Behavioral Services 1/8/14 ee. RSSLC Policy K.01 Physical Nutritional Management 10/21/13 ff. RSSLC Policy K.02 Providing Mechanical Supports 10/21/13 gg. RSSLC Policy K.04 Developing/Revising PNMP & Dining Plan 10/21/13 hh. RSSLC Policy K05.1 Staffing Effectiveness-Occupational Therapy/Physical Therapy Services 10/30/13 ii. RSSLC Policy K.06.2 Speech-Language Pathology Services 10/30/13 jj. RSSLC Policy K.08 Developing Pathway to Oral Intake 10/31/13 kk. RSSLC Policy K.11 Skill Acquisition Planning 10/1/13 ll. RSSLC Policy K.12 Habilitation Therapies-Departmental QA Plan mm. RSSLC Policy O.1 Planning Off-Campus Trips 1/24/14 nn. RSSLC Policy O.2 Responsibilities During Off-Campus Trips 1/24/14 8. List and copy of each new/revised Facility Policy relevant to Requirements of the SA 9. For each new/revised policy, a copy of communication to staff to inform them of the policy, a description of training provided (with a copy of training materials), and/or blank competency evaluation tools. 10. Active Record Order & Guidelines 5/24/13 and Active Record Order & Guidelines Most Current that shows revisions made since the 5/24/13 version 11. Guidelines for Monitoring Active Record 2/4/14 12. Definitions/Criteria to be Used During Monitoring 1/29/14 13. Guidelines for Monitoring of Individual Notebook 1/29/14 14. Checklist for Minimum Documents Included in Master Record 12/6/13 15. Settlement Agreement Provision V.4—Interview Tool for use of the Record Guidelines 2/7/14 16. Settlement Agreement Cross-Referenced with ICF-MR Standards Section V (referred to in this report as Section V monitoring tool) 17. Sample Active Record including all documents that might be in the record 18. Record Audits, including emails regarding corrective actions for 10 audits per month conducted January 2014 for Individuals #24, #82, #184, #423, #478, #524, #540, #551, #584, and #738 and February 2014 for Individuals #248, #259, #260, #316, #342, #428, #465, #544, #604, and #716 19. Active Record Checklists completed by Unit Clerks for Individuals #155, #470, #471, #501, #508, #588, #589, #604, #745, #747, and #779 20. List of individuals whose records were audited in December 2013

	21. List of individuals whose records were scheduled for audit in March 2014 22. Active Record, Individual Notebook, and Master Record for Individual #772 23. Active Record, Individual Notebook, Master Record, and Master Record Checklist (New Admission) for Individual #72 24. Active Treatment Notebook for Individual #160 25. Table of annual assessments filed 10 days prior to meeting (annual ISP planning meeting) 1/1/13-1/22/14 26. Share Drive list of assessments for Individual #306 **People Interviewed:** 1. Group interview of Wanda Hartensteiner, Medical Records Director, and Unified Records Coordinators (URCs) Susan Steamer and Eileen Holmes 2. Andrea Faniel, Adelia Pavliska, Sherita Flowers, and Lester Shelton; and Director of Quality Assurance Georgette Brown. 3. Group interview of Angela Hernandez, QIDP Educator, Leroy Thompson, QIDP Coordinator, Ashley Smith, Services Coordinator, and QIDPs Klassy Bush, Netta Bridgewater, and Magnolia Taylor **Meeting Attended/Observations:** 1. Integrated Support Plan (ISP) Annual Planning Meetings for Individuals #675 and #718 2. ISP Preparation Meeting for Individual #501 3. Grand Rounds addressing Individual #227 4. Location where active records are kept at Tejas Trail 567, Tejas Trail 568, Trinity D, San Antonio C, and Pecos C
	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 ▪ Settlement Agreement Cross-Referenced with ICF-MR Standards Section V (referred to in this report as Section V monitoring tool) o These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. Although the tools themselves included adequate indicators to assess the specific areas they addressed, some areas were not addressed by indicators or tools. For example, a requirement for compliance with Provision V4 is that records must be present and used in meetings at which decisions are

	made about care, treatment, and training; at the last compliance visit, this was not found to occur consistently, but the Self-assessment did not include indicators to address this issue. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. At the same time, the Self-Assessment reported data from the Section V monitoring tool by item, rather than simply an overall compliance percentage; this provides a great deal more information for assessing the status of compliance of records with requirements of this Section, and the Monitoring Team hopes the Facility will continue to assess in this manner. 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 and, for reliability audits, Program Monitors. 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 updated. Number of record audits and percent compliance were reported, as were number of records reviewed for inter-rater reliability and the level of agreement. 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.

	○ All data reported in the Self-Assessment for Section V were collected by the QA Department, including URC who work in the Medical Records Department and Program Monitors. ▪ The Facility rated itself as being in compliance with no provisions of Section V. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with Provision V3. The Self-Assessment, appropriately and consistent with prior findings by the Monitoring Team, rated noncompliance because corrections to audit findings were not made timely in spite of email notifications to managers and staff. Although this remains a significant concern, the Facility also provided data showing that compliance findings were showing consistent improvement over the last several months, thus indicating that actions to limit reoccurrence may be showing effect. The Facility should include data on correction of noncompliance findings from record audits in its regular quality assurance data review and in its self-assessment of compliance with this Settlement Agreement requirement. 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. Some "In Process" items were actually implemented but will be ongoing, such as auditing Overflow records; these are actually completed items in that they have been implemented. ▪ The Facility data identified areas of need/improvement. The Facility made a useful addition to the Self-assessment for this Section; for each provision, the Facility described an issue needing improvement and referenced one or more action steps in the Action Plan established to address the issue. For example, in the Self-Assessment for Provision V3, the Facility stated the Action Plan included creation of a database that will allow for reporting more specific findings from record audits, improve the way staff are notified of deficiencies, and improve the method of tracking the follow-ups to the record audits. This database had been implemented by the time of the compliance visit. Some issues were not assessed in the Self-assessment and not addressed in the Action Plan. For example, one of the requirements of Provision V4 not met at the last compliance visit was the presence and use of the record during IDT meetings; although an interview question asked about this, there was no independent assessment of presence and use of the record at meetings. No action to address this was reported in the Action Plan. ▪ The actions did provide a set of steps likely to lead toward compliance with the requirements of this Section. Some actions involved single actions that needed to be taken. Some others involved a sequence of actions; an excellent example involved the development and implementation of a policy tracking system, on which some steps had been completed since the last compliance visit, so the Facility was farther along on the sequence. Steps included developing a database, collecting data, trending and analyzing findings, and implementing corrective actions as needed. For a different action, making a consistent format for chart check-out binders, it would be good to use a similar approach that would identify not only the steps in developing the format, but also actions needed to introduce the format, implement it at all homes, monitor for accurate use, and take corrective action as needed. Similarly, for correcting lack of correction of findings from audits, the

	development of a database and trending of findings is only a first step; additional actions will be needed to ensure corrections are made.
	Summary of Monitor's Assessment: The Facility maintained a unified record for each individual. One positive process that was unique to this Facility is the use of an 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. Active Records were accessible and secure. The checkout/checkin process needs to become more accurate. Although the presence of documents in the active record had declined slightly, it remained at an acceptable level. There was improvement in compliance with Appendix D requirements; additional improvement is needed, but the processes to continue improvement seem to be in place. This included a robust audit process for which a new database had been developed to make the audit and correction process more efficient. Additional audits by Records Clerks expanded the information needed to identify corrections needed; this was a systemic action the Facility took to improve consistent compliance with Appendix D requirements. The Facility has a system for tracking corrections. The Facility has addressed systemic issues; although most of the actions are relatively recent, the improvement in compliance with Appendix D requirements had been ongoing since the last compliance visit, which indicates that actions to limit reoccurrence may be showing effect. The Facility should continue to develop processes to ensure corrections are made consistently and to minimize future errors. Documents in records were not consistently current, and there were several examples of documents not filed timely. There were also a few lapses in documenting timely in the record. Although staff were able to describe how they used the records for decision-making, actual use of the records in interdisciplinary meetings was improved but variable. The Facility should develop a process to monitor and assess whether information from records is used for planning of supports and services during interdisciplinary meetings. There was continued development and revision of needed policies and procedures.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Policies Governing Recordkeeping 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 1/29/14; a significant revision was that the policy added a requirement that that all Annual ISPs and assessments completed for the Annual ISPs are to be filed in the Active Record within 30 calendar days of the Annual ISP. The Facility policy governed maintenance of a Unified Record with the required components and consistent with requirements of Appendix D. In addition, Policy A06.1 Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
		Notebook provided the requirements for the Individual Notebook and for Active Treatment Notebooks located at various sites "where ISP training, enhancement, and generalization occur." Locations included bedrooms, bathrooms, dining rooms, patios, day programming, workshops, and leisure areas. <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 Individuals #72 and #772. In addition, the Monitoring Team reviewed the 20 Facility record audits from January and February 2014 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, the Overflow Record, and the 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. Two other books contain records but are not considered part of the Unified Record. The first is the Group Data Notebook. This is essentially the same as the Group Data Notebook that had been used in the past; it contains many of the documents in the Individual Notebook plus the data sheets to be used to collect data for programs to be implemented in the living area and other areas except for the day program or vocational service. The second is the Active Treatment Notebook kept at the day program or vocational area. It also included many of the documents in the Individual Notebook; a sample and table of contents included Level of Supervision, the Client Information Summary, the individual's daily schedule, the Physical/Nutritional Management Plan (PNMP), the Special Considerations document, the ISP, program plans to be implemented in the day program/vocational area and the data sheets for those programs, the positive behavior support plan (PBSP), and miscellaneous documents. The sample included one program plan and data sheet, and no miscellaneous documents. 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 usually filed in 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. The Individual Notebook contained information needed by people providing daily service. The Individual Notebook was maintained at the residence; data were not	

#	Provision	Assessment of Status	Compliance
		entered into the Individual Notebook but were entered onto monthly data sheets in the Group Data Notebook and the Active Treatment Notebook, with the information from these monthly data sheets summarized in monthly reviews to be entered into the Active Record. Information needed at day program and vocational services, such as Physical and Nutritional Management Plans (PNMPs) and Positive Behavior Support Programs (PBSPs) were kept in the Active Treatment Books at those locations; these were not considered part of the Unified Record. When documents needed to be updated, they were sent by email to the day programs and vocational services; the Facility should develop a process to ensure that these replace older versions, and that the versions in these locations are the same as those in the Individual Notebooks at the residences. When documents are purged from the Active Record, they are 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. The Facility had continued to complete the Overflow Checklist to check whether required documents had 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 conducted by the Facility, 20 of 20 (100%) audited records included an Active Record, Individual Notebook, and Master Record. In addition, the Monitoring Team audited records for Individuals #72 and #772; both included an Active Record, Individual Notebook, and Master Record. Furthermore, the Self-Assessment reported that 60 of 60 (100%) individuals whose records were audited between 8/1/13 and 1/31/14 had all three of these components. <u>Staffing and Responsibility for Filing in the Record</u> The Facility had staff assigned to oversee the Unified Record. The Facility had two 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> New employee training (NET) 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. Since the last compliance visit, the training provided on recordkeeping at new employee training (NET) had remained essentially the same, but a change had been made in the competency test to require a demonstration of documentation practice rather than only testing of knowledge. "Show What You Know"	

#	Provision	Assessment of Status	Compliance
		exercises required the trainees to complete an Observation Note form using accurate recordkeeping practices including a late entry and correction of an error, or for staff who document in Integrated Progress Notes (IPNs), to complete an IPN, also with a late entry and correction of an error. Trainees signed and turned in these exercises before leaving training. This was a positive change that appropriately responded to a recommendation the Monitoring Team made in its last report. 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 was an informal process that involved a URC looking in the record for documentation that staff would be expected to write. The URC would meet with the individual (or, if review of other documents indicate it is systemic, with the Unit Director) to provide information on what was done well or needed improvement. This process, if implemented for all new employees, could serve as an additional competency test for NET if there were specific criteria for success. In addition, the process of specialized training on documentation for newly employed nurses had continued. <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 Tejas Trail 7, Tejas Trail 8, Pecos, Trinity D, and San Antonio C. In five of five homes (100%), Active Records were kept in an accessible area; records were secure, but at Tejas Trail 8, the names on charts were visible when the office door was open. Staff were easily able to access the Active Records and Individual Notebooks. 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. The Facility had implemented an action developed by a process improvement team; all Checkout Books now used a consistent bright green binder, making them easy to find. In five of five homes (100%), the checkout book was readily available. The Monitoring Team reviewed Checkout Books for seven individuals in five homes. For two of seven records (29%, Individuals #74 and #352), the Checkout Books were accurate. For two individuals (29%, Individuals #301 and #540), a chart was not present but was not checked out; therefore, the Checkout Book would not provide information as to where to find the chart. For two individuals (29%, Individuals #155 and #544), charts remained checked out but were present; while a lesser problem, it does indicate staff were not being careful in completing the	

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		checkout/checkin process. For one individual (Individual #48), the Checkout Book had checkouts completed for charts 2 and 3 in January 2014 but never checked in; chart 2 was present but chart 3 was not. 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 December 2013 through February 2014 and Trend Analysis providing overall percent of compliance for each month covering February 2012 through February 2014. • Reviewed record audits conducted January 2014 for Individuals #24, #82, #184, #423, #478, #524, #540, #551, #584, and #738 and February 2014 for Individuals #248, #259, #260, #316, #342, #428, #465, #544, #604, and #716 • Conducted audits of the Active Record and Individual Notebook, and Checklist for Minimum Documents Included in Master Record, for Individual #72 and the Active Record for Individual #772. Individual #72 was selected by computer randomization from among individuals who had been admitted between the end of the last compliance visit and the end of December 2013 (to permit time for assessments and ISP to be due). Individual #772 was selected by computer randomization from among those individuals who had been randomly selected for audit in March 2013. The audit for Individual #72 was done independently, and the audit for Individual #772 was done in conjunction with the audit done by the URC, who demonstrated how the new database for audits (see Provision V3) was to be used. Completeness of Active Record and Individual 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 and document the presence of each item in the record for Individual #72, and (alongside the URC) used the Active Record Review to check for and document the presence and compliance with Appendix D requirements for Individual #772. 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.	

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		Many documents are not applicable in each record. The Monitoring Team (and the URC) 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 Skill Acquisition Plan would be in the appropriate section of the record. For Individual #72, 59 documents were present in the Active Record, 13 were not present, and 104 were not applicable. The percent of applicable documents present was 82%. For the Individual Notebook, 11 documents were present, one was not present, and seven were not applicable; the percent of applicable documents present was 92%. For Individual #772, the number of documents present in the Active Record was 56, 13 were not present, and 107 were not applicable; the percent of applicable documents present was 81%. These percentages for the Active Record were slightly lower than at the last compliance visit. 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. Consistency with Appendix D Requirements: The Facility provided graphs of audit data (see Provision V3 for a complete description of the audit process) from February 2012 through February 2014. The data were monthly percent of overall compliance as reported on the Section V monitoring tool. The data from audits by the URCs showed an increase in compliance beginning in August 2013. Prior to that, the percent of compliance had consistently ranged between 48% and 60% (except for 67% in February 2012 and 63% in June 2013). Beginning in August 2013, compliance ranged from 64% to 73%, with a gradually increasing trend and a mean for December 2013 through February 2014 of 71%. Neither of the two audited records met all requirements of Appendix D. The compliance percentages found by the Monitoring Team on the Section V monitoring tool were 75% for Individual #72 and 70% for Individual #772. These were consistent with the trend report data provided by the Facility and somewhat higher than findings from Monitoring Team audits of two records at the last compliance visit. Specific comments related to this review of the audited records include: • The Monitoring Team did not review whether access to electronic records was protected, for example by passwords. This was likely the case, and a Yes would have increased the percent of compliance. Likewise, the Monitoring Team did not review records carefully enough to make an assessment of whether the information in the record was adequate for use in decision-making; however, in	

#	Provision	Assessment of Status	Compliance
		doing an audit jointly with the URC, the Monitoring Team was impressed with the care the URC took to compare different documents in the record as a means of checking accuracy of Observation Notes, IPNs, and other documents, and to determine whether there was consistency of information. • Legibility was greatly improved, even for signatures. For one of two records (50%), the record was rated as legible. For the other, most documents were legible; the only legibility problems were with Client Injury Reports, which provide a very small section for Recommendations, leaving little room when there are multiple recommendations (as was the case for this individual). • Both records had gaps at the bottoms of pages or between notes, and some monthly progress notes for skill acquisition plans and specific service objectives were not present in the record for Individual #772. It should be noted that data sheets are not entered into the active record at RSSLC, so the monthly progress notes are the only place in the Unified Record that would have that information readily available. • For Individual #772, a number of assessments were either not present or not current. • For Individual #72, although monthly flow records contained an initial legend, not all staff who initialed on the form put names and initials on the legend. The Monitoring Team reviewed many more records in review of other Sections of the Settlement Agreement. Findings included: • Monthly progress documentation for Individual #529 was found in the active record for Individual #264. • As reported in Provision M1, The daily (Monday through Friday) comprehensive Assessment and Documentation Audits conducted by the Nurse Manager and other relevant Nursing Administrative/Management staff had significantly improved the quality and content of nursing assessments and documentation for acute changes in health status. The most significant improvements included: o The legibility of nursing documentation, signatures and titles. o Documentation entries for acute changes in health status were consistently completed. In addition, the records reviewed showed that the SOAP method of charting was consistently used, there were no gaps found in documentation, documentation errors were properly corrected, and it was rare to find an entry that was not dated and timed. o It was rare to find a late entry, and late entries were consistently documented correctly.	
V2	Except as otherwise specified in this Agreement, commencing within six	<u>Policy</u> RSSLC Policy A.1 Developing/Revising/Reviewing Policy or Procedure was revised to	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	require review of each policy at least annually. The revision also noted that DADS directs RSSLC of which staff are to be trained and the timeframes for training when the revised/new policy/procedure is due to a new/revised policy from DADS. The significant change to the process for developing and reviewing policy is that the responsible person is to review the policy and recommend revisions annually. DADS Policies revised since last visit • DADS Policy 002 Incident Management 11/5/13 • DADS Policy 004 ISP Policy 11/21/13 • DADS Policy 008 Behavioral Health Services Department 11/5/13 • DADS Policy 018.2 Most Integrated Setting Practices 10/18/13 • DADS Policy 021.3 Protection from Harms-Abuse, Neglect, and Exploitation 11/13/13 (in DSSC Policy as CMGMT 01A) There were other DADS policies revised since the last compliance visit and reviewed by the Monitoring Team but not all were reported by the Facility in response to a request for a list of such policies. However, the Facility reported nearly all, and the Monitoring Team identified only one that the Facility had not reported. • DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 11/5/13 RSSLC provided a list of policies revised since last visit. With the new requirement for annual review, the list was lengthy. Policies necessary to implement the Settlement Agreement included: • RSSLC Policy A.1 Developing/Revising/Reviewing a Policy or Procedure 1/10/14 • RSSLC Policy A.6 Recordkeeping 1/29/14 • RSSLC Policy A06.1 Individual Notebook 1/29/14 • RSSLC Policy A.28 Quality Assurance 1/29/14 • RSSLC Policy A.29 Discipline Department Head Monthly Quality Assurance (QA) 1/29/14 • RSSLC Policy A.30 Unit Quality Assurance Monthly Meeting 1/29/14 • RSSLC Policy A.31 Database Request 1/29/14 • RSSLC Policy C.01 Incident Management 11/25/13 • RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation 11/25/13 • RSSLC Policy C.5 Initial Actions Regarding Sexual Abuse, Neglect, Exploitation, and Other Sexual Incidents 1/8/14 • RSSLC Policy F.21 Engagement Monitoring 1/17/14 • RSSLC Policy F.04 Individual Support Plan Process 1/29/14	

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		• RSSLC Policy F.17 Skilled Acquisition Plan Evaluation Process 2/21/14 • RSSLC Policy F.22 Habilitation, Training, Education, and Skill Acquisition Programs (undated) • RSSLC Policy G.01 Admitting/Moving Individuals: Admission Request 1/31/14 • RSSLC Policy G.02 Admitting/Moving Individuals: Admission Request 1/31/14 • RSSLC Policy G.03 Admitting/Moving Individuals: Moving within the Unit 1/31/14 • RSSLC Policy G.04 Admitting/Moving Individuals: Moving to Another Unit 1/31/14 • RSSLC Policy G.05 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement 1/31/14 • RSSLC Policy G.05.1 Admitting/Moving Individuals: Community Exposure • RSSLC Policy G.06 Admitting/Moving Individuals: Community Movement 1/31/14 • RSSLC Policy G.06.1 Admitting/Moving Individuals: Post Move Monitoring • RSSLC Policy G.08 Admitting/Moving Individuals: Withdrawal of Referral for Community Movement 2/6/14 • RSSLC Policy G.09 Admitting/Moving Individuals: Placement/Program Review Team (PRT) 2/6/14 • RSSLC Policy G.13 Admitting/Moving Individuals: High Risk Individuals 2/6/14 • RSSLC Policy I.00e Pharmacy Services 1/24/14 • RSSLC Policy I.01 Emergency Response 1/29/14 (reviewed) • RSSLC Policy I.06 Providing Acute Health Care 9/23/13 • RSSLC Policy I.08 At Risk Individuals 11/26/13 • RSSLC Policy I.12 Routing of Off-Campus Consultations 9/9/13 • RSSLC Policy J.06 Psychological and Behavioral Services 1/8/14 (note that the actual policy name on the policy provided to the Monitoring Team is Behavioral Health Service Department) • RSSLC Policy K.01 Physical Nutritional Management 10/21/13 • RSSLC Policy K.02 Providing Mechanical Supports 10/21/13 • RSSLC Policy K.04 Developing/Revising PNMP & Dining Plan 10/21/13 • RSSLC Policy K05.2 Occupational Therapy/Physical Therapy Services • RSSLC Policy K.06.2 Speech-Language Pathology Services 10/30/13 • RSSLC Policy K.08 Developing Pathway to Oral Intake 10/31/13 • RSSLC Policy K.11 Skill Acquisition Planning 10/1/13 • RSSLC Policy K.12 Habilitation Therapies-Departmental QA Plan 11/1/13 • RSSLC Policy O.1 Planning Off-Campus Trips 1/24/14 • RSSLC Policy O.2 Responsibilities During Off-Campus Trips 1/24/14	

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		The list did not identify which of these were revised or had been reviewed and continued. That is not a requirement of this provision, as it only requires that the Facility revise as appropriate. Having routine annual review satisfies that requirement, if findings throughout the report indicate policies meet the requirements of the various Sections and provisions, reflect current practices, and are implemented accurately, as necessary to "implement Part II of this agreement." In particular, as reported in Provision E1, beginning to articulate the quality assurance activity expected of residential units and departments through policy expectations established in three new policies was a step forward. In addition to this list, various Sections of this report document additional policies that had revision dates since the last compliance visit. These include: • RSSLC Policy E.11 Mealtime Procedure (rev. 1/10/14) • RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 1/15/14) • RSSLC Policy K.06.1 Staffing Effectiveness (rev: 10/30/13) Numerous procedures were updated. For example, as reported in Section M, many DADS and RSSLC nursing procedures and protocols were revised. As reported in Provision Q1, a dental Radiation Policy was implemented during the period. This policy appeared to be a Lubbock SSLC policy, as that facility name was in the policy. There is no problem with adopting or adapting a policy from another facility so long as it is localized as needed. <u>Training on Policies</u> Policy A.1 requires identification of the type of training needed when a policy is implemented or revised. In some cases, only notification of staff is required; for some of these, the Facility provided a copy of an email notification to some or to specific staff; an example is the 2/12/14 email To All Users of reviews/revised training policies. In other cases, the Facility identified a need for training. For some policies, the Facility provided an email to specific departments or responsible staff identifying which staff required training and requested the department or responsible staff to submit evidence by a specific due date that the training occurred. One of several examples was Policy I.08 At Risk Individuals. For a set of policies related to physical and nutritional management, a set of training slides used for Habilitation Department training was provided along with the training sign-in sheet. In some cases, sign-in sheets were provided, but it was unclear whether all staff who needed training received it. For example, for Policy O.02 Responsibilities During Off-Campus Trips, many responsibilities fell to direct support staff (DSPs). The training sheet provided was limited to a few recreation and vocational staff. The Director of Quality Assurance reported Policy A1 is being revised to require more detailed information and accountability on training required and on status of	

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		training. For some policies, the Facility identified the need for competency testing to ensure staff understand the policy. Competency tests were provided for several policies. For example, for Policy E.3, a true/false test of staff responsibilities was provided. This kind of test serves primarily as an additional way to remind staff of the requirements; although appropriate in many cases (especially those in which the policy provides information rather than defining action), the Facility might consider including at least some questions that require staff to state what they need to do in a specific situation. For a few revised policies, no documentation was provided of notice or training.	
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> Policy A6 requires audits of at least five Active Records monthly and states the requirement for correction of problems to minimize reoccurrence. Policy A 06.1 requires audits of at least five Individual Notebooks monthly and states the requirement for correction of problems to minimize reoccurrence. Each month, a set of 10 records is drawn through computer randomization (two individuals per unit) and provided to the URCs. Each URC audits five records. The URCs begin by reviewing the Active Record and Individual Notebook. Since the last compliance visit, the Facility had, in December 2013, implemented a new database for this process; therefore, some audits were done using the paper format Active Record Review, and others used the database version. The information is the same on both the paper and the database versions of the Active Record, and is based on the Active Record Order and Guidelines (AROG). Some audit documents provided to the Monitoring Team included both a paper version and a printout of the database version, as the URCs had the option to document on the paper version and then transfer the information to the database. At the time of this visit, the Monitoring Team completed one audit jointly with a URC in order to observe the database being used. The database will permit real-time and accurate calculation of compliance both for presence of documents and for compliance with Appendix D requirements. As with the paper format, the database has a place to mark whether a document is present or missing; for each document, the URC can check a box to indicate that an Appendix D requirement was not met and can add comments, either to explain what was incorrect regarding Appendix D or simply to provide a note to the URC for follow up. As noted below in discussion about correcting cited documents, the notice of corrections can be taken directly from the database, which will separate those documents needing correction from those that are present and meet Appendix D requirements. Reports can also be provided for percentages of compliance overall, by type of error, or by living unit.	Substantial Compliance

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		Based on information documented on these forms, the URC completes the Section V monitoring tool, which provides the data for reporting and trend analysis. Program Monitors select one Active Record per unit for a total of five (50%) of these records to carry out a reliability audit. This audit is done of the Active Record but not the Individual Notebook. In addition, the Program Monitors audit presence of the data in the Group Data book; although these had been reviewed as part of the audits by program monitors, audits of these books was included as part of the monthly audit since the last compliance visit as recommended in the last report. 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. Audits were not done for the Active Treatment Notebook, kept at the day program area for each individual. This book was to contain program information including the "client information summary," special considerations, daily schedule, Physical Nutritional Management Plan (PNMP), the Individual Support Plan (ISP), Positive Behavior Support Plan (PBSP), and data sheets for training or specific services to be provided in this program area. Because audits are not done, the Facility has no way to assess whether these books are regularly updated and have the current versions of documents. Whether these books are considered part of the Unified Record or not, the information in them is intended to guide provision of supports and services, and it is essential that the guidance in the books is current and accurate. Therefore, the Monitoring Team would encourage the Facility to audit these. The Facility did not audit the monthly flow notebook, PNMP notebook, or Dining book. As with the Active Treatment Notebook, these books must have documents that are consistent with those in the Active Record and Individual Notebook. The Facility had continued to complete the Overflow Checklist to check whether required documents has been purged from the active record and received by Medical Records. 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. 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. The Facility provided copies of the audits conducted in January and February 2014. Ten audits were completed each month, for a total of 20 audits reviewed by the Monitoring Team. • For 20 out of 20 audits (100%), the Facility provided the Section V monitoring	

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		tool. • For 20 out of 20 audits (100%), the Facility provided the Active Record Review. • For 19 out of 20 audits (95%), the Facility provided the Individual Notebook Review. • For 20 out of 20 audits (100%), the Facility provided the Group Data Notebook Audit. • For 20 out of 20 audits (100%), the Overflow Checklists were provided. An additional review of records was conducted by Unit Clerks. Each Unit Clerk audits three records from their own units monthly. The URCs generate a random list from each unit. The Active Record Checklist differs from the Active Record Review in that it audits a more limited set of focus documents and of Appendix D requirements (for some documents, it specifies a requirement, such as having no more than three months of Observation Notes, or Social History being filed according to AROG). The Facility provided 12 Active Record Checklists completed by the Unit Clerks in January 2014. One checklist reviewed the record for Individual #604, whose record was also audited in February 2014. Comparison of these two reviews showed: • The Preferences and Strengths Inventory was not in the record at the time of the January Unit Clerk review (Active Record Checklist) but was in the record at the time of the random audit; thus, an error found in the Unit Clerk review had been corrected. Similarly, the need to purge Observation Notes had been corrected, and a Quarterly Drug Regimen Review that was not present in January was filed before the February audit. Also, a current Active Problem List, not found in the record in January, was in the record in February. This was also true for Quarterly Nursing Assessments. Medication Administration Records and Monthly Flow Records needed purging in January; this had been done according to the February audit. • The Individual Rights Assessment was not present at either review; thus, an error found in the Unit Clerk review had not been corrected. • Quarterly Nursing Record Reviews were found to be current in the Unit Clerk Active Record Review but not in the February random audit. This would either mean the oldest Nursing Record Review had been purged a month early, or that one of the audits was in error. Similarly, the current Dental Annual Assessment was present in the Unit Clerk review but not in the random audit. Although there were two discrepancies in which a document was found not present in the random audit but was marked present in the Unit Clerk review, the documents were, for the most part, either consistent or showed that problems identified in the Unit Clerk audit were rectified in a timely manner. Thus, the Unit Clerk audit appears to be a valuable adjunct to the random audits; it extends the reach of the audit system so that	

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		needed corrections can be addressed more timely. <u>Interobserver Agreement/Interrater Reliability</u> At the last compliance visit, the Monitoring Team and Facility URC audited an Active Record and Individual Notebook; agreement levels between the two audits showed adequate agreement. Therefore, the Monitoring Team did not conduct a reliability audit at this review. Program monitors selected five records each month from the 10 audited by URCs. These were not selected randomly; each program monitor is assigned a home and selects one of the two individuals from the random list being audited by the URCs for that home. URCs and program auditors conducted their audits of an Active Record on the same day 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 there was a misconception or difference in definition, they record that. The URCs showed the Monitoring Team a sample active record with definitions; this included all documents that might be found in the Active Record. The Facility's plan is to update the sample chart as forms change, and to include decisions based on reviews of reliability checks. The entries on the Section V monitoring tool from the URC and the Program Monitor audits are entered onto a database; agreement is calculated directly from the entries. Agreement is reported overall for a record and by specific item on the tool. According to the monitoring data report for 1/1/14-1/31/14 and 2/1/14-2/28/14, the levels of agreement on the monitoring tool between audits conducted by URCs and by program monitors were 86.90% and 92.24% respectively. These were somewhat higher than at the last compliance visit (for June and July, 2013) and continue to be in an acceptable range. The data on agreement for specific items showed that all items met an 80% or greater agreement level each month except for four items in January 2014. The availability of agreement data by item permits the Facility to identify any patterns of poor agreement on specific items and address those. The Facility did not report reliability data for the audit tools for the Active Record and Individual Notebook. With the new database for direct entry by the URC (and with entry of ratings by the Program Monitors), 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. <u>Audit Findings</u>	

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		The Facility provided trend data for compliance percentage as rated on the Section V monitoring tool for February 2012 through February 2014. The data were monthly percent of overall compliance as reported on the Section V monitoring tool. The data from audits by the URCs showed an increase in compliance beginning in August 2013. Prior to that, the percent of compliance had consistently ranged between 48% and 60% (except for 67% in February 2012 and 63% in June 2013). Beginning in August 2013, compliance ranged from 64% to 73%, with a gradually increasing trend and a mean for December 2013 through February 2014 of 71%. The monthly and quarterly data reports on level of compliance showed the percent of audited records for which each item was compliant. This provided a way to determine whether specific requirements were showing improvement, regression, or no change. The Facility provided the quarterly data report for 12/1/13-2/28/14 and monthly report. The monthly report listed which items were found in compliance 80% of records or higher, and which items were found in compliance less than 80% of records. This makes it easy for the Facility staff to identify any items needing to be addressed. Although the information is readily available from the database, there is no report providing data on presence of documents and on whether documents are current, just on the Section V monitoring tool. It would be useful to report on presence of documents, as that would provide a more sensitive measure of improvement than an overall rating on the Section V monitoring tool. <u>Corrective Actions for Audit Findings</u> The Facility had a process to take corrective actions for specific deficiencies identified in audit of an individual record, to ensure corrective actions were completed, and to track deficiencies to determine trends that require systemic action. The Facility reported that the process for correcting findings from audits had remained the same. 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, QIDP for the individual, QIDP Coordinator, unit clerks, specific clinicians if affected, and all URCs & program monitors requesting corrective actions. This email is accompanied by a report titled "Corrections Needed," a report titled "Corrections Needed for Individual Notebook," and a report titled "Corrections Needed for Group Data Notebook Audit". These reports list each item requiring correction from the Active Record Review, Individual Notebook, or Group Data Notebook; each line includes the Document, rating, the category (categories) of requirement that was (were) noncompliant, and comments that describe the error(s). They do not identify who is responsible for correcting the errors.	

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		The email requests that the staff responsible for corrections notify their supervisors 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 (as noted above) 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 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 January and February 2014, as well as follow up emails identifying corrections completed and still required for audits in December 2013 and January 2014. For 20 of 20 audits reviewed (100%), documentation was provided that corrective actions were required for the deficiencies identified. Documentation verified that follow up continued when corrections were not complete. Based on review of the follow up emails, corrections made but overall were not completed consistently. The Monitoring Team randomly by computer selected one individual record from among those audited by a URC in January 2014, Individual #540. The Monitoring Team and URC audited the corrections that were to have been made in the Active Record. Of 17 items needing correction, seven (41%) had been corrected, eight (47%) were noted on the last correction form (done 2/26/14) as not corrected and had still not been corrected, and two (12%) had been corrected but new errors had occurred. For this one individual record, corrections had not been made consistently, nor was there indication that corrections would continue once made. The revised process for Unit Clerk review, which allows for the Unit Clerk to notify the Unit Director of any issues, may provide a process to clarify the responsibility for making and following up on corrections; the Facility might consider adding follow up of corrections to the Unit Clerk monthly audit process. <u>Review of Trends and Use of Audit Information for Systemic Improvement</u>	

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		In the last compliance report, the Monitoring Team recommended the Facility identify one or more requirement that was not compliant in 80% or more of records. To address this recommendation, the Facility established a performance improvement team. Minutes of the initial meeting on October 24, 2013 documented the purpose of reviewing and addressing areas of low compliance. Graphs and tables were attached that showed overall compliance, errors by type for July-September 2013, and errors by type for each document in individual records. Actions to be taken included adding a return demonstration to the test in NET (note in Provision V1 that this was done) and having training for direct support professionals (DSPs) on gaps and legibility. Minutes of the meeting of December 17, 2013 documented the team addressed chart check-out with an action of looking at options for these to look consistent across the Facility (which resulted in all these books being a bright, visible green), the need to file ISPs and assessments promptly (see below for a description of how this was addressed), and a revision of the way Unit Clerks monitor records (note the description of this process above) so they would monitor on their own units and could bring issues to the attention of the Unit Director as necessary. The Facility addressed having ISPs and assessments filed promptly in the record (within 30 calendar days following the ISP annual planning meeting), which should correct a significant source of error in having documents be Current. Policy A.6 Recordkeeping was revised 1/29/14 to require filing of these documents "within 30 days of the annual ISP." During February 2014, the Director of Medical Records provided inservice training on this revision to the Unit Clerks. Although this was too recent to show any improvement, it did address an important systemic issue. <u>Conclusion</u> The audit system is robust and comprehensive. At least five random audits are conducted each month, and these are supplemented with additional audits of specific items in the record. Reliability across auditors is adequate. The Facility recently revised the process for Unit Clerk reviews so they can provide information to Unit Directors about issues they find. Audit findings for individual records are sent to staff for correction. The Facility has a system for tracking corrections. The Facility has addressed systemic issues; although most of the actions are relatively recent, the improvement in compliance with Appendix D requirements had been ongoing since the last compliance visit, which indicates that actions to limit reoccurrence may be showing effect. Nonetheless, the Facility must ensure corrections of findings from the random audits are completed and that processes are in place to minimize reoccurrence and take action when they do occur again; if compliance with Appendix D requirements declines before the next visit and is not addressed effectively, a finding of substantial compliance might not be continued. Although this must be addressed, the robust audit system and improvement in compliance with Appendix D requirements merit a finding that the	

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		Facility is in substantial compliance with this provision.	
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 six 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. Facility random audits of 20 records found 20 (100%) to be accessible. The only problem with accessibility was inaccuracy of the checkout system. As reported in Provision M1, there was no difficultly with the availability of records and documents for onsite review. However, there were two missing Physical Assessments that should have been included with the Comprehensive Record Review and a missing Hospital Transfer Record. Therefore, it could not be determined whether these documents were not completed or simply not copied for offsite review. The Nursing Department had an active Corrective Action Plan for ensuring hospital related information was filed according to policy. One other issue of accessibility involved documentation by the Hospital Liaison Nurse and is reported below. 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. To achieve substantial compliance, the Facility should ensure the checkout/checkin process provides accurate information on the presence of records. <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 20 records (0%) was rated as Current. That was true also for the two records audited by the Monitoring Team. The Facility provided a table of Appendix D requirements not met by document in the Active Record for several individuals; this was attached to minutes of the October 24, 2013 process improvement team meeting, provided valuable information to that team, and would be useful for this review, but unfortunately, the dates on the table indicate that these audits were done prior to the last compliance visit. An updated table would have provided information including whether documents were filed timely. No similar information was provided for audits since the last compliance visit. The Facility should consider whether it would be helpful to have a more sensitive measure of presence and	Noncompliance

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		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. Review of the 20 audits done during January and February 2014 identified numerous documents that were identified as not present or not current in the record. 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 table of annual assessments filed 10 days prior to the annual ISP planning meeting, for 1/1/13-1/22/14, by living unit. The process to identify required assessments was to do so at the pre-ISP preparation meeting held approximately 90 days prior to the annual planning meeting. Although some assessments are required for only a few individuals, some assessments are required for all individuals. For example, annual medical assessments, annual nursing assessments, and pharmacy assessments are required for all individuals. However, the table reported that none of these matched the number of ISP meetings for any unit. The percentages listed as "filed 10 Days Prior to Mtng (sic) were based on the number of assessments filed timely divided by the number of assessments filed; the number of assessments not filed at all (and therefore not timely) was not reported or considered in determining the percent filed timely. The Facility acknowledged it was aware of this flaw in its quality management process. The QIDP Educator indicated the Facility was working on a fix to this problem. The QA Director further explained that the QA Department would be tracking timeliness of the ISP Preparation Meeting and would then monitor the assessments based on the requirements in the ISP Preparation documentation. The Facility needs to complete development of a tracking system that identifies the assessments required for annual ISP planning meetings and the number of those assessments that are completed and filed timely. This was also noted in the last compliance report. As reported in Provision F1c, the Monitoring Team reviewed assessments for a sample of nine completed ISPs and for two ISP annual planning meetings observed during the visit, as well as for a sample of four individuals who had been admitted to the Facility. Findings showed that timely completion occurred for somewhat less than 75% of required assessments, and less than 80% of required assessments were included in the documents provided to the Monitoring Team. Improved timeliness was found for one individual for whom assessments were due. The Monitoring Team also viewed the assessments available on the shared drive for Individual #306, who had an annual ISP planning meeting scheduled within the next ten working days. For 11 assessments that were required per the ISP preparation meeting, 11 (100%) current or updated assessments were posted, and 11 (100%) had been posted by 10 working days prior to the meeting.	

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		As noted in Provision V3, the Recordkeeping policy had been revised to require that assessments be filed in the Active Record within calendar 30 days following the ISP annual planning meeting, and Unit Clerks were trained to check on whether that had been done. This change had occurred recently. QIDPs interviewed indicated that there is difficulty in completing monthly reviews, and that an action plan was in place to facilitate completion. This is consistent with the information reported in Provision F2d that all monthly reviews had been completed for only slightly more than half of a Facility-selected sample of ISPs. Similarly, Provision S1 reported that nearly half of a reviewed sample of ISPs had at least one monthly review report missing. Finally, of the monthly reviews for individuals who had planning meetings (ISP or ISP Preparation) during this visit, monthly reviews were either not completed or were nearly identical for month after month. Effective planning for the future cannot take place if the IDT is not implementing and monitoring the progress of individuals on an ongoing basis. It appeared the monthly review process did not result in use of data for decision-making on supports, services, treatments, and interventions. Several other issues were found in which documents were not filed timely or were not updated as needed. For example: • For Individual #192: o Lack of updates to the PNMP. The PNMP as of 10/23/13 still reflected that the individual was on a ground diet when their diet texture had been changed to puree on 10/18/13. o Lack of updates to the IHCP. The IHCP as of 3/6/14 still stated the individual is on a ground diet when the individual is tube fed. Also, the IHCP still reflected to notify the nurse if no BM in 3 days when this directive was changed on 8/12/13 to notify the nurse if no BM in 2 days. • As reported in Provision K4, in five of 10 records (50%), behavior intervention progress notes were not available for all months. • As noted above and reported in Provision M1, there were two missing Physical Assessments that should have been included with the Comprehensive Record Review and a missing Hospital Transfer Record. Therefore, it could not be determined whether these documents were not completed or simply not copied for offsite review. • As reported in Provision M1, active records were sometimes not available for filing Hospital Liaison Nurse notes and reports. Hospital Transfer Forms, Post Hospital Assessment Forms, Hospital Discharge Summaries, and lab and diagnostic reports were inconsistently completed, and the Facility had established a corrective action plan (CAP), and continued the plan as there was	

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		improvement but still a need to improve further. <u>Data Are Documented/Recorded Timely On Data And Tracking Sheets</u> As reported in Provision V3, program monitors audited the Group Data Notebooks. One item assessed was "Data Sheets filed in group notebook are current." For 18 of 20 (90%) of the group data notebook audits conducted in January and February 2014, this item was checked "Yes"; of the two records checked "No," there was no comment for one, but the other audit stated "no data sheets filed." The Monitoring Team did not ask or determine whether a "Yes" required only that the current sheets were present or required that data were entered up to date as required. As reported in Provision S1, documentation provided by the Facility also reflected numerous lapses in ensuring that data on skill acquisition plan (SAP) training were consistently recorded, tracked, and monitored. Of the nine individuals included in the sample, five (56%) had at least one monthly data sheet missing. To further assess whether the documentation methodologies were sufficient to produce adequate data collection, 13 current SAP data collection forms located in the residences were selected by choosing the top or first data collection book from the storage location in each residence visited and reviewing the current form for the first SAP listed. These 13 data forms included Individuals #19, #56, #68, #235, #284, #417, #515, #526, #569, #576, #600, #669, and #729. Of the 13 data forms reviewed, two (Individuals #235 and #515, 15%) reflected correctly recorded and complete data. This appeared to substantiate concerns about the adequacy of SAP data collection instructions. Additional substantiation was reported in Provision S3a for this same sample; considering just whether the data were current (and not considering whether they were correctly recorded), 54% of sampled data recording forms had current data. As reported in Provision O7, aspiration trigger sheets were not consistently completed with documentation when triggers occurred. On the other hand, it was rare to find a late nursing entry; late entries were consistently documented correctly. <u>IPNs Indicate The Use Of The Record In Making These Decisions (Not Only That There Are Entries Made)</u> The URCs reported that they review Integrated Progress Notes (IPNs) as part of the audits. They determine what disciplines documented in IPNs and review whether reports and consults show that action was taken as planned, such as whether an IPN documents about a consultation. They do not have specific definitions but use this information to answer this item on the Section V monitoring tool, with a focus on	

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		whether IPNs show communication between various disciplines. The Self-Assessment reported that IPNs in 42 of 60 records reviewed from 8/1/13 to 1/31/14 (70%) indicated that staff routinely used the records to make decisions. As the Self-Assessment concluded, improvement is needed. It might be useful for the Facility to provide guidelines for the IPNs that would be useful not only for audits but also for training staff on what should be documented in IPNs to verify that information from records is used for making decisions. <u>Staff Surveyed/Interviewed Indicate How The Unified Record Is Used</u> Each URC is expected to complete one interview tool per month. Selection is from the random audits, but selection of the specific individual is not random; the URCs attempt to ensure each unit is checked periodically. Also, one of the two is selected from among those records for which a program monitor conducted an audit for inter-rater reliability. A program monitor accompanies the URC for that individual and independently rates. 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. Interviews are conducted in person or by telephone, using the Settlement Agreement Provision V.4—Interview Tool for use of the Record. The URC generally selects two interdisciplinary team members to interview. The Facility provided three interviews done as part of the random audits for January and February 2014 for Individuals #184, #465 and #584 (the Facility reported the second interview for February did not occur). • For Individual #184, the document listed the QIDP and one clinician. Although both were rated as indicating the record is used when making decisions, summaries of answers to the questions on the tool were only provided for the QIDP, whose answers did describe use of the record in making decisions. • For Individual #465, the document provided summaries of responses by the QIDP and one clinician. Both were rated as indicating the record is used, and both described details of information from the record that were considered in making specific decisions. • For Individual #584, the document provided summaries of responses by the QIDP and one clinician. Both were rated as indicating the record is used, and the clinician described details of information from the record that were considered in making specific decisions. The interviews indicated staff use of the records. However, as noted in the last report, interviewing a more varied set of clinicians might give a more representative sample. The Self-Assessment reported that nine of 10 Interview Tools (90%) conducted from 8/1/13 to 1/31/14 indicated that staff routinely use the records to make decisions; the	

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		Self-Assessment also summarized and provided examples of responses given to questions. Interviews conducted at prior compliance visits consistently found that staff could report that records were used and could give examples of how they were used. During this visit, the Monitoring Team discussed use of records with two QIDPs but did not interview. If this were a standalone requirement, it would be rated as in substantial compliance. <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 meetings for Individuals #675 and #718, the ISP Preparation meeting for Individual #501, and a Grand Rounds addressing Individual #227 to assess whether and how the unified record was used. At the meeting for Individual #675, the record was present. The record was referred to for results of a medical diagnostic test, and information from the record was discussed regarding the individual's response to community outings, progress on one skill acquisition plan, and injuries. In general, discussion of most issues included objective information rather than general impressions. There were some issues for which a report of data rather than impressions or inferences would have been useful, such as progress on behavior programs and number of community outings attended. Some issues raised in assessments were discussed, but others were not. For example, information about risk versus benefit of surgery for gallstones was provided, and the individual's status and need for monitoring of pain was discussed; the need to consider oral motor therapy, identified in a different assessment, was discussed. The need identified in an assessment for discussion at the ISP meeting of an interdisciplinary approach to management of CP was not mentioned in the meeting, nor were recommendations for an interdisciplinary approach for management of constipation. The Monitoring Team did not observe the record being present at the meeting for Individual #718. At the meeting for Individual #501, the record was present. The record was referenced regarding a skill acquisition plan, and data on incidents and on some lab reports were read. The IDT referred to the record when discussing the individual's history of urinary tract infection (UTI). Data provided for incidences of urinary tract infection were from the 2012 annual nursing assessment, not from more recent information in the record; members of the IDT questioned this, and the record was referenced for more current information. In this case, one staff member clearly did not use information that was current in the record; other IDT members not only questioned the data but checked the	

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		record and reconciled the information. Nonetheless, it remained unclear what the actual incidence of UTI had been. The RN Case Manager at the meeting noted on several occasions that she was fairly new to working with the individual and the only prior nursing assessment she could find was a quarterly version from December 2012. The IDT did agree to research the issue and hold an addendum meeting to resolve. During the remainder of the meeting, the IDT tended to be imprecise. For example: • In a discussion as to whether the individual had a diagnosis of dementia, staff indicated that there was not such a diagnosis, but the individual was "status quo" in this regard, even though regression had been noted. There was no further discussion of what "status quo" actually meant. • There was a discussion about a Service Objective (SO) the individual's use of hand splints and a question as to whether the individual was on a sensory motor program. The Habilitation Services staff present at the meeting stated he was "not the person to answer," as he did not typically work with the individual. The IDT did not consult the record to see if it could ascertain the status. • The RN Case Manager continued to make generalized statements such as the individual was "at the age when everything declines" and that the individual had been "more or less stable." She also noted she had not "heard anything" about incidents of constipation. At the Grand Rounds, the record was present. Data on falls and seizures were reviewed and discussed. Information from a consult was provided. <u>Conclusion</u> This provision is not yet in substantial compliance. Although most information is accessible, accurate use of the checkout system needs improvement. Documents in records were not consistently current, and there were several examples of documents not filed timely. There were also a few lapses in documenting timely in the record. Although staff were able to describe how they used the records for decision-making, actual use of the records in interdisciplinary meetings was improved but variable.	

List of Acronyms

Richmond State Supported Living Center

March 3-7, 2014 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
LTAC	Long Term Acute Care Facility
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
PCA	Program Compliance Auditor
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
PMR-SIB	Protective Mechanical Restraint for Self-Injurious Behavior
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