United States v. State of Texas

Monitoring Team Report

Richmond Supported Living Center
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Introduction

Background

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

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

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

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

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

Methodology

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

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

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

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

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

Organization of Report

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

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

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

Substantial Compliance Ratings and Progress

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

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

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

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

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

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

Executive Summary

As always, the Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators of the Facility for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The Facility Director, Mr. Barrera, was extremely supportive of the Monitoring Team's activities throughout the week of the compliance visit. The Facility made available to the Monitoring Team and number of staff members in order to facilitate the many activities required, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The Monitoring Team greatly appreciates all this assistance from staff throughout the Facility. The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Judy Miller, and the staff who assisted her to keep up with all our requests, especially Susan Steamer, Eileen Holmes, Sameena Zaidi, Brad Hines, Alice Ramirez, and Melissa Salinas. 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.

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. The Facility provided several examples in which it had considered recommendations and ideas presented by the Monitoring Team both in the last compliance report and in discussions during the last visit, and had developed or revised practices.

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. For some Sections and provisions, the Facility provided a rating that was consistent with that found by the Monitoring Team, but the rationale for the rating was unrelated or in addition to the information and data presented in the Self-Assessment; it would be good to include assessment of the specific issues that affected the Facility's decision on whether to find compliance. 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 had expanded use of its internal quality assurance processes and should continue to seek ways to tie self-assessment to these measures, including the development of additional measures to assess ongoing progress toward completion and report the actual outcomes. The Facility should continue to expand on use of information from its QA/QI reviews so that its assessment of status is part of routine practice.

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. For a few provisions, the Facility provided a list of ongoing activities the Facility must maintain in order to maintain compliance and improvements that have been made in services and supports; these listings are important in ensuring the Facility continues to implement those important activities. It also separates those from new actions that remain needed. This change in format is useful.

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

The Facility continued to make progress in achieving compliance with respect to restraint use for crisis intervention but still struggles to implement administrative and clinical practices necessary to achieve compliance with restraint use for medical and dental procedures. Recently initiated processes should help in this regard.

- Positive Practices and Improvements Made
    - The downward trend of use of crisis intervention restraint, as reported in the last several reviews, had continued. The Facility did not use protective mechanical restraint for self-injurious behavior (PMR-SIB).
    - Complete and proper documentation of crisis intervention restraint use improved significantly.
    - No use of prone restraint was identified.
- Improvements Needed
    - Review of restraint episodes improved but had not as yet achieved a level of substantial compliance.
    - Documentation associated with the use of medical restraint remained problematic. The Facility had initiated important actions to improve documentation associated with medical restraint. Compliance with Settlement Agreement requirements associated with the use of medical restraint (unrelated to documentation) remained problematic but improvement was observed over that reported in the last review.
    - Most individuals still lack needed plans to reduce the need for pre-treatment sedation.

Abuse, Neglect and Incident Management

Since the last review the Facility has a new Incident Management Coordinator. This person started as the new IMC just several days before this review. For several months the position was filled on an acting basis by one of the Facility investigators. It is likely that some of the deficient practices noted in this report occurred because of this turnover in IMC leadership.

- Positive Practices and Improvements Made
    - 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
    - Many serious incidents included in the sample by the Monitoring Team were not reported timely. Only six of 15 were reported timely.
    - Many staff were unaware of basic abuse and neglect reporting responsibilities. Training for staff on abuse and incident reporting was in place, and all staff was current in that training; however, staff knowledge of abuse/neglect reporting requirements needed improvement.
    - The number of confirmed cases of abuse/neglect (comparing six-month periods) doubled and the number of serious injuries increased significantly.
    - Required injury audits were completed for only four of the last five months.
    - Injury reports associated with serious incidents were often not completed correctly and fully.
    - The Facility did not complete many of the recommendations made in reviewing investigations.
    - There was insufficient documentation to validate that all investigations began with the required 24 hour timeframe.
    - There was insufficient documentation to validate that all investigations had a clear basis for the conclusions reached by the investigator.

<u>Quality Assurance</u>

The Facility Quality Assurance (QA) process had improved significantly from that observed at the last review. In its last review the Monitoring Team noted that the QA program was in the early stage of development. For this review the Monitoring Team would characterize the QA program as in the early stages of implementation. Moving from development to implementation was an important step.

- Positive Practices and Improvements Made
    - Documentation and observation indicated that QA staff assisted each discipline in analysis of data. The QA Director and Settlement Agreement Coordinator met monthly with each SA Section Lead for this purpose.
    - The Facility's QA process reviewed by the Monitoring Team demonstrated improved consistency among and between departments/disciplines in the organization and collection of data, review and analysis of data, interaction

between the QA Department, Settlement Agreement Coordinator (SAC) and section leads, and presentation and review of data by the QA/QI Council.

- Improvements Needed.
  - During the review entrance conference when section leads briefly highlight accomplishments six different section, leads identified QA components within their section but these were apparently unknown to the QA department and/or were not contained in policies directed at those sections and/or were not yet integrated into the Facility's overall QA program. Although it is appropriate for disciplines and section workgroups to identify and track quality assurance measures that might not routinely be reported to the Facility as a whole, the presence of these should be reported to ensure that there is not duplication or inconsistency across measures.
  - In the QA/QI Council meeting observed by the Monitoring Team, considerable data was presented to the group but there was very little discussion of the data, any implications (good or bad), and whether any of the data suggested a need for a CAP or any other administrative./clinical response. There was little evidence in observation of this meeting, or in review of minutes of other meetings, that discussion at QA/QI Council led to decision-making and action planning. Recommendations and corrective action plans were seldom developed as a result of data presentation and review at the QAQI Council.
  - The Facility's processes for initiating, implementing, and tracking CAPs was still lacking good organization and was not integrated into QA/QI Council practices and protocol. CAPs were not always developed for issues for which data suggested a need for a CAP. The criteria for the development of a CAP were not clear. The Facility had not as yet developed an administrative review process to determine whether each of its nine CAPs had been implemented fully and timely.

<u>Integrated Protections, Services, Treatments and Supports</u>

The Facility again requested the Monitoring Team focus its observations on selected ISP planning meetings and ISP Preparation meetings held during the monitoring visit, and the resulting ISPs,. 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 for 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
  - There were examples of improved coordination of services at the Facility as well as a degree of improvement in integration observed in on-site planning meetings.
  - The Facility was continuing to develop its 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.
- Improvements Needed

- IDTs still failed to consistently conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. Facilitation continued to provide mixed results.
- The Facility needs to make efforts to develop and subsequently implement the ISP in accordance with the Americans with Disabilities Act (ADA) and Olmstead decision.
- 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 yet reflect encouragement of community participation in a meaningful or purposeful manner, although some progress was noted.
- Identification of barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies.
- ISPs were not implemented as written, nor was monitoring of progress effective.

<u>Integrated Clinical Services</u>

Although there is still a need for increased integration of clinical services, the Monitoring Team commends the Facility for a significant shift in the way clinical disciplines work together. As new procedures mature and clinicians gain experience in collaborative activities, integrated planning should improve. If the collaborative work evidenced over the last two compliance periods continues to increase, the Facility should approach substantial compliance with the requirements of this provision in the near future.

- Positive Practices and Improvements Made
  - The Facility had recently implemented an Integrated Clinical Services policy.
  - The Clinical Morning Report meeting continued to include participation of a wide range of clinical disciplines as well as residential services, and participants were more interactive, and more assertive in raising questions and solutions to clinical issues.
  - The Medical Grand Rounds continued to provide integrated review of individuals who are experiencing a significant medical and/or behavioral issue.
  - Processes for review of consultations by Facility clinicians are defined in policy and are implemented consistently. Reviews by Facility clinicians of consultations were timely and documented agreement with recommendations.
  - The Facility had an effective process in place to track information on consultations at the level of the individual consultation, including information on acceptance of recommendations and on IDT follow up.
- Improvements Needed
  - The Facility must make additional progress toward involving multiple disciplines in addressing in the ISP specific needs and preferences of individuals.

- Attendance at annual ISP planning meetings, one forum for integrated planning to address needs and preferences and to establish services, was variable across disciplines.
- Although consultation documentation did not indicate referral to the IDT, the Facility had appropriate processes in place to facilitate documentation of review of recommendations from non-facility clinicians by the IDT when appropriate, and provided evidence that this occurred.

Minimum Common Elements of Clinical Care

Although no provisions of this Section achieved substantial compliance, the Monitoring Team would like to commend the Facility for significant progress, particularly in Medical Services and in the development of databases that provide extensive information and could be useful in assisting other clinical disciplines to meet the requirements of this Section.

- Positive Practices and Improvements Made
  - A new Facility process for meetings 15 days prior to the annual ISP planning meeting has potential to improve review of assessments and their use in decision-making.
  - Medical diagnoses were consistent with the ICD classification system and clinically fit corresponding assessments.
  - The Facility had developed clinical pathways for several chronic health conditions. For several pathways, clinical indicators of health status had been identified based on review of national standards and review of professional literature. Databases had been developed to track these clinical indicators for individuals and to provide both individual and aggregated reports that were assessed to evaluations of trends. Trend analyses 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. The Monitoring Team commends the Facility for this remarkable system.
  - The Physician Quarterly Review, which had been revised to require review of information from the Nursing Quarterly Review and now using a standard template for documentation and requiring physical examination, promotes frequent monitoring of the status of each individual. Nursing quarterly assessments similarly ensure monitoring of health status.
  - Policies were in place regarding timeliness of assessments. The Facility had also developed policies that included requirements for integrated clinical services, as well as for use of clinical indicators of chronic health conditions.
- Improvements Needed
  - Timeliness of routine assessments needs improvement, as assessments required to develop an appropriate ISP were still not consistently completed in time for IDT members to review before the meeting.
  - Comprehensiveness of assessments had improved for several disciplines and were compliant with standards in some areas, but some required assessments needed further improvement. Examples were found both of use of information from assessments and lack of such use.

- Psychiatric diagnoses were consistent with the DSM IV classification system but differed across the psychiatry department database and the active problem lists for individuals. Diagnostic justification was not consistently found in comprehensive psychiatric evaluations.
- Although there were examples of timely implementation of treatments and interventions, there were examples in which these were not timely or in which the Monitoring Team could not determine (and the Facility could not track) whether these were or were not timely.
- Outside of medical care, the use of clinical indicators had progressed but was not yet consistent across clinical disciplines.
- For some clinical disciplines, there was not consistent monitoring of health status and of effectiveness of treatments and interventions. The QIDP Monthly Review process was not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development. Content of the reviews seldom provided meaningful evaluation of progress.
- Further development of policy is needed to address 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.

<u>At-Risk Individuals</u>

The Facility's efforts to move towards compliance with Section I of the Settlement Agreement had progressed in some areas and regressed in others. For example, as reported in Provision I.3 for eight metrics assessed by the Monitoring Team Facility compliance scores improved in five instances and regressed in three instances. The Facility had implemented or refined several administrative processes since the last review, most notably the implementation of a "15 day" pre-ISP meeting to review the IRRF and IHCP.

- Positive Practices and Improvements Made
  - 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.
- Improvements Needed
  - The Facility's management system to identify individuals whose health or well-being is at risk still lacked consistency in implementation although improvement in many areas was noted.
  - Interdisciplinary discussion of clinical data was, for the most part, not evident.
  - The quality and comprehensiveness of plans to address risks 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 was limited due to the absence of the Facility's Lead Psychiatrist, who was deployed to active duty. In his absence, psychiatric staffing was maintained by two contract psychiatrists (both of whom had the required qualifications and experience) who worked under the guidance of the Medical Director. Most processes remained in place, but there was little progress toward additional compliance. Individuals who required comprehensive psychiatric assessments continued to receive them, and psychiatrists started to do annual reviews of those assessments. Reiss Screen procedures remained in place for new admissions and for change of status evaluations.

- Positive Practices and Improvements Made
    - All individuals who are seen by psychiatry had CPEs in place.
    - Data provided by the Facility showed a reduction in the amount of psychiatric polypharmacy since the last visit and reflected continued Facility efforts to minimize the use of psychiatric polypharmacy.
    - Interdisciplinary review of medications used for both epilepsy and psychiatric symptoms continued.
    - 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 addressed side effects and side effect screenings, medication interactions, laboratory reviews and suggestions.
- Improvements Needed
    - Annual reviews of the CPE had just started (a positive finding) and were in place for only six individuals. The Facility should maintain this process.
    - Although the clinical record cited diagnoses in the Diagnostic and Statistical Manual (DSM) format, different sections of the chart sometimes continued to cite different diagnoses.
    - Behavioral treatment programs do not provide needed information about psychiatric treatment and the role of psychotropic medications. Planned introduction of Psychoactive Medication Treatment Plans (PMTPs) to help link diagnoses, treatments, and monitoring for efficacy was delayed.
    - Approximately 35% of CPEs remained to be done in the required Appendix B format.
    - CPEs for individuals who had positive Reiss Screens were not always done in a timely manner.
    - MOSES and DISCUS screens administered by nurses were sometimes not done with the required frequency, screens that were done were often not reviewed by physician in a timely manner, and the required physician review section of the screen was not completed in many cases.

<u>Psychological services</u>

There was turnover in the position of Behavioral Services Director since the last compliance visit. The new Behavioral Services Director meets the requirements of the Settlement Agreement. The Facility demonstrated both numerous areas of improvement and lack of progress in other areas.

- Positive Practices and Improvements Made
    - Although the number of BCBAs had decreased, the percentage of staff either holding or actively pursuing Board Certification had increased to 93%.
    - The new administrator of the Behavioral Health Services department possessed board certification as a behavior analyst.
    - Behavior assessments reflected substantial improvement in several areas and adhered more closely to accepted practices.
    - Behavior assessments reflected careful consideration of issues involving challenging behavior and mental illness.
    - Behavior interventions reflected many areas of improvement, including operational definitions, use of accepted assessment procedures, identification of potential functions, and the inclusion of replacement behavior training.
    - Readability statistics for behavior interventions reflected that interventions were written in accessible language.
- Improvements Needed
    - There were considerable weaknesses in the internal and external peer review process. More than one quarter of individuals with behavior intervention plans had not been reviewed in over a year.
    - It was not evident that the Facility maintained adequate procedures for monitoring the psychological assessment process and ensuring that all individuals received the necessary assessments.
    - Behavior assessments did not consistently address establishing operations or setting events.
    - Due to the limitations noted regarding the assessment of establishing operations and setting events, it was frequently unclear whether behavior interventions included adequate procedures for avoiding challenging behaviors.
    - There was no evidence that the Facility had processes in place to provide direct contact staff and their supervisors with competency-based training on Positive Behavior Support Plans (PBSPs).

<u>Medical Care</u>

The Facility has made marked improvement since the last compliance visit. The Facility has continued to expand clinical pathways based on national standards and literature, and databases to track the clinical indicators of health status included in the pathways.

- Positive Practices and Improvements Made
    - The Facility demonstrated exemplary follow-up to acute medical conditions; ensured comprehensive review of the qualifying condition for DNR orders; ensured appropriate management for pneumonia, acute management of fractures, and management of malignancy; ensured influenza vaccination was provided; and provided assertive preventative health care management by ensuring screening for prostate and breast cancer.
    - Through the use and regular review of clinical indicators, the Facility has improved monitoring of health status for several chronic health conditions.

- The Facility developed, implemented, and reviewed efficacy of its processes to assess clinical performance of practicing medical providers. The Facility enhanced and expanded on the external medical quality assurance audit by including review of clinical indicators and audits of compliance with standards identified in clinical pathways.

- Improvements Needed
  - Improvement is needed in screening, diagnosis, and management of osteoarthritis.
  - The Facility must continue to further develop medical policies, procedures and guidelines for all of its clinical practices, and ensure that they are substantially implemented and clinically efficacious.

Nursing Care

The Facility continued to make significant progress toward achieving compliance with the requirements of this Section. This was evidenced by progressive improvement found by the Monitoring Team's review of records, interviews with responsible nursing staff, and through observations. The Facility had implemented corrective action plans (CAPs) to address issues such as notification of primary care providers (PCPs) to ensure the nursing staff documented their assessments in the Integrated Progress Notes on individuals' acute change in health status from baseline, as well as the information communicated to the PCPs. If this and other self-initiated corrective actions put in place are continued and show effectiveness most provisions could be found in substantial compliance at the next review.

- Positive Practices and Improvements Made
  - The Nursing Department continued to maintain a stable and highly motivated nursing staff.
  - The Infection Control, Skin Integrity and Emergency Response Committees continue to be to show integration and active participation with other relevant disciplines. The Facility maintained processes to track, trend and analyze Infection Control and Skin Integrity data.
  - The Nursing Department continued to self-identify and self-initiate corrective action where areas of deficiencies were found.
  - The Nurse Educator continued to maintain a robust competency based educational program that tracked all required training to ensure the training was completed.
  - There was evidence through interviews with nursing administration and management staff, and individuals' records reviewed that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed sufficient to meet individuals' health care needs.
  - The Facility had a robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances.
- Improvements Needed
  - There remained the need for continuous improvement to ensure Acute Care Plans were consistently followed through to resolution with resolution notes documented in the Integrated Progress Notes and on the care plan.

- The RN Case Managers need to ensure that all relevant information is contained in the Community Placement Transition Packets and that all training provided to the agency providers is listed on the In-service Training Sheets.
- The Integrated Risk Rating Form and Integrated Health Care Plan processes were still evolving and will require Facility-wide improvement to achieve substantial compliance with Provision M5.

Pharmacy Services and Safe Medication Practices

The Facility has continued to make significant improvements towards substantial compliance with Provision N.

- Positive Practices and Improvements Made
  - Each Quarterly Drug Regimen Review (QDRR) reviewed was noted to be comprehensive, and clearly delineated issues related to medication usage.
  - The Facility has made substantial improvements with its assessment of benzodiazepine, anticholinergic, and polypharmacy review by the pharmacists, and the pharmacists' review of metabolic syndrome and stat chemical restraint usage.
  - Pharmacists completed a single patient drug intervention (SPDI) report for individuals identified as having drug-drug interactions or other clinical concerns regarding the prescribing of drugs. The medical providers addressed the pharmacist's recommendations in a substantial majority of cases.
  - The Facility does have a mechanism in place to identify, report, and assess adverse drug reactions (ADRs); however, the Monitoring Team is very concerned that the numbers of reported ADRs had significantly decreased since the previous compliance report, and that in most cases (90%) the pharmacist was the reporting professional. The P&TC meeting minutes indicated concern over the small number of ADRs reported, which reflected a meaningful review of the ADR process, and the Monitoring Team is complimentary of the P&TCs vigilance in attempting to ensure ADRs are reported. It will be essential, for continued finding of compliance, that the Facility ensures that staff are carefully assessing individuals for signs and symptoms of adverse drug reactions, and promptly reporting them as ADRs.
  - The Facility maintained an effective drug utilization evaluation (DUE) process that enabled scheduled DUEs to be developed per request of the medical staff, developed unplanned DUEs that were based on institutional need, had a process to monitor for FDA advisories, and is prepared to develop and implement DUEs for FDA product warnings.
  - The Facility had continued to implement its medication variance process, and ensured a robust reporting process, conducted efficacious Medication Variance Committee meetings, and addressed 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.
- Improvements Needed

- MOSES and DISCUS assessments used by the pharmacist were not regularly completed by the prescribing medical provider. It is essential that the clinical pharmacist review the prescribing medical provider's comments, and diagnosis on the MOSES and DISCUS assessment reports. Furthermore, there was no indication that that the psychiatrist reviewed the QDRRs, when the QDRR included review of psychotropic medications.
- The Facility needs to develop processes to ensure that metabolic risk factors are carefully assessed by the clinical pharmacists, including those risk factors, such as blood glucose levels, that are normalized because of current treatment; and to ensure that common and serious risks associated with anticholinergic, polypharmacy, and benzodiazepine usage are well documented by the clinical pharmacist.
- The Facility should develop a mechanism for the psychiatrist to document a formal post chemical restraint assessment.
- The Facility must ensure that the psychiatrists document their review of the QDRRs and acceptance of the pharmacist's recommendations, or provide clinical rationale for not following the pharmacist's recommendations.

<u>Physical and Nutritional Management</u>
Overall, significant improvement was noted throughout all provisions. The PNMT continued to improve their process as well as their assessments. 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.

- Positive Practices and Improvements Made
  - PNMPs showed significant improvement and contained 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.
  - 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 PNMT had a sustainable system that was fully implemented for resolution of systemic issues/concerns. All areas related to PNM were now effectively tracked and analyzed.
  - PNMPs contained all the required components in the areas of dining, medication administration, bathing, personal care, and lifting/transfers. PNMPs across the various locations (i.e., MARs and "Me" books) were consistently and appropriately updated.
  - 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.
- Improvements Needed

- Although staff had improved their knowledge of the plans and why the proposed strategies were relevant to the individuals' well being, implementation continued to be a concern.. Staff was observed not consistently implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were not consistently provided with safe dining or positioning strategies, although improvement was noted especially as it related to positioning in bed.
- 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. 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. A proportionate number of monitors were focused on all areas in which PNM difficulties were likely to be provoked. Also noted upon review of the monitoring data was the inclusion of all three shifts in the monitoring process. Although substantial retraining of staff had occurred, the acquired data showed compliance and implementation of plans as being significantly higher than what was noted by the Monitoring Team. These disparities in scores again bring into question the reliability and/or effectiveness of RSSLC to identify and intervene when plans are not implemented.
- 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.
- 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.
- Individuals were not consistently provided with clear treatment plans as it relates to oral motor therapy. Information regarding medical necessity and potential for oral intake was not consistently present in the IRRF and IHCP.

<u>Physical and Occupational Therapy</u>

Overall, there continued to be improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at RSSLC. The parties agreed the Monitoring Team would not monitor Provision P.1, because the Facility was in substantial compliance for more than three consecutive reviews; review of data provided by RSSLC from audits of assessments continued to show the presence of all the needed assessment components. Therefore, the finding of substantial compliance continues.

- Positive Practices and Improvements Made
  - Assessments continued to improve and did a respectable job in providing a comprehensive review of the individual.

- All staff, new and existing, received both foundational as well as individual specific training. Greater than 95% 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.
- Adaptive equipment and wheelchairs were largely in good repair and a system was in place to ensure they remained so.

- 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.
  - Disparities in percentages of compliance found in monitoring by the Facility versus Monitoring Team observations bring into question the reliability and/or effectiveness of monitoring in identifying and intervening when plans are not implemented.

Dental Services

The Facility continued to make significant progress towards substantial compliance. It was obvious to the Monitoring Team that the dental office developed and implemented many new strategies to enhance documentation practice, which in turn demonstrated the Facility's provision of high quality dental service.

- Positive Practices and Improvements Made
  - The Facility provided annual dental examinations, dental hygiene, provision of restorative treatments, application of suction tooth brushing, and of oral health care at the living area at a level of generally accepted practice.
  - The Facility developed a robust database mechanism to help ensure effective tracking and trending of past and future dental appointments, developed an effective process to track missed dental appointments, and developed a committee process to evaluate the Facility's usage of pre-treatment sedation.
- Improvements Needed
  - There was no evidence provided to support the living area, or dental office's effort to triage, manage, and follow-up on dental emergencies.
  - There was improvement in provision of dental imaging, but the Facility did not provide clinical rationale for not adhering to the ADA's recommendations for dental imaging studies.
  - The Facility should ensure that the IDT is informed of when dental services are not provided as necessary, such as failure to obtain dental imaging studies and other dental support services, so that the IDT can help develop mechanisms to overcome barriers that prevent dental services.
  - The Facility must develop a policy that clearly delineates its process to help reduce the need for pre-treatment sedation, ensure that all individuals who require pre-treatment oral sedation have been identified, and develop individualized plans to help reduce the need for pre-treatment oral sedation.

Communication

RSSLC showed overall improvement with Provision R. In general, the issues requiring improvement involved transfer of information from assessments into functional and meaningful goals, and implementation of planned augmentative communication and environmental control.

- Positive Practices and Improvements Made
  - Assessments continued to become more comprehensive and provided a much clearer picture of the individuals' level of functioning.
  - A comprehensive Speech Policy existed that included but was not limited to information regarding staffing effectiveness, assessment schedule, IDT attendance expectations, and monitoring guidelines.
- 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.
  - 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 and integrated as part of the ISP.
  - Communication strategies and programs were not consistently integrated into the ISP. DSPs interviewed were not knowledgeable of the communication programs.

Habilitation, Training, Education, and Skill Acquisition Programs

Almost all areas related to this Section showed no improvement. The Facility needs to focus efforts on both improving the quality of skill acquisition programs (SAPs) and on increasing the emphasis on providing training opportunities in community settings.

- Improvements Needed
  - Skill acquisition programs (SAPs) typically did not reflect needs identified in assessments or the ISP.
  - The components of skill acquisition programs were often insufficient to ensure that training could be conducted consistently or in a manner likely to provide meaningful improvements in skills and abilities.
  - Substantial declines were noted in the provision of functional engagement.
  - Documentation reflected that skill acquisition data frequently were recorded incorrectly and that skill acquisition programs were often not implemented according to the schedule in the program instructions.
  - Community outings had dropped by more than 50%.

Most Integrated Setting

Although the review noted positive developments, more work remained to ensure transitions were effectively planned and successfully implemented. The Post-Move Monitor (PMM) position was vacant at the time of the visit, which might have affected timeliness of completing PMM checklists. Seven individuals had transitioned to community living and there were 17 active referrals. The Department of Admissions and Placement staff, including a Placement Coordinator, 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.

- Positive Practices and Improvements Made
  - The Facility had also revised its policies to ensure routine IDT review of PMM visits, and enhanced certain quality management procedures.
  - The Facility 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.
  - Ongoing implementation of a Grand Rounds process for reviewing CLDP assessments in advance of the actual CLDP meeting provided an opportunity to identify any questions, concerns, or discrepancies that might need to be addressed.

- Improvements Needed
  - RSSLC 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 his or her 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.
  - CLDPs did not yet adequately reflect the protections, services and supports an individual would need to make a successful transition to community living. RSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDPs, particularly because the CLDPs did not yet provide adequate monitoring parameters for the Post-Move Monitor to reference.
  - Post Move Monitoring Checklists were not as consistently completed in a timely manner as in the past.

Consent

There had been little action or progress in this Section since the last time it was reviewed, with the exception of the creation of an electronic database for tracking guardianship requests and prioritization. This was a helpful management tool that will take on additional importance once the Facility implements a standardized tool, process. and/or methodology for IDTs to use

to assess and prioritize the need for a Legally Authorized Representative (LAR), an advocate, or other assistance an individual might need in decision-making.

- Positive Practices and Improvements Made
  - The Facility did maintain a list of individuals without a guardian.
- Improvements Needed
  - Although the Facility maintained a list of individuals without a guardian, not all individuals on the list had yet been assigned a priority.
  - DADS policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized tools, process and/or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate, or other assistance an individual might need in decision-making. Facility IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria or process. This remained the most significant barrier to achievement of substantial compliance for this Section.
  - The Facility's Guardianship Committee had met on two occasions since the last monitoring visit, but the minutes did not reflect significant ongoing actions and deliberations. The Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. These data were not adequately reflected in the ongoing minutes and provided little follow-up information from one meeting to the next.

<u>Recordkeeping and General Plan Implementation</u>
The Facility maintained a unified record for each individual. Prior improvements were maintained, including a comprehensive and robust random record audit process.

- Positive Practices and Improvements Made
  - The Facility had established a more sensitive measure that rates compliance with Appendix D requirements on each required document; compliance rates were higher on this tool and approached an acceptable level of compliance.
  - Processes for development, revision, and implementation of policies were in place.
  - The audit system is robust, comprehensive, and sets high standards for finding compliance. Ten random audits are conducted each month (doubling the requirement in this provision), and these are supplemented with additional audits of specific items in the record. Reliability across auditors is adequate.
  - 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.
- Improvements Needed
  - Percentage of required documents found present remained similar to that found at the last compliance visit; improvement remains needed.

- Improvement found for the last compliance period in consistency with Appendix D requirements as reported on the Section V Monitoring tool were maintained, but not improved, during this compliance period.
- There remains a need for policies to address a few requirements of the Settlement Agreement (note, for example, the requirement reported in Section U for a policy or process to assess capacity for decision-making).
- The Facility needs to ensure all staff who are required to have training on new or revised policies receive consistent training.
- 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.
- 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 identified by the Facility or Monitoring Team.
- Although staff were able to describe how they used the records for decision-making, actual use of the records in interdisciplinary meetings continued to improve but remained variable.

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

Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment 8/12/14 2. RSSLC Action Plan 8/11/14 3. RSSLC Section C Presentation Book 4. DADS Policy 001.2: Use of Restraint 4/4/14 5. RSSLC Policy J.1: Use of Restraint 5/19/14 6. Facility training materials for restraint monitors 7. Sample C.1: 10 crisis intervention restraint records and related documentation. This consisted of 19% of the crisis intervention restraints reported by the Facility as having occurred between 3/9/14 and 6/30/14. This included restraint of seven different Individuals, including the two most frequently restrained Individuals. 8. Sample C.2: 18 medical restraint records and related documentation. This consisted of 15% of the medical restraints reported by the Facility as having occurred between 3/9/14 and 6/30/14. 9. Sample C.3: records and related documentation associated with use of chemical restraint for crisis intervention. This sample of three represented 50% of the chemical restraints between 3/9/14 and 8/25/14. 10. Sample C.4: documentation associated with those Individuals restrained four or more times within a rolling 30 day period 11. Sample C.5: staff training records of 24 direct support professionals (DCPs). Staff selected were those who had applied restraint and/or been involved in investigations of abuse/neglect. 12. Sample C.6: documentation associated with 13 individuals who use abdominal binders (Individuals #16, #73, #77, #192, #228, #259, #388, #500, #523, #570, #621, #651, and #787) 13. State report "Percent of All Employees Completing Courses of Training Program" 8/1/14 14. Restraint related monitoring/QA forms and reports 15. Crisis Intervention Restraint log 2/1/14 to 6/30/14 16. Medical Restraint log 2/1/14 to 6/30/14 17. Facility Restraint Trend Analysis 7/13 **People Interviewed:** 1. Maryam Majlessi, M.ED, LPC, BCBA –Director of Behavioral Services 2. Pat Newell, Behavior Health Specialist 3. Roxy Wolf, Behavior Analyst I 4. Monica Labrie, Behavior Analyst 5. Donna Honeycutt, Security Officer 3 6. Eddie Borak, Security Officer 3 7. Cheryl Luna, DSP 1 8. Sandra Jackson, DSP 2

	9. Alfreda Aldridge, DSP 1 10. Ten Direct Support Professionals (DSPs) **Meetings Attended/Observations:** 1. Incident Management Team meeting (IMRT) 8/26/14 and 8/27/14 2. Administrative Review Team (ART) meeting 8/26/14 and 8/27/14 3. Four Rivers Unit morning meeting 8/26/14 4. Quality Assurance/Quality Improvement (QA/QI) Council 8/25/14
	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 111 crisis intervention restraints that occurred between 1/1/14 and 6/30/14. The self-assessment also did not report the use of any inter-rater reliability in its assessment of restraint practices and documentation although in interview the Director of Behavioral Services reported IRR was part of the Facility self-assessment. 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 other than the presentation in the self-assessment document. ○ While the Monitoring Team believes the Facility self-assessment produced, for the most part, reliable results looking at reliable indicators, the Facility should use a more formalized system such as using the Monitoring Tools already completed by the Behavior Services Department and the QA Department. ○ 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 clarified this in interview), the Facility presented data in a useful way. Specifically, the Facility's Self-Assessment: ○ Presented findings based on specific, measurable indicators. ○ Measured the quality as well as presence of items. ○ Did not, however, distinguish data collected and analyzed 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 reported it had a process to compare audit results from the QA Auditor with audit results from the Behavioral Services Department. • The Facility rated itself as being in compliance with Provisions C.2 and C.3 of Section C. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in

	compliance with Provision C.1, C.2 and C.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 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. For those Provisions determined to be in noncompliance by the Monitoring Team, the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome 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: The Facility continued to make progress in achieving compliance with respect to restraint use for crisis intervention but still struggles to implement administrative and clinical practices necessary to achieve compliance with restraint use for medical and dental procedures. Recently initiated processes should help in this regard. The downward trend of use of crisis intervention restraint, as reported in the last several reviews, had continued. When comparing the two most recent six-month periods the number of crisis intervention restraints decreased from 162 (an average of 27/month) to 105 (an average of 18/month). The Monitoring Team was able to confirm that the Facility did not use protective mechanical restraint for self-injurious behavior (PMR-SIB). Complete and proper documentation of crisis intervention restraint use improved significantly. Complete and proper review of restraint episodes improved but had not as yet achieved a level of substantial compliance. Documentation associated with the use of medical restraint remained problematic. The Facility had initiated important actions to improve documentation associated with medical restraint. Compliance with Settlement Agreement requirements associated with the use of medical restraint (unrelated to documentation) remained problematic but improvement was observed over that reported in the last review.

	Staff knowledge, as demonstrated through answering seven questions, remained acceptable. 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. Video surveillance tapes that had recorded a horizontal restraint episode were used with regularity as part of the restraint review process. Most individuals still lack needed plans to reduce the need for pre-treatment sedation. This is a major impediment to compliance with Provision C.4. The Facility continues to have difficulty in achieving compliance with the nursing components of Provision C.5, which addresses nursing monitoring during and after a crisis intervention restraint. The RSSLC's self-assessment reported that the Facility was in substantial compliance with Provisions C.2 and C.3. The Monitoring Team confirmed substantial compliance with Provision C.1, which addresses various components of restraint administration, 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.

<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>8/1/13 to 1/31/14</th><th>2/1/14 to 7/31/14</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>147</td><td>96</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>10</td><td>8</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>5</td><td>1</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>162</td><td>105</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>30</td><td>28</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>9</td><td>5</td></tr>
<tr><td>Medical restraints/dental
Medical restraints/medical procedures</td><td>50
92</td><td>51
82</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons*</td><td>142</td><td>133</td></tr>
</table>
It is noteworthy that the use of crisis intervention restraint had decreased, when</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		comparing six-month periods from 162 (an average of 27/month) to 105 (an average of 18/month). <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 seven 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 consistent with the score reported at the last 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. The Facility had updated its restraint policy since the last review to comport with changes in the State policy. 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 10 of the 10 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • For the 10 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 10 (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 10 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. • Facility policies do identify a list of approved restraints. Based on the review of 10 restraints, involving seven Individuals, 10 (100%) were	

#	Provision	Assessment of Status	Compliance
		approved restraints. In 10 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. The Monitoring Team interviewed two Security Camera Monitors to confirm their training in restraint use and their acknowledgement that identifying and reporting questionable interactions between staff and Individuals as possible restraint was within their scope of responsibilities. Both were knowledgeable of appropriate and inappropriate interactions between staff and Individuals and knew to report any interaction that might be perceived as restraint to Behavioral Services for review. The Facility reported it had not used physical mechanical restraint for self-injurious behavior (PMR-SIB) during this review period. To validate this the Monitoring Team reviewed 13 Individuals who used abdominal binders related to G/J tube placement (Sample C.6). 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 Monitoring Team reviewed the physician order for the abdominal binder. In 12 of 13 (92%) there was nothing in the physician order that would indicate the purpose of the abdominal binder was to inhibit controllable behavior on the part of the Individual. For three of the Individuals in Sample C.6 the Monitoring Team interviewed staff who regularly worked with each Individual. Staff responses were variable but none contradicted the rationale stated in Physician orders. Typical responses were "she doesn't pull at it", "to hold it in place", "to keep it secure so it doesn't accidentally get dislodged", and "precautionary because of involuntary movement". The Monitoring Team found no evidence to suggest abdominal binders were being used as restraint. Based on this review this Provision was in substantial compliance.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the seven Individuals in Sample C.1 were reviewed. Of these, four of the Individuals had Crisis Intervention Plans at the time of restraint. For the four Individuals (involving seven restraints) who had Crisis Intervention Plans (CIP), all seven restraints (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 three Individuals (involving three restraints) who did not have Crisis Intervention Plans at the time of restraint, three (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 24 staff (Sample C.5). This review showed that: • 22 of the 24 (92%) had current training in RES0105 Restraint Prevention and Rules. • 22 of the 24 (92%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training. • 22 of the 24 (92%) had completed PMAB training within the past 12 months. Note: the two deficient staff resulted because the training transcript provided to the Monitoring Team did not have readable dates noting course completion. 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 • 100% RES0110 Applying Restraint Devices • 100% PMA0320 – PMAB Basic • 100% PMA0700 –PMAB Prevention • 100% PBS0100 – Positive Behavior Support In order to evaluate staff knowledge in the area of restraint, 10 DSPs 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 Director of Residential Services, 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 DSPs provided satisfactory responses to the following questions as follows:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• "When is the only time we should restrain an individual?" Twenty-five of 30 responses were evaluated as satisfactory (83%). This compares to the 90% reported in the last review. • "What other things should we have done before we restrain?" Twenty-eight of 30 responses were evaluated as satisfactory (93%). This compares to the 87% reported in the last review. • "Give an example of verbal redirection that you have used." All 30 responses were evaluated as satisfactory (100%). This compares to the 100% reported in the last review. • "Tell me two of the three kinds of restraint we can use here." Twenty-four of 30 responses were evaluated as satisfactory (80%). This compares to the 100% reported in the last review. • "What level of supervision should happen when an individual is in restraint?" All 30 responses were evaluated as satisfactory (100%). This compares to the 100% reported in the last review. • "Is it ever OK to restrain a person face down (prone)?" All 30 responses were evaluated as satisfactory (100%). This compares to the 100% reported in the last review. • Name the two staff that should be contacted immediately regarding restraints?" Twenty-six of 30 responses were evaluated as satisfactory (87%). This compares to the 100% reported in the last review. Overall for the seven questions, 193 of 210 (92%) responses were assessed as satisfactory. This compares to the 97% reported in the last review. In 10 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 restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical	Based on a review of 10 restraint records (Sample C.1), in 10 (100%) there was evidence that documented that restraint was used as a crisis intervention. In review of seven 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 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.	Noncompliance

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	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.	The Facility maintained a "Do Not Restrain" list consisting of Individuals who were not to be restrained under any circumstance. None were restrained. Additionally, for Sample C.1, 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 provision requirement that restraint not be used that is prohibited by the individual's medical orders. This form was present for all seven (100%) Individuals in Sample C.1 and was completed correctly including a dated physician signature. 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. As noted in the last report by the Monitoring Team, 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 10 of 10 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 18 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • Fourteen (77%) showed there had been appropriate authorization (i.e., Human Rights Committee approval and adequate consent; and • None (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. 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	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, nine staff at the Facility who performed the duties of	Noncompliance

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	document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	a restraint monitor for restraints in Sample C.1 nine (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 10 restraint records (Sample C.1), a face-to-face assessment was conducted: • In 10 out of 10 incidents of restraint (100%) the assessment indicated the restraint was monitored by an adequately trained staff member. • In nine of 10 instances (90%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. This was not the case for restraint of Individual #314. • In 10 of 10 instances of restraint (100%), the documentation showed that an assessment was completed of the application of the restraint. In each case the section of the FFAD to be completed by a psychologist was completed fully. • In 10 of 10 instances of restraint (100%), the documentation showed that an assessment was completed of the consequences of the restraint. In each case the section of the FFAD to be completed by a psychologist was completed fully. • In no case had a physician ordered an alternative monitoring schedule. Sample C.1 consisted of 10 restraint records for restraints that occurred at the Facility of which one of 10 (10%) was for chemical restraint and nine (90%) were for physical restraints. For the nine physical restraints in Sample C.1. There was documentation that a licensed health care professional: • Conducted monitoring within 30 minutes from the initiation of the physical restraint in seven of nine (78%). Records that did not contain documentation of this included: o Individual #314: On 3/15/14 at 5:50 p.m., Individual #314 was physically restrained. The nurse was not notified until 6:30 p.m. Individual #314 was monitored by the nurse at 6:40 p.m. o Individual #787: On 6/9/14 at 3:37 p.m., Individual #787 was	

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		physically restrained. The nurse was not notified until 3:39 p.m. Individual #787 was monitored by the nurse at 4:10 p.m. • Monitored and documented vital signs in six of nine (67%) of the instances of physical restraint. Records that did not contain documentation of this included: o Individual #363, Individual On 4/18/14 at 9:07 a.m., #363 was physically restrained. The nurse documented that Individual #363 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 #350: On 5/24/14 at 2:45 p.m., Individual #350 was physically restrained. The nurse documented that Individual #350 refused to allow vital sign monitoring. There was no documentation that the nurse visually observed for respiratory and cardiac/circulatory distress. o Individual #13: On 6/16/14 at 2:45 p.m., Individual #13 was physically restrained. The nurse documented that Individual #13 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 eight of nine (89%) of the instances of physical restraint. o Individual #13: On 6/16/14 at 2:45 p.m., Individual #13 was physically restrained. The nurse documented that Individual #13 refused to allow monitoring mental status. There was no documentation that the nurse visually observed Individual #13's mental status. For Sample C.3 (Chemical restraint) which included one chemical restraint: • 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 one of one (100%). There should be documentation from nursing that objectively described individuals' physical and mental status. Visual observations of individuals' respiratory and cardiac/circulatory status should be conducted; they do not require an individual's cooperation and the nurse should be able to determine whether the individual was having any respiratory/cardiac distress. The mental status monitoring should include specific behaviors that support the current mental status description. Merely documenting "refused" is not acceptable. The nursing staff should be notified immediately when crisis interventions restraints are applied so that monitoring can begin within 30 minutes as required by policy.	

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		For Sample C.1 there were two of 10 (20%) reports that indicated non-serious injuries were sustained during crisis intervention restraint application. Sample C.3 was selected from the list of Individuals who had medical restraint in the last six months. It represents 15% of the Individuals for whom medical restraint was used (Sample C.3 is defined in the Documents Reviewed section above). For these Individuals, the physician orders were reviewed, as well as documentation of monitoring. • In five of 18 (27%) the physician specified the schedule of monitoring required or specified facility policy regarding this was followed. • In zero of 18 (0%) the physician specified the type of monitoring required if it was different than the facility policy. • In five of 18 of the medical restraints (27%) appropriate monitoring was completed either as required by the SA, facility policy, or as the physician prescribed. Based on this review this Provision was not in substantial compliance.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be	A sample (Sample C.1) of 10 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: • In 10 (100%), continuous one-to-one supervision was provided; • In 10 (100%), the date and time restraint was begun; • In 10 (100%), the location of the restraint; • In seven (70%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. This compares to the 50% reported in the last review. 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 three restraints (Individuals #787 5/7, #278 5/4, and #314) the documentation was insufficient. For example, for Individual #314 the Restraint Checklist reports what happened immediately preceding the behavior that necessitated restraint but did not provide any information about anything that preceded that event (i.e. "the individual's environment, actions, and interactions with others") that might be useful to the IDT in understanding the circumstances that led to restraint and developing strategies for the future that might make restraint unnecessary. • In 10 (100%), the actions taken by staff prior to the use of restraint were described on the restraint checklist and FFAD with enough data to permit	Noncompliance

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	documented consistent with Appendix A.	adequate review of restraint application per Provision C.8. • In 10 (100%), the specific reasons for the use of the restraint; • In 10 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • In 10 (100%), the names of staff involved in the restraint episode; • Observations of the individual and actions taken by staff while the individual was in restraint, including in 10 (100%), the observations documented every 15 minutes and at release. Note: all restraints were of short duration. Only one exceeded 15 minutes (it was 16 minutes) and most were less than five minutes. • In 10 (100%), the level of supervision provided during the restraint episode; • In 10 (100%), the date and time the individual was released from restraint; • In nine (90%), 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 Individual #350. • In a sample of 10 records (Sample C.1), restraint debriefing forms had been completed for 10 (100%). • In 10 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. A sample of 18 Individuals subject to medical restraint was reviewed (Sample C.2), and in five (27%), there was evidence that the monitoring had been completed as required by the physician's order. 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 five individuals were placed in restraint more than three times in any rolling 30-day period. A sample (Sample #C.7) of five 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 three of five individuals reviewed (60%) reflected documentation of a timely ISPA following each episode in which the individual experienced more	Noncompliance

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		than three applications of restraint in a rolling 30 day period. Of the remaining two individuals, one (Individual #787) experienced seven applications of restraint between 3/20/2014 and 5/16/2014 before being provided an ISPA on 5/16/2014. The second remaining individual (Individual #475, 20%) had a restraint review ISPA on 5/5/2014. The individual then experienced restraint applications on 5/12/2014, 5/27/2014 (2 applications), and 6/3/2014 (2 applications) before being provided another restraint review ISPA on 6/4/2014. • Of the five individuals reviewed, none (0%) of individuals' IDTs (as reflected in ISPAs) discussed each individual's adaptive skills and biological, medical, and psychosocial factors and raised questions about all of these variables, thereby acknowledging the possibility of these variables affecting the individual's behavior. • For none of the five individuals (0%), were these factors adequately reviewed and hypotheses developed to guide treatment decisions to address the behaviors that provoked restraints.	
	(b) review possibly contributing environmental conditions;	Records for three of five individuals reviewed (60%) 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. ISPAs reflected: • Of the five individuals reviewed who were provided ISPAs following more than three restraint applications in a rolling 30-day period, one (Individual #787) was provided an adequate ISPA review of environmental factors. • For Individual #787, environmental factors were hypothesized to affect the behaviors that provoked restraints.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Records for three of five individuals reviewed (60%) 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. ISPAs reflected: • Of the five individuals reviewed who were provided ISPAs following more than three restraint applications in a rolling 30-day period, none (0%) was provided an adequate ISPA review of structural assessments.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	Records for three of five individuals reviewed (60%) 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. ISPAs reflected: • Of the five individuals reviewed who were provided ISPAs following more than three restraint applications in a rolling 30-day period, none (0%) was provided an adequate ISPA review of functional assessments.	Noncompliance
	(e) develop (if one does not exist)	Records for three of five individuals reviewed (60%) reflected documentation of a timely	Noncompliance

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	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;	ISPA following each episode in which the individual experienced more than three applications of restraint in a rolling 30 day period. ISPAs reflected: • Four of five PBSPs reviewed (80%) had operationally defined target behaviors. • Four of five PBSPs reviewed (80%) contained functional replacement behaviors. • Two of five PBSPs reviewed (40%) specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint. • Four of five PBSPs reviewed (80%) contained adequate interventions to weaken or reduce the behaviors that provoked restraint that were clear, precise, and based on a functional assessment. • Four of the four crisis intervention plans (100%) delineated the type of restraint authorized. • None of the four crisis intervention plans (0%) specified the maximum duration of restraint authorized. • Four of the four crisis intervention plans (100%) specified the designated approved restraint situation. • Four of the four crisis intervention plans (100%) specified the criteria for terminating the use of the restraint.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	Records for three of five individuals reviewed (60%) 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. ISPAs reflected: • The records of four of five individuals (80%) reflected monthly checks of treatment integrity on current behavior interventions. Of the four individuals with documented treatment integrity checks, records for four individuals (100%) reflected treatment integrity ratings of at least 80%. While this is a positive finding and improvement, ratings of at least 90% are required for substantial compliance.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Records for none of the five 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 circumstances under which such	The Facility had an organized process for restraint review. This was described in the Facility restraint policy, which closely mirrors the State restraint policy. Review starts with a FFAD done by a restraint monitor immediately after the restraint episode. The restraint episode is to be reviewed in the unit morning meeting the next business day	Noncompliance

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	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.	with whatever information had been available by the time of the meeting. It is to be reviewed within three business days by the IMRT, using available data including verbal reports from staff involved in the restraint. The IMRT is to decide if the circumstances associated with the restraint merit a specific referral to the IDT, in addition to the required IDT meeting within one business day for Individuals without a Crisis Intervention Plan. In its last report the Monitoring Team noted that documentation to validate substantive IMRT review was not always apparent because at the time of its review, the IMRT usually did not have sufficient behavioral and other observational data, to accurately determine "the circumstances under which restraint was used". This continued to be the case. The purpose of this initial IDT meeting required by policy is to assess any immediate needed interventions or changes in the Individual's program plan, including the Positive Behavior Support Plan and/or the need for a Crisis Intervention Plan. In its last report the Monitoring Team noted that if an individual does not have a Crisis Intervention Plan (CIP), RSSLC did not require (even though it is required by DADS and Facility policy) that the IDT meet and review each use of restraint for Individuals without a Crisis Intervention Plan. For Individuals with a Crisis Intervention Plan, policy requires that the IDT determine the review schedule based upon the individual's needs, but at least quarterly. The Facility acknowledged this issue and reported it would take action to correct this by the time of this review. Four Individuals (with a total of seven restraints) in Sample C.1 had Crisis Intervention Plans and in no instance (0%) did the ISP or CIP specify a review schedule. Nevertheless in all seven instances of restraint involving Individuals with a CIP the IDT met to review restraint occurrences within several days after each restraint of an Individual with a CIP in Sample C.1.There was no documentation presented to the Monitoring Team to validate that the IDT met within one day of the restraint for the other three Individuals in Sample C.1. In summary, in Sample C.1, for seven of 10 (70%) restraints, documentation was available to support either an IDT review within one working day (in the case of those without a CIP) or by the next quarterly review (in the case of those with a CIP). Documentation related to Facility review of 10 incidents of crisis intervention restraint was reviewed by the Monitoring Team. This included the Unit Review Team meeting minutes, IMRT meeting minutes, ISP addenda, and debriefing documentation. This documentation showed that: • In eight (80%), the review by the Unit IDT occurred within one business day of the restraint episode and this review is documented by signature on the Restraint Checklist and review of unit review meeting minutes. This was not the case with restraint of Individuals #787 (5/16) and #314.	

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		• In eight (80%), the review by the IMRT occurred within three business days of the restraint episode and this review is documented by date entry on the Restraint Checklist and review of IMRT minutes. This was not the case with restraint of Individuals #13 and #314. • In ten (100%), the circumstances under which the restraint was used was determined and was documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • In none (0%), the review conducted in the Unit morning meeting and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. Minutes of the IMRT meetings were provided for all ten restraints in Sample C.1. 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 two reviews and had not been addressed by the Facility. The Facility reported it had recently taken steps to modify the template for the Unit review meetings requiring more information to facilitate proper restraint review. It was anticipated this action would result in improved compliance in future reviews. As noted in previous reports by the Monitoring Team, the Facility believes this issue may be primarily a matter of properly documenting restraint review in meeting minutes. The unit restraint review observed by the Monitoring Team at Four Rivers on 8/26/14 was thorough, substantive, and adequately addressed SA requirements. Additionally, the Facility had recently modified the report template for the restraint section of Unit meeting minutes to prompt the collection of data important for a substantive review. It is important that minutes reflect the substantive discussion that occurs at a unit morning meeting and that IMRT has these data to ensure that intended follow-up actions by the IDT are articulated and their occurrence can be verified. If not, the IMRT should be referring the restraint review back to the Unit IDT for additional follow-up. No minutes of either the unit meetings or IMRT meetings (0%) reported an additional referral made to the IDT, and the Monitoring Team could not validate that any were clearly needed. In its last report the Monitoring Team noted that he Facility had implemented a more formalized process for video review of restraints than that described in previous reports.	

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		The expectation was described as when video surveillance footage of a restraint was 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 were to 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 reported it was using video review for all horizontal restraints when those restraints occurred in areas covered by cameras. In reviewing Sample C.1 the Monitoring Team found this to be the case. 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 8/12/14 2. RSSLC Action Plans 8/11/14 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 5/2/14 10. RSSLC Policy E.17 Completing Incident Information Reports 5/2/14 11. Log of Department of Family and Protective Services (DFPS) cases 2/1/14 to 6/30/14 12. Log of serious injuries 2/1/14 to 6/30/14 13. Log of serious incidents 2/1/14 to 6/30/14 14. Log of witnessed Injuries 2/1/14 to 6/30/14 15. Log of discovered Injuries 2/1/14 to 6/30/14 16. Log of peer to peer injuries 2/1/14 to 6/30/14 17. CMS 2567 survey reports since the last review 18. Minutes from joint DFPS/OIG/Facility quarterly meetings 3/20/14 and 6/25/14 19. Acknowledgement of Reporting signed forms for 24 randomly selected employees 20. 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 20% of reported investigations initiated and completed since the last review and included DFPS cases 43053823, 43095799, 43161117, 43169881, 43110674, 43123751, 43170617, 43127608, 43179292, 43184285, 43158641, 43161347, 43168865, 43054840, and 43153277. The sample represented investigations that resulted in confirmed, unconfirmed, inconclusive, and administrative referral findings. Five of the 15 investigations in Sample D.1 were also investigated by the Office of Inspector General (OIG) 21. 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 20% of reported investigations initiated and completed since the last compliance visit. Sample D.2 included UIRs 201, 125, 141, 143, and 175. The sample included four serious injuries and one unauthorized departure. 22. Sample D.3: a sample of completed Record Audits to determine whether significant injuries had been reported. 23. DFPS Investigation 43211811(confirmed abuse reported 46 days late)

	24. Sample D.4: ISPs for Individuals #781, #377, #125, #468, #632, #212, #794, #479, #309, and #651 25. DADS report MHMR0102 Percent of All Employees Completing Course of Training 8/1/14 26. QA/QI meeting minutes 5/30/14 27. Abuse/neglect quiz used by campus administrators (undated) and April and May reported results 28. Self-Advocate meeting minutes for six meetings since the last review 29. RSSLC Trend Reports 7/13 **People interviewed:** 1. Adelia Pavliska, Incident Management Coordinator 2. Georgette Brown, Quality Assurance (QA) Director 3. Judy Miller, SA Coordinator 4. Al Barrera , Facility Director 5. Cynthia Fannin, Assistant Director of Programs 6. Autumn Patrick, Facility Investigator 7. Dorothea Williams, IMC Administrative Assistant 8. Donna Honeycutt, Security Officer 3 9. Eddie Borak, Security Officer 3 10. Ten Direct Support Professionals **Meetings attended/Observations:** 1. Incident Management Team meeting (IMRT) 8/26/14 and 8/27/14 2. Administrative Review Team (ART) meeting 8/26/14 and 8/27/14 3. Four Rivers Unit morning meeting 8/26/14 4. Quality Assurance/Quality Improvement (QA/QI) Council 8/25/14
	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 20% sample of the 78 abuse/neglect investigations or the 36% sample of the 28 Facility only investigations that occurred between 1/1/14 and 6/30/14. It appeared IMC staff reviewed documentation associated with their sample and tallied data on a worksheet. The self-assessment also did not report the use of any inter-rater reliability in its self-assessment of Section D. Through interview the Facility reported it had IRR for Section D but did not include these data in the Self-assessment. • 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 even though it was available and could have been used as part of the self-assessment. • Data collected and recorded from the self-assessment review conducted by the Incident Management Coordinator (IMC) appeared to be informal and was not organized into a report or

	other similar document summarizing results. • The absence of use of any type of formal monitoring/auditing tool resulted in the absence of clear 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 19 of the 22 Provisions in Section D. The self-assessment reported noncompliance with Provisions D.2.a (timely reporting), D.3.e (timely initiation and completion of investigations), and D.4 (tracking and trending). This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following 14 provisions: D.1, D.2.b, c, d, e, f, g, and h, D.3a, b, c, d, and j, and D.5. Generally, the Facility's self-assessment did not include all of the components included in specific provisions of the Settlement Agreement (e.g., provisions often include multiple requirements, and the self-assessment did not always address all of them) or the Facility did not probe with sufficient thoroughness to determine compliance. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Actions were reported as complete**,** in process, and ongoing. The Facility data identified areas of needed improvement. For example, the Facility self-assessment reported 14 distinct action steps intended to improve compliance with Provision D.2.a (timely 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", "test 30 randomly selected staff monthly", and "in-service staff on reporting procedures". The action plan steps did not include any detail with regard to how these action steps would happen. For those Provisions determined to be in noncompliance by the Monitoring Team the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome 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: Since the last review the Facility has a new Incident Management Coordinator. This person started as the new

IMC just several days before this review. For several months the position was filled on an acting basis by one of the Facility investigators. It is likely that some of the deficient practices noted in this report occurred because of this turnover in IMC leadership.

The Facility had an adequate policy addressing abuse and neglect and incident management practices. 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.

Incident management implementation issues were pervasive and the Facility had substantive issues related to client protection that needed to be immediately addressed. For example:

- Many serious incidents included in the sample by the Monitoring Team were not reported timely. Only six of 15 were reported timely.
- Many staff were unaware of basic abuse and neglect reporting responsibilities. In questioning staff on abuse and neglect policies, the Monitoring Team was provided with unsatisfactory responses 42% of the time. Training for staff on abuse and incident reporting was in place, and all staff was current in that training; however, as noted above and in the last three reports, staff knowledge of abuse/neglect reporting requirements needed improvement.
- The number of confirmed cases of abuse/neglect (comparing six-month periods) doubled and the number of serious injuries increased significantly.
- Staff reported fear of retaliation but reported they were to report if retaliation occurred.
- Required injury audits were completed for only four of the last five months.
- Injury reports associated with serious incidents were often not completed correctly and fully.
- The Facility did not complete many of the recommendations made in reviewing investigations. Only 35% of recommended actions were completed and completed within the timeframe specified.
- There was insufficient documentation to validate that all investigations began with the required 24 hour timeframe.
- There was insufficient documentation to validate that all investigations had a clear basis for the conclusions reached by the investigator.

In most cases the Facility had not used the above data to identify systemic issues that should have been addressed through a formal Corrective Action Plan or other administrative initiatives.

As noted above, the number of confirmed cases of abuse doubled (from five to ten) and the number of other serious incidents increased significantly when comparing six-month periods. It did not appear that data

	review pursuant to Provision D.4 or QA review conducted under Section E of the SA identified this as an issue requiring closer examination. The trend reports and related data maintained by the Facility showed that corrective action plans were oftentimes needed but generally not initiated. As noted in previous reports the Monitoring Team could not validate the data reported by the Facility was accurate. As noted above, staff were not retaining information learned in formal training classes, and ostensibly reinforced through periodic competency checks. It appeared whatever actions the Facility had taken to address this had not been effective. The Facility rated itself as being in compliance with the 19 of the 22 Provisions in Section D. The self-assessment reported noncompliance with Provisions D.2.a (timely reporting), D.3.e (timely initiation and completion of investigations), and D.4 (tracking and trending). This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following 14 provisions: D.1, D.2.b, c, d, e, f, g, and h, D.3a, b, c, d, and j, and D.5. Five Provisions rated as in compliance by the Facility self-assessment were determined to be noncompliant by the Monitoring Team. These were: 1. Provision D.2.i which addresses injury audits. 2. Provision D.3.f, which addresses investigation report content. 3. Provision D.3.g, which addresses Facility review of investigation reports. 4. Provision D.3.h which addresses preparation of Facility reports. 5. Provision D.3.i which addresses administrative follow-up subsequent to investigation findings.

#	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 conduct reduced monitoring because previous reviews showed substantial compliance. The reduced monitoring consisted of a review of the Facility's current policies governing abuse/neglect reporting and incident management. The Facility's policies and procedures did: 1. Include a commitment that abuse and neglect of individuals will not be tolerated, 2. Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The Facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Since the last review the Facility has a new Incident Management Coordinator. This person started as the new IMC just several days before this review. For several months the position was filled on an acting basis by one of the Facility investigators. It is likely that some of the deficient practices noted in this report occurred because of this turnover in IMC leadership. <u>Client Protection</u> The Facility had an adequate policy addressing abuse and neglect and incident management practices. Implementation issues were pervasive and the Facility had substantive issues related to client protection that needed to be immediately addressed. For example, since the last review the Facility received Statements of Deficiencies from DADS Regulatory for client protection on five different occasions, including one that was a Condition of Participation (i.e. major) finding. These deficiencies all addressed various elements of "failure to supervise Individuals" and "failure to protect Individuals." In four of the five cases injury to the Individual resulted, including a broken nose, lacerations, and a broken leg. Subsequent to these five investigations by DADS Regulatory the Facility experienced five unauthorized departures by five different Individuals over a six week period beginning in late June. Unauthorized departures can often be attributable, at least in part, to lack of supervision of Individuals. While the Facility responded with an action plan to each specific incident it did not identify this set of similar events as representing a possible systemic issue requiring a formal Corrective Action Plan with a root cause analysis. 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 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 Monitoring Team did not observe significant improvement in this regard from what was observed at the last review and, in fact, in some areas noted regression. 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 where time and date information was provided. This compares to the 30% reported in the last review. • As reported in Provision D.2.a, the Monitoring Team was only able to validate timely reporting to the Facility Director/designee of three of five (60%) other serious incidents. This compares to the 80% reported in the last review. • Therefore, collectively, only six of 15 (40%) serious incidents were reported timely where time and date information was provided. This compares to the 47% reported in the last review. • As reported in Provision D.2.a the Facility self-assessment reported with respect to allegations of abuse/neglect in only five of 16 (31%) cases the Facility reviewed were reported within the required timeframes. This compares to the	

#	Provision	Assessment of Status	Compliance
		45% reported in the last review. • As reported in Provision D.2.a, the Monitoring Team, in questioning staff on abuse and neglect policies, was provided with unsatisfactory responses 42% of the time. • As reported in Provision D.2.a the number of confirmed cases of abuse/neglect (comparing six-month periods) doubled and the number of serious injuries increased significantly. • As reported in Provision D.2.h staff reported fear of retaliation. • As reported in Provision D.2.i required injury audits were completed for only four of the last five months (80%). • As reported in Provision D.3.f injury reports associated with serious incidents were often not completed correctly and fully. • As reported in Provision D.3.i the Facility did not complete many of the recommendations made in reviewing investigations. Only 35% of recommended actions were completed and completed within the timeframe specified. In most cases the Facility had not used these data to identify systemic issues that should have been addressed through a formal Corrective Action Plan. In the one case where it did (late reporting) only two of five action steps in the CAP were completed. 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 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	Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether, for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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:	

	8/1/13 to 1/31/14	2/1/14 to 7/31/14
Total abuse allegations	71	76
Physical	50	49
Verbal/Emotional	21	27
Abuse confirmed	5	10
Physical	5	7
Verbal/Emotional	0	3
Abuse inconclusive	13	6
Physical	11	5
Verbal/Emotional	2	1
Total neglect allegations	62	45
Neglect confirmed	2	3
Neglect inconclusive	4	4
Total exploitation allegations	2	0
Exploitation confirmed	0	0
Exploitation inconclusive	0	0

It is noteworthy that the number of confirmed cases of abuse doubled (from five to ten) when comparing six-month periods. It did not appear that data review pursuant to Provision D.4 or QA review conducted under Section E of the SA identified this as an issue requiring closer examination.

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:

	8/1/13 to 1/31/14	2/1/14 to 7/31/14
Deaths	0	2
Serious Injuries	12	20
Sexual Incidents	0	7

#	Provision	Assessment of Status	Compliance

Suicide Threat (credible)	3	0
Unauthorized Departure	9	7
Choking	0	1
Total	24	37

It is noteworthy that the number of other serious incidents increased from 24 to 37 when comparing six-month periods, including an increase in serious injuries from 12 to 20. It did not appear that data review pursuant to Provision D.4 or QA review conducted under Section E of the SA identified this as an issue requiring closer examination.

NOTE: As noted in previous reports the Monitoring Team could not validate the data reported by the Facility was accurate. For example, the Monitoring Team crosschecked DADS Regulatory reports which cited unauthorized departures with UIR data. For an incident on 4/23/14 involving Individual #363 a UIR was present (UIR 14-129) but this UIR was not included in the list of serious incidents provided in response to document request III.18 and therefore was not included in the set of UIRs from which Sample D.2 was drawn. Lapses such as this can make all data submitted by the Facility questionable as to its accuracy. As recommended in the last review 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

#	Provision	Assessment of Status	Compliance
		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 Director of Residential Services, 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). 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." Eight of 30 responses were evaluated as satisfactory (27%).This compares to the 43% reported in the last review. "Describe the reporting procedure and timeframe for other serious incidents." Fourteen of 30 responses were evaluated as satisfactory (47%). This compares to the 23% reported in the last review report. "Describe two acts/events that would constitute abuse." Twenty-four of 30 responses were evaluated as satisfactory (80%). This compares to the 33% reported in the last review. "Describe two signs/symptoms of neglect." Twenty-three of 30 responses were evaluated as satisfactory (77%). This compares to the 63% reported in the last review. Overall for the four questions, 69 of 120 (58%) responses were assessed as satisfactory. This compares to the 41% reported in the last review. The Facility had a regular process to quiz staff on the above elements of abuse/neglect reporting. The Monitoring Team reviewed data associated with this process for the months of April and May, 2014. This review showed that only 18 of 54 (33%) staff answered all four questions accurately. Those that did not required "coaching" or were sent for refresher training. 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 below (and 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	

#	Provision	Assessment of Status	Compliance
		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 43168865, 43054840, and 43153277. This compares to the 30% compliance score reported in the last review. ▪ 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 43168865, 43054840, and 43153277. ▪ For the seven allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, five UIRs (71%) included recommendations for corrective actions. The exceptions were UIR 169 and 150. The corrective action rate of 71% compares to the 43% reported in the last review. Finally, the Facility self-assessment reported that timely reporting occurred in only five of 16 cases (31%) reviewed as part of the self-assessment. The Facility, through its QA process, had initiated a Corrective Action Plan (CAP) to address this significant and systemic problem. This CAP was initiated on 4/10/14 with expected completion dates of 5/31/14. CAP data provided to the monitoring Team dated 8/28/14 reported only two of seven action steps as having been completed. No data was provided that reported the effectiveness, or lack of effectiveness, of the CAP. No data was provided that indicated the CAP had been modified even though this review occurred nearly two months after the last projected completion date in the CAP. This CAP was still noted as open. Based on a review of five investigation reports included in Sample D.2: ▪ Three (60%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. The exceptions were UIRs 201 and 141, both serious injuries. In fact the serious injury for UIR 201 was not known to the IMC office until discovered in response to the Monitoring Team's document request. This injury occurred on 3/17/14 and the UIR was generated on 8/4/14. This compliance score of 60% compares to the 80% reported in the last review. ▪ Three (60%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. The exceptions were UIRs 201 and 143, both serious injuries. This compliance score of 60% compares	

#	Provision	Assessment of Status	Compliance
		to the 80% reported in the last review. ▪ For the two unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs did include recommendations for corrective actions. The Monitoring Team also reviewed DFPS case 43211811 because of its special circumstances (reported 46 days late). This allegation of physical abuse (subsequently confirmed by DFPS) was reported on 7/22/14 after the Facility was notified by an onsite DFPS investigator that while reviewing video surveillance data from 6/6/14 associated with a different investigation the DFPS investigator observed what appeared to be physical abuse. The staff present in the room should have reported the allegation and didn't. The incident, while captured in video surveillance, was not caught by the video camera operators. In its last two reports 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. In its last report the Monitoring Team noted that the lack of timely reporting places the health and safety of Individuals living at the Facility at risk and must be addressed immediately and aggressively. From this review it appears whatever actions the Facility had taken to address this had not been effective. The Facility did have a standardized reporting format as required by the SA. 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. Nineteen (95%) were completed fully. UIR 175 did not include necessary supervisory approvals. Through the course of reviewing investigations the Monitoring Team noted that the video surveillance cameras had been helpful in ascertaining the facts associated with many allegations. Additionally, the Monitoring Team interviewed two Security Camera Monitors to confirm their training in abuse and neglect and their acknowledgement that identifying and reporting questionable interactions between staff and Individuals as possible abuse or neglect was within their scope of responsibilities. Both were knowledgeable of appropriate and inappropriate interactions between staff and Individuals and knew to report any interaction that might be perceived as abuse or neglect and in one case had in fact done so. Finally, the Facility had effectively implemented its policy to review non-serious injuries of unknown origin or of a suspicious nature. These are referred to as NSI Investigations.	

#	Provision	Assessment of Status	Compliance
		This is an important component of compliance with Provision D.2.a. These investigations ensure that non-serious injuries identified as being of unknown origin, or of a suspicious nature, are investigated to determine if abuse or neglect is suspected and, if so, properly reported to DFPS. 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.	Based on a review of the 15 investigation reports included in Sample D.1, in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no direct contact (NDC) status. As noted in the previous reports, the Facility should understand the relationship between late reporting (refer to Provision D.2.a) and this SA requirement. When late reporting occurs this can impact the Facility's ability to immediately remove alleged perpetrators 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. In one particularly egregious case an allegation of physical abuse (subsequently confirmed by DFPS) was reported on 7/22/14 after the Facility was notified by an onsite DFPS investigator that while reviewing video surveillance data from 6/6/14 associated with a different investigation the DFPS investigator observed what appeared to be physical abuse. The staff person with a confirmed abuse finding had been working 46 days placing other Individuals at risk. The Facility had taken no action (such as reviewing injury data) to assess whether this staff might have abused anyone else during this time period. Review of 15 investigation files included in Sample D.1 showed there were no instances where staff that had been removed from direct contact had been subsequently reinstated prior to completion of the investigation. This conclusion was reached by reviewing the UIR that accompanied each DFPS investigation. Based on a review of the 15 investigation files in Sample D.1, it was documented that adequate additional action was taken to protect individuals in each case once an allegation was known and reported. For example: nursing assessments were done and treatment rendered as appropriate, alleged perpetrators were put in NDC status, and psychology staff conducted emotional assessments of victim trauma. Based on this review the Monitoring Team determined this Provision remained in compliance in that temporary failure to comply during a period of otherwise sustained compliance does not constitute failure to maintain substantial compliance. In future reviews the Facility will need to include in its investigation (UIR) an explanation of steps	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		taken to identify any injuries or incidents for which an AP may have been responsible.	
	(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.	A review of the training curricula related to abuse and neglect was carried out for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: In relation to the requirement that training is competency-based, the material reviewed included provisions for trainees to demonstrate their understanding of what constituted abuse, neglect, and exploitation and how to report observations or suspicion of abuse, neglect, or exploitation. The material also included adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 24 staff training transcripts (Sample C.5) showed that 22 of 24 (92%) had completed competency-based training on abuse and neglect and unusual incidents within the last 12 months. Note: the two deficient staff resulted because the training transcript provided to the Monitoring Team did not have readable dates noting course completion. Additionally, the Monitoring Team reviewed the DADS report MHMR0102 Percent of All Employees Completing Course of Training (8/1/14), which reported a 99% compliance rate for staff completion within the last 12 months for ABU0100 and 100% for UNU0100. As reported in Provision D.2.a staff knowledge of abuse/neglect reporting responsibilities was variable. This may suggest the effectiveness of the training should be further probed by the Facility through quality assurance monitoring and that consideration be given to modifying training strategies, including consideration of a formal Corrective Action Plan (CAP). Facility practices address the requirements of this Provision that the training be competency-based, that staff complete the training, and that documentation of training completion is maintained. As noted in previous reports the Monitoring Team suggests the Facility take additional steps to ensure the retention of knowledge and that staff implement the knowledge provided in the training. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to	The Monitoring Team asked for copies of the DADS Form 1020 Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation (7/09) for staff included in Sample C.5. This consisted of 24 staff. There was a properly completed and signed 1020 in 19 of 24 (79%) instances. In two instances the form was not dated so the Monitoring Team could not determine if it had been signed within the last year. In two other	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	instances the handwritten date was illegible so the Monitoring Team could not determine if it had been signed within the last year. In one case no 1020 form was presented to the Monitoring Team. Through document review and interview the Monitoring Team found two instances, involving four staff, of a mandatory reporter failing to report abuse or neglect. In each case the staff were re-inserviced on reporting requirements. Based on this review the Monitoring Team determined this Provision remained in compliance in that temporary failure to comply during a period of otherwise sustained compliance does not constitute failure to maintain substantial compliance. To remain in compliance the Facility will need to demonstrate at the next review that at least 90% of staff have met the requirements of this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	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. 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 (Sample D.4) Nine of 10 (90%) included information with respect to abuse and neglect identification and reporting procedures. The exception was for Individual #468. The Facility regularly checked 10 ISP documents each month for compliance with this requirement. For the 50 ISPs checked by the Facility (February, 2014 through June, 2014) 40 (80%) contained the required information. The Facility had initiated a CAP in April after which the compliance rate averaged 90%. Also considered in assessing compliance with this Provision are Self-advocate meetings, which occurred periodically at the Facility. In reviewing minutes of the five meetings held since the last review the Monitoring Team found agenda topics relevant to this provision were presented in all five (100%) meetings. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to	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. Nevertheless, the Monitoring Team validated the Facility's internal QA process to confirm compliance was still in place.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	report violations of such rights.		
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	To be in substantial compliance with this component of the SA there should be evidence that at least all allegations of physical abuse received a law enforcement referral. All allegations of physical abuse, if substantiated, may represent some form of assault or battery that could result in the perpetrator being criminally charged. Therefore, it is important that all allegations of physical abuse receive law enforcement referral. In all six (100%) allegations of Physical Abuse in Sample D.1 law enforcement notification occurred. Based on a review of five investigations completed by the Facility (Sample D.2), law enforcement referral was not necessary or appropriate given the nature of the incident being investigated and the facts discovered during the course of the investigation. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	Based on interviews with Facility administrative staff 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 no indication of expressed concern by those interviewed of retaliation. The Monitoring Team met with 10 randomly selected staff to ask several questions associated with abuse/neglect policy. One question was "if you reported abuse or neglect would you worry about being retaliated against by a co-worker or supervisor?" Two of 10 (20%) responded yes. Both knew that if they experienced retaliation they should report it to the Facility Director. Based on this review this Provision was in substantial compliance.	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) defined sufficient procedures to audit whether significant injuries are reported for investigation. This included doing 11-12 audits a month which over a six-month period would satisfy the 20% sample size required by both DADS and Facility policy. During this review the Monitoring Team determined injury audits were completed in March (N=12), April (N=12), May (N=12), and June (N=12). No documentation was provided to the Monitoring Team that could validate any audits being done in July. Consequently the injury audit activity over this time period did not meet the sample requirements of DADS/Facility policy. Where policy	Noncompliance

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		has been established to address SA compliance the Monitoring Team expects policy to be followed to validate SA compliance. Based on this review this Provision was not in substantial compliance. This represents regression as in the last review the Monitoring Team determined that injury audits were completed monthly, according to Facility policy, and collectively included the required 20% sample of Individuals.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The RSSLC policies C.01 Incident Management (11/25/13) and RSSLC Policy C.02 Protection From Harm – Abuse, Neglect, and Exploitation (11/25/13), included specific operational descriptions providing for the conduct of investigations. DFPS has similar descriptions and related training. The Monitoring Team review of facility policy found it described the conduct of investigations and required that investigators be qualified. The policy specifies that Facility Investigators (and any other staff authorized to conduct investigations) successfully complete Comprehensive Investigator Training (CIT0100), Conducting Serious Incident Investigations (INV0100), and a class in Root Cause Analysis. The policy required that investigators have training in working with people with developmental disabilities, including persons with mental retardation. This was accomplished through successful completion of People with MR (MEN0300). The Monitoring Team believes this training, if completed as described, should be adequate for the conduct of investigations at RSSLC. Finally, the Facility policy required that investigators be outside of the direct line of supervision of alleged perpetrators. The Monitoring Team had reviewed material used by DFPS in training its investigators. The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS	Substantial Compliance

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		2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 4. Time and Stress Management In reviewing the materials associated with these modules the Monitoring Team believes this training is competency-based. DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire. While not required, it appears many investigators also take a class titled "MH&MR Overview – APS Investigator Role." Completion of this class would demonstrate additional training in working with people with developmental disabilities. RSSLC requires facility investigators to have completed the following classes: 1. ABU0100 Abuse and Neglect 2. UNU0100 Unusual Incidents 3. CIT0100 Comprehensive Investigator Training – (this class is apparently no longer offered. Per interview with the IMC the LRA course noted below has been deemed as the appropriate alternative although this was not able to be corroborated by DADS Central Office when asked during the compliance visit.) 4. MEN0300 People with Mental Retardation 5. LRA training Fundamentals of Investigations and Conducting Serious Investigations (INV0100) 6. Training in Root Cause Analysis. Since the last review the Facility has a new Incident Management Coordinator (IMC). Her	

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		training records were reviewed and she had completed the requirements for investigation training. DFPS had two investigators that worked the RSSLC cases in Sample D.1. The training records for these investigators were reviewed. Both (100%) completed the requirements for investigations training. RSSLC had two staff designated as investigators and were assigned to the cases in Sample D.2. The training records for these staff were reviewed. Both (100%) had completed the requirements for investigations training. None of the staff designated as facility investigators had supervisory responsibilities that extend beyond the IMC Department; therefore, they are unlikely to be in the direct line of supervision of anyone subject to investigation. Based on this review this Provision was in substantial compliance.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The Monitoring Team did not detect any instances of lack of cooperation between Facility staff and outside entities in its review of the 15 DFPS investigations in Sample D.1. Five of these 15 investigations included an OIG investigation. The Facility convened quarterly joint meetings with DFPS and OIG at which any issues of mutual cooperation can be reviewed and resolved. The Monitoring Team reviewed the minutes of meetings held on 3/20/14 and 6/25/14. Both DFPS and OIG reported satisfaction with the cooperation extended by the Facility. Based on this review this Provision was in substantial compliance.	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 Monitoring Team did not find any issues with lack of coordination with law enforcement agencies. A Memorandum of Understanding including multiple agencies with potential law enforcement roles, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. In the MOU "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy 002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency."	Substantial Compliance

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		Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ In 15 of 15 (100%) investigation records from DFPS (Sample D.1) no evidence of interference by one agency or the other was identified. The Facility convened quarterly joint meetings with DFPS and OIG at which any issues of interagency coordination can be reviewed and resolved. The Monitoring Team reviewed the minutes of meetings held on 3/30/14 and 6/25/14. Both DFPS and OIG reported satisfaction with the coordination among and between all three agencies. Based on this review this Provision was in substantial compliance.	
	(d) Provide for the safeguarding of evidence.	The Monitoring Team confirmed that the area the Facility uses for safeguarding physical evidence was still in use and used for evidence storage. Additionally the Facility continued to have a portable evidence kit used by investigators. Materials were kept in a rolling suitcase and included everything potentially needed to collect and process evidence, including a camera, plastic gloves, evidence bags, marking pens, a ruler, and more. 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. 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. To its credit the Facility had taken some steps to address the issue of protection of testimonial evidence. This consisted primarily of including the following statement on the form titled "Expectations While on Non-Client Contact Reassignment": I will not contact my peer regarding any DFPS matter, RSS matter, inquire, or discuss the circumstances leading to my status as Non-Client Contact staff. This form is acknowledged and signed by the staff being placed on Non-Client Contact	Substantial Compliance

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		status and notes that failure to comply would lead to disciplinary action up to and including termination of employment. Based on this review this Provision was in substantial compliance.	
	(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 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 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 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 six 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: • Thirteen of 15 (87%) commenced within 24 hours of being reported 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. For case 43169881 (an administrative referral) the Monitoring Team in reading the report could not determine when investigatory activity began. For case 43127608 the usual narrative	Noncompliance

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		documentation relative to initiating an investigation was not included in the investigative report. It appears the first substantive investigative activity occurred on 5/11 at 2:33pm (the incident was reported on 5/8). The report notes that "commencement was started on at 1:59pm" on 5/8 but the report does not describe (as is customary in other reports) the specific steps that were taken to document commencement of the investigation. • 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. • Twelve of 15 investigations (80%) were completed within 10 calendar days of the report of the incident. Based on documentation provided by the Facility for the three that were not completed within 10 days, approved extension requests were provided for two. Investigation 43153277 began on 5/29/14 and was completed on 6/9/14 (11 days). No documentation requesting an extension was provided to the Monitoring Team. Consequently, 14 of 15 (93%) investigations were completed within 10 days or had approved extensions acceptable to the Monitoring Team. • 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 six (40%) 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: • Five of five (100%) commenced within 24 hours of being reported 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. • Four of five (80%) were completed within 10 calendar days of the incident being reported, including sign-off by the supervisor (IMC). The exception was UIR 143. This case was reported to DFPS during the course of the initial 10 day period (day four). 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	

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		Settlement Agreement. • All five (100%) included recommendations for corrective action. Based on this review this Provision was not in substantial compliance as only 87% of DFPS investigations in Sample D.1 commenced within 24 hours of the incident being 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 13 out of 15 investigations reviewed (87%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. This was not the case for: 1) investigation 43161117 (the Monitoring Team could not determine who interviewed who, and when. Because of this the Monitoring Team cannot confirm that the contents of the investigation report were sufficient to provide a clear basis for its conclusion.), and 2) investigation 43053823 (the Monitoring Team found many inconsistencies in the Facility injury reports associated with this investigation. A more detailed review of these injury reports, and an attempt to reconcile discrepancies, may have led to a conclusion other than to not conduct a complete investigation but send the matter to the Facility as an administrative referral. Because of this the Monitoring Team cannot confirm that the contents of the investigation report were sufficient to provide a clear basis for its conclusion). For one other case, investigation 43110674, it appeared to the Monitoring Team that there was sufficient evidence, including video evidence, to confirm neglect or abuse, rather than the inconclusive determination. In fact, for both APs the Facility Director review resulted in changing the final finding to confirmed; it was positive to find that the Facility completed a thorough review. ▪ 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;	Noncompliance

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		○ 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. ○ In 15 (100%), all documents reviewed during the investigation; ○ 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. ○ In 12 (80%) investigation reports were sufficient to provide a clear basis for its conclusion. ○ In 15 (100%), the investigator's findings; and ○ 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 none of five investigations reviewed (0%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that did not include: ○ UIR 201 – this incident included a very egregious lack of reporting of a serious injury which resulted in the IMC office not learning of the serious injury until over four months after it happened. The IMC office learned of this incident when it was preparing documents for the Monitoring Team. As noted in the last several reports by the Monitoring Team the Facility has had an ongoing significant problem with timely reporting of incidents. The Facility investigation did not attempt to identify the individual staff who were responsible for not following Facility policy. As a result no action was taken with specific employees. Rather the investigation concluded that "nursing staff failed to……" and the "IDT did not ensure….." This resulted in general recommendations for more training. Additionally, investigation follow-up recommendations did not include anything that might serve to identify these types of problems earlier, such as a periodic (e.g. weekly) reconciliation of the injury database with the incident data base). ○ UIR 125– only two of eight staff identified in the UIR as "staff involved" were interviewed. The UIR did not provide any explanation/rationale as to why only some of the staff identified as involved were interviewed. The injury report associated with this investigation was not fully completed. As a result this investigation cannot be considered thorough, complete, and sufficient to provide a clear basis for its conclusion. ○ UIR 141- only one of four staff identified in the UIR as "staff involved" were interviewed. The UIR did not provide any explanation/rationale as to why only some of the staff identified as involved were interviewed.	

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		The injury report associated with this investigation was not fully completed. As a result this investigation cannot be considered thorough, complete, and sufficient to provide a clear basis for its conclusion. o UIR 143 - only two of seven staff identified in the UIR as "staff involved" were interviewed. The UIR did not provide any explanation/rationale as to why only some of the staff identified as involved were interviewed. The injury report associated with this investigation was not fully completed. The investigation of this serious injury included an investigation of neglect by DFPS. DFPS confirmed neglect as a "system issue" concluding that the Facility "did not provide a safe environment with appropriately trained staff members." The "Future Actions" section of the UIR did not directly address this finding by DFPS. As a result this investigation cannot be considered thorough, complete, and sufficient to provide a clear basis for its conclusion. o UIR 175 - only three of six staff identified in the UIR as "staff involved" were interviewed. The UIR did not provide any explanation/rationale as to why only some of the staff identified as involved were interviewed. The UIR did not include notations indicating supervisory approvals. As a result this investigation cannot be considered thorough, complete, and sufficient to provide a clear basis for its conclusion. • 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 (staff involved); 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 (although as noted above numerous staff were identified as "involved" but were not interviewed and the UIR provided no explanation or rationale for this); 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; 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 four (80%), the investigator's reasons for his/her conclusions. UIR 175 did not. o None of the five Facility investigations (0%) can be considered thorough and complete.	

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		Based on this review this Provision was not in substantial compliance.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The Facility policy and procedures did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. The Facility policy did require that any further inquiries or deficiencies be addressed promptly. This result of this review of DFPS investigations is recorded on a form titled "DFPS Investigation Cover Sheet-Allegation & Final Report." Two other forms are used for facility investigations, one signed by the QA reviewer and/or Settlement Agreement Coordinator and another signed by the IMC or QA Director. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ The DFPS investigations in Sample D.1 did not meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; ▪ The Facility Incident Review Team (IRT) did accept at least ninety-four percent of the investigations over the six months prior to the onsite review. ▪ The investigation review documentation (DFPS Investigation Cover Sheet-Allegation & Final Report) was provided to the Monitoring Team and deemed to be completed fully for four of 15 (27%) investigations in Sample D.1. ▪ In one investigation found to be inconclusive by DFPS (43110674) the Facility review resulted in the Facility Director changing the finding to confirmed abuse. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ The investigation review documentation used by the Facility for UIRs (DFPS Investigation Cover Sheet-Allegation & Final Report) was provided to the Monitoring Team and deemed to be completed fully for none (0%) of the Facility investigations in Sample D.2. Consequently, for none of the five (0%), had the supervisor identified and documented concerns. ▪ For the five 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	The Facility-only investigations did not meet the requirements outlined in Section D.3.f. Based on this review this Provision was not in substantial compliance.	Noncompliance

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	unusual incident.		
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes. The Monitoring Team reviewed the UIR Tracking Log maintained by the Facility and for select investigations from Samples D.1 and D.2 cross-referenced data on the log with the "Recommendations for Current/Future Actions" section of the UIR and with documentation provided for Samples D.1 and D.2. This confirmed that the data maintained in the UIR log accurately reflected the data in the UIR and source documentation related to completed recommendations. In reviewing the UIR Tracking Log the Monitoring Team found: 1. For the 15 DFPS investigations in Sample D.2 the Facility identified 66 planned follow-up actions. Fifty-four (82%) were completed but only 19 of those 54 were completed by the planned completion date noted in the UIR. Therefore, 19 of 66 (29%) of planned actions were completed and completed on time. 2. For the five Facility investigations in Sample D.2 the Facility identified 14 planned follow-up actions. Eleven (79%) were completed but only five of those 11 were completed by the planned completion date noted in the UIR. Therefore five of 14 (36%) of planned actions were completed and completed on time. 3. In summary, for the 20 DFPS and Facility investigations in Samples D.1 and D.2 only 24 of 68 (35%) recommendations were completed and completed within the timeframe specified in the UIR. In none (0%) of the 20 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 20 investigations for which recommendations for administrative/programmatic action were made, the following was found: ▪ For none of 20 investigations reviewed (0%), prompt and thorough actions had been taken and documented. None of the 20 investigations had evidence of all recommendations completed within the timeframe specified in the UIR. ▪ For none of 20 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.	Noncompliance
	(j) Require that records of the	The parties agreed the Monitoring Team would conduct reduced monitoring because	Substantial

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	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.	previous reviews showed substantial compliance. The reduced monitoring consisted of observing a demonstration of the database available to check on past investigations involving a particular staff member or Individual. Based on this review this Provision was in substantial compliance.	Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	For all categories of unusual incident categories and investigations, the Facility did have a system that allowed tracking and trending by: ▪ Type of incident; ▪ Staff alleged to have caused the incident; ▪ Individuals directly involved; ▪ Location of incident; ▪ Date and time of incident; ▪ Cause(s) of incident; and ▪ Outcome of investigation. Over the past two quarters, the Facility's trend analyses: ▪ Were conducted at least quarterly; ▪ Did address the minimum data elements; ▪ Did use appropriate trend analysis procedures; ▪ Did provide a narrative description/explanation of the results and conclusions; and ▪ Did**,** as appropriate, contain recommendations for corrective actions. The Facility review of data, for the most part, did not identify trends that should have been formally addressed, most likely with a CAP. 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. This was addressed with a CAP but only two of seven action steps had been completed. • As reported in Provision D.2.a, the Monitoring Team was only able to validate timely reporting to the Facility Director/designee of three of five (60%) other serious incidents. This was addressed with a CAP but only two of seven action steps had been completed. • Therefore, collectively, only six of 15 (40%) serious incidents were reported timely. This was addressed with a CAP but only two of seven action steps had been completed. • As reported in Provision D.2.a the number of confirmed cases of abuse/neglect (comparing six-month periods) doubled and the number of serious injuries increased significantly. This significant increase was not identified by the Facility and	Noncompliance

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		addressed with a CAP or other QA review activity. • As reported in Provision D.2.h staff reported fear of retaliation. This was not identified by the Facility and addressed with a CAP or other QA review activity. • As reported in Provision D.2.i required injury audits were completed for only four of the last five months (80%). This was not identified by the Facility and addressed with a CAP or other QA review activity. • As reported in Provision D.3.f injury reports associated with serious incidents were often not completed correctly and fully. This was not identified by the Facility and addressed with a CAP or other QA review activity. • As reported in Provision D.3.i the Facility did not complete many of the recommendations made in reviewing investigations. Only 35% of recommended actions were completed and completed within the timeframe specified. This was not identified by the Facility and addressed with a CAP or other QA review activity. In most cases the Facility had not used these data to identify systemic issues that should have been addressed through a formal Corrective Action Plan. In the one case where it did (late reporting) only two of seven action steps in the CAP were completed. Compliance with this Provision requires not only tracking of data but also trending of data. Trending means analyzing changes in the data and, depending on what the data describes, identifying the need for 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 the Facility's QA process, especially in regard to Corrective Action Planning, was still in the early stages of implementation 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.	
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	The parties agreed the Monitoring Team would conduct reduced monitoring because previous reviews showed substantial compliance. The reduced monitoring consisted of reviewing past practice with Facility administrators and confirming the administrative processes (including data bases) that had been put in place to demonstrate compliance with this Provision remained in place. Based on this review this Provision was in substantial compliance.	Substantial Compliance

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	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.		

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment 8/12/14 2. RSSLC Action Plans 8/11/14 3. RSSLC Section E Presentation Book 4. DADS Policy 003.1 - Quality Assurance 5/22/13 5. RSSLC Policy A.28 Quality Assurance 1/29/14 6. RSSLC Policy A.29 Discipline Department Head Monthly Quality Assurance 1/29/14 7. RSSLC Policy A.30 Unit Quality Assurance Monthly Meeting 1/29/14 8. RSSLC Policy A.31 Database Request 1/29/14 9. RSSLC Policy K.12 Habilitation Therapies Departmental QA Plan 11/1/13 10. List of Facility policies that contain a Quality Assurance (QA) component (undated) 11. RSSLC QA Plan (including monitoring and key indicator matrix) 8/22/14 12. Quality Assurance/Quality Improvement Council meeting minutes since the last review 13. Monitoring tools and guidelines for each provision of the Settlement Agreement (SA) used by QA department (various dates) 14. Monitoring tools used by departments/disciplines 15. Corrective Action Plans (CAPs) initiated since the last review 16. CAPs completed since the last review 17. CAP tracking logs and related documentation **People Interviewed:** 1. Georgette Brown, Director of Quality Assurance 2. Judy Miller, Settlement Agreement Coordinator **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/26/14 and 8/27/14 2. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 8/25/14
	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, 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. A notable exception was that the Facility's Self-Assessment did not provide sufficient detail to determine the status of QA implementation by departments and disciplines. As noted in its last report the Monitoring Team continued to observe that

	different departments and disciplines were at different stages of QA implementation. The QA self-assessment should be more detailed describing implementation status by department/discipline. The Facility did not appear to have a comprehensive monitoring tool to assess its progress towards implementing its QA program and meeting all requirements associated with Section E. The Facility rated itself as being in compliance with Provision E.3 of Section E. The Monitoring Team determined the Facility was in compliance with this Provision. 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. Some Action Steps were specific and targeted to needed administrative activity directed at SA compliance. Others were more general and were not as descriptive as described to the Monitoring Team by the QA Director during the course of the review. The Action Plan should include, where appropriate, Action Steps for each department/discipline as well as Facility-wide actions and benchmarks for completion of all actions that need to be taken by departments/disciplines necessary to complete Facility-wide actions. For those Provisions determined by the Monitoring Team to be in noncompliance, the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome 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: The Facility QA process had improved significantly from that observed at the last review. In its last review the Monitoring Team noted that the QA program was in the early stage of development. For this review the Monitoring Team would characterize the QA program as in the early stages of implementation. Moving from development to implementation was an important step. During the review entrance conference when section leads briefly highlight accomplishments six different section, leads identified QA components within their section but these were apparently unknown to the QA department and/or were not contained in policies directed at those sections and/or were not yet integrated into the Facility's overall QA program. Although it is appropriate for disciplines and section workgroups to identify and track quality assurance measures that might not routinely be reported to the Facility as a whole, the presence of these should be reported to ensure that there is not duplication or inconsistency across measures. The Facility's QA process reviewed by the Monitoring Team demonstrated improved consistency among

	and between departments/disciplines in the organization and collection of data, review and analysis of data, interaction between the QA Department, Settlement Agreement Coordinator (SAC) and section leads, and presentation and review of data by the QA/QI Council. The reports prepared by the QA department for the QA/QI Council had improved month to month. Documentation and observation indicated that QA staff assisted each discipline in analysis of data. The QA Director and Settlement Agreement Coordinator met monthly with each SA Section Lead for this purpose. Recommendations and corrective action plans were seldom developed as a result of data presentation and review at the QAQI Council. In the QA/QI Council meeting observed by the Monitoring Team, considerable data was presented to the group but there was very little discussion of the data, any implications (good or bad), and whether any of the data suggested a need for a CAP or any other administrative./clinical response. There was little evidence in observation of this meeting, or in review of minutes of other meetings, that discussion at QA/QI Council led to decision-making and action planning. The Facility's processes for initiating, implementing, and tracking CAPs was still lacking good organization and was not integrated into QA/QI Council practices and protocol. In developing Corrective Action Plans (CAPs) the Facility had struggled with developing problem statements that identified the outcomes to be achieved and from which action steps to remedy the problem or prevent recurrence could be articulated and achievement of outcomes measured. This still, for the most part, was the case. CAPs were not always developed for issues for which data suggested a need for a CAP. The criteria for the development of a CAP were not clear. The Facility had not as yet developed an administrative review process to determine whether each of its nine CAPs had been implemented fully and timely. The entire CAP process needs significant improvement.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The Facility QA process had improved significantly from that observed at the last review. In its last review the Monitoring Team noted that the QA program was in the early stage of development. For this review the Monitoring Team would characterize the QA program as in the early stages of implementation. Moving from development to implementation was an important step. Most administrative systems associated with the QA Plan had been developed and most had been implemented and in use for at least several months.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility continued to use Policy A.28 Quality Assurance as its primary QA policy. This over-arching 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. The Facility had decided to suspend Unit based QA meetings until the Facility's overall QA program, and the QA/QI Council, could better define a set of expectations for Unit-based QA meetings. When unit based QA meetings had occurred they tended to focus on "case studies" rather than meaningful data reflecting key indicators of unit-based performance measures. 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. As noted in its last report the Monitoring Team determined that 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 exception was Policy K.12 Habilitation Therapies Departmental QA Plan (11/1/13). This remains a necessary activity to ensure the Facility can comprehensively present its QA program to the QAQI Council and executive leadership at the Facility. It is important that departments/disciplines embrace QA; one way of achieving this is to ensure policies that are specific to departments and disciplines address, where appropriate, QA processes specific to the subject matter of the respective policy. During the review entrance conference when section leads briefly highlight accomplishments, six different section leads identified QA components within their section but these were apparently unknown to the QA department and/or were not contained in policies directed at those sections and/or were not yet integrated into the Facility's overall QA program. The Facility's QA process reviewed by the Monitoring Team demonstrated improved 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. Considerable improvement in inter-departmental collaboration was observed during this review, both in minutes documenting various meetings and in QA/QI Council activity. For example, since the last review the Facility reported that 12 of 19 (63%) Section Leads were assisted in data review by QA staff and these data were also reviewed by discipline/department staff. <u>Facility QA policies and practices</u> There were facility policies that adequately supported the state policy for quality assurance. The Facility had a Quality Assurance/Quality Improvement (QA/QI) Council	

#	Provision	Assessment of Status	Compliance
		required by State policy. The Facility's QA process reviewed by the Monitoring Team demonstrated continued improvement in the organization and collection of data. The review and analysis of data had improved and was better for some sections of the SA than others. Interaction between the QA Department, SAC, and section leads, and presentation and review of data and analysis by the QA/QI Council had improved from that observed in the last review, but additional improvement, and consistency, was needed. Since the last review use of inter-rater reliability had expanded to include many sections of the SA. The data list/inventory at the Facility was not complete (no data was noted for Section J of the SA); the list was current. The inventory was maintained by the QA Director and was regularly reviewed. The QA plan narrative at the Facility had been updated in August, 2014. The plan was comprehensive and addressed 16 distinct elements of the QA program at the Facility. These included: ▪ Description of the purpose of the QA program, ▪ Description of the requirements of the data list/inventory ▪ Description of the requirements of the QA matrix ▪ Description of the requirements of the performance indicators ▪ The narrative analysis of data required of department/discipline heads ▪ Procedures for monitoring and sample selections ▪ Requirements associated with databases and presentation of data ▪ Requirements associated with inter-rater reliability ▪ Corrective Action Plan (CAP) requirements and procedures ▪ Requirements associated with monthly section lead meetings ▪ Requirements associated with program and residential services quality assurance meetings ▪ Requirements associated with department/discipline monthly quality assurance meetings ▪ Requirements associated with unit quality assurance meetings ▪ Requirements associated with the QAQI Council activities ▪ Requirements for the QA report ▪ Required Committee meetings The QA plan matrix contained the data to be submitted to the QA department; these data are then included in QA reports and presented to the QA/QI Council. The Facility's QA Plan matrix consisted of two separate matrixes. One described the monitoring/auditing requirements associated with the use of monitoring tools for all 19 sections of the SA (one is not required for Section E). The other described the data review and process for	

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		key/clinical indicators which had been developed to date. There were at least some key/clinical indicators for 18 of the 19 sections of the SA (one is not required for Section E). The exception was Section J. 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 18 sections (95%). None had been developed for Section J and all others were in need of continued refinement. For example 16 sections of the SA did not have both process and outcome indicators. Nevertheless this was a significant improvement since the last review when the Monitoring Team reported no key indicators had been developed. The key indicator matrix consisted of 67 distinct indicators some of which addressed multiple SA Sections. In sum, 114 indicators were applied across the 19 sections of the SA as noted below:	

Section	# of Indicators
C	3
D	5
F	3
G, H, L	23
I	10
J	0
K	4
M	30
N	2
O/P	17
Q	4
R	4
S	3
T	3
U	1
V	2

For these 19 Sections of the SA, both process and outcome indicators were identified for three (16%). No indicators were reported for Section J. For the remaining 15 Sections, either process or outcome indicators were provided; thus, the Facility had identified either process or outcome indicators, or both, for 18 of 19 Sections (95%). Of these, in 18 of 18 (100%), the indicators provided data that could be used, if appropriate, to identify the information specified in requirements for Provision E1: trends across, among, within and/or regarding: program areas; living units; work shifts; protections,

#	Provision	Assessment of Status	Compliance
		supports and services: areas of care; individual staff; and/or Individuals receiving services and supports, as necessary and appropriate to each key indicator. The Facility's data system had achieved a level of maturity such that multiple variables could be examined for almost every data point. The QA plan matrix included all self-monitoring tools and self-monitoring procedures. All data that QA staff members collect were listed on the matrix. All of the items in the QA plan matrix also appeared in the QA data list/inventory. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that of the 36 data items in the QA plan matrix (not including key indicators), 18 (50%) were submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). Those that were not included data items associated with sections D, G, H, K, L, N, T, and U of the SA. Most of this activity had been initiated since the last review by the Monitoring Team, and departmental/discipline compliance was variable. The reports prepared by the QA department for the QA/QI Council had improved month to month. The most recent report (July, 2014) was very good. It covered sections M, N, Q, U, S, and T of the SA. Much useful data for review, analysis, discussion, and decision-making was included. In some cases (such as nursing) section leads also prepared narrative information that included: accomplishments for the last three months; upcoming challenges and plans for overcoming these challenges; data analysis; review of corrective action plan(s); status of policy/procedure review, revisions, and implementation; summary of any relevant committee recommendations; and priorities for the next quarter. The Monitoring Team found the organization of this report to be very user friendly. Of the 36 items in the QA plan matrix, 18 (50%) 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). Those that were not included sections D, G, H, K, L, N, T, and U of the SA. At the time of this review the Facility reported inter-rater reliability was occurring for 25 of 36 (69%) items in the QA plan matrix. Much of this had only recently been implemented. The QA Plan Matrix included 36 items. The QA Plan Narrative contained 16 components. At the time of the review, of the 52 items/components of the QA plan narrative and QA plan matrix, the Facility implemented 48 (92%). The four components of the QA Plan matrix/narrative that were not fully implemented were: 1) Data Analysis, 2) Program and Residential Services Quality Assurance Meetings, 3) Department Discipline Monthly Quality Assurance Meetings, and 4) Unit Quality Assurance Meetings. These are four very	

#	Provision	Assessment of Status	Compliance
		important components of the Facility QA plan and need to be implemented as soon as possible. In its last review the Monitoring Team noted that in developing Corrective Action Plans (CAPs) the Facility struggled with developing problem statements that identified the outcomes to be achieved and from which action steps to remedy the problem or prevent recurrence could be articulated and achievement of outcomes measured. This still, for the most part, was the case. Documentation and observation indicated that QA staff assisted each discipline in analysis of data. The QA Director and Settlement Agreement Coordinator met monthly with each SA Section Lead for this purpose. The Facility had self-monitoring tools for 14 of the 19 sections of the SA (74%). Those that did not included Sections G, H, K, L, and N. This consisted of 34 monitoring tools. Of the 34 self-monitoring tools for the SA, the content of 34 (100%) appeared to be appropriate. The QA Director reported all 34 (100%) were reviewed within the past six months and revised as appropriate. For example monitoring tools for Sections F and U of the SA had undergone revision since the last review. Of the 34 self-monitoring tools for the SA, 16 (47%) had adequate formal written instructions and guidelines for their use. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that since the last onsite review, of the 34 self-monitoring tools, covering 14 of the 19 sections of the SA (one is not expected for Section E), 34 (100%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-rater reliability). From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that since the last onsite review, of the 19 sections of the SA, there was documentation that the implementation and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for 14 (74%) of the 19 sections. Based on this review the Monitoring Team determined this Provision was not in compliance; however, the Facility had made substantial progress since the last review.	
E2	Analyze data regularly and, whenever appropriate, require the	All data in the QA plan matrix should be summarized, graphed, and analyzed by discipline department with oversight and assistance as needed by the QA department.	Noncompliance

#	Provision	Assessment of Status	Compliance
	development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	Data from the QA plan matrix for four of the 19 (21%) sections of the SA (not section E) were, as appropriate, summarized, graphed showing trends over time, and analyzed across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as appropriate to the indicator being measured. Those that were not included sections G, H, I, J, L, M, N, O, P, R, Q, S, T, U, and V. As reported in Provision E.1 the Monitoring Team noted several deficiencies that potentially affect the accuracy of data and, therefore, potentially impact the Facility's ability to analyze data regularly as required in this Provision. These include: • Of the 36 items in the QA plan matrix, only 18 (50%) 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). • At the time of this review the Facility reported inter-rater reliability was occurring for only 25 of 36 (69%) items in the QA plan matrix. Much of this had only recently been implemented. • Data associated with monitoring tools for five of 19 (26%) sections of the SA were not being reviewed monthly by the QA Department and department/discipline staff. Since the last onsite review, a meeting occurred between discipline/department staff and QA staff at least once for 19 of the 19 (100%) sections of the SA. The Facility reported these meetings did not include: • A review of the data listing inventory and matrix, • Discussion of data and apparent outcomes, • A review of the conduct of the self-monitoring tools, • The creation of corrective action plans as appropriate, • A review of previous corrective action plans. It appeared to the Monitoring Team that the primary purpose of these meetings was to get QA Activity defined, clarified, and organized into a set of task oriented activities. The reports prepared by the QA department for the QA/QI Council had improved month to month. The most recent report (July, 2014) was very good. It covered sections M, N, Q, U, S, and T of the SA. Much useful data for review, analysis, discussion, and decision-making was included. In some cases (such as nursing) section leads also prepared narrative information that included: accomplishments for the last three months; upcoming challenges and plans for overcoming these challenges; data analysis; review of corrective action plan(s); status of policy/procedure review, revisions, and implementation; summary of any relevant committee recommendations; and priorities	

#	Provision	Assessment of Status	Compliance
		for the next quarter. The Monitoring Team found the organization of this report to be very user friendly. Of the 20 sections of the SA, all 20 (100%) appeared in a QA report at least once in each quarter since the last onsite review. Of the sections of the SA that were presented, 20 of 20 (100%) contained the following components: • Self-monitoring data (reported for a rolling 12 months or more and broken down by program areas, living units, work shifts, etc., as appropriate) • Key indicators (reported for a rolling 12 months or more and broken down by program areas, living units, work shifts, etc., as appropriate). • Narrative analysis There was an adequate description of the QA/QI Council in the QA plan narrative and in a separate QA/QI Council policy/ procedure document. Since the last onsite review, the QA/QI Council met at least once each month. Each SA section on a particular months agenda reported on: 1. Accomplishments for the last three months. 2. Upcoming challenges and plans for overcoming these challenges. 3. Data analysis 4. Review of Corrective Action Plan(s) 5. Status of policy/procedure review, revisions, and implementation 6. Summary of any relevant committee recommendations 7. Priorities for the next quarter Agendas were structured so that each Section of the SA was reviewed at least once every three months. Minutes from six of six (100%) QA/QI Council meetings since the last review indicated that the meeting occurred according to schedule. Minutes from six of six (100%) QA/QI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. Minutes from six of six (100%) QA/QI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes from six of six (100%) QA/QI Council meetings since the last review documented that (a) data from the QA plan matrix (key indicators, self-monitoring) were presented, (b) data were trended over time, (c) comments, interpretation, and analysis of	

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		data were presented. Recommendations and action plans were seldom developed as a result of data presentation and review at the QAQI Council. Numerous examples of client protection issues are provided in Provision D.1 of this report and data associated with most were either not presented to the QAQI Council or it was it was not acted upon. The Facility reported that none of its nine active CAPs resulted from QAQI Council deliberation. In the QA/QI Council meeting observed by the Monitoring Team, considerable data was presented to the group but there was very little discussion of the data, any implications (good or bad), and whether any of the data suggested a need for a CAP or any other administrative./clinical response. There was little evidence in observation of this meeting, or in review of minutes of other meetings, that discussion at QA/QI led to decision making and action planning. The Facility processes for initiating, implementing, and tracking CAPs was still lacking good organization and was not integrated into QA/QI Council practices and protocol. An adequate written description did exist that indicated how CAPs are generated. The criteria for the development of a CAP were not clear. In reviewing the Facility's nine active CAPs there did not appear to be any consistent logic (or data) as to why those subject matters were selected to be addressed with a CAP. Each of the nine active CAPs contained a "reason for CAP" section. In no case was the reason stated in quantifiable terms, such as "monitoring compliance scores for Section D of the SA are only 65% and need to improve". Each of the nine active CAPs contained what was characterized as a goal. In some cases the goal was expressed in quantifiable terms such as "increase the compliance scores to at least 90%". Without citing baseline performance it would be difficult to determine if the action steps in a CAP were having positive results. Because of this, of the nine CAPs reviewed by the Monitoring Team, none (0%) appeared to appropriately address the problem for which they were created. The problem for which they were created was typically unclear, ambiguous, and/or not quantified and therefore it would be impossible to measure CAP-related improvement or regression. This was the case even in an instance where data was clearly available. Please refer to the issue of late reporting of serious incidents in Provision D.2.a. Additionally, CAPs were not always developed for issues for which data suggested a need for a CAP. For example, as noted in Provision D.3.i, following up on investigation/IMRT recommendations appears to be a significant problem at the Facility yet no CAP was initiated to address this.	

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		Based on a sample of nine CAPs: • Nine (100%) included action steps to be taken to remedy and/or prevent the reoccurrence. • Nine (100%) included the anticipated outcome of each action step although this was rarely an outcome that could be objectively measured. • Nine (100%) included the person(s) responsible. • Five (56%) included the time frame in which each action step must occur. Others did not have a projected completion date for each action step. Based on this review this Provision was not in substantial compliance. Progress had occurred since the last review but full and complete implementation of data collection, review, and analysis had not as yet been achieved. The entire CAP process needs significant improvement.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a sample of nine CAPs: • Nine (100%) included documentation about how the CAP was disseminated. • Nine (100%) included documentation of when each CAP was disseminated. • Nine (100%) included documentation of to whom it was disseminated, including specific person(s) responsible. These data were recorded on each CAP. Additionally a review of CAP status was included in SA Section presentations at QA/QI Council meetings. Based on this review this Provision was in substantial compliance.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	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 an administrative review process to determine whether each of its nine CAPs had been implemented fully and timely. Such a process should include at least the following features: 1. When a CAP is developed the CAP should describe in measurable terms the expected outcome of the CAP, for example, "a reduction in injuries in home xyz." 2. As the CAP is implemented, predetermined relevant data should be recorded at predetermined intervals (e.g. monthly). 3. If after implementation of CAP action steps, data does not begin to show a positive trend, the CAP should be modified. The QA Director and QA/QI Council	Noncompliance

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		should review CAP data monthly. 4. After the CAP is closed (i.e. "fully implemented") data should continue to be recorded for a period of time specified in the original CAP, for example "three months after CAP closure." These more longitudinal data should be used to ultimately determine the effectiveness of the CAP. This process should be monitored by both the QA Department and the QA/QI Council. Based on this review this Provision was not in compliance. The entire CAP process needs significant improvement.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	As reported in Provision E.4 the Facility had not as yet developed an administrative review process to determine whether each of its nine CAPs had been effective, and if not required modification, and if so were modified. None of the nine CAPs had undergone an effectiveness review that resulted in modification. Based on this review this Provision was not in compliance. The entire CAP process needs significant improvement.	Noncompliance

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: 08/12/2014 2. Richmond State Supported Living Center Action Plans, updated: 08/11/2014 3. Section F Presentation Book materials 4. Richmond State Supported Living Center Settlement Agreement presentation, August 2014, Round 8 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 revised 5/12/2014 8. RSSLC Policy F.1:Scheduling Annual Personal Support Plan Meetings, revised 5/02/14 9. RSSLC Policy F.5: Completing Individual Support Plan Meeting Documentation, revised 03/27/12 10. RSSLC Policy F.6: Participating In/Documenting Addendum Meetings, revised 7/08/14 11. RSSLC Policy F.17: Habilitation, Training, Education, and Skill Acquisition Programs, Reviewed O2/21/14 12. RSSLC Policy F.22: Skill Acquisition Plan Development, Reviewed O2/21/14 13. Required Assessments Filed 10 Days Prior to the ISP Meeting encompassing the meeting dates of 4/1/2014-6/30/2014 14. Participation of Required Attendees at ISP Meeting, Meeting Dates of 4/1/2014 - 6/30/2014, dated July 30, 2014 15. Number of ISPs Held, ISPs Not Held within 365 Days and ISPs Not Filed within 30 days, covering the period of 8/1/2013 - 7/30/2014 16. 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, undated 17. Record Reviews for Individuals #497, #680 and #745 18. 30-Day ISPs and Assessments for Individuals #85, #153, #395, and #795 19. Individual Support Plans (ISPs) including assessments for Individuals #243, #501, #530, #596, #630, #655, and #753 20. Preferences and Strengths Inventory (PSI) for Individuals 30-Day ISPs and Assessments for Individuals #85, #153, #395, and #795 21. Sample of Monthly Reviews for Individuals #243, #497, #501, #530, #596, #630, #655, #680, #745 and #753 22. Documentation of Living Options Action Plans implementation for Individuals #86, #144, #149, #184, #302, #324, #349, #487, #503, #582, #723 and #758 23. Document entitled Monitoring the Timeliness of Monthlies 24. Section F Monitoring Tool 25. Quality Assurance Plan, Richmond State Supported Living Center, Revised 06/24/2014 **People Interviewed:** 1. Angela Hernandez, Program Compliance QIDP 2. Leroy Thompson, QIDP Coordinator

	3. Dameyon Landrum, incoming QIDP Educator 4. Georgette Brown, Director of Quality Assurance (QA) 5. Ashley Smith, Services Coordinator **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #680 and #745 2. Pre-ISP meeting for Individual #497
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F. 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 relied on data collected through the Facility's QA/QI processes and monitoring/auditing tools in some instances, but the F Monitoring Tool had continued to be undergoing revision In order to improve its Self-Assessment for use in achieving compliance, the Monitoring Team again suggests 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 as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. 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. 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. The Facility indicated in was not yet in substantial compliance for any of the provisions of Section F and the Monitoring Team concurred.
	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 that follows represents a compilation and synthesis of the interdisciplinary findings of the Monitoring Team. Positive developments included a 15-Day Integrated Assessment Meeting prior to each individual's annual ISP planning meeting to identify any discrepancies in assessments and review the IRRF; and, an innovative two-month QIDP "Boot Camp" to refresh all QIDP staff on the basic requirements of their roles. The Facility was also continuing to develop its 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 and had significantly improved its ability to track some related activities through the creation of useful databases. The Facility again requested the Monitoring Team focus its observations on selected ISP planning meetings

	and ISP Preparation meetings held during the monitoring visit, and the resulting ISPs,. 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:** This provision was not in compliance. No changes had been made to ISP format and process but considerable training and coaching continued to be provided to the QIDPs and IDTs. Overall, however, the Facility was still meeting with limited success specific to the requirements of this Section of the SA. IDTs still failed to consistently conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. Facilitation continued to provide mixed results. The Monitoring Team also remained concerned with the Facility's development and subsequent implementation of the ISP in accordance with the Americans with Disabilities Act (ADA) and Olmstead decision. **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 (SAPs) were not yet sufficiently constructed. The Monitoring Team found ISP strategies did not yet reflect encouragement of community participation in a meaningful or purposeful manner, although some progress was noted. Identification of barriers to living in the most integrated setting did not 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 continuing to develop its 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. It had significantly improved its ability to track some related activities through the creation of useful databases, but most of its key indicators remained focused on outputs rather than outcomes.

#	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:		

#	Provision	Assessment of Status	Compliance
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	The Qualified Intellectual Disabilities Professional (QIDP) was the one person assigned to each individual to facilitate the work of each IDT. <u>Staffing of QIDP Department:</u> The Facility reported that it currently had 20 QIDP positions, with two vacancies. The Facility also had a QIDP Educator, a QIDP Coordinator, and a Services Coordinator position which provided administrative and programmatic support for the QIDP Department and participation in departmental and quality assurance initiatives. The Facility had also developed a Program Compliance QIDP position. It was reported at the time of the last monitoring visit 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. The Section F Team described in interview a "co-supervision" process as it had developed since that time. Beginning on September 1, 2014, the QIDP Coordinator will meet with each Unit Director on a monthly basis on an ongoing basis to review the work of the QIDPs assigned to the respective living units. If corrective or disciplinary action is needed, the Unit Director will be responsible for implementation. It was also noted the QIDP Coordinator would take immediate action to meet with a Unit Director in situations that appeared to call for it. <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. As reported at the time of the last monitoring visit, the Facility was not currently assessing QIDP competency with regard to the facilitation of ISP meetings and the writing of the ISP documents. The Facility reported it was still 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 provided training using the standard curriculum as there were no certified trainers on staff at the Facility. RSSLC had continued to devote considerable resources to coaching and training for QIDP staff, as described in more detail in Provision F2e. The Facility requested the Monitoring Team continue to focus attention in this regard on two ISP annual meetings observed during the monitoring visit. There was 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 seven 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 seven ISPs reviewed (0%) did the facilitation process result in an adequate discussion of the most integrated setting.	Noncompliance

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Although progress was again 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 Monitoring Team observed the QIDP Educator 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. This remained an area of significant concern. Timeliness of assessments did appear to be improving.

<u>Conclusion:</u> This provision was found to be not in compliance.
</td><td></td></tr>
<tr><td>F1b</td><td>Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.</td><td>
<u>Composition and Participation of IDT:</u>
The Facility tracked the attendance of IDT members at annual ISP meetings. The Monitoring Team relied largely on a document provided by the Facility entitled Participation of Required Attendees at ISP Meeting, Meeting Dates of 4/1/2014 - 6/30/2014, dated July 30, 2014. This document tracked required attendance by discipline in the aggregate. These data, represented in the table below for the most frequently required disciplines, indicated there was fairly wide variation by discipline in compliance with attendance requirements.
<table>
<tr><th>Discipline</th><th>Total Meetings</th><th>Required Attendance</th><th>Compliance</th></tr>
<tr><td>Active Treatment</td><td>39</td><td>33</td><td>85%</td></tr>
<tr><td>Day Programming/Retirement</td><td>35</td><td>32</td><td>91%</td></tr>
<tr><td>Dietician</td><td>16</td><td>6</td><td>38%</td></tr>
<tr><td>Direct Support Professional</td><td>93</td><td>81</td><td>87%</td></tr>
<tr><td>Family</td><td>25</td><td>23</td><td>92%</td></tr>
<tr><td>Individual</td><td>94</td><td>77</td><td>82%</td></tr>
<tr><td>LAR</td><td>48</td><td>41</td><td>85%</td></tr>
<tr><td>Local Authority(Contracted)</td><td>65</td><td>56</td><td>86%</td></tr>
<tr><td>Occupational Therapist</td><td>73</td><td>64</td><td>88%</td></tr>
<tr><td>Physical Therapist</td><td>84</td><td>76</td><td>90%</td></tr>
<tr><td>Primary Care Physician</td><td>27</td><td>20</td><td>74%</td></tr>
<tr><td>Psychologist/Behavior Analyst</td><td>94</td><td>85</td><td>90%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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<tr><td>QIDP</td><td>94</td><td>94</td><td>100%</td></tr>
<tr><td>Registered Nurse</td><td>93</td><td>91</td><td>98%</td></tr>
<tr><td>Residential Coordinator</td><td>45</td><td>42</td><td>93%</td></tr>
<tr><td>Social Worker</td><td>75</td><td>73</td><td>97%</td></tr>
<tr><td>Speech Therapist</td><td>62</td><td>48</td><td>77%</td></tr>
<tr><td>Vocational</td><td>38</td><td>36</td><td>95%</td></tr>
</table>

In the Self-Assessment for Section F, the Facility reported overall required attendance rates for the months of April, May and June, 2014 were 93%, 88% and 74%, which appeared to represent a concerning downward trend. The Monitoring Team reviewed annual meeting attendance for a sample of seven ISPs completed across the past six months. For this sample, the ISP Preparation meetings indicated that 83 IDT members were expected to attend the annual planning meetings. Of these 83, 66 (77%) actually participated as evidenced by the completed signature sheets.

<u>Extent of Individual participation in ISP:</u>
Overall, the Facility reported in its self-assessment that the individual attended 89% of the 84 ISP meetings. Lack of attendance was reported to be generally linked to factors such as individual's illness or choice not to attend due to other preferences.

The Monitoring Team observed two ISP annual planning meetings as a part of this focused review and found there was progress in the process for facilitating the individual's participation. This was particularly true for Individual #680 who was verbal and able to actively participate in the discussion, The Monitoring Team encourages the Facility to continue to develop effective approaches for facilitating the participation of individuals who are not as verbal.

<u>Conclusion:</u>
This provision was found to be not in compliance.</td><td></td></tr>
<tr><td>F1c</td><td>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.</td><td><u>Policy:</u>
DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 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."

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</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		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. <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. There was evidence the IDTs had begun routinely making use of these processes to ensure needed assessments were completed on a timely basis, as seven of seven (100%) recent ISPs clearly defined the assessments that were to be completed. According to the Facility's self-assessment, on 07/21/2014 Facility staff reviewed a tracking spreadsheet for assessments due 02/01/2014 through 06/30/2014 to determine if all required assessments were posted on the shared drive 10 working days prior to the ISP meeting. Data remained consistent at around 70% each month for that period. The Monitoring Team also reviewed a document provided by the Facility entitled Required Assessments Filed 10 Days Prior to the ISP Meeting encompassing the meeting dates of 4/1/2014-6/30/2014. These data also hovered around 70% throughout the period. In order to further assess the actual timeliness of assessments, the Monitoring Team reviewed assessments for a sample of seven completed ISPs, including the ISP Preparation documentation. Findings included: • In the sample of seven 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 88 required assessments, 63 were both present and completed according to the timeliness requirements. Overall for this sample, the rate of timeliness was 72%, just slightly below the timeliness rate of 74% found during the last monitoring period. This finding was	

#	Provision	Assessment of Status	Compliance
		consistent with the Facility's data reported above. • Some assessments were not simply late, but were not completed at all. For the nine individuals in this sample, there were 88 total required but only 81 (92%) present in the assessment packets provided to the Monitoring Team. • On a positive note, as reported in Provision V4, the Monitoring Team found for Individual #181, who was scheduled to have annual ISP planning meeting within the ten working days, that for 12 assessments required per the ISP preparation meeting, 12 (100%) current or updated assessments were posted, and 12 (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> RSSLC had taken several steps to improve the quality of its assessments such that they would more likely reliably identify the individual's strengths, preferences and needs. These included: • The Facility continued to implement an "assessment of assessments" for some disciplines, including Medical, Pharmacy, Vocational, OT/PT and Speech. This was a quality assurance process implemented by each of those departments in which some sample of assessments was reviewed by departmental managers or, as in the case of the physicians, an external reviewer. • The Section F Team reported in interview that each IDT had begun holding a "15-Day" meeting prior to each individual's annual ISP planning meeting to identify any discrepancies in assessments and review the IRRF. This was in place of the "3-Day" meeting held in the past, which would provide additional time to resolve any discrepancies or take any additional needed actions. Although it was reported this was an informal process implemented in June 2014, the Monitoring Team noted that RSSLC Policy F.1: Scheduling Annual Personal Support Plan Meetings, as revised 5/02/14, called for an Integrated Assessment Meeting, in which the IDT meets 15 days prior to the ISP to review all assessments and identify strengths, deficits, barriers and recommendations to correct any discrepancies among the different assessments as well as to is to collect and reconcile information for the History, Current Supports, Current Status, and Proposed Recommendations sections of the IRRF. The RN Case Manager was to facilitate this latter part of the meeting, For an initial ISP, this meeting was required to be held 5 days prior to the ISP. The Facility was to be commended for taking this recent action to improve the quality and accuracy of assessments, although its implementation was too recent for the Monitoring Team to assess its impact.	

#	Provision	Assessment of Status	Compliance
		Progress continued to be noted in certain discipline specific assessment processes and outcomes throughout this report. Examples included: • As reported in Provision L1, the Monitoring Team was extremely impressed by the many clinical improvements noted for Section L.1, and found the Facility was near substantial compliance. • As reported in Provision P2, the Monitoring Team continued to find substantial compliance. The Habilitation Therapies Department continued to audit assessments to ensure they were completed in a timely and comprehensive manner. Results in the data provided by RSSLC continued to show the presence of all the needed assessment components. • As reported in Provision M2, the Nursing Department had continued to maintain the positive practices identified in the last compliance review, continued to make improvements to the nursing assessment process and remained in substantial compliance. 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, K6, L1, O2, O8, R2, S2, T1b1, T1b3, T1d and U1. These findings, taken together, demonstrated assessments were still not routinely of sufficient quality overall to reliably identify the individual's strengths, preferences and needs. Examples included: • As reported in Provision R2, communication assessments needed improvement in the identification of objectives and/or methods to improve individuals' abilities to communicate and promote the expansion of their skills. Additionally, more input needed to be given with regards to how the strategies provided in the assessment could be better integrated throughout the individual's day, thus allowing for maximum generalization of skills. • The Monitoring Team attended the ISP annual planning meeting for Individual #680. The annual medical assessment, dated 8/05/2014, indicated the following information: ◦ "History of Abnormal EEG 11/4/2008: During hospitalization for syncope on 11/04/08 EEG showed frank epileptiform activity and mild occasional generalized spikes. He was started on Keppra while in the hospital. CT of brain showed microscopic ischemic changes in periventricular white matter bilaterally. No seizure reported since November 2008. He was treated with Keppra then Vimpat and repeat EEG on 9/2013 was normal, Neurologist recommended to taper Vimpat until discontinued and monitor for seizures as it could have been a hypoglycemic episode. Seen again on 03/25/14 by Neurology. No seizure after tapering off Vimpat. Recommended PRN flu."	

#	Provision	Assessment of Status	Compliance
		According to the review of injuries as documented in the ISP Guide that was used at the ISP annual planning meeting and in the final ISP narrative, on 3/22/14, the individual was found on the floor by a DSP stretched out rapidly moving arms and legs and it was noted the individual had bitten his lower lip. The medical assessment did not reflect this information. • As reported in Provision O2, six of eight individuals in Sample O.1 (75%) 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). Four other individuals not included as part of the sample were also noted to have inaccurate risk scores as it related to falls. • As reported in Provision O8, three of seven individuals (43%) 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. <u>Conclusion:</u> This provision was found to be not yet in compliance.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	<u>Extent to which assessment results are used to develop ISPs:</u> Current assessment practices at RSSLC, in terms of timeliness, accuracy and thoroughness, did not yet 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. Examples of continuing deficiencies in the use of assessment results that negatively affected compliance included the following: • As reported in Provision T1e, assessment recommendations and proposed monitoring parameters for individuals with Community Living Discharge Plans (CLDPs) in the past six months were not adequately used to address significant issues that could impact a safe transition to community living. • As reported in Provision S1, it was not evident that assessments were consistently used in the development of SAPs for the majority of individuals living at the Facility. Furthermore, there was no indication of substantive improvement in the use of assessments in comparison with the previous site visit. For example: o ISPs for only two of 10 SAPs (20%) reflected evidence to support the reviewed SAP. o Functional Skill Assessments (FSAs) for only one of 10 SAPs (10%) reflected evidence to support the reviewed SAP. Records did reflect that each individual had been provided with skill assessment by means of the FSA. In 90% of the reviewed SAPs, however, it was not evident that the FSA had been effectively used in the development of skill acquisition	Noncompliance

#	Provision	Assessment of Status	Compliance
		programs. • As reported in Provision R3, only six of 11 ISPs reviewed (55%) contained SAPs to promote functional communication. In addition, for four individuals, who were recommended as part of the Speech Assessment to receive indirect supports in the form of a SAP, there was no evidence this was integrated into the ISP and implemented. • As reported in Provision P2, in eight of the fourteen ISPs or ISPAs reviewed (57%), SAPs that had been recommended in the OT/PT assessment were present. • As reported in Provision O2, for zero of four individuals (0%) in Sample O.2, all recommendations by the PNMT were addressed / integrated in the ISPA, Action Plans, IRRFs and IHCPs. <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 seven recent ISPs reviewed, for none (0%) did all of the discipline assessments include the applicable statement/recommendation. • Of the 51 total discipline assessments that were present and should have had a statement, 36 (71%) included a determination of whether the individual could be served in a more integrated setting. This was noted to be a significant percentage increase from the previous six month period. • Of the 51 assessments that should have included a determination and recommendation, only four (8%) included substantive recommendations for how the individual's needs could be met 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. The template statement more often 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Six of seven ISPs (86%) included an independent recommendation from the professionals on the team to the individual and LAR. For Individual #753, the IDT indicated it was the determination of the professionals that the individual could not be served in a more integrated setting because the LAR wanted the individual to remain at RSSLC, perhaps indicating this IDT needed some additional guidance as to their responsibility to make an independent determination. • 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. As also described in Provision T1b2, IDTs did not develop individualized plans for education and awareness that would be sufficient to meet the learning needs of the individuals residing at the Facility. In Provision T1b1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such obstacles. Overall, the Facility was not yet effectively identifying or addressing obstacles. A review of six recently completed ISPs for which a referral was not made continued to indicate IDT members need additional training in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs: • None of six (0%) of the recently completed ISPs reviewed for which a referral for transition was not made evidenced proficiency in identification and addressing of obstacles. • In none of the six (0%) that identified LAR or individual choice as a barrier were there specific, individualized action plans developed to address these specific barriers. There was some continued 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. 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. For example, for Individual #680, for whom an ISP annual planning meeting was held during the monitoring visit, the IDT did not include any supports related to employment in their description of what would be needed in the most integrated setting, even though the potential for meaningful integrated employment was a significant strength for the individual.	

#	Provision	Assessment of Status	Compliance
		The IDT must identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported. The identification of needed services and supports is also pre-requisite to assisting the team to identify and address potential obstacles to movement. If the IDT members have reached a general consensus that the individual could be served in a community setting, it is incumbent upon them under the SA and Olmstead to address what would be needed to facilitate that, regardless of whether a referral is made. If the team does not address these needs because a referral is not made, this results in little likelihood of a referral being made or even that appropriate supports and services are included in the ISP that would foster an individual's eventual move to the most integrated setting. 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 six recent ISPs that did not result in a referral, none (0%) adequately identified the protections, services and supports that would be needed by the individual in the most integrated setting. The Monitoring Team remained concerned that the new standardized assessment templates did not clearly require the IDT members to provide an affirmative description of the individualized needs in a community living setting. Finally, at the time of the last monitoring visit, the Monitoring Team reviewed the ISPs for 12 individuals for the living options obstacles and Action Plans and found these were typically minimal, not individualized and not measurable. During the present visit, these were reviewed to ascertain the level of implementation of these plans for the past six months, including any ISPA, documentation related to any community education and awareness activities and, if held, any updated ISP or ISP Preparation documents. The outcomes were that very little implementation of even these minimal plans had taken place, resulting in little to no information upon which to understand individuals' preferences or base future Action Plans. Examples included: • For Individual #503, the facility discipline members had 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 a 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 Fair. There were no individualized plans or measurable outcomes defined.	

#	Provision	Assessment of Status	Compliance
		○ For the current monitoring visit, the Facility provided one Trip Memo for the period 2/1/2014-8/27/2014, which was for a visit to a local park. The noted purpose was community engagement. The Monthly Review for March 2014 indicated that the individual would go on trips scheduled by the recreation department to increase community awareness skills. The Monthly Reviews for April, May and June 2014 all stated the individual had taken several trips in April. The Monthly Review for July indicated the individual is "schedule" (sic) to go on different trips with Day Program. There was no reference to attendance at the Provider Fair held in May 2014 and the attendance record provided for review indicated the individual did not participate. • For Individual #149, facility discipline members had 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 the current monitoring visit, six months of Monthly Reviews indicated the individual did not make any community group home tours, nor attend the Provider Fair. Review of attendance records for tours and the Provider Fair confirmed this. No ISPA held addressed the LAR-identified obstacle of being able to communicate the occurrence of hazardous conditions or any other activity related to community education or awareness. • 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.	

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		There was no discussion of the individual's specific learning needs, desired measurable outcomes or monitoring of results documented. o For the current monitoring visit, documentation indicated the individual had participated in six community outings and that the intent was either community engagement or community awareness. There was no documentation that indicated how these activities were intended to support community awareness or any measurement of effectiveness in that regard. No living options tours were documented and the Monthly Review for May 2014 indicated the individual did not attend the provider fair because "no fairs were offered during this period." In fact, the Facility did hold a Provider Fair in May, but the individual did not attend. The Monthly Reviews also indicated each month that the individual and brother would meet with the contract LA in July 2014 to receive CLOIP information; the Monthly Review for the month of July made the same statement, with no reference as to whether any CLOIP interview was held or had been delayed or what the individual's response to it had been. At the ISP Preparation Meeting held on 6/16/14, there was no evaluation of the implementation or effectiveness of the Living Options Action Plans, any discussion of the obstacles noted in the current plan, or any projected plans for the upcoming year. The tentative Living Options goal was the generic template statement for the individual to live in the most integrated setting appropriate to the individual's preferences, strengths and needs, yet no actions had been taken to ascertain the individual's preferences. • For Individual #324, the narrative of the Community Awareness and Education Discussion reflected a discussion of the individual's needs in a more integrated 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. o For the current monitoring visit, the data provided indicated the individual took no tours of community living options in the past six	

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		months. The Monthly Reviews indicated the individual did not attend the Provider Fair in May 2014, but the recent ISP Preparation meeting stated the individual was in attendance. The attendance list provided for review did not include the individual, however. There was no evaluation of the individual's response in either the Monthly Reviews or the ISP Preparation documentation, nor any discussion of the obstacles noted in the current plan, or any projected plans for the upcoming year. The tentative Living Options goal was the generic template statement for the individual to live in the most integrated setting appropriate to the individual's preferences, strengths and needs. • 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. o For the current monitoring visit, the Monthly Reviews for March and April 2014 did not include tracking of community excursions or the delivery of community awareness information to the individual or LAR, and there were no Monthly Reviews for May through July 2014. Trip Memo documentation indicated the individual had been scheduled for five community activities and had participated in three. There were no tours of community living options. • 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	

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		participate in group home tours had an implementation date, but no one was assigned responsibility and no outcome criteria were indicated. o For the current monitoring visit, no living options tours were documented in the Monthly Reviews during the past six months. The individual's annual ISP planning meeting was held on 8/19/14 and indicated the obstacles were Individual Choice, due to a lack of understanding of the options, and LAR Choice. There was no Action Plan for acquainting the individual with community living alternatives. Only a generalized Action Plan to provide opportunities to educate the LAR was present. There continued to be no discussion of the individual's or LAR's specific learning needs in this regard, desired measurable outcomes, or plans to monitor results. • 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. o For the current monitoring visit, the unsigned Monthly Reviews were identical for each month provided, indicating the individual took no tours as none were scheduled and did not attend Provider Fairs as none were held. While it did appear to be the case that no tours were held in June, tours were available in the remaining months, and a Provider Fair was held in May 2014. <u>Conclusion</u>: This provision was found to be not in compliance.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate,		

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	and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	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>Identification and Use of Individuals' Preferences and Strengths:</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 the 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 QIDP 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. In the review of seven recently completed ISPs, the Monitoring Team found there was some progress in the efforts by IDTs to incorporate individuals' preferences into action plans. Preferences and strengths identified in the PSI were acknowledged at the beginning of the ISP Preparation meetings and annual ISP planning meetings, although the Monitoring Team remained concerned that the PSI process, as it is currently implemented, was not adequate for identifying preferences and strengths. Preferences continued to be focused on favorite foods and environmental likes and	Noncompliance

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		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. The Monitoring Team did observe some Action Plans and Service Objectives related to identified preferences. Some continued to be formulated in a generic manner, i.e. will go on community outings "consistent with preferences," but some were more thoughtful and specific. • As reported in Provision S1, a review of SAPs for ten individuals found only 30% were related to individuals' identified preferences. • Seven of seven ISPs (100%) incorporated preferences to a degree in the Action Plans, but none (0%) were observed to have done so in a thorough and effective manner. The Monitoring Team was also concerned that even when IDTs were identifying Action Plans related to preferences, these were not being consistently implemented. For example, for Individual #745, whose annual ISP planning meeting was observed during this monitoring visit, the IDT noted the individual's positive response to aromatherapy and developed an Action Plan for the individual to visit Bath and Body Works as a means of integrating her preference with a community integration activity. The Monitoring Team found in review of the Monthly Reviews that this same Action Plan was in the ISP for all of the preceding year, but had never been implemented. Action Plans to address strengths were not yet consistently observed, but there was improvement noted in the discussion held for the annual planning meeting for Individual #680. The ISP annual planning meeting began with a discussion about what the individual was good at. The Facility might want to consider for using that approach for all individuals. Other helpful questions could include: • What do people like about the individual? • What is your favorite thing about the individual? • What can/does the individual contribute to friends, family, community? • What special talents does the individual have? The Monitoring Team was also impressed with the discussion in the ISP annual planning meeting for #680 regarding the individual's musical talents and a plan to assist the individual to obtain community employment in a music store. The Action Plans developed for employment, as observed in the written ISP, were considerably less	

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		detailed and did not reference the specific plan; rather, the plans simply indicated the individual would be referred for off campus employment and that a service request for supported employment would be sent. The ISP should include sufficient, measurable steps, either in a Service Objective or SAP, to meet the desired outcome. The written ISP for #680 did not include sufficient detail in the Action Plans, nor was there a Service Objective or SAP related to this goal. <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 seven (0%) completed plans reviewed 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> Overall, the Monitoring Team found there had been little progress in developing and implementing ISPs that provided adequate strategies to encourage meaningful community participation. • As reported in Provision S3b, of 10 SAPs submitted by the Facility, none of the sampled SAPs included indications of potential implementation in the community. Tracking data maintained by the Facility reflected that efforts to provide skill acquisition training had declined in recent months. It therefore did not appear that the Facility had a comprehensive plan for providing community instruction when developing the SAPs. • As reported in Provision S3 (b), only one individual living at RSSLC was currently provided community employment. The Monitoring Team was impressed, however, with the Facility's efforts during the monitoring visit in holding a Job Fair for employers to meet with and interview individuals who were interested in community employment. The early outcomes of this activity were reported to be positive and likely to result in increased opportunities for integrated community employment. In addition, the Monitoring Team was further impressed with the community employment efforts IDT members discussed in Individual #680's annual ISP planning meeting as described above. The Facility is encouraged to expand such efforts to achieve the outcome of community employment for a greater number of individuals. • The Monitoring Team also observed that, for the two focus ISP annual planning meetings observed on-site, there were leisure and recreational activities identified to be conducted in the community that were related to preferences, but few meaningful SAPs were created for skill acquisition in the community. For Individual #680, there were only three SAPs, two of which called for the	

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		individual to be able to identify symptoms of low blood sugar; the third was to make a low sugar drink. The Action Plans indicated all of these could be implemented in the community. The two completed SAPs provided for review indicated they would be implemented in the home and did not include specific instructions for community implementation. It therefore did not appear that the Facility had a comprehensive plan for providing community instruction when developing SAPs. As has been recommended in Provision T1b2 on various occasions, the Facility's IDTs should develop an individualized community participation strategy for each individual that takes in to account their specific learning needs, preferences, and strengths. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community; and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual. <u>Conclusion:</u> This provision was found to be not in compliance.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	<u>Extent to which ISP specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet needs:</u> For none of seven (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. Additional examples included: • As reported in Provision S1, a review of ISPs for ten individuals revealed that SAPs were often not developed to address needs identified in adaptive skill, psychological or habilitation assessments. • Also reported in Provision S1, only 20% of SAPs developed for the sample of ten individuals were chosen in an individualized manner. • 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. • As reported in Provision O2, in zero of the four individuals' plans reviewed (0%), there were appropriate, functional, and measurable objectives to allow the	Noncompliance

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		PNMT to measure the individual's progress and efficacy of the plan. 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 #680 had three SAPs, all related to management of diabetes. While this was of essential importance to the health and independence of the individual, there were many other preferences, needs and opportunities identified in the assessments and discussion that were appropriate for skill development. The SAPs developed were not so time intensive or overly complicated as to make additional skill acquisition burdensome or impractical in any way. • Individual #745 had only one SAP. <u>Adequacy of processes for identification of and plans to overcome barriers to living in the most integrated setting:</u> 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 six (0%) recent ISPs reviewed for which a referral was not made evidenced proficiency in this regard. Also see Provision F1e above. <u>Conclusion:</u> This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	<u>Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions:</u> This provision requires that all protections, services and supports, treatment plans, clinical care plans, and other interventions are delivered in a manner that forms a unified approach to meeting an individual's needs and supporting his/her aspirations and preferences. 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;	Noncompliance

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		• Individuals' personal goals, preferences and/or needs are integrated across and throughout Action Plans; • Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.) • Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary. As the Monitoring Team has described in previous reports, 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. 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. 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, zero of eleven ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. • As reported in Provision F1e and T1b2, for none of the six (0%) recently completed ISPs for which a referral was not made was there an individualized plan for increasing awareness of community living options that took into account the learning needs of the individual. 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	

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		should be considered in developing an integrated and individualized strategy for each individual. <u>Conclusion:</u> This provision was found to be not in compliance. To move in the direction of substantial compliance, the Facility should focus its efforts for the next six months on the following: providing 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. Some progress was noted. For example, at the time of the last monitoring visit, it was reported that a review of behavioral interventions for required elements indicated that in nine of 17 areas (53%), the Facility was rated as having poorer performance in the development of methodology for implementation for Positive Behavior Support Plans (PBSPs) than in previous reviews. For this visit, as reported in Provision K9, RSSLC had achieved improvement in 14 of the 17 areas (82%), and twelve of the 17 areas (71%) were rated as fully successful. This progress was not consistent across all areas however. Examples included: • As reported in Provision S1, methods for implementation of SAPs for ten individuals indicated there was some modest improvement in some areas, but continued to be lacking overall: o Forty percent (40%) reflected adequate behavioral objectives. o Forty percent (40%) adequate operational definitions. o Twenty percent (20%) reflected an adequate description of teaching conditions o None (0%) reflected sufficient trials for learning to take place. o Thirty percent (30%) included adequate instructions for staff. o Eighty percent (80%) reflected the opportunity for the target skill to be performed. This was the criterion in which most progress was observed. • As reported in Provision R3, for zero of four individuals (0%), were staff instructions provided for individuals' Augmentative/Alternative Communication (AAC) devices, including written step-by-step instructions and pictures. • Also reported in Provision R3, a pervasive issue noted was that there was not a clearly developed treatment plan that outlines not only the expected frequency and schedule of treatment but the underlying relevance and functionality of the chosen program and/or treatment. • As reported in F2a1 above, the written ISP for #680 did not include sufficient	Noncompliance

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		detail in the Action Plans, nor was there a Service Objective or SAP related to the achievement of an employment goal. Extent to which ISP identifies timeframes for completion: For none of the nine ISPs reviewed (0%) including the sample of seven recently completed and the final written versions for the annual ISP planning meetings observed on site, did action plans include adequate timeframes for completion. ISP Action Plans typically documented an implementation date as well as a projected timeframe and overall projected completion date, but 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 only three of six individuals' plans reviewed (50%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. Extent to which ISP identifies responsible staff: The seven 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. Conclusion: This provision was found to be not in compliance.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Extent to which interventions, strategies, and supports are practical and functional: 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 Provision S3, only five of 10 sampled SAPs (50%) targeted skills that would likely be useful for the individual. • As reported in Provision S3b, the provision of skill acquisition training in the community had declined in recent months. • As reported in Provision P2, for only one of six individuals' records (17%) reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA.	Noncompliance

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		Conclusion: 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.	Extent to which ISP identifies data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress: The Monitoring Team found the Facility did not yet consistently identify the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress. Some progress was reported. For example, as reported in Provision K9, data collection methodologies were found to be adequate for 80% of Positive Behavior Support Plans (PBSP) reviewed., which was a substantial improvement over the previous monitoring period. Examples of continuing 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 remained, however, and included: • As reported in Provision O2, in zero of four 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 S1, twenty percent (20%) of reviewed SAPs reflected a potentially adequate documentation methodology. Extent to which ISP identifies the persons responsible for the data collection and the persons responsible for data review: There was some continued progress in this area. For example, for seven of seven ISPs reviewed (100%) the Action Plans clearly defined the person(s) responsible for data review. For only four of seven ISPs reviewed (57%), however, did the Action Plans clearly and consistently define the person(s) responsible for implementation and data collection. Issues observed included designating the IDT as a whole for implementation and data collection, as well as designating the Residential Coordinator for data collection and implementation in the Action Plans, but designating the Direct Support Professional (DSP) in the actual programs. There continued to be evidence that even when the ISP appropriately designated the person(s) responsible for these tasks, it was not sufficient to achieve the outcomes of ensuring program implementation and review were accomplished as required, as evidenced by the findings described in Provision F2d below. This also reflects the need to make this designation clearly in all cases, so that there is no confusion about responsibility leading, in turn, to lack of implementation Conclusion: This provision was found to be not in compliance.	Noncompliance
F2b	Commencing within six months of	Extent to which goals, objectives, anticipated outcomes, services, supports, and	Noncompliance

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	the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	<u>treatments are coordinated in the ISP:</u> This provision requires that disciplines work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. The 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. For example: • The Facility continued to implement 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. It also continued to implement a CLDP-specific Grand Rounds process. • As reported in Provision R2, the Behavioral Health and Speech Language Collaboration Procedures were fully implemented, including a scheduled conference between the Behavior Analyst and the Speech Language Pathologist when behavioral assessments were revised or updated. Any current strategies or supports that are related to either discipline, communication strengths, deficits and barriers to communication were to be discussed and communication deficits or barriers that could contribute to challenging behaviors documented. • The Facility was found to be in substantial compliance for Provision J15, based on Steps taken by the Facility to facilitate coordination and integration of neurological and psychiatric care. 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, psychiatrist and other healthcare professionals. The Monitoring Team commends the Facility for these initiatives to promote staff coordination in the development and monitoring of supports and services. Overall, however, coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP continued to be lacking, as described throughout this report and this Section F. Examples included: • As reported in Provision F1c, there was information in the record and in the ISP Guide for Individual #680 that indicated the IDT should have evaluated whether the individual might be having seizure activity given a positive history in the relatively recent past. There was no discussion documented at time of the event or at the ISP annual planning meeting about the possible etiology of this event, nor was there any discussion in the IRRF proceedings held at the time of the ISP annual planning meeting. Given the individual's history, it would have been expected the IDT would consider whether this episode may have been seizure-related. This failure to would indicate that the system to ensure protection from	

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		harm was not adequately coordinated with the processes for medical assessments and health care. • As reported in Provision T1b2, the Facility should have created, 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. <u>Conclusion:</u> This provision was found to be not in compliance.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	<u>Extent to which ISP is accessible to staff:</u> As reported in Provision V1, Active Records and Individual Notebooks were generally, but not consistently, available and accessible. The Facility also self-reported that audits of records found many records were not accessible (that is, not present when the audit was done). <u>Extent to which ISP is comprehensible to staff:</u> 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 from the 10 PBSPs all fell at or 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 Provision K11. For the seven 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 continued to be 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 reported at the time of last monitoring visit that it was considering a revision that would integrate the schedule and special considerations, but this had not been implemented.	Noncompliance

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		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 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 S1, observations revealed that across all settings 35% of observed individuals were functionally engaged. Furthermore, slightly less than one-third (31%) of all environments observed reflected at least 50% engagement. • As reported in Provision R3, four of eight staff interviewed (50%) were knowledgeable of the individuals in Samples R.4 and R.5 and their communication related programs. • As reported in Provision O4, while staff knowledge of the individuals' PNMPs continued to show improvement since the previous visit, staff still did not consistently engage in safe mealtime or positioning practices. Seventeen of 31 individuals' (55%) dining plans/PNMPs were implemented as written. <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>: According to RSSLC Policy F.17: Habilitation, Training, Education, and Skill Acquisition Programs, Reviewed O2/21/14, at least monthly, or more often if deemed necessary, the IDT member or discipline identified as responsible for overseeing the training plan must assess the effectiveness of the programs for which they are responsible. If there is a lack of expected progress, the responsible IDT member takes action as needed. These actions may include trying to determine the cause(s) for the lack of progress and taking corrective actions such as revising the teaching methodology, changing the scheduled time of the training, using more effective reinforcement for correct responses, providing improved staff training, and providing closer monitoring of plan implementation. The IDT member was to document the monitoring in a monthly progress note. The QIDP was also to provide oversight of this monthly review process through monthly reviews of the ISP. The Facility had also recently modified its procedures to address ongoing issues of timeliness of Monthly Reviews of the ISP by the QIDP. It provided a document for review entitled Monitoring the Timeliness of Monthlies. This document indicated that Monthly Reviews would be tracked according to a rolling schedule of reporting periods based on an alphabetized list of individuals' names. QIDPs were to submit Monthlies via email to the QIDP Coordinator and Service Coordinator (as well as submitting to the Unit Clerk for filing) by close of business on the date due. On the day following the due date, the Service	Noncompliance

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		Coordinator was to enter on the spreadsheet completed and delinquent Monthlies, with an email to be sent to the QIDP Coordinator regarding delinquencies. As follow-up, the QIDP Coordinator was to notify appropriate QIDPs and Unit Directors for appropriate action. The Monitoring Team would recommend the Section F team develop some approach to sampling the Monthly Reviews for quality as well, as the findings that follow would indicate. The Monitoring Team continued to find that the QIDP Monthly Review process was 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 seven individuals with recent ISPs were reviewed. These were generally available and most appeared to be timely, but the content of the reviews remained well below standard and seldom provided any meaningful evaluation of progress. There were still many instances in which the same comments were provided for months at a time. • As reported in F1e above, Living Options Action Plans for 12 individuals indicated minimal implementation, review or modification • The Monitoring Team also requested the monthly reviews for individuals who had annual ISP planning meetings or ISP Preparation during this visit. These also reflected a lack of a rigorous approach to the tasks of review, monitoring and modification. Effective planning for the future cannot take place if the IDT is not implementing and monitoring the progress of individuals on an ongoing basis. For none of three (0%) had the ISP had been consistently implemented. See additional detail below in this provision. 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, individuals receiving direct Speech Services were not provided with comprehensive progress notes that contained each of the required indicators, and zero of five individuals (0%) receiving indirect Speech Services) were provided with comprehensive progress notes. • As reported in Provision P2, for individuals with PNMPs, for 0 of 14 individuals sampled was there evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. Only one of six individuals receiving direct OT/PT Services (17%) was provided with comprehensive progress notes (IPNs) that contained all of the required indicators.	

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		Extent to which ISPs are modified as appropriate: The Monitoring Team found there remained significant concerns as to the appropriate and timely monitoring, review and modification of the ISP on an ongoing basis and in response to change of status, progress or lack of progress. Some positive findings were noted in certain areas. For example, as reported in Provision O3, for five of five individuals (100%) 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. However, the overall failure to complete timely or meaningful reviews continued to produce a concomitant negative outcome in terms of appropriate modification. Absent those reviews, no meaningful modification could have taken place. Many Action Plans were not implemented on a timely basis or at all, and individuals often remained on programs with very little progress noted and very little modification made for many months. As described above, the Monitoring Team attended the ISP annual planning meeting for Individuals #680 and #745 and the ISP Preparation meeting for Individual #497 during this monitoring visit, and reviewed the individual's record for evidence of implementation and any necessary modifications of the current year ISP. For none of three (0%) had the ISP had been consistently implemented. For example, the Monitoring Team attended the ISP Preparation meeting for Individual #497. Prior to the meeting, the individual's record was reviewed with the following findings: • Many ISP Training Objective Progress Notes were not present in the record. For example, the individual's ISP had Action Plans that included SAPs for Self-Administration of Medication (SAMS) objective, social dining and tooth-brushing. The record contained no Training Objective Progress Notes for the latter two programs until July 2014. Of these, only the Training Objective Progress Note for tooth-brushing had actual data documented. • The Monthly Reviews provided no information regarding the tooth-brushing SAP from February-May 2014. In June and July, the Monthly Reviews indicated the staff would be re-inserviced on prompting levels. The Monitoring Team requested the staff in-service sheets for the past six months and none were provided regarding the tooth-brushing. • No Training Objective Progress Notes for this objective were found, but there were data in the Monthly Reviews that had demonstrated some progress over a period of months. The Self Administration of Medications (SAMS) program was noted as discontinued in June 2014, but there was no rationale provided. • The individual had objectives related to building relationships that included off campus activities, to be documented in observation notes and trip memos, and having visits with the Psych Assistant, to be documented in the IPNs. The	

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		Monitoring Team requested the Trip Memos for the past six months and received only three, which did not indicate any specific activities related to relationship-building. The Monitoring Team also reviewed the IPNs since Feb and found no documentation of visits with the Psych Assistant. • It was stated during the ISP Preparation meeting that the SLP was working with the individual in vocational and day program settings using a speech generating device. The QIDP asked whether this use of the device could be expanded upon in the upcoming year and the response was some additional phrases could be used. This was a positive, as far as it went. There was no discussion regarding the nature of its current use, the skills demonstrated by the individual or other areas with which this communication device might be integrated. The only references in the record were in IPNs dated December 2013 through February 2014; the latest was a late entry dated 2/12/2014 that noted the individual was presented with the device and had been able to push the button on request in three of nine trials, with the SLP to provide follow-up on device implementation. There was no reference to this in the QIDP Monthly Reviews. The Monitoring Team requested any additional documentation regarding implementation of this program in any setting. No information was provided. It was noted the IDT met in an ISPA the day following the Monitoring Team's request to address the non-implementation of this program. <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-	<u>Extent and adequacy of competency-based training for staff responsible for development of ISPs:</u> RSSLC Policy F.04 Individual Support Plan Process revised 5/12/2014 required all staff responsible for the development and implementation of the ISP to receive competency-based training upon initial employment, as needed and on a refresher basis at least every 12 months thereafter. In addition, QIDPs received training in the facilitation of ISP meetings upon initial employment with monitoring as needed. RSSLC had also continued to focus considerable resources on additional training for QIDPs. From March through May 2014, the Facility held a QIDP "Boot Camp" to refresh all QIDP staff on the basic requirements of their roles. The sessions included the following: • The Importance of a QIDP and Monthly Reviews • ISP Preparation Meeting • ISP Draft/Integrating Assessments • Meeting and Integration Facilitation • Program Development/Active Treatment	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• ISP-Finalization and At-Risk Process • Living Options Discussion Overall, as the findings of Section F as a whole indicate, training had not yet been adequate to achieve competency in fulfilling the QIDP responsibilities. The Monitoring Team commended the Facility for its innovative Boot Camp approach, however. <u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u> RSSLC Policy F.04 Individual Support Plan Process revised 5/12/2014 required all staff responsible for implementation of individuals' ISPs must receive competency-based training on the implementation of the individuals' plans for which they are responsible prior to performing employment duties without direct supervision and must also receive competency-based training when the plans are revised. 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 sustained substantial compliance in competency-based training for nursing. • Provisions P3 and O5 were found to be in Substantial Compliance. All staff, new and existing received both foundational as well as individual specific training. Greater than 98% 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 any changes in the plan. 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 behavioral programs. 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.	

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		Conclusion: This provision was found to be not in compliance.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Extent to which ISPs are developed within 30 days of admission: RSSLC reported ten admissions since the last monitoring visit. For each of individuals who had been living at the Facility for more than 30 days, 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 (Individuals #85, #153, #395, and #795.) The ISP annual planning meeting was held for each of these within 30 days of admission. Assessments were not yet routinely available completed in advance of the ISP meeting as required, as 72% were completed within the required timeframe prior to the ISP. There were still instances in which assessments were not completed until after the ISP meeting was held or were not included in the packets reviewed. This was concerning, in that the ISP developed could not have taken these assessment findings into account. For example, as reported in Provision K7, for nine individuals reviewed who had been admitted to the Facility since the previous site visit, data regarding assessments indicated that, although seven of nine individuals (78%) received a psychological assessment within 30 days following admission, not all components of these assessments had been conducted: • None of nine individuals (0%) had been provided an assessment of adaptive skills within 30 days following admission. • None of nine individuals (0%) had an assessment of adaptive skills from the previous year included in their records upon admission. • None of nine individuals (0%) had been provided an assessment of intellectual ability within 30 days following admission to the Facility. • Three of nine individuals (33%) had an assessment of intellectual ability from the previous five years included in their records upon admission. • Nine of nine individuals (100%) were provided with behavior assessments within 30 days of admission. Extent to which ISPs are revised annually and as needed and put into effect within thirty days of preparation: The Facility reported that, for the period of 8/1/2013 - 7/30/2014, 309 of 324 (95%) ISP annual meetings had occurred within 365 days after the previous annual meeting. This was a positive finding overall. RSSLC Policy F.5: Completing Individual Support Plan Meeting Documentation, revised 03/27/12, also required the ISP be filed within 30 days of the ISP meeting. The Facility provided a document that indicated 199 of 324 ISPs (61%) held between 8/1/2013 - 7/30/2014were filed within 30 days. This was essentially the same rate reported during the previous six months, indicating very little progress had been made in the timeliness of filing and consequent implementation of the ISP.	Noncompliance

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		As further examples of the failure to implement the ISP on a timely basis, the Monitoring Team found the following: • Monthly Reviews for none of four (0%) newly admitted individuals evidenced consistent implementation on a timely basis, as many action steps showed little to no activity for two to three months following the ISP meeting. • In addition, there was evidence that other plans were not always implemented on a timely basis. For example: o As reported in Provision R3, only two of five individuals' indirect plans (40%) (i.e., SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. o As reported in Provision P2, in two of four individuals' plans reviewed (50%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provided an explanation for any delays and a plan for completing the action steps. o As reported in Provision F2d, Individual #497 had many components of the ISP that were not implemented on a timely and consistent basis, if at all. The Facility acknowledged that data collection could only be demonstrated for two of the last six months. o Also as reported in Provision F2d, Living Options Action Plans were often not implemented as required, if at all. <u>Conclusion:</u> This provision was found to be not in compliance. There continued to be a significant incidence of failure to provide timely implementation of an ISP for each individual.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The Monitoring Team reviewed the Richmond State Supported Living Center Quality Assurance Plan, dated 06/24/2014, and interviewed the Section F team and the Quality Assurance Director regarding the status of quality assurance processes for identification and remediation of problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section. The Facility QA Plan included a number of monitoring devices related to the Provisions of the section, to be tracked and reported on quarterly. Many of these are referenced throughout this section. Some of the processes (those related to quality of the ISP-related documents) have not been implemented at this point: • ISP Attendance Tracking • Facilitation Monitoring Tool • Section F Monitoring Tool • Timeliness of Monthly Reviews Process	Noncompliance

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		• Timeliness of ISP Preparation Meetings Process • Timeliness of PSIs Tracking • Quality of Monthly Reviews • Quality of ISP Preparation • Quality of PSI • Quality of ISP Additional quality measures implemented by the Facility during this past six months included: • The Facility had significantly improved its ability to track some Section F activities through the creation of useful databases. • As detailed in Provision F1c, the Facility had begun holding a 15-Day Integrated Assessment Meeting prior to each individual's annual ISP planning meeting to identify any discrepancies in assessments and review the IRRF. This was an additional quality assurance measure that allowed IDTs correct any issues in advance of the ISP planning meeting. • RSSLC Policy F.17: Habilitation, Training, Education, and Skill Acquisition Programs, reviewed on 02/21/14, detailed a set of steps to be taken for assuring quality of SAPs. These included: o Team consultants will perform inter-rater reliability checks of 20 percent of SAP Review Tools completed by the SAP review teams. o Department of Education and Training will review inter-rater reliability data once a month at the monthly departmental QA/QI. o Department of Education and Training will review data on the development of the SAPs once a month. o All data collected will be analyzed and presented to the QA/QI Council once a quarter by the Director of Education & Training. The Monitoring Team also reviewed the Key Indicators, dated 07/08/2014, for Section F related measures. Most of the key indicators are measures of outputs at this point, including the number of ISPs and ISP meetings held, and the number of ISP, PSIs and ISP Preparation Meeting documents completed. The only outcome oriented indicator was for timeliness of assessments. The Monitoring Team encourages the Facility to develop additional outcome-based quality indicators that would demonstrate the requirements of the Section F provisions are being met <u>Conclusion:</u> This provision was found to be not in compliance. The Facility was again commended for its efforts toward developing a comprehensive quality assurance system for this Section, including the integration of the ongoing QA/QI processes with the Self-Assessment for this Section. These processes were continuing to develop and better	

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		capture meaningful data, although much work remained to be done in terms of identifying and remediating issues to ensure ISPs are developed and implemented consistent with the provisions of this section. As noted in the Monitoring Team's review of the Self-Assessment, the Facility still needed to develop clear outcome indicators for each of the provisions.	

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 8/12/14 2. RSSLC Action Plans 8/11/14 3. Presentation Book for Section G 4. Provision Action Information 5. DADS Policy 009.2 Medical Care 5/15/13 6. RSSLC Policy (unnumbered) Integrated Clinical Services Policy 8/6/14 7. RSSLC Policy I.00a Medical Services 5/15/13 8. RSSLC Policy I.26 Physician Quarterly Review 7/15/14 9. RSSLC Policy I.31 Providing Health Care Services: Chronic Clinical Indicators 8/20/13 10. RSSLC Policy I.12 Routing of Off-Campus Consultations 9/9/13 11. RSSLC Policy I.13 Routing of On-Campus Consultations 1/6/11 12. RSSLC Policy PCP Consultation Letter Policy (no number) 8/22/12 13. RSSLC Policy I.33 Medical Follow Up Database Policy 12/10/13 14. RSSLC Policy I.44 Morning Report 11/4/13 15. List and copies of policies and procedures in response to a request for "A copy of any State or Facility policy or procedure guiding integrated clinical services. 16. Clinical Morning Report minutes for 3/4/14, for the first morning meeting of each month from March 2014 through August 2014, and for 8/26/14 17. Grand Rounds minutes of meeting of 8/27/14 18. Participation of Required Attendees at ISP Meeting, ISP meeting dates of 4/1/2014-6/30/2014 19. Sample of medical consultation reports for Individuals #29, #57, #177 #241, #272 (X2), #403, #487, #512, and #701, and Modified Barium Swallow Studies for Individuals #169, #192, #442, and #463 20. Consultation database screens for Individual #623 for consultations of 7/24/14 and 8/12/14 **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 #745 2. ISP Preparation Meeting for Individual #497 3. Clinical Morning Report 8/26/14 4. Grand Rounds 8/27/14 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, 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 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 monitoring tools included adequate methodologies, such as review of minutes and of clinical records. It might be useful also to include observations of meetings for integrated discussion, as minutes do not always reflect all the discussion held. 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 The Monitoring Team could not determine whether there were adequate instructions/guidelines to ensure consistency in monitoring and the validity of assessment of whether clinical meeting minutes included documentation supporting integration. o The Self-Assessment did not identify the staff who completed the audits. o Adequate inter-rater reliability was not reported between the various Facility staff responsible for the completion of the tools. ▪ 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; the Facility reported during the compliance visit that this is a subjective determination based on input from multiple disciplines. Monitoring Team observation and review of the minutes of meetings such as Clinical Morning Report, Grand Rounds, polypharmacy review, and hospital discharge meetings verified integrated discussion regularly occurred.. 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:

	○ 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, data from the Medical Followup Database were provided regarding consultations, and the data were provided on the specific questions from the Internal and External Medical Audits that were relevant to Provision G2. ○ 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. ○ 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. ▪ Actions were reported as Completed or In Process for Provision G1. For Provision G2, which had been found in substantial compliance, the action was to continue to mnitor for compliance to the revised Medical Follow Up Policy. ▪ The Facility data did not identify areas of need/improvement. Instead, the Action Plan was limited to developing diabetic education—certainly one good area for integrated planning, but not a comprehensive approach to ensuring integrated planning across all clinical disciplines. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. The self-rating for Provision G1 was based on the need for improved participation among clinical disciplines, but that was not addressed in the Action Plan.
	Summary of Monitor's Assessment: Although there is still a need for increased integration of clinical services, the Monitoring Team commends the Facility for a significant shift in the way clinical disciplines work together. As new procedures mature and clinicians gain experience in collaborative activities, integrated planning should improve. The Facility must make additional progress toward involving multiple disciplines in addressing in the ISP specific needs and preferences of individuals. If the collaborative work evidenced over the last two compliance periods continues to increase, the Facility should approach substantial compliance with the requirements of this provision in the near future. Provision G1: Collaboration and integrated planning continued to improve. The Facility had recently implemented an Integrated Clinical Services policy. The Clinical Morning Report meeting continued to

	include participation of a wide range of clinical disciplines as well as residential services, and participants were more interactive, and more assertive in raising questions and solutions to clinical issues. The Medical Grand Rounds continued to provide integrated review of individuals who are experiencing a significant medical and/or behavioral issue. The Facility had several committees and workgroups that brought together numerous disciplines for interdisciplinary reviews of individuals and systemic issues. There were examples of excellent integrated planning for individuals, but also a few examples in which this needed improvement. The Facility must make additional progress toward involving multiple disciplines in addressing in the ISP specific needs and preferences of individuals. Attendance at annual ISP planning meetings, one forum for integrated planning to address needs and preferences and to establish services, was variable across disciplines. The Facility is approaching substantial compliance with the provision. Provision G2: Processes for review of consultations by Facility clinicians are defined in policy and are implemented consistently. Reviews by Facility clinicians of consultations were timely and documented agreement with recommendations. Although consultation documentation did not indicate referral to the IDT, the Facility had appropriate processes in place to facilitate documentation of review of recommendations from non-facility clinicians by the IDT when appropriate, and provided evidence that this occurred. The Facility had an effective process in place to track information on consultations at the level of the individual consultation, including information on acceptance of recommendations and on IDT follow up, as well as to aggregate information by individual and by the Facility as a whole.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility has continued to take steps to provide integrated clinical services. The Self-assessment reported "this provision is not in substantial compliance based on the need for improved participation among the clinical disciplines, especially PCPs." Although the Monitoring Team concurs in this finding, it also finds that the Facility had developed numerous processes for integrated clinical planning and services and had greatly improved interdisciplinary collaboration. <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 the newly implemented (and, as yet, unnumbered) Integrated Clinical Services Policy, which included a list of 40 current facility policies that "involves (sic) the integration of clinical services" as well as several policies and procedures. Including these and others provided to the Monitoring Team, the Facility provided copies of the overall policy and 46 policies or procedures related to specific areas, including committees and areas of care. These policies and procedures addressed or required integrated services in some manner. 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.	Noncompliance

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		The Integrated Clinical Services Policy dated 8/6/14 requires clinical services to "show integration through the ISP process and procedures established from the clinical services," and provides guidance and required actions (with reference to RSSLC Policy F04 that guides the ISP process). These include: • IDT meetings when there is a change in an individual's clinical status and on a regularly scheduled basis, with coordination by the QIDP • A requirement that clinical services (referencing specifically medical, pharmacy, dental, psychiatry, nursing, habilitation, dietary, respiratory therapy, and behavioral services) "update the QIDPs, residential services, and other clinical services each time a new process or policy that involves clinical integration is implemented." • Share with the IDT significant clinical decisions from clinical meeting held outside the IDT meetings. Implementation of an overall policy that provides general guidance is a positive step that establishes expectations for integration. Given the large number of policies and procedures that the Facility considers relevant to integrated clinical services, it will be important for the Facility to determine how consistently those are implemented. <u>Clinical Morning Report Meeting</u> The Clinical 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 meeting followed a standardized agenda. The agenda included: • 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/ Significant Diagnostic Studies • Non-Medical consultations • 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 • Announcements	

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		Review of the meeting minutes for the first morning reports of each month that occurred during the reporting period; in addition to the Monitoring Team's observation of the Morning Medical Meeting on 8/27/2014, indicated that the Facility included staff members from a variety of clinical disciplines, including PT/OT, nursing, medical, psychology, psychiatry, pharmacy, and residential services. The Monitoring Team noted improvement since the last compliance review period; participants were more interactive, and more assertive in raising questions, and solutions to clinical issues. Review of the clinical morning report minutes for 3/4/2014, 4/3/2014, 5/6/2014, 7/1/2014, and 8/5/2014 indicated a comprehensive summary of issues addressed, during the meetings. Meeting minutes included subsections for on-call report; hospital report; infirmary report; behavioral health report; medical consultation and significant diagnostic report; among other topics. The Monitoring Team did not identify in the minutes that assertive measures were in place to develop, implement, and follow-up on action plans, for relevant clinical issues identified at the meeting. For example: the clinical morning report, dated 3/4/2014 documented that Individual #228 "leukocytosis, reactive lymphocytosis", and there was no documentation of follow-up plans; the clinical morning report, dated, 4/3/2014 documented that Individual #279 "called 911 herself stated suicidal thoughts. EMS did come but they did not take her", and again, there was no documented action plan for follow-up to this issue. To document that action had occurred, the minutes should provide a very brief summary of the important and major steps that would be or have been taken to ensure appropriate clinical management of such issues. The Facility held only one Clinical Morning Report meeting during this compliance visit, so the Monitoring Team would have an opportunity to observe a different meeting (Pre-Hospital Discharge Meeting). The Monitoring Team attended the Clinical Morning Report meeting of 8/26/14. 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 the following: • Integrated discussion occurred for several issues. For example, regarding abdominal distention for one individual, there was discussion by the PCCP on an order for consult and on lab results and bowel movements, by the dietitian regarding current formula and change from being active to now spending most time in bed, and from habilitation staff regarding increasing activity. • The IDT report included identification of follow ups the IDTs will be asked to do based on reports during the meeting. There was a report of a meeting held the prior Friday by the IDT for an individual with cancer, and report by the primary care provider (PCP) of discussion with the family regarding hospice. The Medical Director reported getting a question for an IDT about removing the g-	

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		tube for an individual who is eating, but where there are still concerns about hydration; she indicated she will meet with the IDT. All these examples provide evidence that the IDT receives information from and conducts follow up to issues raised during the Clinical Morning Report. <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 and clinical disciplines, including PT/OT, behavioral services, residential services, psychiatry, dietary services, quality assurance, dental, specialty nursing staff (such as Infection Control) and pharmacy services. The purpose of the meeting is to review the case of one or more individuals who are experiencing a significant medical and/or behavioral issue. The Monitoring Team (Independent Monitor, psychiatrist, and nurse) attended the Grand Rounds Meeting on 8/27/14, and the Monitoring Team physician reviewed the minutes. The meeting was attended by relevant interdisciplinary team (IDT) members and other relevant Facility staff as noted above. The Medical Director led the meeting. The focus of the meeting centered on a thorough review of Individual #737's pica behavior and related medical issues. The team discussed the history/background of the behaviors, potential underlying causes for the behavior, current management plan, and elicited further strategies for management and treatment. The team summarized action plans and provided recommendations for strategies to manage and treat Individual #737's severe PICA behaviors. Information was provided and/or questions raised by numerous disciplines, including PCPs, nursing, behavioral services, and psychiatry. Action plans were developed including training residential staff to recognize signs and symptoms of ingestions, determining when to do KUBs (to determine whether the individual had ingested items), expanding environmental sweeps, completing a functional assessment, and a decision to wait on use of psychotropic medication unless the other plans are not effective. The Grand Rounds Meetings continued to serve 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, Workgroups, and Activities</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 J11, the Facility provided minutes from the monthly polypharmacy meetings. The meetings were attended by physicians (PCPs and	

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		psychiatrists), pharmacists, RN case managers, Behavioral Health Specialists, BCBAs, and other IDT members. • As reported in Provision N3, the monthly polypharmacy review panel meeting includes assessment of the appropriateness of polypharmacy usage for individuals. The review consists of a pharmacist, medical provider, psychiatrist, psychologist, and nursing representatives. • The Skin Integrity Committee Meeting Process was implemented to identify the core members, which included: Skin Integrity Coordinator, Physician or designee, Dietitian, RN Case Managers, Habilitation Staff, Infection Control Nurses, QA Nurses, and Pharmacist. Attendance was more consistent than found in prior reviews. In addition, from March 2014 through June 2014 the Skin Integrity Coordinator met with other disciplines to discuss analysis and trending for underlying causes that contribute to pressure ulcers. The respective disciplines identified planning and treatment for such issues as nutrition, positioning, and the frequency for checking and changing individuals who were incontinent to prevent/reduce the incidences of pressure ulcers. • 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. There was substantive information presented, reviewed, discussed, and decisions made for improvement/corrective action on relevant topics. • Hospital Discharge Planning meetings were held weekly. They were attended by several relevant disciplines, including clinicians on the IDT, the Hospital Liaison Nurse, and the Skin Integrity Coordinator, who reviewed/discussed individuals' current and future need for supports and services during hospitalization and upon discharge from the hospital. Additional integrated activities included: • The Nurse Educator facilitated the biannual Diabetic Education Fair for all individuals and family members in collaboration with other disciplines. The target audience was the 20 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 when they out on visits outside the Facility. This was one of the Action Steps in the Action Plan.	

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		• Medication Administration for nurses for Individuals with I/DD: To date, 100% of all RSSLC nursing staff were trained on the state mandated Medication Administration for Individuals with Dysphagia, which was jointly taught by Habilitation Therapy, Physical Nutritional Management Team (PNMT) Nurse, and the Nurse Educator. • The Facility reported a change in the Physician Quarterly Review process. The report of the last compliance visit commented that there was inconsistency between medical evaluations and nursing quarterly evaluations. To address this the Facility determined the information used needed to be consistent. The RN Case Manager Supervisor in collaboration with the Medical Director developed and implemented in June 2014, a joint Nursing and Physician Quarterly Review process to ensure the quality/accuracy, and completeness of both disciplines' Quarterly Reviews and to ensure continuity of care. The process involved these actions and requirements: o Additional information needed by the physician was added to the nursing quarterly, and a new template was developed so all the information would be in a consistent place. The nurse completes this and provides it to the PCP. This template includes a section for PCP evaluation. o The PCP is required to do a physical assessment each quarter; this is to address each chronic condition the individual has but may also include a focused examination. PCP adds any updates and information that is new since the nursing information was provided and is to notify the nurse. o This template is put onto the shared drive so the nurse and PCP can have ready access. The Facility reported this process is still in an early stage, with practice needed in coordination and use of the information being provided but is showing promise at improving consistency and integration. This was only recently implemented, and its effect was not yet clear. <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 J15, there were several examples of coordinated and integrated treatment between psychiatry and neurology. Examples were given of: o Individual #630, for whom selection of an antiseizure medication when moving to monotherapy reflected attention to integrated care needs.	

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		○ Individual #561, whom the neurologist reviewed wequelae of head injury, and worked with the psychiatrist to facilitate the engagement of a traumatic brain injury specialist to evaluate for possible benefit from neurological rehabilitation. • As reported in Provision M1: ○ On 8/26/14, the Monitoring Team, accompanied by the CNE, Hospital Liaison Nurse, and Skin Integrity Coordinator, visited Individual #306 in the hospital. The hospital Physical Therapist provided an update on the physical therapy plan of care and response to therapy regarding ability to stand and a concern regarding what was considered temporary contracture of the left knee. The floor nurse continued to provide an update on her health status. The hospital Speech Pathologist had completed a bedside swallow evaluation. The Direct Support Professionals were with Individual #306 to assist with personal care needs. The RSSLC Skin Integrity Coordinator evaluated wounds. Upon return to the Facility the Monitoring Team, CNE, Hospital Liaison Nurse, and Skin Integrity Nurse attended an IDT meeting where the Hospital Liaison Nurse and Skin Integrity Coordinator reported on Individual #306's health status. The IDT discussed future needs for supports and services. ○ The Infection Control Committee along with the Trinity staff, Medical staff, and dietary staff continued to carry out the action plan implemented in September 2013 to decrease Urinary Tract Infections (UTIs), specifically on this unit where medically fragile individuals live. The Committee continued to discuss possible reasons for episodes of UTIs and discussed way of prevention. ○ The Infection Control Committee in collaboration with the Medical Director and medical staff implemented a Pneumonia Post Hospital Monitoring and Infection Control Data List. The Pneumonia Post Hospital Monitoring consisted of dates when individuals were discharged from the hospital. The Primary Physicians' followed up initially, within three to five days later, then in two weeks, and then one month post pneumonia. The Infection Control Nurse Data List used for monitoring consisted of all of the factors that could be implemented to prevent pneumonia. This information was sent to the Primary Physician, Medical Director, CNE, and NOO with recommendations. • As reported in Provision O1, PNMT minutes reviewed showed integrated clinical collaboration among all disciplines contained within the team. The collaboration of the team was substantiated through observation of the PNMT meeting on 8/27/14.	

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		• As reported in Provision O1, additional improvements noted with regards to the overall PNM system included the PNMT utilizing various databases (osteoporosis, pneumonia, body weight, and skin integrity) and collaborating with other disciplines to obtain a better overview of PNM-related systemic issues. • As reported in Provision R2, based on review of the Positive Behavior Support Committee meeting attendance sheets, the SLP participated in 0% of the meetings. Although the SLP did not participate in the meetings, the process for information sharing between the SLP and the Behavior Analyst was clearly defined in policy and required a conference between Behavioral Services and SLP staff at which assessments were reviewed. Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans (PBSPs), the following was noted: o 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. o For four of four individuals (100%) communication strategies identified in the assessment were included in the PBSP. o As reported in Provision M1, the Monitoring Team Attended the Pre-Hospital Discharge Planning Meeting for Individual #84. The meeting was well attended by all relevant disciplines. The Pre-Hospital Discharge Planning Meeting results and recommendations were to be submitted to Individual #84's IDT for further review and follow-up. • As reported in Provision J2, the Monitoring Team attended a Psychiatric and Behavior Management Clinic (PBMC) on 8/28/14. Participants included the psychiatrist, behavioral health specialist, nurse case managers, 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 interdisciplinary and collaborative. <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 annual planning meeting. The Facility's self-assessment reported that attendance at ISP meetings between 1/1/14 and 6/30/14 for a sample of 30 randomly selected individuals (collected from the Program Monitors/Auditor's Tool for ISP Tracking) found that there was variation in	

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		attendance by various disciplines, ranging from 93% for social workers to 37% for PCPs. Speech therapists (SLPs) attended 57%, occupational therapists (OTs) and physical therapists (PTs) each attended 83%, nurses and QIDPs attended 90%, and psychology/behavioral staff attended 93%. Also, the Facility provided a document for review, entitled Participation of Required Attendees at ISP Meeting, covering required attendance at ISP meetings held from 4/1/14-6/30/14, which tracked required attendance by discipline. This document provided attendance data for a much broader set of participants, including clinicians, residential managers/supervisors, direct service professionals, other staff, the individual, family/guardian (LAR), and local authority. These data apparently covered a total of 94 ISP meetings (assuming QIDPs were expected to attend all meetings) and showed 100% attendance by QIDPs, over 95% of required meetings by nursing, psychologist/behavior analyst, and social worker. PCPs attended 74% of required meetings but were required to attend only 27 meetings. The Monitoring Team reviewed annual meeting attendance for a sample of seven ISPs completed across the past six months. For this sample, the ISP Preparation meetings indicated that 83 IDT members were expected to attend the annual planning meetings. Of these 83, 66 (77%) actually participated as evidenced by the completed signature sheets. 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. <u>Integration of interventions into ISPs and Integrated Health Care Plans (IHCPs)</u> The level of integration of interventions into ISPs and IHCPs provides insight into the integration of clinical services. • For four individuals discharged by the PNMT, zero (0%) provided evidence that any new recommendations were integrated into the IHCP. • As reported in Section P, for 14 of 14 individuals in Samples P.1 and P.2 (100%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. However, eleven of 14 (79%) integrated the OT/PT interventions. The ISP or ISPA did not consistently describe the supports based on the rationale provided in the therapy assessment. Integration was primarily in the form of PNMP review and acceptance. There had been improvement in addressing the need for skill acquisition in OT/PT assessments, but only eight of the fourteen ISPs or ISPAs reviewed (57%) contained skill acquisition programs that had been recommended in the OT/PT assessment. • As reported in Provision M5, six of nine (67%) IHCPs showed adequate	

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		integration among all appropriate disciplines. This was improved compared to the last compliance visit. <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 noted above in Provision M5, only six of nine (67%) Integrated Health Care Plans (IHCPs) showed adequate integration among all appropriate disciplines. • As reported in Provision F2a3, 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. 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. For example, as reported in Provision R3, zero of eleven ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. Although there is still a need for increased integration of clinical services, the Monitoring Team commends the Facility for a significant shift in the way clinical disciplines work together. As new procedures mature and clinicians gain experience in collaborative activities, integrated planning should improve. The Facility must make additional progress toward involving multiple disciplines in addressing in the ISP specific needs and preferences of individuals. If the collaborative work evidenced over the last two compliance periods continues to increase, the Facility should approach substantial compliance with the requirements of this provision in the near future.	
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 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. These were unchanged since the last compliance visit. • 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 I.38 PCP Consultation Letter Policy 8/22/12	Substantial Compliance

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		• RSSLC Policy I.33 Medical Follow Up Database Policy 12/10/13 • RSSLC Policy I.44 Morning Report 11/4/13 Policies I.12 and I.13 provide steps to be taken for routing off-campus and on-campus consultations. This policy 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. Policy I.33 governs the process for tracking and trending medical consultations and significant diagnostic studies. It establishes a tracking system and assigns responsibility for actions. <u>Procedures and Forms</u> The Facility provided copies 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)" (although a sample provided stated in this section, "See IPN/database" and the IPN in the database provided the PCP's acknowledgement of and agreement with recommendations as well as a summary of the IDT meeting documenting review) 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 nurse case manager to document receiving PCP's	

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		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. The Facility reported that the database process had not changed since the last compliance visit but that more training had been done with QIDPs to increase IDT participation in acknowledging consultation recommendations, and tracking of QIDP acknowledgment was not ongoing, with a report added to capture delinquent QIDP acknowledgment. The Facility reported that the QA nurse monitors send a report on the first and 15th of each month of blanks left in sections of the consult until these are resolved. QIDPs get a report of consultations pending acknowledgement. The Facility showed the Consultation Follow Up Database to the Monitoring Team, showing how each component of the database worked, including entry and various reports. The Monitoring Team requested a hard copy of a consultation for Individual #623, which was provided. This documented the PCP acknowledgment of recommendation—a detailed discussion that included questions by the IDT and the PCPs response to those questions, which included return to the Neurology clinic with key members of the IDT in attendance to express concerns and provide information. A follow-up consultation note was provided that documented the follow-up consultation and a revision in the consultant's recommendation. This was an excellent example of IDT review and involvement in the consultation process. <u>Review of Consultations by Facility Clinicians</u> The Monitoring Team reviewed a sample of 15 consultation reports for 14 individuals; 11 reports for 10 individuals were for medical consultations (Individuals #29, #57, #177 #241, #272 (X2), #403, #487, #512, and #701), and four were for (MBSS) consultations (#169, #192, #442, and #463). Of the 15 sampled reports: • For 15 of 15 (100%), review was documented on the consult form. • For 15 (100%) an IPN was found. • For 15 IPNs (100), IPNs were dated within five working days. • Fifteen IPNs (100%) documented agreement with consultant recommendations.	

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		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 Clinical Morning Report conducted twice per week included reports of consultations. Review of minutes of Clinical Morning Report meetings showed that consultations were reported at nearly every meeting. Minutes documented, in the IDT Report section, follow up on several individuals. For example, for Individual #589, there was documentation stating, an IDT meeting needs to be held to discuss the individual's health condition and request from a consultant for a biopsy. For the remainder, the comments merely indicated follow up or a condition. It would be more useful to document what the IDT addressed, was asked to address, or is asking for assistance on, as done for Individual #589. Several consultations were reported at the meeting observed by the Monitoring Team. As noted above, information on the database for Individual #623 provided an example of IDT involvement following a consultation. 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 reported that 73% of "Consultations/Diagnostic Studies had evidence in the form of ISP addendum that they were reviewed by the IDT." The Monitoring Team did not review the ISPAs for the sample. 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 8/12/14 2. RSSLC Action Plans 8/11/14 3. Presentation Book for Section H, including, among other documents, a. Relevant policies b. Trend analysis reports and action plans for medical follow up, diabetes, osteoporosis, developmental disability preventive healthcare screening, pneumonia, sepsis, neuromotor/musculoskeletal disorder, and urinary tract infection c. Daily sick call logs with integrated progress notes (IPNs) from nurses and primary care providers d. Minutes of pre-hospital discharge planning meetings e. Physician Quarterly Review policy and template f. 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 g. Documentation to support psychiatric diagnoses for a sample of individuals 4. Presentation Book for Provisions L2 and L3, including a. Clinical Pathways b. Audit tools c. Trend Analysis Reports, including Action Plan Reports for chronic health conditions 5. Provision Action Information for Section H 6. DADS Draft Policy 005 Minimum Common Elements of Care (undated) 7. RSSLC Policy I.00a Medical Services 5/15/13 8. RSSLC Policy I.26 Physician Quarterly Review 7/15/14 9. RSSLC Policy I.31 Providing Health Care Services: Chronic Clinical Indicators 8/20/13 10. RSSLC Policy I.44 Morning Report 11/4/13 11. RSSLC Policy F.04 Individual Support Plan Process revised 5/12/2014 12. Table of annual assessments filed 10 days prior to meeting (annual ISP planning meeting) for meeting dates of 4/1/14-6/30/14, totaled by month by assessment 13. Share Drive list of assessments for Individual #181 14. Clinical Morning Report minutes for 8/26/14 15. Most recent Active Problem List (APL) and Department of Psychiatry Database for Individuals #25, #39, #74, #76, #101, #151, #179, #192, #200, #235, #320, #368, #475, #623, and #723 16. Integrated Progress Notes (IPNs) for Individuals #153, #530, #613, and #680 17. Individual Support Plans (ISPs) including assessments for Individuals #243, #501, #530, #596, #630, #655, and #753 **People Interviewed:** 1. Tran Quan, D.O., Medical Director and Raj Thakur, Medical Compliance Coordinator

	Meetings Attended/Observations: 1. Integrated Support Plan (ISP) Annual Planning Meetings for Individuals #745 2. ISP Preparation Meeting for Individual #497 3. Grand Rounds addressing Individual #737 4. Morning Report 8/26/14
	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 The Monitoring Team would like to point out especially the extraordinarily thorough review of accuracy of diagnoses. The self-assessment not only included whether documentation was present, but also included reports of actual clinical indicator levels for the sampled individuals. This was similar to the review of diagnoses the Facility reported to be part of the audit process for medical care of chronic health conditions. o Although the Facility provided useful data, 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. Furthermore, review activities were limited to medical care (except for review of QDRRs, which are a pharmacy responsibility), whereas several provisions of this Section cover all clinical disciplines. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. • The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Generally presented findings consistently based on specific, measurable indicators. These included measures of timeliness. As noted above, the Monitoring Team commends the Facility for tracking and reporting clinical indicators of health conditions as evidence of accuracy of diagnoses. o Although the Facility did not consistently report assessing quality as well as presence of items (for example, only timeliness of assessments was reported), the data on accuracy of diagnoses clearly indicated review of quality, and the medical management audits also assessed and reported quality. For Provision H5, the Facility provided data on timeliness of assessments, but the self-rating clearly indicated the Facility had assessed the quality of risk ratings and IDT monitoring of health status; the Self-Assessment should include the information the Facility assessed in rating its compliance. o Identified the sources of data collected, including identifying data collected by the QA Department (although there were no clear statements of data collected by the program/discipline). • The Facility rated itself as being in compliance with no provisions of Section H. This was consistent with the Monitoring Team's findings. It was clear that the Facility has set high standards for compliance of medical services. Even if medical services meets the Facility's and Monitoring Team's standards for compliance, there will remain the need for other clinical disciplines to provide services that are consistent and compliant with the requirements of this Section 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 Completed, In Process, or Not Started. The Action Plans for Provisions H4 and H6 reference Provision L3, for which actions were identified for maintenance of compliance, but no additional actions were identified for the provisions of Section H. • The Facility data identified areas of need/improvement, but the only actions related to those areas was the revision (completed) and review for completion and documentation (in process) of the Physician Quarterly Review. • The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. For Medical care and services, the actions were appropriate and might lead to substantial compliance. There is a need to identify actions needed so that other clinical disciplines will also meet requirements. The action steps specific to Section H did provide a sequential set of activities that were clearly and specifically stated, and that should lead to completion of effective actions. Remaining actions should be established in the same manner.

	Summary of Monitor's Assessment: Although no provisions of this Section achieved substantial compliance, the Monitoring Team would like to commend the Facility for significant progress, particularly in Medical Services and in the development of databases that provide extensive information and could be useful in assisting other clinical disciplines to meet the requirements of this Section. Provision H1: Timeliness of routine assessments need improvement, as assessments required to develop an appropriate ISP were still not consistently completed in time for IDT members to review before the meeting. Comprehensiveness of assessments had improved for several disciplines and were compliant with standards in some areas, but some required assessments needed further improvement. Examples were found both of use of information from assessments and lack of such use. A new Facility process for meetings 15 days prior to the annual ISP planning meeting has potential to improve review of assessments and their use in decision-making. Provision H2: Medical diagnoses were consistent with the ICD classification system and clinically fit corresponding assessments. Psychiatric diagnoses were consistent with the DSM IV classification system but differed across the psychiatry department database and the active problem lists for individuals. Diagnostic justification was not consistently found in comprehensive psychiatric evaluations. Provision H3: Although there were examples of timely implementation of treatments and interventions, there were examples in which these were not timely or in which the Monitoring Team could not determine (and the Facility could not track) whether these were or were not timely. Clinical appropriateness of treatment and interventions continued to improve, albeit not yet to a level of substantial compliance for most clinical disciplines. Provision H4: The Facility had developed clinical pathways for several chronic health conditions. For several pathways, clinical indicators of health status had been identified based on review of national standards and review of professional literature. Databases had been developed to track these clinical indicators for individuals and to provide both individual and aggregated reports that were assessed to evaluations of trends. Trend analyses 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. The Monitoring Team commends the Facility for this remarkable system. Outside of medical care, the use of clinical indicators had progressed but was not yet consistent across clinical disciplines. Provision H5: As noted in Provision H4, a process was in place to monitor health status for individuals with chronic health conditions, but similar processes were not in place for other health issues. Assessments required to develop an appropriate ISP were still not consistently completed in time for IDT members to review before the meeting. The Physician Quarterly Review, which had been revised to require review of information from the Nursing Quarterly Review and now using a standard template for documentation and requiring physical examination, promotes frequent monitoring of the status of each individual. Nursing

	quarterly assessments similarly ensure monitoring of health status. Across other clinical disciplines, there was not consistent monitoring of health status and of effectiveness of treatments and interventions. The QIDP Monthly Review process was not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development. Content of the reviews seldom provided meaningful evaluation of progress. The Facility had also recently modified its procedures to address ongoing issues of timeliness of Monthly Reviews of the ISP by the QIDP. Provision H6: Although there were many examples of modifying treatments and interventions in response to clinical indicators, the lack of assessment of clinical indicators consistently across disciplines limited the ability to use them to identify the need to modify treatments. Examples were found in which either treatments and interventions were not modified timely based on clinical indicators, or in which documentation did not indicate whether progress or other change of status was occurring. Provision H7: Policies were in place regarding timeliness of assessments. The Facility had also developed policies that included requirements for integrated clinical services, as well as for use of clinical indicators of chronic health conditions. Further development of policy is needed to address 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.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	<u>Policy</u> DADS Policy 004.2 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. 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. 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> In order to assess the actual timeliness of assessments, the Monitoring Team reviewed assessments for a sample of seven completed ISPs, including the ISP Preparation documentation. Information reported in Provision F1c substantiated that assessments required to develop an appropriate ISP were still not consistently completed in time for IDT members to review before the meeting. Findings included: • In the sample of seven 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 88 required assessments, 63 were both present and completed according to the timeliness requirements. Overall	Noncompliance

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		for this sample, the rate of timeliness was 72%, just slightly below the timeliness rate of 74% found during the last monitoring period. This finding was consistent with the Facility's data reported above. • Some assessments were not simply late, but were not completed at all. For the nine individuals in this sample, there were 88 total required but only 81 (92%) present in the assessment packets provided to the Monitoring Team. Improved timeliness was found for one individual for whom assessments were due and for one whose annual ISP planning meeting was held during the compliance visit (and who the Facility identified for focused review by the Monitoring Team). The Facility identified Individual #181 as having an annual ISP planning meeting scheduled within the next ten working days. The Facility provided the list of required assessments, and the Monitoring Team viewed the assessments available on the shared drive. For 12 assessments that were required per the ISP preparation meeting, 12 (100%) current or updated assessments were posted, and 12 (100%) had been posted by 10 working days prior to the meeting. This was consistent with the findings from the last compliance visit. The Monitoring Team reviewed the assessments required for the annual ISP planning meeting for Individual #745. For 14 assessments that were required per the ISP preparation meeting, 14 (100%) current or updated assessments were posted, and 12 (86%) had been posted by 10 working days prior to the meeting (with the other two posted nine working days prior to the meeting). The Facility also provided a table of Required Annual Assessments Filed 10 Days Prior to ISP Meeting for meeting dates of 4/1/14-6/30/14. The table reported that the percent of required assessments filed 10 (working) days prior to the ISP meeting for April, May, and June 2014 was 72%, 72%, and 69% respectively. For new admissions, for whom an ISP was to be developed within 30 days following admission, assessments were not yet routinely available completed in advance of the ISP meeting as required, as 72% were completed within the required timeframe prior to the ISP. There were still instances in which assessments were not completed until after the ISP meeting was held or were not included in the packets reviewed Progress continued to be noted in certain discipline specific assessment processes and outcomes throughout this report. Examples included: • As reported in Provision J7, Individuals #85, #153, #306, #343, #350, #395, #458, #527, #737, #749, and #795 were admitted since the last visit. All received Reiss Screens within 30 days of admission. Individuals #85, #153, #350, #749 and #795 required CPEs since they took psychotropic medications.	

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		Comprehensive psychiatric evaluations (CPEs) were in place for all individuals who took psychotropic medications except Individual #85. • As reported in Provision L1, the Monitoring Team was extremely impressed by the many clinical improvements noted for Section L.1, and found the Facility was near substantial compliance. • As reported in Provision M2, the Nursing Department had continued to maintain the positive practices identified in the last compliance review, continued to make improvements to the nursing assessment process and remained in substantial compliance. All sampled Admission, Annual Comprehensive Nursing Reviews, and or Quarterly Nursing Reviews were completed according to mandated timelines. • As reported in Provision O8, the Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Eight of eight sampled individuals who receive enteral nutrition were evaluated at a minimum annually as evidenced by review of their IRRF, ISP, OT/PT Assessment and Nutritional Assessment. • As reported in Provision P2, the Monitoring Team continued to find substantial compliance. The Habilitation Therapies Department continued to audit assessments to ensure they were completed in a timely and comprehensive manner. Results in the data provided by RSSLC continued to show the presence of all the needed assessment components. • As reported in Provision Q1 regarding a sample of four annual dental assessments, four out of four (100%) were obtained at least 14 days prior to the annual ISP meeting. Furthermore, the Facility provided documentation that 326 out of 335 individuals (98%) were current with their annual dental examination. • As reported in Provision R2, assessments or updates were completed timely for all sampled individuals. Nevertheless, a need remained to improve completion and timeliness of assessments. • As reported in Provision J1, CPEs were needed for all individuals who received ongoing psychiatric care. CPEs were in place for 132 of 135 (98%) of individuals. The three individuals who did not have CPEs had been admitted in 2014; they were scheduled to have CPEs but those were not yet completed. DADS Psychiatry Policy required that CPEs be re-evaluated on an annual basis. The Facility had just started to do so in July 2014. At the time of the visit, six of 135 (4%) individuals with CPEs had annual reviews in place. • As reported in Provision K7, psychological assessments were not conducted at least annually, nor were assessments consistently completed for individuals who were newly admitted.	

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		Comprehensiveness of Scheduled Assessments RSSLC had taken several steps to improve the quality of its assessments. These included: • The Facility continued to implement an "assessment of assessments" for some disciplines, including Medical, Pharmacy, Vocational, OT/PT and Speech. This was a quality assurance process implemented by each of those departments in which some sample of assessments was reviewed by departmental managers or, as in the case of the physicians, an external reviewer. • The Physician Quarterly Review process was revised in July 2014 to involve a collaborative process in which the PCP is to review information from the Nursing Quarterly, perform a physical examination and address each chronic clinical condition, and update clinical information on the Nursing Quarterly as needed. A standard template is used for documentation. The Facility reported close monitoring of this process has identified some issues needing to be addressed so that this process can be most effective, and actions being taken to address these issues. The process holds promise for ensuring accuracy and comprehensiveness of information, as well as for identifying changes of health status that need to be reviewed with the IDT for decisions on treatments and interventions. There were areas in which assessments were fully compliant with requirements or showed significant improvement. • As reported in Provision L1, review of annual medical summaries for a sample of individuals found that documentation practice was noted to be exceptional, with the medical providers documenting physical assessments, and indicating specific assessment and plans. An area of improvement needed was in documenting action plans and clinical rationales. • As reported in Section M, annual and quarterly nursing assessments were found to meet requirements for a finding of substantial compliance. Areas needing improvement remain. • As reported in Provision J6, there had been a slight improvement in completion of CPEs in conformance to Appendix B format requirements, but approximately one-third of CPEs still needed to come into compliance with that format. Of sampled CPEs, diagnoses were not consistently justified by the evaluation. However, the case formulation section of the CPEs had continued to improve. • As reported in Provisions K6 and K7, although psychological assessments for most individuals included intellectual and adaptive assessments, in most cases those were not current, so that it was not possible to determine whether those accurately reflected the individual's status. • As reported in Provision K5, there had been significant improvement in the use	

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		of formal assessment practices to identify both identification of behavioral function and relationships between mental illness and environmentally based behavior. It will be important for additional improvement to occur. • As reported in Provision R2, communication assessments needed improvement in the identification of objectives and/or methods to improve individuals' abilities to communicate and promote the expansion of their skills. Additionally, more input needed to be given with regards to how the strategies provided in the assessment could be better integrated throughout the individual's day, thus allowing for maximum generalization of skills. <u>Assessments in Response to a Change of Status</u> The Facility had several processes in place to identify change in an individual's status so as to determine whether new assessments are needed. • As reported in Provision J7, the Facility had a protocol 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. Per the Facility protocol, the one identified with a change of status (Individual #758) received a Reiss Screen and was referred to psychiatry for a CPE. As required, the CPE was done within 30 days. • 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 for Individual #84 observed by the Monitoring Team), 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. • 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. Eight of eight individuals (100%) in Sample O.1 were seen within five days of their change in status or by the PNMT Nurse within five days of their return from the hospital (but note that in an additional sample not related to PNMT issues, as reported in Provision M1, the PNMT nurse assessed zero of three individuals following hospitalization, resulting in a total of eight of 11, or 73%). Another method in which the PNMT was made aware of changes in status was through participation by the PNMT RN in the clinical morning report	

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		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. <u>Use of information from assessments</u> Examples were found both of use of information from assessments and lack of such use. The Facility had implemented a process for meetings 15 days prior to the annual ISP planning meeting as one way to improve review of assessments and their use in decision-making. Examples of both use of information and of need for improvement included: • 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. o Observations of the ISP annual planning meetings for Individuals #680 and #745, the ISP Preparation meeting for Individual #497, a 15-day ISP preparation meeting for Individual #613, found: ▪ The active record was present at the meetings for Individuals #680 and #745. Several IDT members brought assessment information to the meeting for Individual #745 and referenced it or shared information as needed. This was not noted at the meeting for Individual #680, but the assessment information might have been present. ▪ At the 15-day meeting, most clinical information was provided on the Integrated Risk Rating Form (IRRF), which included health information and detailed behavioral data. There was little discussion of the information. ▪ The Monitoring Team did not observe the record being present at the meeting for Individual #497 (the record had been provided for review by the Monitoring Team and was not brought back for the meeting). • At the Grand Rounds meeting, extensive data and other information were provided and discussed, including information from assessments of both health and behavioral status. Information was provided on further assessments that were planned, and discussion was held to identify whether other assessments were needed, should be on a scheduled basis, or should be conducted as needed. • 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.	
H2	Commencing within six months of	In the Self-Assessment, the Facility reported completing a review of medical diagnoses of	Noncompliance

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	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.	a total 30 randomly selected individuals. For each individual with one of the following diagnoses, the Facility reviewed whether the diagnosis clinically fit corresponding assessments/evaluations, based on specific criteria for the selected diagnosis. The Facility not only rated whether documentation was present, but also provided specific clinical indicator data for each individual. In all cases, the Facility found the diagnosis clinically fit corresponding assessments/evaluations. The Facility also did not report review of Psychiatric diagnoses but rated the provision not in compliance due to psychiatric evaluations showing lack of consistent documentation following DSM standards. <u>Monitoring Team findings</u> Medical diagnoses were consistent with the ICD classification system. Of the individuals reviewed, there were no indications that diagnoses were inconsistent with medical assessments and evaluations. In particular, the use of clinical indicators of chronic health conditions provides documentation of whether diagnoses were based on appropriate assessments. For the most recent external medical audit assessed through the associated clinical pathway for three conditions, as reported in Provision L2, there remained a need to improve compliance, but the external medical management review reported that care plans contained detailed analysis of current problems. Regarding psychiatric diagnoses, clinically justified diagnoses were provided for four of seven (57%) individuals. That was an improvement over past visits. Diagnoses and diagnostic justification were also a part of annual updates of comprehensive psychiatric evaluations (CPEs). Six such evaluations were available, for Individuals #51, #220, #264, #346, #487, and #680. Diagnoses were justified for five of six (83%) individuals. DSM Diagnoses in the Clinical Record: The Monitoring Team reviewed the active problem lists (APLs) for the 15 individuals in Sample J1. All individuals had psychiatric diagnosis or diagnoses in the Diagnostic and Statistical Manual IV format. For each of the individuals in Sample J1, the Monitoring Team also compared the APL and the diagnosis listed in the Department of Psychiatry Database (chosen since the Facility indicated that was the most up to date diagnosis). In eight of 15 (53%) there were differences between the database information and the APL. Most often the difference was the inclusion of one or more diagnosis in one source but not the other. Differences in cited diagnoses were not limited to the APL and departmental database. For example, for Individual #51 the APL from 4/24/14 cited Post Traumatic Stress Disorder (PTSD), the current database cited PTSD and Brief Psychotic Disorder, the most recent CPE from 2012 cited PTSD and Psychosis NOS, and the most recent PBMC note cited PTSD and Schizophreniform Disorder and Schizotypal Personality Disorder. Overall, there remained a need to have	

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		an agreed upon diagnosis that would be used in the various sections of the record. The overall quality of the newer CPEs was good but many older CPEs need to be reviewed and their quality improved. That can be done in the course of the annual reviews of the CPEs that had just started. 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 for that continues to be 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. At the time of the visit annual reviews were in place for only six of 135 (4%) individuals. Now that annual reviews have started the process of examination and review of diagnoses for older CPEs can proceed in an orderly manner. Even for individuals for whom evaluations had been completed using the Appendix B format, it was not consistently clear that diagnoses matched evaluation results. As reported in Provision J6 for a sample of individuals for whom Appendix B evaluations were done during the review period, for four of seven (57%) individuals, the diagnoses were justified.	
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.	<u>Timeliness of Implementation</u> The Self-assessment provided information on timeliness of assessments but did not provide any information documenting review of timeliness of implementation of medical treatments and interventions. The Self-assessment for Section K reported that 68% of Positive Behavior Support Plans (PBSPs) were implemented within 14 days of receiving consent (with an increase to 10% in June 2014 following a training session) 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 20% of a sample of 10 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. As reported in Provision L1, response to acute medical conditions remained timely. Initial triage, clinical management, and follow-up through full resolution of acute medical conditions was exemplary. As reported in Provision K9, lack of consistency across tracking data made it impossible to determine whether behavior interventions were implemented within 14 days of final consent or approval.	Noncompliance

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		As reported in Provision Q1, restorative treatments were completed as clinically indicated and, for the sample reviewed, within a reasonable period. As reported in Provision O2, individuals who had a change of status related to PNM or 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. Following involvement of the Physical and Nutritional Management Team (PNMT) in development of plans to address PNM difficulties with referred individuals, documentation was provided to confirm that only two of four individuals' plans reviewed (50%), showed action plan steps had been completed within established timeframes, or IPNs/monthly reports provided an explanation for any delays and a plan for completing the action steps. As reported in Provision P2, one of six individuals' direct intervention plans (17%) was 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 five individuals' plans were implemented timely as the Facility did not provide OT/PT treatment plans that indicated the referral date and treatment start date. A positive finding, and a significant improvement compared to the last compliance period, was reported in Provision R3. For ten of ten individuals in Sample R.1 for whom the IDT directed a revision in the communication dictionary (100%), the communication dictionary was revised within 30 days. Although there were examples of timely implementation of treatments and interventions, there were examples in which these were not timely or in which the Monitoring Team could not determine (and the Facility could not track) whether these were or were not timely. <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, the quality of PBSPs had improved considerably, with gains in most required components. However, some components still were still not consistently addressed.	

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		As reported in Provision L1: • Clinical management of acute conditions was exemplary. • The Facility ensured appropriate follow-up with medical consultants to address the one case of malignancy diagnosed at the Facility. • For individuals diagnosed with recurrent pneumonia, the medical provider assertively managed the acute case of pneumonia, through resolution. • For individuals diagnosed with osteoarthritis, there was lack of assertive clinical follow-up. Clinical appropriateness of treatment and interventions continued to improve, albeit not yet to a level of substantial compliance for most clinical disciplines.	
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.	Although the Facility, in its Self-Assessment, provided information only from the external and internal medical audits for this provision and found noncompliance due to a need to further review and trend clinical indicators, the Self-Assessment for Provision H2 included specific data from clinical indicators of several health conditions. The Facility, through documents provided and databases presented for view, demonstrated both an advanced establishment of clinical indicators as part of routine monitoring of care and health status, and attention to those indicators when providing care to individuals and identifying systemic areas of medical care to enhance. This was not as clearly demonstrated for other clinical disciplines, although some examples were also evident. <u>Policy</u> DADS draft Policy 005 Minimum Common Elements of Care requires discipline leads to identify clinical indicators to measure efficacy of treatments and interventions. RSSLC Policy I31 Chronic Clinical Indicators establishes a process to identify, based on review of national standards and review of professional literature, clinical indicators of chronic diseases and standards of care that medical providers are to follow except when an individual's needs requires tailoring of medical management. This policy also establishes a requirement for a chronic disease database for each of the chronic conditions for which clinical indicators have been identified. The PCP is to enter data for individuals on their caseload. Trend analyses are to be conducted through meetings with medical staff and other clinical services to review the data, observe for trends, and develop action plans. <u>Use of Clinical Indicators for Individual Care and Treatment Decisions</u> The Facility had developed, and provided to the Monitoring Team, clinical pathways for the following conditions: diabetes mellitus, osteoporosis, seizure disorder, constipation, hypertension, chronic kidney disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease, Downs (sic) Syndrome, cerebral palsy, degenerative spine disease, aspiration syndrome, anemia, dyslipidemia, pneumonia, sepsis,	Noncompliance

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		neuromotor/musculoskeletal disorder, and unintentional weight loss. Each of these included information on diagnosis and on what should be observed and monitored. For several conditions (where appropriate), specific data such as lab values, blood pressure, airflow limitation, or number of hospitalizations were listed as data required to be monitored and reported. Many of the clinical indicators were listed in the last compliance report for RSSLC. The Facility provided databases, for review by the Monitoring Team, for diabetes, osteoporosis neuromotor/musculoskeletal, and pneumonia. These verified the data to be entered, and that the databases provided a number of useful reports based on clinical indicators. These reports can provide rapid information on issues needing to be addressed, whether individuals or systemic issues. In addition, the Facility provided databases for both urinary tract infections (UTIs) and developmental disabilities preventive screening. Each of these databases was accompanied by a trend analysis including action plans, lists of individuals diagnosed with the condition, lists of individuals whose clinical indicators were outside accepted range, and verification that action plans were implemented. Trend analyses 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. This process had been in place and evolving for at least a year and a half. At this stage, data were routinely entered, trend analyses were well developed and led to actions, and there were extensive data over time for both individuals and Facility-aggregate health status. In addition, as reported in Provisions L2 and L3, the data from the databases had been integrated into the medical quality assurance process. Outside of medical care and chronic health conditions (and some acute conditions such as UTI), the use of clinical indicators had progressed but was not yet consistent across clinical disciplines. • As reported in Provision O2, review of records of four individuals referred to the PNMT found four of four (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. However, zero of four (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 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	

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		change. • As reported in Provision O2 for individuals discharged from PNMT oversight, four of four individuals' (100%) discharge summaries/action plans provided objective clinical data to justify the discharge. However, zero of four 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 pneumonia and not objective clinical data that will proactively help the PNMT address concerns before they become a risk to one's health. • As reported in Provision M5, Integrated Health Care Plans (IHCPs) consistently identified appropriate clinical indicators to be monitored and the frequency. For example, the IHCP for Infection #468 identified realistic and measurable objectives, sufficient clinical indicators, and frequency for monitoring. • As reported in Provision K4, data collection methodologies for targeted behavior were found to be adequate for 80% of Positive Behavior Support Plans (PBSP) reviewed, which was a substantial improvement over the previous monitoring period. Data collection for replacement behavior were sufficient for 40% of PBSPs, a decline since the last period. • As reported in Provision J4, although the Facility reported that plans were in place to reduce the need for the pre-treatment sedation in 35 of 120 (29%) of the pretreatment episodes that took place during the reporting period, the Self-Assessment reported that there was not yet a process in place to determine if plans to reduce the need for pre-treatment sedation were implemented or if they were effective. • As reported in Provision T1e, there was a continued emphasis placed on the identification of clinical indicators in the medical summaries to be used as monitoring parameters to be included in the CLDP. It would be advisable for the other disciplines to provide similar monitoring parameters.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	Similar to the findings in Provision H4, a process was in place to monitor health status for individuals with chronic health conditions, but similar processes were not in place for other health issues. One basic process for monitoring health status of individuals is the process for annual clinical assessments (with additional assessments provided as needed). As reported in Provision H1, assessments required to develop an appropriate ISP were still not consistently completed in time for IDT members to review before the meeting. Both the Self-Assessment for this provision and the table of Required Annual Assessments Filed 10 Days Prior to ISP Meeting for meeting dates of 4/1/14-6/30/14 documented a need	Noncompliance

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		for improvement. In particular, medical assessments/Annual Medical Summaries were not consistently provided timely. Dental assessments were consistently timely, and Nursing, OT/PT, and Behavioral Services Assessments were generally timely but needed improvement. Chronic Care Review Process: A positive finding, as noted above, is the chronic care process. The database facilitates tracking of quarterly monitoring of individuals with chronic condition, and of indicators of health status to be assessed and documented. Physician Quarterly Review, using a standard template for documentation and requiring physical examination, promotes frequent monitoring of the status of each individual. Nursing quarterly assessments similarly ensure monitoring of health status. As the new process for collaborative quarterly nursing and PCP review is fully implemented over time, this monitoring should be enhanced. Audit tools for medical care for chronic health conditions included, where appropriate, questions about whether the PCP discussed specific clinical indicators identified in the Clinical Pathways. Thus, not only were clinical indicators of chronic health conditions identified and expectations for PCP review established, but also there was a process to audit a sample of individuals to determine whether PCPs actually documented review of those indicators as part of their process of making decisions on care and treatment. PCP IPNs provided by the Facility for several individuals with diabetes (Individuals #153, #530, #613, and #680) included documentation in each IPN of specific clinical indicators, including not only direct measures of diabetic control such as HbA1c and blood glucose, but also measures of health affected by diabetes, such as BUN and creatinine, and presence or absence of retinopathy. The Facility needs to continue to develop the quarterly review process. As reported in Provision L4, the Facility had not yet ensured implementation of quarterly assessments of chronic medical conditions, such as osteoarthritis. Reviews by other clinical disciplines: Across clinical disciplines, there was not consistent monitoring of health status and of effectiveness of treatments and interventions. • As reported in Provision O7, 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.	

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		• As reported in Section P, for individuals with PNMPs, there was little evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. For individuals in Samples P.1 and P.2, 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). Monthly QIDP reviews: As reported in Provision F2d, the QIDP Monthly Review process was not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development. Content of the reviews seldom provided meaningful evaluation of progress. In many instances, the same comments were repeated from month to month without action. The Facility had also recently modified its procedures to address ongoing issues of timeliness of Monthly Reviews of the ISP by the QIDP. These new procedures require QIDPs to submit monthly reviews to the QIDP Coordinator and Service Coordinator when due, and tracking of delinquent reviews.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	<u>Policy</u> DADS draft Policy 005 Minimum Common Elements of Care would require that "disciplines identify response to treatment and intervention through tracking, trending and analyzing the data obtained from utilizing the clinical indicators." Although this policy had not yet been implemented, this requirement, if met, would comply with the requirements of this provision. As reported above, medical services had identified clinical indicators of chronic health conditions and was tracking and reviewing these for individuals and trending them for the Facility. However, this was not consistently the case for other disciplines. Examples are provided throughout this report of modifying treatments and interventions, including: • As reported in Provision L1: o Medical providers provide assertive triage, appropriate clinical management, and follow-up through resolution of fractures. o The Facility's medical providers provide exceptional initial triage, clinical management, and follow-up through full resolution of acute medical conditions. Examples in which improvement is needed included: • As reported in Provision K4, progress was evident, or the program was modified	Noncompliance

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		within three months of lack of progress, for 60% of sampled programs (an improvement compared to the last compliance period). For the remainder, it was not possible to determine if changes were attempted or if those changes were evidence based due to lack of markers or indicators of treatment changes on graphs. • As reported in Section P and above in Provision H5, 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). Therefore, the Monitoring Team (and the Facility) could not determine whether treatments and interventions were modified in response to clinical indicators. Evidence was not provided to indicate such modifications occurred. Furthermore, as reported in Provision O2, following involvement of the Physical and Nutritional Management Team (PNMT) in development of plans to address PNM difficulties with referred individuals, documentation was provided to confirm that only two of four individuals' plans reviewed (50%), showed action plan steps had been completed within established timeframes, or IPNs/monthly reports provided an explanation for any delays and a plan for completing the action steps. • As reported in Provision C7, records for three of five individuals reviewed (60%) reflected documentation of a timely individual support plan addendum (ISPA) following each episode in which the individual experienced more than three applications of restraint in a rolling 30-day period. For the other two individuals, ISPAs did not occur until additional restraints had continued to occur. For the Facility to ensure that treatments and interventions are consistently modified in response to clinical indicators, two conditions must be in place. First, clinical indicators to measure progress of treatments and interventions must be identified; then, regular review must be conducted, with frequency based on risk associated with lack of progress and on the time that treatment effect is likely to occur, but at least monthly. To progress toward substantial compliance, the Monitoring Team recommends the Facility build on the processes developed by Medical Services and ensure initial steps taken to track QIDP monthly reviews are assessed for effectiveness and either continued or revised as necessary.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish	DADS draft Policy 005 Minimum Common Elements of Care addresses several requirements of this Section, particularly those regarding development and use of clinical indicators, but has not yet been implemented. DADS Policy 004.2: Individual Support Plan Process addresses requirements for assessment timeliness.	Noncompliance

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	and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility had developed numerous policies that included requirements for integrated clinical services. As reported in Provision G1, the newly implemented (and, as yet, unnumbered) Integrated Clinical Services Policy guides integrated clinical services and includes a list of 40 current facility policies that include a component requiring integration. The Facility provided 46 policies related to specific areas, including committees and areas of care, that addressed or required integrated services in some manner. 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. The requirements for integrated services are small sections of these policies. Still, additional examples in which integration was built into policies provided an indication that the Facility seeks to ensure integrated planning occurs. RSSLC Policy F.04 Individual Support Plan Process included requirements for completion of assessments. RSSLC Policy I.31 Providing Health Care Services: Chronic Clinical Indicators guides the development and use of clinical indicators for chronic health conditions. The procedures for chronic care clinical pathways were a positive step to promote use of clinical indicators and recommended practices. The Facility provided no similar policy that provided guidance to all disciplines on requirements for clinical indicators; the draft DADS policy could provide an initial outline for such a policy. To achieve substantial compliance, the Facility should ensure that policies and processes to meet the requirements of this Section address 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 8/12/14 2. RSSLC Section I Action Plan 8/11/14 3. RSSLC Section I Presentation Book 4. DADS At-Risk Policy 006.1 12/7/12 5. RSSLC Policy I.08 At-Risk Individuals 6/6/14 6. RSSLC Policy K.01 Physical and Nutritional Management (rev: 5/15/14) 7. RSSLC Policy K.07 PNMP Training and Monitoring Policy (rev: 6/6/14) 8. RSSLC Policy K.12 Departmental Quality Assurance Plan (11/1/13) 9. RSSLC Policy D.23 Using Bed Rails (5/8/13) 10. Record or partial record review: o Sample O.1: Individuals #84, #192, #340, #429, #442, #523, #649 and #666 • Sample O.2: Individuals #106, #325, #463, and #621 • Sample O.3: Individuals #73, #159, #169, #173, #352, #500, and #553 • Sample O.4: Individuals #57, #109, #125, #138, #142, #169, #173, #180, #259, #268, #302, #384, #386, #413, #458, #477, #484, #501, #512, #515, #525, #526, #551, #589, #597, #661, #666, #701, #753, #789, and #791 11. Records reviews for compliance analysis for Individuals #468, #499, #716, #66, #173, #107, #442, #666, #621, #192, #523, #649, #475, #179, #368, #623, and #151 12. Integrated Risk Rating Form (IRRF) and accompanying Integrated Health Care Plan (IHCP) for Individuals #499, #468, #66, #82, #248, #399, #107, #173, #321, #716, #157, #225, #73, and #787 13. List of individuals supported with bedrails 7/31/14 **People Interviewed** 1. Leroy Thompson, QIDP Coordinator, Section Lead 2. Angela Hernandez, Program Compliance QIDP 3. Charlotte Dalton, QIDP 4. Kristina Sheets, Director of Residential Services 5. Ping Law OTR Habilitation Therapies Director 6. David Taylor OTR PNM OT 7. Brandie Rabe PNMT SLP 8. Jean Cuevo PNMT PT 9. DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meetings Attended/Observations:** 1. ISP Meeting for Individuals #745 2. ISP Preparation Meeting for Individual #613 3. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon)
	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: ▪ Used monitoring and/or audit tools. ▪ Reported that it examined a sample of 40 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 (i.e., discipline staff, QA staff, or both), or whether or not there were written instructions or guidelines associated with the review of data to ensure consistency. The Facility did report on inter-rater reliability for Provision I.1. 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. As noted in the last report the Facility Self-Assessment for Provision I.3 again 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 two reports 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, "monitor development of IRRF and IHCP in ISP meeting." Additionally, the Action Plan did not address any of the necessary components within Provision I.3. The Action Plans did not contain sufficiently targeted steps that would likely lead to compliance with this Section of the SA. For those Provisions determined to be in noncompliance by the Monitoring Team the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome 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: The Facility's efforts to move towards compliance with Section I of the Settlement Agreement had progressed in some areas and regressed in others. For example, as reported in Provision I.3 for eight metrics assessed by the Monitoring Team Facility compliance scores improved in five instances (63%) and regressed in three instances (37%). 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 as recently as June 2014. The Facility had implemented or refined several administrative processes since the last review, most notably the implementation of a "15 day" pre-ISP meeting to review the IRRF and IHCP. Staff responsible for implementing various aspects of the At-Risk policy demonstrated an improved understanding of risk assessment policies and procedures. The Facility's management system to identify individuals whose health or well-being is at risk still lacked consistency in implementation although improvement in many areas was noted. Training of staff involved in risk identification activity and of IDTs responsible for the development of risk action plans continued. While improvement in some compliance scores was noted many 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. Nevertheless, interdisciplinary discussion of clinical data was, for the most part, not evident. 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	The Facility's management system to identify individuals whose health or well-being is at risk was improved but still lacked consistency in implementation. Data associated with this is reported in Provisions I.2 and I.3. Additional examples from Sample 0.2 are reported in detail in Section O of this report. When asked what the biggest obstacle was	Noncompliance

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	implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	related to achieving compliance with Section I the Facility responded "integration of services as opposed to integration of paperwork". In its last report the Monitored Team reported on problems with significant risks not being identified, and PNMT recommendations finding their way into IHCPs and ISPs, During this review improvements were noted in both areas. Refer to Provision O.1 and O.2 for specific examples. 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 6/6/14. This update provided additional detailed requirements associated with IDT responsibilities regarding the at-risk process, particularly implementing what was described as the "15 day meeting." This was a meeting of the IDT 15 days before the ISP meeting specifically for the purpose of reviewing the IRRF and discussing and agreeing on recommended changes. The Facility reported that the intent of the 15 day meeting was to focus on clinical review and inter-disciplinary collaboration in assigning risk levels leading to the development of the Integrated Health Care Plan (IHCP), and developing, where appropriate, clinical indicators and the type and frequency of monitoring of clinical indicators. The Monitoring Team had an opportunity to observe a 15 day meeting for Individual #613 during the review. While the Facility is to be commended for initiating this process, the outcome from the one meeting observed by the Monitoring Team was disappointing. For nearly all risk categories the review consisted of a reading of the text on the IRRF (which could have been read by IDT members prior to the meeting since these data were posted on a share drive) followed by the QIDP asking, "team agree?" IDT discussion and deliberation was not present for most risk categories. The greatest area of IDT discussion was in regard to the Individual's significant planned weight loss and issues related to achieving compliance with getting to medical and dental appointments. The Individual's record was seldom referred to and clinical data was discussed only twice. In the behavioral health portion of the meeting the IRRF noted regression in targeted behaviors. There was no discussion or observation as to whether or not this may be attributed to reactions to the strict diet the Individual was on in order to lose weight. The Monitoring Team also had the opportunity to observe the ISP meeting for Individual #745. The Monitoring Team noted very little interdisciplinary clinical discussion. In this case, however, the IDT did use the Risk Level Guidelines and supporting clinical data, in designating risk levels appropriate to each category of risk. The Facility reported several administrative initiatives that it felt had strengthened its ability to identify change in status in Individuals and react timely and appropriately. These included: 1. Facility level morning medical meetings twice a week.	

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		2. Unit level daily meetings with RN Case Managers. 3. IMRT review of injury and hospitalization reports. 4. QIDDP participation in hospital discharge planning/Facility infirmary admissions. Additional 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. This had mixed results indicating ongoing training was still needed. As reported in Provision I.3, there were improved compliance scores in five areas and lower compliance scores in three areas. The Facility's regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk was not always producing reliable and valid results. Some examples were: 1. Individual #442 was identified as being at a low risk of choking and medium risk of falls. Individual #442's mobility presented with impaired balance, abnormal gait, decreased awareness of surroundings and 16 falls in the past twelve months, but risk for this individual was only listed as medium risk. Individual #442's mealtimes were characterized by rapid eating pace, overstuffing, and a choking event on 6/12/14, yet the Individual was only listed as being at low risk. Based on the information provided, the Monitoring Team felt that the risk scores did not accurately reflect the risk score. 2. Individual #72 had 24 falls over the past six months but was not rated as being at a high risk for falls. 3. Individual #174 had nine falls over the past six months but was only rated as being at a low risk for falls. 4. Individual #561 had 11 falls over the past six months but was only rated as being at a low risk for falls. 5. Individual #718 had 12 falls over the past six months but was not rated as being at a high risk for falls. 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 many 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	

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		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 each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	Review of seven records for individuals determined to have had a change in condition meriting risk assessment review by the IDT (Individuals #66, #442, #666, #621, #192, #523, and #648) 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 seven (100%). This was consistent with the 100% compliance score reported in the last review by the Monitoring Team. This was also consistent with data reported in Provision O.1. Based on a review of records of a sample of six individuals (Individuals #468, #499, #716, #66, #173, and #107) for whom assessments had been completed to address the individuals' at risk conditions, three (50%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This compares to the 50% compliance score reported in the last review by the Monitoring Team. Those that did not included Individuals #716, #173, and #107. The nursing assessments for these three 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 #716's clinical data revealed a cleft palate and hair lip which was not taken into consideration in rating risk for aspiration. Additionally Individual #66 clinical data revealed a genetic disorder (neurofibromatosis) which was not addressed in the Individuals Integrated Health Care Plan (IHCP). Refer to Section M for additional information. Based on a review of records of a sample of six Individuals (Individuals #442, #666, #621, #192, #523 and #649) for whom assessments had been completed to address the individuals' at risk conditions, five (83%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. The exception was for Individual #666. In this case the Individual was recommended for a diagnostic procedure (swallow study) which was never carried out. This compliance score of 83% compares to the 100% compliance score noted in the last review. Refer to Section O for additional information. Based on a review of records of five individuals (Individuals #475, #179, #368, #623, and #151) with polypharmacy risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, four (80%) included an adequate risk assessment to assist the team in developing an appropriate plan. The exception was for Individual #179. This compliance score of 80% compares to the 100% compliance score noted in the last review. Refer to Section J for additional information. In summary for the four metrics noted above in one the compliance score remained at	Noncompliance

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		100%, in one the compliance score did not improve (remained at 50%), and in two the compliance score regressed from that noted in the last review by the Monitoring Team. Based on this review this Provision was not in compliance because only 12 of 17 (71%) Individuals reviewed by the Monitoring Team had adequate risk assessments completed. This compares to the compliance score of 73% reported in the in the last review.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The Facility self-assessment for Provision I.3 addressed only the single issue of bedrail use and bedrail safety. In this regard the Facility had aggressively assessed bedrail use and developed alternatives for many Individuals, As a result the number of Individuals using bedrails had decreased from 106 to 75 since the last review. Very impressive. The substance of Provision I.3 was not self-assessed by the Facility. The Monitor Teams findings were: Based on a review of 17 records of risks for 17 individuals determined to be at risk, (#468, #499, #716, #66, #173, #107, #442, #666, #621, #192, #523, #649, #475, #179, #368, #623, and #151), 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 15 (88%)) cases. Records that did not contain documentation of this included Individuals #66, and #179. This compares to the compliance score of 73% reported in the last review. • Implemented a plan that met the needs identified by the IDT assessment in 12 (71%) cases. Records that did not contain documentation of this included Individuals #621, #179, #716, #66, and #173. This compares to the compliance score of 87% reported in the last review. • Included preventative interventions in the plan to minimize the condition of risk in 12 (71%) cases. Records that did not contain documentation of this included Individuals #621, #179, #716, #66, and #173. This compares to the compliance score of 67% reported in the last review. • When the risk to the individual warranted, took immediate action in seven of nine (78%) cases. Records that did not contain documentation of this included Individuals #179 and #621. This compares to the compliance score of 100% reported in the last review. • Integrated the plans into the ISPs in 14 (82%) cases. Records that did not contain documentation of this included Individuals #179, #621, and #66. This compares to the compliance score of 67% reported in the last review. • In seven (41%), 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 #716, #66, #107, #179,	Noncompliance

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		#442, #666, #621, #192, #523, and #649. This compares to the compliance score of 53% reported in the last review. • In eight (47%) appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. Records that did not contain documentation of this included Individuals #716, #66, #107, #179, #666, #523, #173, #368, and #649. This compares to the compliance score of 0% reported in the last review. • Included the clinical indicators to be monitored and the frequency of monitoring in 12 (71%) cases. Records that did not contain documentation of this included Individuals #179, #368, #623, #151, and #66. This compares to the compliance score of 60% reported in the last review. In summary, for these eight metrics Facility compliance scores improved in five instances (63%) and regressed in three instances (37%). Additionally, as reported in Provision O.2 recommendations by the PNMT for those Individual in Sample O.2 were not addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. Further information on the Individuals referenced in this Section of this review may be found in Sections J, M, and O of this report. Based on this review this Provision was not in compliance.	

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-assessment 08/12/2014 2. RSSLC Action Plans 08/11/2013 3. 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, and 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 #25, #39, #74, #76, #101, #151, #179, #192, #200, #235, #320, #368, #475, #623, and #723. 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 (QDRRs) 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, copy of the plan to reduce risk (ISP addendum) 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: Individuals who had episodes of medical restraint. To review each episode 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 #751, #791, #456, #142, #598, #535, #389, #623, #798, #223, #612, #758, #526, #588, #399, #502, #220, and #785.

26. Sample J3: Individuals who took seizure medications for both neurological and psychiatric indications: Individuals #101, #140, #561, #623, and #630
27. Individuals admitted since the last visit. These were Individuals #85, #153, #306, #343, #350, #395, #458, #527, #737, #749, and #795. Materials reviewed included a copy of the Reiss Screen (administration and scoring), CPE (if done) a copy of the medical examination done on admission, the Integrated Risk Reduction Form (IRRF) and Integrated Health Care Plan (IHCP)
28. All Individuals who had a behavioral change of status evaluation. Materials reviewed included Reiss Screen, 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. There was one such evaluation, for Individual #758.
29. All Psychotropic Medication Treatment Plans in place at the time of the visit. There were two, for Individuals #192 and #623.

People Interviewed:

1. Tran Quan, D0, Medical Director
2. Babu Draksharam, MD, Contract Psychiatrist
3. Hugh Pharies, MD, Contract MD
4. Erica Johnson, Behavioral Health Specialist 1

Meetings Attended/Observations:

1. ISP meeting for Individual #680, on 08/26/2014
2. Grand Rounds, conference regarding Individual #737, 08/27/2014
3. Behavior Support Committee meeting, 08/27/2014
4. PBMC Clinic, 08/28/14

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 Facility Self-Rating for compliance.

The Self Assessment reported that the Psychiatry Department reviewed records of 134 individuals supported by psychiatry for the presence of services by a board-certified or board eligible psychiatrist. That was present for 134 of 134 (100%) individuals. Appendix B psychiatric evaluations were present for 89 of 134 (66%) of those individuals.

The Facility also reviewed a sample of 18 of 134 (13%) records for the presence of diagnoses that were clinically justified. That was reported to be present for 18 of 18 (100%) individuals. The Facility also looked for a justified link between the clinical diagnosis made and the medication used for treatment. That was present for 18 of 18 (100%) individuals. Another Facility review of 15 records showed that 11 of 15 (75%)

	had a current PBSP. Facility review of pre-treatment sedation showed that there was no documentation to determine if plans or strategies to reduce the need for the pretreatment were in place. Review of Reiss screening showed that all admissions during the review period had been screened. Monthly polypharmacy meetings were conducted as required. MOSES and DISCUS were completed, but signatures were not signed in a timely manner. Neurology clinic integration with psychiatry continued with input from the PCP and pharmacist. During the visit the Monitoring Team learned from the Quality Assurance (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). There were 10 audits completed by the QA Department (external audits) and ten by the Psychiatry Department (internal audits). For the period reviewed, the Facility reported a level of compliance that ranged from 46% to 95% for the internal audits, and 49% to 64% for the external audits. The level of agreement between the internal audits that were validated by QA's external audits was 57.14%. That was an improvement in the level of agreement over the 47% agreement noted for the last review but is not adequate to substantiate that items are observable and are defined adequately to ensure valid observation. Overall, the Monitoring Team was encouraged by the Facility's use of data in the Self Assessment, although the data provided to the Monitoring Team by the QA Department should have been included in the Self-Assessment. The Facility also provided as part of its self-assessment an Action Plan that reported steps taken or planned to achieve compliance. The Action Steps appeared to be relevant to achieving compliance, and they defined the provision-specific outcomes the Facility hoped to achieve as a result of these Action Steps as well as how they will be measured. In many cases the Action Steps listed by the Facility were very broad and sometimes they simply restated the problem that needed a remedy. For example, although the Facility acknowledged in the Self-Assessment the need for plans to reduce the need for the pretreatment sedation (see above) the relevant Action Step stated only that plans were to be developed. That was too broad and did not guide IDTs to specifics that could be monitored in an ongoing manner by Facility leadership, for example the QA/QI council. 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. Additionally, it might be helpful for the Facility Action Plan to include the Action Steps 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. For provisions that had been found in compliance, the Action Plan for Section J included actions to maintain

	compliance. It was valuable for the Facility to recognize and act on the need to maintain compliance, and to implement actions to prevent decline in performance. The Facility self-rated for continued compliance with Provisions J1, J5, J7, J11, and J15. The Monitoring Team concurred.
	Summary of Monitor's Assessment: Progress was limited due to the absence of the Facility's Lead Psychiatrist, who was deployed to active duty. In his absence, psychiatric staffing was maintained by two contract psychiatrists who worked under the guidance of the Medical Director. Individuals who required comprehensive psychiatric assessments continued to receive them, and psychiatrists started to do annual reviews of those assessments. Reiss Screen procedures remained in place for new admissions and for change of status evaluations. Planned introduction of Psychoactive Medication Treatment Plans (PMTPs) to help link diagnoses, treatments, and monitoring for efficacy was delayed. The Facility remained in compliance with Provisions J1, J5, J7 and J15, but no additional Provisions came into compliance. Findings for each Provision of Section J were: Provision J1: The Facility 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. Annual reviews of the CPE had just started and were in place for only six individuals. The clinical record cited diagnoses in the Diagnostic and Statistical Manual (DSM) format, but different sections of the chart sometimes continued to cite different diagnoses. Provision J3: Behavioral treatment programs do not provide needed information about psychiatric treatment and the role of psychotropic medications. Planned implementation of PMTPs that will contain the needed treatment plan information about psychotropic medications was delayed. Provision J4: Difficulties with development, implementation and tracking of supports to minimize the use of pre-treatment sedation persisted. Monitoring for safety during and after pre-treatment sedation had 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 89 of 138 (65%) of CPEs were in the required Appendix B format. Provision J7: Reiss Screens were done for all individuals admitted to the Facility and for individuals who

	had change of status evaluations. CPEs were done for individuals who had positive screens, but those CPEs were not always done in a timely manner. The matter should be addressed promptly, to reduce risk to affected individuals. Provision J8: The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. Provision J9: The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. Provision J10: The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. Provision J11 Data provided by the Facility showed a reduction in the amount of psychiatric polypharmacy since the last visit and reflected continued Facility efforts to minimize the use of psychiatric polypharmacy. 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 addressed side effects and side effect screenings, medication interactions, laboratory reviews and suggestions. MOSES and DISCUS screens administered by nurses were sometimes not done with the required frequency, screens that were done were often not reviewed by physician in a timely manner, and the required physician review section of the screen was not completed in many cases. 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: The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. Provision J15: Interdisciplinary review of medications used for both epilepsy and psychiatric symptoms continued.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications and Experience of the Psychiatrists</u> During the review period, two psychiatrists worked at the Facility. Babu Draksharam, MD has been working at Richmond since June 2014. He is a 1969 graduate of the Guntur Medical College in Andhra Pradesh, India. He completed his psychiatric residency at the Baylor College of Medicine in 1976 and he has worked in Texas	Substantial Compliance

		for the past 35+ years. He has experience in developmental and intellectual disabilities, including employment at DADS facilities at Rio Grande and San Angelo. Hugh Pharies, MD has worked at the Facility since summer 2012. He a 1967 graduate of the University of Texas at Galveston School of Medicine, and he completed his psychiatry residencies in adult and child psychiatry at the Department of Psychiatry, Baylor University School of Medicine, in 1997 and 1999, respectively. For ten years he worked as an Assistant Professor at Baylor, and then he then joined the staff of the Mental Health and Mental Retardation Authority (MHMRA) of Harris County, Texas. Dr. Pharies worked there from 1993 until 2012. Dr. Pharies had prior experience in intellectual disability psychiatry as part of his overall clinical responsibilities at the MHMRA. He also worked as a contractor for another DADS facility for three months, prior to coming to RSSLC. Dr. Pharies has been board certified in psychiatry since 1987. He is employed by the Facility on a full-time basis, as a contractor. <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.	
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>Process for Evaluation and Diagnosis</u> CPEs were needed for all individuals who received ongoing psychiatric care. CPEs were in place for 134 of 135 (99%) of individuals followed by psychiatry. Individual #85 did not yet have a CPE; he was admitted in 2014 and his CPE was scheduled but had not yet been completed. In the Facility Self-Assessment, prepared prior to the visit and based on the Facility census at the time the Self Assessment was written, the Facility reported that CPEs were in the Appendix B format for 89 of 134 (66%) of individuals followed by psychiatry . The Facility reported that it planned to complete the conversions of the remaining CPEs to the required format over the course of the coming year. 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. The Monitoring Team reviewed the CPEs of the 15 individuals in Sample J1. Thirteen of 15 (87%) CPEs were in the Appendix B format. For details on evaluations in the Appendix B format please see Provision J6. Two of 15 (13%) were not in the Appendix B format. The Facility reported plans to have CPEs in the Appendix B format in place by July 2015. DADS Psychiatry Policy required that CPEs be re-evaluated on an annual basis. The Facility had just started to do so in July 2014. At the time of the visit, six of 135 (4%) individuals with CPEs had annual reviews in place. The reviews were detailed and ranged from 4 to 6 single spaced pages. The reviews contained updated information on the individual's history of present illness and diagnostic information. The annual reviews contained pertinent	Noncompliance

information on individual's response to medications, hospitalizations and other important events.

<u>CPEs for Admission Treated with Psychotropic Medications</u>
During the review period five individuals were admitted to the Facility who took psychotropic medications prior to admission. Four of five (80%) of those individuals were seen by psychiatry and had CPEs within 30 days. Individual #85, admitted in March 2014 and treated with psychotropics, did not yet have a CPE. While the Monitoring Team recognizes that not all relevant information may be available at the time of admission, at least a preliminary assessment needs to be done.

<u>CPEs for Admission with Positive Reiss Screens</u>
CPEs were required for individuals who had positive Reiss Screen on admission.
That was the case for Individuals #306 and #527 who were admitted several months prior to the visit and for whom CPEs were still pending.

<u>CPEs for Change of Status</u>
Per the Facility protocol, (see prior reports) individuals who live at the Facility and have a clinical change of status receive a Reiss screen. There was one change of status and that was for Individual #758. That individual received a Reiss Screen and was referred to psychiatry for a CPE. As required, the CPE was done within 30 days. The individual is now followed in the PBMC for ongoing psychiatric care.

<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. These included PBMC clinics, ISP meetings, and Grand Rounds. Information on DSM diagnosis was part of each of these venues. During the visit the Monitoring Team observed each of these processes:

- PBMC clinic was observed on 08/28/14. Participants included the psychiatrist, behavioral health specialists, nurse case managers, 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 interdisciplinary and collaborative. In several of the reviews there was attention to diagnosis. Overall, the clinic demonstrated adequate detail to diagnosis, and was evidence of an ongoing process for diagnostic evaluation/reevaluation. For example:
    - Individual #795 was newly admitted; the behavior asked about the diagnosis and the relevant symptoms for tracking. The Individual had been diagnosed by the psychiatrist during the CPE with schizoaffective disorder; there was a discussion of whether a diagnosis of autism should be added. That was relevant since some of the behaviors of concern could be linked to either of the two diagnoses. The IDT wisely opted to defer final decisions until completion of screenings for symptoms of autism that were underway.

		○ Individual #85 was also newly admitted. In her case there were multiple conflicting diagnoses (referral materials, prior diagnoses, diagnoses on the admission medical evaluation). The Individual had been admitted in March of 2014, but did not yet have a CPE in place. That was of course problematic, since an initial psychiatric evaluation should have been done during the first 30 days of the admission. The psychiatrist listened to the information and deferred decisions to the upcoming CPE. ○ Individual #795 was also newly admitted. She had symptoms of both psychosis and depression and there were several conflicting diagnoses. In her case the psychiatrist had recently completed a CPE and had diagnosed Schizophrenia, Paranoid Type. He explained the reasons and provided a diagnostic justification. • An ISP meeting for Individual #680 was observed on 08/26/14. The individual was diagnosed with Major Depression and with ADHD. There was some discussion in the meeting about the severity of the depression and the individual had a CPE in place that addressed those issues. It was unfortunate that the psychiatrist was not able to the ISP meeting, although the Monitoring Team was informed that the psychiatrists typically do attend. • A Grand Rounds was observed on 08/27/14. The focus of the meeting was Individual #737 admitted to the Facility in May 2014. That individual was diagnosed with PICA, and the discussion focused on the medical and environmental management of the ongoing risk of foreign body ingestion. The meeting was attended by more than 20 staff members from a wide range of clinical disciplines, residential, and other staff. The discussion was excellent. It served both to enhance the level of care for the individual being discussed, and also to educate the Facility staff about a condition that affects many individuals at the Facility. The presentation included some discussion of the various conditions in which foreign body ingestion can be a presenting symptom. <u>Clinically Justified Diagnoses</u> Seven new CPEs were completed since the last visit for individuals #153, #350, #395, #458, #749, #758, and #795. Six for new admissions and one (#758) was done for an individual who lived at the Facility and had a change of behavioral status. Each of the evaluations is reviewed under Provision J6, and the Monitoring Team found that diagnoses were fully justified for four of seven (57%) evaluations. That was an improvement over past visits. Annual reviews of existing CPEs had just started, and were available for Individuals #51, #220, #264, #346, #487, #680. The annual review format provided an opportunity to review, update and justify diagnoses. The Monitoring Team found that diagnoses were fully justified in five of six (83%) annual reviews. The Facility had a review tool called "Diagnostic and Treatment Analysis" that addressed diagnostic justification, but it was not used during this review period.	

		DSM Diagnoses in the Clinical Record: The Monitoring Team reviewed the APLs for the 15 individuals in Sample J1. All individuals had a psychiatric diagnosis or diagnoses in the Diagnostic and Statistical Manual IV format. For each of the individuals in Sample J1, the Monitoring Team also compared the APL and the diagnosis listed in the Department of Psychiatry Database (chosen since the Facility indicated that was the most up to date diagnosis). In eight of 15 (53%) there were differences between the database information and the APL. Most often the difference was the inclusion of one or more diagnosis in one source but not the other. Differences were not limited to the APL and departmental database. For example, for Individual #51 the APL from 4/24/14 cited Post Traumatic Stress Disorder (PTSD), the current database cited PTSD and Brief Psychotic Disorder, the most recent CPE from 2012 cited PTSD and Psychosis NOS, and the most recent PBMC note cited PTSD and Schizophreniform Disorder and Schizotypal Personality Disorder. Overall, there remained a need to have an agreed upon diagnosis that would be used in the various sections of the record. Monitoring Team Findings and Compliance Rating CPEs were in place for 134 of 135 (99%) individuals followed by psychiatry. The overall quality of the newer CPEs was good but many older CPEs need to be reviewed and their quality improved. That can be done in the course of the annual reviews of the CPEs that had just started. 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 for that continues to be 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. At the time of the visit annual reviews were in place for only six of 135 (4%) individuals. Now that annual reviews have started the process of examination and review of diagnoses for older CPEs can proceed in an orderly manner. Prior to the visit the parties agreed the Monitoring Team would conduct reduced monitoring for this provision because the Facility had made limited progress. The above review showed that a good process was for in place for diagnostic evaluation but further work was needed to make sure that up to date evaluations with justified diagnoses were in place for all individuals. Additional work was required to assure that a uniform psychiatric diagnosis is cited in the various sections of the record.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis,	Diagnosis or Specific Behavioral-Pharmacological Hypothesis Psychotropic medications were in place for 135 of 335 (40%) of individuals who lived at the Facility. 134 of 135 (99%) had DSM IV TR psychiatric diagnosis in place as documented in their 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	Noncompliance

	neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	treatment program. The Monitoring Team reviewed the records of the 15 individuals in Sample J1, all of whom took psychotropic medications. Treatment programs for these individuals consisted of ISPs for fifteen of fifteen individuals (100%), and PBSPs for 14 of 15 (93%). The Monitoring Team reviewed PBSPs and ISPs to assess whether the programs properly included both behavioral and psychiatric contributions to describe 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 Diagnosis: The PBSPs/ISPs contained a psychiatric diagnosis in 10 of 15 (67%) records • 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 11 of 15 (73%) individuals. That was an increase over the number noted during the last review. • Operational Definitions: These were descriptions of what was intended by the psychiatric indicator. Operational definitions were present 11 of 15 (73%) individuals. • Information on psychiatric medication was present in the PBSP for four of 15 (26%) PBSPs. In many of the newer PBSPs, that information was lacking. During the previous visit the Facility informed the Monitoring Team that it planned to transition information on psychiatric medication to PMTPs, which would be the treatment plan that documented information obtained by the various healthcare disciplines (see discussion in Provision J3 from the March 2014 visit). However, the Facility informed the Monitoring Team that at this time there are only two PMTPs in place, for Individuals #192 and #623. The treatment plans for those individuals included information on the medications and how they were used. The Facility clarified to the Monitoring Team that the process to develop PMTPs for all individuals treated with psychotropic medication had stalled due to the deployment of the Lead Psychiatrist to military service. The development of PMTPs will resume upon his return to the Facility (see comments on Provisions J8, J9, J10 and J13). <u>Appropriate Use of Medication</u> The Provision prohibits the use of psychotropic medication for staff convenience or punishment. Review of 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> There were six episodes of chemical restraint during the review period. These were for Individuals # 278 (three episodes), # 561 (two episodes) and # 649 (one episode). The	

		Monitoring Team reviewed documentation for four of six (67%) episodes. In all four cases (100%), the psychiatrist documented clinical information in IPNs and completed a post restraint clinical review. General Assessment 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 delay in the development and deployment of implementation of the PMTPs was unfortunate. Nonetheless there was no evidence of inappropriate use of medication, and the rate of chemical restraint remained low. Monitoring Team's Compliance Rating Progress was limited and 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.	The parties agreed that there would be reduced monitoring of this provision. Frequency of use of Pre-Treatment Sedation The Facility reported 120 uses of pretreatment sedation between 02/01/14 and 06/30/14. Seventy-three of 120 (61%) were for medical procedures and 47 (39%) were for dental procedures. Monitoring for Safety following Pre-Treatment Sedation The Monitoring Team reviewed a sample of 18 individuals who received pretreatment sedation procedures on specified dates (Sample J2). The sample included six cases of pretreatment sedation for dental procedures and 12 cases of pretreatment sedation for medical procedures such as cardiac echoes and imaging studies. Vital sign monitoring was provided for 18 of 18 (100%) individuals. Facility nursing protocols specified that vital signs were to be monitored for 24 hours (oral pretreatment) or 72 hours (TIVA sedation), starting with a baseline measure prior to administration of the pretreatment sedation. Documentation was provided on Medical Restraint Checklists and IPNs. In five of 18 (28%) procedures the physician or dentist specified the particular nursing protocol to be used. In 13 of 18 (72%) individuals the physician or dentist the physician or dentist did not specify the nursing protocol to be used. In all such cases nurses provided 24 hour monitoring for oral sedation and 72 hour monitoring for TIVA sedation. Informed Consent for Pre-Treatment Sedation Appropriate informed consent for the sedation was provided for 14 of 18 (77%) individuals. Plans to Reduce the Need for Pretreatment Sedation The provision required that if pre-treatment sedation is to be used for routine medical or	Noncompliance

		dental care for an individual, the ISP for that individual shall include treatments or strategies to reduce the need for pretreatment sedation. The Facility reported that plans were in place to reduce the need for the pre-treatment sedation in 35 of 120 (29%) of the pretreatment episodes that took place during the reporting period. In the Facility Self Assessment the Facility informed the Monitoring Team that there was not yet a process in place to determine if plans to reduce the need for pre-treatment sedation were implemented or if they were effective. None (0%) of the 18 episodes of pre-treatment sedation reviewed in Sample J2 included appropriately developed treatments or strategies to minimize eliminate the need for restraint. <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. Accordingly, the provision remains in noncompliance.	
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 Drs. Draksharam, and Pharies. The 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 135 of the 335 (40%) of individuals who lived at the Facility. Each individual followed by psychiatry was assigned to the care of one of the two psychiatrists, and their caseloads were roughly equal. The psychiatrists examined all individuals in PBMC on a quarterly basis, and more often as clinically appropriate. Ms. Erica Johnson assisted the psychiatrists in their work. She 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 assessments for review during the clinic. Ms. Johnson tracked changes decided upon during the clinic and entered the data into Department of Psychiatry databases, and she maintained Department of Psychiatry spreadsheets for diagnoses, and she maintained the MOSES and DISCUS database. Ms. Johnson helped prepare the schedule and materials for the PBMC clinics. <u>Determination of Required FTEs</u> During the previous review of the Facility the Monitoring Team reviewed the results of a time study that was conducted to establish how much psychiatric time was needed to complete the tasks required by the various sections of the SA. The Monitoring Team concurred with the Facility's assessment that the requirements of the SA could be accomplished with the staffing level of two FTEs psychiatrists. The Facility provided that level of staffing at the time of the visit. <u>Monitoring Team's Compliance Rating</u> The Monitoring Team agreed that the Facility had a sufficient number of FTE psychiatrists	Substantial Compliance

		and other staffing, to ensure the provision of required services. The Provision is found in substantial compliance with the requirements of the Provision.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	<u>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 89 of 134 (66%) 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 Monitoring Team reviewed seven Appendix B evaluations done during the review period. These were for Individuals #153, #350, #395, #458, #749, #758, and #795. Details were as follows: • Individual #153: Diagnosis Major Depressive disorder recurrent moderate. There was some question about the apparent worsening of the patient's symptoms after a stroke. The psychiatrist noted that there was a need to solidify the diagnosis of IED. More specifics would have been helpful regarding why episodes of aggressive behaviors, severe intense anger and aggression toward others were described as psychosis. Monitoring Team comments – diagnosis was not fully justified. • Individual #350 Diagnosis: Bipolar Disorder and Intermittent Explosive Disorder. The information was consistent with the diagnosis but the psychiatrist needed to provide detail to assure that the individual meets criteria for the diagnosis. The psychiatrist should have clarified why both diagnoses were needed, for example by identifying whether episodes that were the basis for the IED diagnosis occurred during a time when the individual was manic. If they did not, and episodes during non-manic periods were the basis for the diagnosis of IED, the psychiatrist should have said so. Monitoring Team comments – diagnosis was not fully justified. • Individual # 395: Diagnosis Neurocognitive disorder: Monitoring Team Comments: Appropriate justification was provided. • Individual # 458: Diagnosis: Autism. There was a discussion of assessment around the age of 2½ at the UTMB Child Development Division and the diagnosis of autism there and by another clinician in 1985. The symptoms described at the time included the lack of language development after age 18 months. In this case the signs and symptoms that were the basis for the diagnosis of autism needed to be better described. If that evidence was not available, a diagnosis of pervasive developmental disorder may have been more appropriate. Monitoring Team comments – diagnosis was not fully justified. • Individual # 758: Diagnosis: Dementia. Monitoring Team comments - appropriate justification was provided. • Individual # 795: Diagnosis: Schizoaffective disorder, bipolar type. The psychiatrist	Noncompliance

noted that "at this point there is enough data to solidify her axis 1 diagnosis as schizoaffective disorder, bipolar type. We will reevaluate the possibility of autistic disorder or pervasive developmental disorder." In addition the psychiatrist should have provided clinical specifics that supported his conclusion about the schizoaffective disorder. Monitoring Team comments – diagnosis was not fully justified.

- Individual #749. The diagnoses for Axis I and Axis II are provided in full: "Axis I (Provisional) 295.30 Schizophrenia - Paranoid Type - as evidenced by the presence of delusions and hallucinations, with social and occupational dysfunction and continuous signs of the disturbance for the past 6 months or more, with the exclusion of Schizoaffective Disorder, Mood Disorder, because there have been no full criteria met for a Major Depressive Disorder, Manic Disorder or Mixed Disorder and symptoms are not due to the presence of substance abuse or general medical conditions and not due to a Pervasive Developmental Disorder. Axis II: 319 Mild Intellectual Disability - As evidenced by significantly sub-normal, general intellectual functioning (measured by intelligence testing - More than 2 standard deviations below the mean for her age group), concurrent with deficits or in present adaptive functioning in the areas of self-care, self-direction, health and safety with onset during the developmental years." Monitoring Team comments: The diagnoses were justified.

Overall, the Monitoring Team concluded that for four of seven (57%) individuals, the diagnoses were justified.

In other areas of the CPE, the case formulation section continued to improve and was acceptable in five of seven (71%) of the CPEs.

<u>CPE's Use across the Campus</u>

- CPE's were needed for new admissions who took psychotropic medications. Five such individuals were admitted during the review period. Four had timely CPEs within 30 days of admission. For Individual #85 the CPE was pending although she had been admitted in March 2014.
- CPE's were also needed for Individuals who did not take psychotropics and had a positive Reiss Screen. There were two such individuals, admitted in March and May 2014; those evaluations were still pending, for Individuals #306 and #527. For details see Provision J7.
- CPEs were due for Positive Reiss screens done during a change of status evaluation. That was the case for Individual # 758. The CPE was done in a timely manner. For details see Provision J7.

<u>Summary</u>

The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller

		sample) for this subsection, because the Facility had made limited progress; Appendix B evaluations were available for only 61% of individuals. The Monitoring Team reviewed the seven Appendix B evaluations that were done during the review period. Some progress was made in the areas of diagnostic justification and case formulation, but further work is needed. Monitoring Team's Compliance Rating The noncompliance finding from the last review stands.	
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.	Reiss Screens for Individuals who lived at the Facility As described in previous reports, Reiss Screens were given to all individuals who lived at the Facility. Reiss Screens for Recent Admissions Individuals #85, #153, #306, #343, #350, #395, #458, #527, #737, #749, and #795 were admitted since the last visit. All received Reiss Screens within 30 days of admission. Individuals #85, #153, #350, #749 and #795 required CPEs since they took psychotropic medications. CPEs were in place for all individuals who took psychotropic medications except Individual #85. Individuals #306 and #527 also needed CPE's since they had positive Reiss screens. Their CPEs were pending. Change of Status Evaluations Per the Facility protocol, (see prior reports) individuals who live at the Facility and have a clinical change of status receive a Reiss screen. There was one change of status, for Individual #758. That individual received a Reiss Screen and was referred to psychiatry for a CPE. As required, the CPE was done within 30 days. The individual is now followed in the PBMC for ongoing psychiatric care. Monitoring Team's Compliance Rating 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 as required by the provision. The Monitoring Team identified three individuals who needed CPE's and whose CPEs were not completed in a timely manner (30 days); those evaluations are still pending. The provision did not specify a time frame for CPE completion. During the last review the Monitoring Team found that Provision J7 was currently in substantial compliance with the requirements of the SA, and that status is continued. However, the Facility is encouraged to complete scheduled CPEs in a timely manner. Failure to do so, in particular for individuals such as #306 and #527, who are not followed in the	Substantial Compliance

		psychiatry clinic and have no contact with the psychiatrist, places them at risk.	
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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
J10	Commencing within six months of the Effective Date hereof and	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review	Noncompliance

<table>
<tr><td></td><td>with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.</td><td>stands.</td><td></td></tr>
<tr><td>J11</td><td>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.</td><td><u>Rates of Facility Polypharmacy</u>
At the time of the visit the Facility reported that there were 43 individuals with interclass polypharmacy (three or more medications) and 16 individuals with intraclass polypharmacy (two or more medication for the same clinical purpose, such as antipsychotics). Ten individuals had both interclass polypharmacy and intraclass polypharmacy. Accordingly, 49 of 135 (36%) of individuals at the Facility had some form of psychiatric polypharmacy. In the past, the Facility had also reported polypharmacy in a somewhat different format, based on the medical, psychiatric, and mixed index polypharmacy. That tracking of polypharmacy included somatic medications, and individuals who took psychotropic medications were included in two groups – psychiatric polypharmacy (psychiatric medications only) and mixed index polypharmacy (psychiatric and somatic medications). The latter group included some individuals for whom the determination of polypharmacy might not have been made, had the somatic medications not been included.

The following table compares current and past rates of polypharmacy, limited to psychiatric interclass and intraclass polypharmacy, as defined above.

<table><tr><td></td><td>September 2013</td><td>November 2013</td><td>December 2013</td><td>February 2014</td><td>April 2014</td><td>June 2014</td><td>August 2014</td></tr><tr><td>Psychiatric polypharmacy</td><td>58</td><td>63</td><td>63</td><td>62</td><td>53</td><td>50</td><td>49</td></tr></table>
The data showed a reduction in the amount of psychiatric polypharmacy since the last visit and reflects continued Facility efforts to minimize the use of psychiatric polypharmacy.</td><td>Substantial Compliance</td></tr>
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		QDRR reports: QDRR reports were provided to psychiatrists on a quarterly basis. QDRR reports were examined for the 15 individuals in Sample J1. Since January 2014 the pharmacy has reported the format of QDRRs to address side effects, metabolic syndrome, anticholinergics, benzodiazapines, polypolypharmacy and drug drug interactions separately. As per the observations of the Monitoring Team during the PBMC clinics (see Provision J3), the new reporting format led to more focused discussion during that meeting. Facility Level Reviews of Polypharmacy The SA required that there should be Facility- level reviews at least monthly for individuals who receive prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) or prescriptions of three or more psychotropic medications, regardless of class. The Facility provided minutes from the monthly polypharmacy meetings. The meetings were attended by physicians (PCPs and psychiatrists), pharmacists, RN case managers, Behavioral Health Specialists, BCBAs, and other IDT members. The meetings continued to take the form of clinical case review for particularly challenging case. The minutes documented that the reviews were clinically substantive and they served to anchor good clinical care with solid pharmacological information provided by the pharmacy staff. In past reviews the Monitoring Team had emphasized the need for the Facility level review to take place regularly. The minutes showed that regular meetings had taken place with the exception of the months of April and May, due to the absence of the clinical pharmacist from work. Monitoring Team's Compliance Rating Data provided by the Facility showed a reduction in the amount of psychiatric polypharmacy since the last visit and reflects continued Facility efforts to minimize the use of psychiatric polypharmacy. The Facility had achieved a rating of substantial compliance in the past. The review showed that good practices remained in place and the finding of substantial compliance will be continued.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as 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.	Policy and Procedure: 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. Process in Place for Side Effect Screening 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	Noncompliance

		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. <u>Quality of IDT Discussions about Side Effects</u> 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. <u>Individual Case Reviews:</u> 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 screens were done for an average of 1.6 screens per individual. Fifteen of 15 individuals (100%) 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, and 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. <u>Facility-Level Review of DISCUS Scores and Diagnoses</u> The Facility reported that two individuals were diagnosed with tardive dyskinesia. In addition, there were three for whom there were DISCUS scores of five or higher during the review period but who were not diagnosed with dyskinesia. One of the individuals took	

		metoclopramide, and two took atypical neuroleptics. DISCUS Monitoring for Individuals taking Metoclopramide Metoclopramide is a medication used for gastrointestinal indications but structurally related to antipsychotics and, like them, it 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. Training for Administration of the MOSES and DISCUS Side Effect Screens: 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 were 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 clinical pharmacist led the training. 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. Monitoring Team Compliance Ratings: 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 QDDR reports that included good discussion of matters that were rated on the MOSES and DISCUS. Case reviews by the Monitoring Team showed that not all screen were done with the required frequency, that screens that were done by nurses were often not reviewed in a timely manner, and that the required physician review section of the screen were not completed in many cases. The Facility was aware of these problems and had put a process in place to improve the timely sign off and to improve the electronic system that managed the information. For now, the Provision remains in non-compliance.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18	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	Noncompliance

	months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	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. <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 • Brand and generic name • Start date • Dose • Highest dose reached • Blood level (if applicable) • Rationale • Statistical and/or subjective support for efficacy • Time line for medication to be effective • Risk of Medication • Risk of Illness • Risk/ Benefit Discussion • Non Pharmacological Treatment The Monitoring Team requested copies of all PMTPs currently in place. Two were provided, for Individuals #192 and #623. Individual #623 was diagnosed with Bipolar Disorder and with vascular dementia. Symptoms of the diagnosis were self-injurious behavior, aggression to others and hyperactivity. No target symptoms for medication were identified. The combined behavioral health review formulation (which originates in the IRRF evaluation) identified a biological contribution from the organic dementia and psychological contributions from impulsive self- and other-directed aggression resulting in self-injury. The medication for treatment was Ativan; the rationale for its use was that the self injury could not be controlled by the use of another medication or behavioral treatments. Risk of the medication was cited, as were the risks of the illness. The plan cited that a PBSP was in place. There was a brief review of past pharmacotherapy and future plans for continued treatment with a statement that the medication had been effective in reducing SIB.	

		Monitoring Team comments for the plan were that it was not clear what was meant by "psychological contributions from impulsive self and other-directed aggression." Perhaps it would have been helpful to provide a summary of the functional assessment for the individual. In this individual there were no identified target symptoms for the medication. Reduced self-injury, if present, is certainly positive. It was not clear whether the cited symptoms of the diagnosis (self- injurious behavior, aggression to others and hyperactivity) were the target symptoms for the behavioral interventions, whether they were the intended targets for medication, or both. Individual #192 was diagnosed with schizophrenia; symptoms of the diagnosis were listed as "delusions, hallucinations, disoriented speech, gross disorganized, almost sometimes catatonic behaviors and negative symptoms such as affective flattening." Target symptoms for monitoring were hallucinations and disorganized behavior. The combined behavioral health review provided some history of past treatments, and cited that there was a PBSP. The review cited the Individual's numerous medical concerns, including aspiration pneumonia, possible adrenal insufficiency, and weight loss. All of these were cited along with a statement that the individual will need to be monitored closely by the medical team. There was speculation that the individual may be trying to escape demands or obtain tangibles. A vocabulary book to assist with communications was suggested as a way to help. Monitoring Team comments for the plan were that target symptoms were reasonable, although operational definitions of the symptoms were needed. The combined formulation cited above was more of an attempt at case summary, rather than case formulation. The difference is important and it is the latter that is needed for an overall treatment plan. The Monitoring Team in several past reports reviewed the difference. <u>PBMC Monitoring of Medication Efficacy</u> The Monitoring Team attended the PBMC on 08/28/14. Participants included the psychiatrist, behavioral health specialist, nurse case managers, and DSPs. Individuals #85, #192, #316, #363, #588, #672, #749, and #795 were reviewed. In some but not all cases psychiatric "targets" were identified and discussion was focused on information on tracking data. Examples were reviews for Individuals #85 (psychosis, defined), #363 (psychosis), and #588 (psychosis and nightmares). IDT discussion was data-based with graphing of the identified indicators. In other cases data discussed were for behavioral interventions and not identified parameters for pharmacological interventions. <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. The Facility had identified a target date for completion of the process by 12/01/14, however that has now been delayed and treatment plans are in place for only two of 135 (1%) individuals. 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	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 J3): • Individual #623 who was seen by both psychiatry and neurology for care of her dementia. She took two medications, Donepezil and Namenda. Unfortunately, these were not effective in preventing the progression of the illness. She was also treated with Depakote for psychiatric difficulties. The neurologist's note showed that the neurologist knew that the medication was prescribed for psychiatric symptoms. • Individual #630 was treated for seizures with two medications, Zonegran and Depakote; the latter was a dual-purpose medication. The neurologist noted that the client had not had a seizure since 1999. Reflecting the use of Depakote by psychiatry and neurology, the neurologist opted to convert the individual to monotherapy, and did so by preserving the Depakote and discontinuing Zonegran. That reflected attention to integrated care needs, appropriate efforts to reduce polypharmacy when appropriate, and good neurological practice regarding seizure management. The PBMC notes show that the psychiatrist was aware of the decisions made in the neurology clinic and his concurrence with those decisions. That reflected good quality integrated care. • Individual #140 was seen on the unit since she declined to come to clinic. Dyskinesia, Parkinsonism and gait were reviewed. The care included monitoring for residual Dyskinesia that was associated with past use of narcoleptics. The neurologist listed current psych meds and reviewed for possible neurological side effects (none were found). In turn, the psychiatrist maintained clarity about the behavioral targets for all medication and participated in monitoring for efficacy • Individual #561 was reviewed for sequelae of head injury. He had been treated for seizure prophylaxis with Phenytoin (for seizure disorder only) and Depakote (dual purpose, for seizure disorder, and as a psychiatric treatment). The neurologist reviewed both medications for side effects. In the PBMC clinic, the psychiatrist facilitated the engagement of a traumatic brain injury specialist to evaluate for possible benefit from neurological rehabilitation. The above examples provided a picture of active coordination and collaboration between neurology and psychiatry. Participation of Psychiatry in Neurology Clinic Psychiatrists now attend the neurology clinic and discussions are raised in the clinic with input from the PCP, pharmacist direct care and nursing. Monitoring Team's Compliance Rating 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, psychiatrist and other healthcare professionals. 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 4. Positive Behavior Support Committee meeting minutes 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 #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. • The review of Psychological Assessment reports in K.5 included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. • The review of SFAs concerning assessment of behavior in K.5 included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. • The review of SFAs in the context of the integration of mental illness and behavior assessment in K.5 included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. • The review of psychological testing, including adaptive skills and intelligence, in K.6 included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. • 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 #85, #153, #350, #395, #458, #527, #737, #749, and #795. • The review of PBSPs in K.9 included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. • The review of data graphs in K.10 included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. **People Interviewed:** 1. Maryam Majlessi, M.Ed., BCBA – Behavior Services director 2. Roxanne Wolf, MS, BCBA – Behavior Analyst 3. Sasha Ayad, M.Ed., LPCi - Counselor 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. 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 use additional relevant data sources, such as Facility tracking spreadsheets and peer review data. ▪ 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 and did not address qualitative issues needed to achieve substantial compliance.

	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 8/25/2014 through 8/29/2014. 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. Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved. • Although the number of BCBAs had decreased, the percentage of staff either holding or actively pursuing Board Certification had increased to 93%. • The new administrator of the Behavioral Health Services department possessed board certification as a behavior analyst. • Behavior assessments reflected substantial improvement in several areas and adhered more closely to accepted practices. • Behavior assessments reflected careful consideration of issues involving challenging behavior and mental illness. • Behavior interventions reflected many areas of improvement, including operational definitions, use of accepted assessment procedures, identification of potential functions, and the inclusion of replacement behavior training. • Readability statistics for behavior interventions reflected that interventions were written in accessible language. Despite the numerous areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas. • A sizable portion of behavior assessments and intervention plans were developed by staff who were not BCBAs. • There were considerable weaknesses in the internal and external peer review process. More than one quarter of individuals with behavior intervention plans had not been reviewed in over a year. • It was not evident that the Facility maintained adequate procedures for monitoring the psychological assessment process and ensuring that all individuals received the necessary assessments. • Behavior assessments did not consistently address establishing operations or setting events. • Due to the limitations noted regarding the assessment of establishing operations and setting events, it was frequently unclear whether behavior interventions included adequate procedures for avoiding challenging behaviors. • There was no evidence that the Facility had processes in place to provide direct contact staff and their supervisors with competency-based training on PBSPs. 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. In March 2014, the number of BCBAs dropped to 6.

Current Site Visit
During the current site visit, Facility records regarding Behavior Support Department staff were reviewed. These records reflected that four of 14 staff (29%) were board certified as a behavior analyst. Of the remaining 10 staff, nine (90%) were actively pursuing board certification. Therefore, it was determined that 93% of the current Psychology Department staff either possessed or were actively pursuing board certification.

<table><tr><td></td><td>Baseline</td><td>3/2014</td><td>8/2014</td></tr><tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>33%</td><td>29%</td></tr><tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>0%</td><td>58%</td><td>90%</td></tr><tr><td>Percent of staff who were BCBAs or were pursuing board certification</td><td>0%</td><td>72%</td><td>93%</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 10 behavior</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		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 #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. Based upon the information provided from the review, five of 10 behavior intervention plans (50%) were completed by a BCBA. The Facility demonstrated improvement in hiring and developing BCBAs. As fewer BCBAs, were employed by the Facility and only half 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.	There was turnover in the position of Behavioral Services Director since the last compliance visit. The Facility had hired Maryam Majlessi, M.Ed. as Behavior Services Director. Ms. Majlessi possessed board certification in applied behavior analysis, was a Licensed Professional Counselor, and had extensive experience in working with people with intellectual and developmental disabilities. Based upon her credentials, Ms. Majlessi 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, four of 11 individuals in the sample selected by the Facility (36%), had SFAs for which more than a year had passed since a BRC review. In	Noncompliance

#	Provision	Assessment of Status	Compliance
		one of the four, the most recent review for the SFA had occurred 35 months prior to the 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. During the March 2014 site visit, it was noted that substantial lapses continued in relation to the provision of annual BRC review of SFAs and PBSPs. <u>Current Site Visit</u> <u>Internal Peer Review</u> The Facility maintained an internal peer review committee, titled the Behavior Support Committee (BSC). A review of BSC Minutes revealed that the committee met 25 of 25 weeks (100%) between 1/6/2014 and 6/25/2014. 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; an RN also routinely attended. 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 8/27/2014. During that meeting, a single case was reviewed. Observations reflected that the committee conducted a robust discussion of the case presented. Discussion generally followed the BSC checklist items, although substantial discussion also reflected broader topics such as the appropriate management of psychotropic drug interventions. 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. During the previous site visit, documentation from RSSLC reflected that 67 of 171 individuals with PBSPs (39%) had not been reviewed by the BRC in over a year at the time of the site visit. During the current site visit, 55 of 194 with PBSPs (28%) had not been reviewed by the BRC in over one year. Although this reflected an improvement, failing to provide adequate review of 28% of PBSPs was an indication of substantial limitations in the peer review process. Following the visit, the Facility pointed out that a document provided in response to the document request showed that only 24 PBSPs had not been reviewed in over a year; the Monitoring Team reviewed that document and found 31 of 172 listed PBSPs (18%) were not reported as having been reviewed in over a year prior to the compliance visit (the disparity apparently was because of the date on which the document was provided, but no updated information was provided to permit assessment by the Monitoring Team). Because the total of PBSPs reported by varying	

#	Provision	Assessment of Status	Compliance
		documents were not the same, the Monitoring Team cannot be certain of the timeliness of reviews but does note all documentation showed improvement. 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. This was the third 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 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.	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. 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. Minimal improvement was noted during the March 2014 site visit. Current Site Visit 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
psychotropic medication reviews. The specific individuals included in the sample were Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787.

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

<table>
<tr><td></td><td>Baseline</td><td>3/2014</td><td>8/2014</td></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>80%</td><td>80%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>70%</td><td>40%</td></tr>
<tr><td>Data reliability is assessed</td><td>0%</td><td>10%</td><td>0%</td></tr>
<tr><td>Target behaviors analyzed individually</td><td>0%</td><td>80%</td><td>90%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making</td><td>0%</td><td>50%</td><td>20%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making</td><td>0%</td><td>30%</td><td>60%</td></tr>
</table>

Information gained from the record sample reflected that RSSLC had achieved at least modest improvement in two of the six areas (33%), demonstrated no change in one of six areas (17%), and regressed in three areas (50%).

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.

<table>
<tr><td></td><td>Baseline</td><td>3/2014</td><td>8/2014</td></tr>
<tr><td>Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level</td><td>0%</td><td>60%</td><td>80%</td></tr>
<tr><td>Review is conducted by a BCBA</td><td>0%</td><td>30%</td><td>30%</td></tr>
<tr><td>Input from direct care staff is solicited and documented</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Modifications to the PBSP reflect data-based decisions</td><td>0%</td><td>0%</td><td>40%</td></tr>
<tr><td>Criteria for revision are included in the PBSP</td><td>0%</td><td>0%</td><td>10%</td></tr>
<tr><td>Progress evident, or program modified in timely manner (3 Months)</td><td>0%</td><td>30%</td><td>60%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Information gained from the record sample reflected that RSSLC had achieved improvement in four of the six areas (67%), demonstrated no change in two of six areas (33%), and regressed in no areas (0%). 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. • 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 two of 10 records (20%), 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	<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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>that may require intervention.</td><td>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 adaptive skills. Minimal improvement was noted in March 2014.

<u>Current Site Visit</u>
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 #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787.

<table>
<tr><th></th><th>Baseline</th><th>3/2014</th><th>8/2014</th></tr>
<tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>60%</td><td>100%</td></tr>
<tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>60%</td><td>100%</td></tr>
<tr><td>The Psychological Assessment contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>30%</td><td>20%</td></tr>
<tr><td>The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>0%</td><td>10%</td><td>10%</td></tr>
</table>

Information gained from the record sample reflected that RSSLC had achieved improvement in two of the four areas (50%), demonstrated no change in one of four areas (25%), and regressed in one of four areas (25%).

<u>Behavior Assessment</u>
The assessment of behavioral function is an essential component of effective behavior change and requires more than the completion of a screening tool, interview or series of observations. Determining the function of a behavior is an empirical process that begins with general observation and progresses with increasing control and focus through screenings, interviews and formal observations until a specific hypothesis regarding the function or purpose of the undesired behavior is developed. An acceptable functional assessment or functional analysis does not produce a series of ambiguous statements regarding the function of the undesired behavior. Rather, the product of the assessment process is a specific statement regarding the most likely function of the behavior or an</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		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. In March 2014, efforts by RSSLC to address the issues in Provision K.5 were inadequate and inconsistent. A sizable portion of the individuals residing at the Facility 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 identify pertinent issues. 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. These 10 records included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787.	

	Baseline	3/2014	8/2014
Assessment or review of biological, physical, and medical status	0%	40%	100%
Review of personal history	0%	47%	90%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	33%	100%
The process or tool utilizes both direct and indirect measures	0%	33%	100%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	13%	10%
Identification of antecedents relevant to the undesired behavior	0%	27%	10%
Identification of consequences relevant to the undesired behavior	0%	33%	90%
Identification of functions relevant to the undesired behavior	0%	20%	90%
Summary statement identifying the variable or	0%	20%	100%

#	Provision	Assessment of Status	Compliance

variables maintaining the target behavior			
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	7%	80%
Identification of preferences and reinforcers	0%	27%	90%

Information gained from the record sample reflected that RSSLC had achieved improvement in nine of the 11 areas (82%), demonstrated no change in one of 11 areas (9%), and regressed in one of 11 areas (9%).

Of particular concern was the absence of establishing operations and setting events in the behavior assessment process. Even though the Facility followed accepted practices for behavior assessment, including the use of direct and indirect measures, the SFAs often did not report findings regarding establishing operations or setting events. These two areas are important for understanding why a behavior was displayed and essential to developing strategies for avoiding the display of challenging behaviors. No explanation was provided in any report for the lack of this information.

During the current site visit, a sample of 10 psychological and behavior assessment reports revealed the following about the integration of mental illness and behavior assessment. These 10 records included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787.

	Baseline	3/2014	8/2014
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	33%	10%
The assessment process included differentiation between learned and biologically based behaviors.	0%	0%	80%
Identification of behavioral indices of psychopathology	0%	7%	50%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	27%	10%

Information gained from the record sample reflected that RSSLC had achieved improvement in two of the four areas (50%), demonstrated no change in none of four areas (0%), and regressed in two of four areas (50%).

#	Provision	Assessment of Status	Compliance
		Based upon the review of the current sample, it was evident that the majority of behavior assessments included abundant information about each individual's mental illness and history of psychiatric services. The majority of SFAs reviewed reflected that the necessary formal assessment practices were used to identify relationships between mental illness and environmentally based behavior. Although there was significant improvement in identifying behavioral indices of mental illnesses in assessments, many assessments, many assessments still did not clearly identify such indices. Furthermore, behavior assessments for most individuals did not reflect that psychiatric screenings and assessments had made use of tools and procedures appropriate for individuals with intellectual and developmental disabilities, such as a Reiss Screen. The Facility made considerable progress in several aspects of assessment such as identification of behavioral function using an accepted process and differentiation between learned and biologically based behaviors. Nonetheless, information obtained during the current site visit suggested that the Facility continued to experience considerable difficulty in some areas. In order to obtain substantial compliance, it will be necessary for the Facility to implement substantive changes in relation to psychological evaluation assessments, as well as the integration of behavioral and psychiatric assessments and intervention.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	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 two of 10 individuals (20%). • 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 10 of 10 individuals (100%). The psychological assessment tracking spreadsheet maintained by the Facility was used to determine the degree to which intellectual and adaptive skill assessments were completed for individuals living at the Facility. • For 312 of 334 individuals included in the tracking spreadsheet (93%), there was documentation of an intellectual assessment. • For 40 of 334 individuals included in the tracking spreadsheet (12%), there was documentation of an intellectual assessment within the past five years. • For 327 of 334 individuals included in the tracking spreadsheet (98%), there was documentation of an adaptive skill assessment. • For 10 of 334 individuals included in the tracking spreadsheet (3%), there was documentation of an adaptive skill assessment within the past year.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Based upon the information reviewed, it was evident that many of the psychological assessments at the Facility were neither current nor included complete clinical and behavioral data.</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. A sample of 10 records was used to determine the degree to which individuals were provided with annual psychological assessment reports. These 10 records included Individuals #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787.

<table>
<tr><th></th><th>Baseline</th><th>3/2014</th><th>8/2014</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>N/A</td><td>100%</td></tr>
<tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>86%</td><td>78%</td></tr>
</table>

As noted in Provision K.6 of this report, individuals living at the Facility were seldom provided current assessments of intellectual and adaptive skill abilities. In the sample of 10 individuals, all were provided with an annual Psychological Assessment. Records reflected, however, that an individual living at the Facility might be provided with an annual Psychological Assessment, Psychological Update, or Integrated Behavioral Health Assessment, or a combination of the three types of reports. Intellectual and adaptive skill assessment information was not consistently included in any one of the three reports. In some cases, the intellectual and adaptive skill assessment information was not in any of the three reports but was included in the Structural and Functional Assessment. The lack of consistent presentation of testing results introduced considerable difficulty into determining the abilities of each individual.

The Facility reported that nine individuals had been admitted to the Facility since the previous site visit. These nine individuals included Individuals #85, #153, #350, #395, #458, #527, #737, #749, and #795. Individuals recently admitted to the Facility were often provided with a psychological assessment report. As was the case with the general population of the Facility, however, individuals recently admitted to the Facility were seldom provided with current assessments. Nine individuals had been admitted to the Facility since the previous site visit. Data regarding assessments is presented below for those nine individuals.
• For seven of nine individuals (78%), a psychological assessment was completed</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>within 30 days following admission.
• None of nine individuals (0%) had been provided an assessment of adaptive skills within 30 days following admission.
• None of nine individuals (0%) had an assessment of adaptive skills from the previous year included in their records upon admission.
• None of nine individuals (0%) had been provided an assessment of intellectual ability within 30 days following admission to the Facility.
• Three of nine individuals (33%) had an assessment of intellectual ability from the previous five years included in their records upon admission.
• Nine of nine individuals (100%) were provided with behavior assessments within 30 days of admission.

Based upon the information presented by the Facility, although 78% of recently admitted individuals were provided psychological assessment reports, none of those reports included the necessary testing. As a result, the Facility did not meet criteria for substantial compliance.</td><td></td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td><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 #19, #151, #243, #417, #475, #493, #530, #543, #588, and #600.

<table>
<tr><th></th><th>Baseline</th><th>3/2014</th><th>8/2014</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 skill or intervention target)</td><td>0%</td><td>100%</td><td>0%</td></tr>
<tr><td>Services are goal directed with measurable objectives and treatment expectations</td><td>0%</td><td>0%</td><td>80%</td></tr>
<tr><td>Services reflect evidence-based practices</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>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</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Service plan includes “fail criteria”—criteria,</td><td>0%</td><td>10%</td><td>100%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention			
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%	40%	100%
Service identified in ISP and, if applicable, PBSP	0%	0%	100%
Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	0%	100%	100%
Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists	0%	100%	100%

Information gained from the record sample reflected that RSSLC had achieved improvement in four of the 10 areas (40%), demonstrated no change in five of 10 areas (50%), and regressed in one of 10 areas (10%).

Although counseling interventions were well organized and documented, it was not evident that counseling was based upon an evidence-based approach to treatment. None of the counseling plans included in the sample reflected an assessment of the presenting problem. For example, Individual #600 indicated she often became frustrated and angry while waiting in line and wanted to fight. The counseling treatment plan, however, did not present any investigation of the factors that contributed to the individual's emotional response. For an intervention to reflect evidence-based practices, there must be a formal assessment that identifies intervention targets and that provides a basis for the selection of intervention strategies. Without such an assessment, there is the strong probability that interventions will not be successful or beneficial for the individual.

Despite several areas that identified as successful, the lack of adequate assessments introduced substantial concerns regarding the efficacy of counseling efforts at the Facility. As a result, Provision K.8 was not determined to have met the criteria for substantial compliance.

K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual	Historical Perspective 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.</td><td>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 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. In March 2013, there was minimal improvement, and it did not appear that the Facility had developed a coherent and comprehensive plan to improve the quality of PBSPs.

Current Site Visit
<u>PBSP Approval and Consent</u>
It was not possible to determine the ability of the Facility to ensure that behavior interventions were implemented within 14 days of final consent or approval. One reason for this was the lack of consistency between tracking data. For example, the BHS Active Programs tracking spreadsheet reflected there were 166 active behavior interventions at the Facility. The BSC Due Process Tracking spreadsheet, however, reflected 194 individuals with active behavior interventions, while the Facility Self-Assessment stated 175 individuals were provided PBSPs. In addition, there was often relevant information missing from tracking data. For example, the BSC Due Process Tracking spreadsheet did not include implementation dates for 50 of 194 PBSPs (26%).

Based upon the information provided by the Facility, it could not be determined if approvals and consents were obtained promptly or for all pertinent PBSPs.

<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 #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787.

<table>
<tr><th>PBSP Element</th><th>Baseline</th><th>3/2014</th><th>8/2014</th></tr>
<tr><td>Rationale for selection of the proposed intervention</td><td>0%</td><td>33%</td><td>100%</td></tr>
<tr><td>History of prior intervention strategies and outcomes</td><td>0%</td><td>47%</td><td>90%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status				Compliance
		Consideration of medical, psychiatric and healthcare issues	0%	40%	100%	
		Operational definitions of target behaviors	0%	73%	100%	
		Operational definitions of replacement behaviors	0%	53%	100%	
		Description of potential function(s) of behavior	0%	27%	100%	
		Use of positive reinforcement sufficient for strengthening desired behavior	0%	13%	100%	
		Strategies addressing setting event and motivating operation issues	0%	27%	10%	
		Strategies addressing antecedent issues	0%	40%	10%	
		Strategies that include the teaching of desired replacement behaviors	0%	60%	100%	
		Strategies to weaken undesired behavior	0%	27%	100%	
		Description of data collection procedures	0%	60%	80%	
		Baseline or comparison data	0%	27%	100%	
		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%	47%	100%	
		Plan, or considerations, to reduce intensity of intervention, if applicable	0%	0%	20%	
		Signature of individual responsible for developing the PBSP	0%	53%	100%	

Information gained from the record sample reflected that RSSLC had achieved improvement in 14 of the 17 areas (82%), demonstrated no change in one of 17 areas (6%), and regressed in two of 17 areas (12%).

In the majority of elements, RSSLC demonstrated considerable improvement in PBSPs. Areas in which improvement was not noted or was modest are presented below.

- As noted in Provision K.5 of this report, SFAs frequently did not include information regarding establishing operations and setting events. Because of that limitation in the assessment process, it was determined that behavior interventions did not include adequately supported strategies for preventing or avoiding challenging behaviors.
- Although behavior interventions consistently included success criteria, none of the reviewed behavior interventions included criteria for determining when an

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>intervention lacked efficacy and was in need of review or revision.
• The majority of behavior interventions did not provide a strategy for reducing or fading interventions.

Despite the substantial progress in several components of behavior intervention plans, additional improvement was needed in four areas. As a result, it was determined that the Facility had not achieved substantial compliance in Provision K.9.</td><td></td></tr>
<tr><td>K10</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.</td><td><u>Historical Perspective</u>
Through March 2014, weaknesses in the presentation of treatment data were frequently noted. Although modest efforts at revising data graphs were reported by the Facility in the past, none had proven generally effective.

<u>Current Site Visit</u>
During the current site visit, 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 #74, #101, #140, #243, #314, #387, #429, #475, #524, and #787.

<table>
<tr><th>Graph Element</th><th>Baseline</th><th>3/2014</th><th>8/2014</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>80%</td><td>20%</td></tr>
<tr><td>Horizontal axis and label</td><td>8%</td><td>90%</td><td>80%</td></tr>
<tr><td>Vertical axis and label</td><td>8%</td><td>90%</td><td>70%</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>80%</td><td>100%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

Although the Facility had maintained some improvement in graphing noted during previous site visits, progress had been achieved concerning previous weaknesses in only one area. 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</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		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.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of the readability of formal behavior interventions. These individuals included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals ##74, #101, #140, #243, #314, #387, #429, #475, #524, and #787. According to Microsoft Word 2013, the readability scores from the 10 PBSPs all fell at or 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.	Substantial Compliance
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 four staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 84 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 11 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. RSSLC Self-Assessment, 8/12/2014 2. RSSLC Action Plan, 8/11/2014 3. RSSLC Presentation Book, August 2014 4. RSSLC Policy I.57, Providing Health Care Services, Mortality Review, Revised: 8/12/14 5. RSSLC Policy (not numbered) Mortality Review Policy, Revised: 7/30/14 6. RSSLC Policy A.7, Administration, Actions Following Death of Individual Served, Revised: 10/10/12 7. RSSLC Policy 1.00A, Medical Services, dated 1/21/2011 8. RSSLC Policy (not numbered) Physician Annual Medical Assessment, dated 8/5/2014 9. RSSLC Policy I.26 Physician Quarterly Review, revised 7/15/2014 10. RSSLC Policy: Integrated Clinical Services Policy, dated 8/6/2014 11. RSSLC Policy I.31 Chronic Clinical Indicators Policy, revised 8/20/2013 12. RSSLC Policy Providing Health Care Services; Designating Out-of-Hospital DNR, 09/17/2010 13. RSSLC Clinical Pathway for Standard of Care and Documentation, not dated: a. Osteoporosis b. Diabetes Mellitus c. Dyslipidemia d. Constipation e. Hypertension f. Down Syndrome g. Cerebral Palsy h. Degenerative Spine Disease 14. Clinical indicators for: a. Diabetes Mellitus b. Osteoporosis c. Developmental Disability Healthcare Screening d. Neuromotor/Musculoskeletal e. UTI f. Pneumonia g. Medical Consultation Follow-up h. Mortality Review i. Chronic care j. Preventive care health screening k. Sepsis 15. Healthcare Trend Report and action plans, that were presented to QA/QI Council Policy a. Urinary tract infections, October 2013 and January 2014 b. Medical follow-up, December 2013 c. Diabetes, 6/18/2014 d. Pneumonia. 6/27/2014

	16. RSSLC Template for the Clinical Death Review 17. RSSLC Clinical Death Review Committee Minutes for Individuals #340 and #564 18. RSSLC Administrative Death Committee Minutes Individuals #340 and #564 19. RSSLC Unusual Incident Investigations for Individuals #340 and #564 20. RSSLC Death Review Investigation – Nursing Services Reports for Individuals #340 and #564 21. RSSLC Physician Death/Discharge Summaries for Individuals #340 and #564 22. RSSLC Clinical and Administrative Death Review Committees' Recommendations for Individuals #340 and #564 23. RSSLC Clinical and Administrative Death Review Committee Recommendation Tracking Data and Follow-up for Individuals for Individual #340 24. Texas Department of Health Services, Vital Statistics Unit – Certificates of Death for Individuals #340 and #564 25. State of Texas, the County of Galveston, Medical Examiner's Office Autopsy Report for Individual #579 26. Internal Medical Provider quality assurance audit process for round nine. 27. Clinical performance audits for round nine 28. Medical quality assurance database printout 29. Updated mortality review form 30. Assessments, graphs, summaries, action plans, and quality assurance (QA) reports for internal and external medical audits for round nine 31. Clinical pathway tools 32. Clinical pathway audits for round nine 33. All QA/QI follow-up to action plans for the clinical performance audits, and the medical audits for round nine 34. Statement by external physician documenting findings, and recommendations for round nine of the medical audits 35. List of all medical providers, including number of hours worked, case load, and employment status 36. 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 37. Copy of morning medical meeting minutes for the first week of March 2013 through August 2014 38. Copy of nurse practitioners' practice agreements 39. Medical provider's IPNs through, full resolution of an acute medical condition for the first acute medical issue triaged by a medical provider, for each month during the reporting period (Individuals #351, #388, #712, #130, #777, #493, #456, #542, #479, and #513) 40. Alpha list of all men 50 years old and older 41. Alpha list of all men who have had prostate specific antigen (PSA) testing for prostate cancer screening 42. Alpha list of all men who were not provided PSA screening, and documentation of alternative prostate cancer screening, or clinical rationale for not completing annual prostate cancer screening. 43. Alpha list of all females 40 years old and older 44. Alpha list of all females 40 years old and older who were current with mammogram screening

	45. Alpha list of all females 40 years old and older who were not current with mammogram screening, and the clinical rationale for not being current 46. List of all individuals who were not immunized for influenza for the 2013 influenza season, and the clinical indication for not administering influenza vaccine 47. List of all individuals who were prescribed a do not resuscitate (DNR) order 48. For all individuals on 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 rationale for the DNR 49. Alpha list of all individuals with known diagnosis of malignancy 50. Alpha list of all individuals with a diagnosis of malignancy in remission 51. For the first five individuals on the list of malignancy, and first five individuals diagnosed with malignancy in remission (Facility indicated only one individual with diagnosis of malignancy, Individual #275): a. Most recent annual medical assessment b. Most recent quarterly medical review c. Las six months IPNs by the medical provider, specifically addressing evaluation of the malignancy diagnosis. d. All consultation reports, specific to the management of malignancy e. Most recent ISP and, or IPN documenting review of malignancy f. Most recent IRRF 52. Alpha list of all individuals who developed pneumonia during this reporting period 53. List of all individuals who developed at least three or more episodes of pneumonia during the past five years 54. For Individuals #783, #666, #523, #192, and #621: a. Most recent annual physician's summary b. Most recent quarterly medical review c. Most recent IRRF assessment d. All medical provider's IPNs documenting initial assessment and follow-up of pneumonia e. All diagnostics, and consultations, specific to the most recent episode of pneumonia f. Medical provider's IPN, and other evidence documenting the etiology of recurrent pneumonia, and steps taken to help reduce or mitigate recurrent pneumonia 55. Alpha list of all individuals who sustained a fracture during the reporting period 56. Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures 57. For Individuals #634, #448, #700, #415, and #204:

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

58. For Individuals #462, #177, #137, and #772:
a. Medical providers' IPNs, specific to routine follow-up for chronic condition
b. All diagnostics, obtained in past 12 months, specific for chronic condition
c. All consultations, for past 12 months, specific for chronic condition
d. Most recent IRRF
e. Most recent annual medical assessment
f. Quarterly medical review, specific to the chronic condition

People Interviewed:

1. Tran Quan, MD, Medical Director
2. Sherene Green-Blaber, RN, Chief Nurse Executive (CNE)
3. Primary Care Providers
4. Wilma Parker, RN, Quality Assurance Nurse (QA)
5. Robyn Partridge, BSN, RN, QA
6. Wanda Hartensteiner, Medical Records Director

Meetings Attended/Observations:

1. Meeting with the above staff to review Clinical and Administrative Death Reviews, 8/28/14
2. Meeting with Dr. Tran Quan to discuss compliance issues for Section L
3. Clinical morning report meeting, 8/27/2014

Facility Self-Assessment:

The Facility submitted a Self-Assessment for Section L. 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 L, in conducting its self-assessment, the Facility:

- Did use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement.
- The monitoring tools did include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. For example, there were standards of care or clinical indicators documented to assess the provision of medical services.
- The Self-Assessment did identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were

	adequate to consider them representative samples. The number or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, but just overall percentage of compliance. • The Monitoring Team could not determine if the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. ▪ It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. The Facility determined substantial compliance for Sections L.2 and L.3; and noncompliance for Sections L.1 and L.4. The Monitoring Team concurs with the Facilities self-assessment of Sections L.1 through L.4. 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. For Provision L3, actions were identified for maintenance of compliance. • The Facility identified areas of need/improvement. It was unclear whether the action steps addressed those specific areas. • The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section, in particular the issue of PCP participation in the ISP and CLDP process.
	Summary of Monitor's Assessment: The Monitoring Team is extremely impressed by the many clinical improvements noted for Section L.1, and the Facility is near substantial compliance. Further more, the Monitoring Team compliments the medical providers, medical director, nursing staff, support staff, and Facility leadership for the marked improvements that have taken place during this reporting period. The Facility demonstrated exemplary follow-up to acute medical conditions; ensured comprehensive review of the qualifying condition for DNR orders; ensured appropriate management for pneumonia, acute management of fractures, and management of malignancy; ensured influenza vaccination was provided; and provided assertive preventative health care management by ensuring assertive screening for prostate and breast cancer. Substantial compliance was not determined because of significant issues identified with the screening, diagnosing, and overall management of osteoarthritis, and because there was no evidence of a comprehensive review, that included the medical provider, in determining the underlying cause of fractures. Substantial compliance was determined for Sections L.2 and L.3, because the Facility developed, implemented, and reviewed efficacy of its processes to assess clinical performance of practicing medical providers, and because it developed and maintained a medical quality assurance process to help enhance the delivery of medical services. Because the Facility must continue to further develop medical policies, procedures and guidelines for all of

	its clinical practices at the Facility, and ensure that they are substantially implemented, and clinically efficacious, the Monitoring Team determined noncompliance for Section L.4.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	<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 through August 2014 • Copy of nurse practitioners' practice agreements Medical Providers: The Facility's medical department maintained the following staffing: • One full time medical director, who provides 15 hours per week of direct care • Two full-time State employed physicians • One full-time Locum physician • Two full-time nurse practitioners • Three full-time support staff Medical licenses were reviewed, and noted to be current for all medical providers. Two medical providers are nurse practitioners, and are supervised by the medical director. Although requested, the nurse practice agreements were 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 Practitioners were currently registered under the medical director's 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Medical Meetings The Facility conducted three medical meetings. Clinical 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 (3/4/2014, 4/3/2014, 5/6/2014, 7/1/2014, and 8/5/2014); in addition to the Monitoring Team's observation of the Morning Medical Meeting on 8/27/2014, indicated that the Facility included staff members from a variety of clinical disciplines, including PT/OT, nursing, medical, psychology, psychiatry, pharmacy, and residential services. The Monitoring Team noted improvement since the last compliance review period; minutes indicated participants were more interactive, and more assertive in raising questions, and solutions to clinical issues. Review of the clinical morning report minutes indicated a comprehensive summary of issues addressed during the meetings. Meeting minutes included subsections for on-call report; hospital report; infirmary report; behavioral health report; medical consultation and significant diagnostic report; among other topics. The Monitoring Team did not identify in the minutes, or observe at the clinical morning meeting, that assertive measures were in place to develop, implement, and follow-up on action plans for relevant clinical issues identified at the meeting. For example, the clinical morning report minutes dated 3/4/2014 documented for Individual #228 "leukocytosis, reactive lymphocytosis, but there was no documentation of follow-up plans; the clinical morning report, dated, 4/3/2014 documented that Individual #279 "called 911 herself stated suicidal thoughts. EMS did come but they did not take her", and again, there was no documented action plan for follow-up to this issue. The Facility should document the steps being planned to address significant issues, including referrals made to the IDT. Grand rounds: Medical Grand Rounds occur once per week. This meeting 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	

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		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, but did review the grand round's minutes, dated 8/27/2014. The minutes reflected a comprehensive, and clinically appropriate review of clinical issues manifested by Individual #737. The minutes also documented a comprehensive list of medical and behavioral action plans to address the issue, which were determined by the Monitoring Team to be clinically rational. Additional information on this meeting is reported in Provision G1. Medical staffing meeting: Medical staff meetings occur twice per week, and were reported by the medical director to include discussion regarding continuity of care, systems issues related to medical services, and review of medical audit, and other peer review, and medical quality assurance issues. The Monitoring Team did not observe this meeting. <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 #351, #388, #712, #130, #777, #493, #456, #542, #479, and #513. Documentation practice was noted to be exceptional, with the medical providers documenting in SOAP format, documenting physical assessments, and indicating specific assessment and plans. <u>Observation of medical examination rooms</u> Unless there is a mitigating factor, such as an individual 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. <u>Follow-up to acute medical 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 the first acute medical issue triaged by a medical provider, for each month during the reporting period (Individuals #351, #388, #712, #130, #777, #493, #456, #542, #479, and #513), and found: • Initial assessment that documented an individual physical assessment, action plan, and follow-up was noted in ten out of ten examples (100%). • In eight out of ten examples (80%), follow-up was documented on the initial	

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		medical provider IPN for an acute medical condition. • 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 #351: The Monitoring Team compliments the Facility on assertiveness in management and follow-up for pneumonia care. The level of clinical care, on the part of the medical provider was exceptional. • Individual #388: Initial assessment was timely and comprehensive. The 3/11/2014 medical provider IPN did not document a physical assessment, and did not document when the individual would be re-evaluated by the medical provider, through resolution of the acute medical condition. • Individual #712: Was seen on 3/1/14 by the medical provider for breakthrough seizure. A complete physical assessment was documented, that included a review of other recent seizure activity, and management strategy. In addition, the IPN documented a plan to follow up with an epileptologist, and there was supporting documentation that the Individual followed-up with the epileptologist on 5/13/2014. Furthermore, there was a comprehensive note by the medical provider documenting the medical provider's phone call discussion with the epileptologist regarding the treatment plan. • Individual #130: The Individual sustained a 20 second seizure on 4/2/2014, and was evaluated by the medical provider on 4/3/2014. A complete physical assessment was performed. The Monitoring Team noted very good follow-up for seizures, including follow-up on laboratory diagnostics; however, there was no documentation indicating a follow-up plan for the assessed "bruising to penis". Despite documentation that the bruising only involved a "small area", a specific clinical action plan should have been developed, to ensure resolution. All clinical issues identified should be followed up through resolution. • Individual #777: The medical provider documented results of a routine chest x/ray, on 3/6/2014, and documented that "congestive heart failure remains unchanged. The assessment and plan documented results of laboratory diagnostics, and results from a recent cardiology consultation, that indicated "compensated" congestive heart failure. The medical provider documented a comprehensive consultation note to the cardiologist, on 3/6/2014. Appropriate laboratory diagnostics were obtained, and were unremarkable. Documentation indicating follow-up with the cardiologist was provided, which indicated no acute management was necessary and for the Facility to continue with chronic care follow-up. There was documented evidence that the medical provider	

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		followed-up on the cardiologists recommendations, including obtaining an annual echocardiogram. The Monitoring Team determined follow-up on the abnormal routine chest x-ray for congestive heart failure to be excellent. • Individual #493: Was evaluated for cerumen impaction, which was assessed, and treated pharmacologically by the medical provider, and was followed through full resolution. • Individual #456: The Individual was evaluated for signs and symptoms of UTI; the medical provider documented a focused physical assessment on 4/10/2104, initiated treatment, obtained periodic follow-up diagnostics, and documented a resolution IPN for the UTI. This was another example of exceptional follow-up of acute medical conditions, through resolution. • Individual #542: Seen by the medical provider on 6/3/2014 for redness to face and arms. A focused physical assessment was documented, and an action plan documented pharmacological treatment and follow-up plan. The medical provider re-assessed the individual the following day, documenting a focused physical assessment, and indicating that the condition resolved. • Individual #479: The Individual was seen on 7/10/2014 for ear drainage of the right ear. The medical provider documented a focused examination, and diagnosed and treated the Individual for otitis media. An IPN documented follow-up and resolution of the acute otitis media. • Individual #513: Was evaluated for abrasion to lower lip. The medical provider documented a focused physical assessment, and diagnosed and treatment the individuals for cellulitis; furthermore, there was a follow-up IPN by the medical provider documenting a physical assessment and statement indicating that the acute medical problem has resolved. Summary: Review of the documentation, and per observations made by the Monitoring Team during attendance at the clinical morning report meeting, the Facility's medical providers provide exceptional initial triage, clinical management, and follow-up through full resolution of acute medical conditions. The Facility is exemplary in this area. It should be noted that, as delineated in Section L.2, of this report, the external review physician noted the same findings regarding the Facility's management of acute medical conditions. <u>Routine Preventative Healthcare Screening:</u> For this compliance visit, the Monitoring Team assessed the Facility's management of routine preventative healthcare screening by reviewing prostate cancer screening by PSA and breast cancer screening by mammogram. The Monitoring Team requested the following documentation: • Alpha list of all men 50 years old and older	

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		• Alpha list of all men who have had prostate specific antigen testing for prostate cancer screening • Alpha list of all men who were not provided PSA screening, and documentation of alternative prostate cancer screening, or clinical rationale for not completing annual prostate cancer screening. • Alpha list of all females 40 years old and older • Alpha list of all females 40 years old and older who were current with mammogram screening • Alpha list of all females 40 years old and older who were not current with mammogram screening, and the clinical rationale for not being current. Prostate cancer screening by PSA: The Facility provided documentation of 121 men, age 50 and older. Of this group, 114 individual (94%), were documented as having had a screening PSA within the past 12 months. For the seven individuals who did not have annual PSA screening, the Facility provided IDT documentation that demonstrated a review for lack of PSA screening, and documentation by the IDT recommending that the Individual be regularly screened by PSA. There was follow-up evidence indicating the PSA test was obtained. Breast cancer screening by mammography: The Facility provided a spreadsheet of 120 individuals who were females age 40 and older, and a spreadsheet indicating 108 out of 120 examples (90%) were current with screening mammography. A spreadsheet documented 12 individuals who were not current with screening mammography, and included the rationale for not being current: Compliance issues: 5 Guardian refusal: 4 Anatomic limitations: 2 Other: 1 (individual turned forty years old, at the time of this compliance visit) Summary: The Facility performed regular cancer screening by prostate specific antigen testing for men 50 years old and older, and regular breast cancer screening by mammography. The Facility demonstrated effective monitoring by the IDT to ensure that prostate cancer screening was obtained annually. <u>Immunizations:</u> To assess the Facility's provision of immunizations, the Monitoring Team selected influenza vaccine as an assessment determinant for this compliance review period, and requested: • List of all individuals who were not immunized for influenza for the 2013	

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		influenza season, and the clinical indication for not administering influenza vaccine The Facility provided written documentation that four out of 479 individuals were not immunized, and in all four examples, the clinical rationale for lack of vaccination was guardian refusal. <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 • RSSLC Policy Providing Health Care Services; Designating Out-of-Hospital DNR; 09/17/2010 • For all individuals of the list of DNRs (Individual #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 DNR o Copy of the medical provider's interdisciplinary progress notes (IPN) documenting the clinical rationale for the DNR Review of DNR Policy: Review of RSSL Policy Providing Health Care Services; Designating Out-of-Hospital DNR; 09/17/2010, indicated no change to the policy since September 2010. The Facility indicated only one active DNR, for Individual #149. Review of the requested documents indicated the following for Individual #149: • The annual medical summary clearly delineated the qualifying condition for the DNR in one out of one examples (100%). • In one out of one examples (100%), 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 one out of one examples (100%) there 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	

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		need of the DNR order. This individual's DNR status was comprehensively reviewed by the IDT. • In one out of one examples (100%) there was a comprehensive IPN by the physician documenting the qualifying condition and possible alternatives to the DNR. • The DNR form was fully completed in one out of one examples (100%). • The DNR form did not allow for specific levels of do not resuscitate; however, the physician documented a note indicating the level of DNR, and documented specifics on what clinical support to provide at the time of a terminal event. • The Facility provided a written document stating that the ethics committee had not reviewed the DNR. Texas law does not require a DNR order to be reviewed by an ethics committee. The Monitoring Team recommends that all DNR orders be reviewed be regularly reviewed by an ethics committee. This issue will not be factored into a decision about compliance. • There was evidence that specific instruction was provided to direct care staff on what supports and services were necessary during a terminal event in one out of one examples (100%). For the one DNR order at the Facility, the Monitoring Team noted that the medical provider clearly delineated the rationale for the DNR; documented what supports and services were necessary during a terminal event; appropriately completed the DNR form; provided specific instructions for direct care support staff; and ensured IDT review, that included the guardian. The Monitoring Team compliments the physician and Facility for the comprehensive assessment and documentation of the DNR. <u>Management of malignancy:</u> To assess the Facility's clinical management of malignancy, the Monitoring Team reviewed the following information: • Alpha list of all individuals with known diagnosis of malignancy • Alpha list of all individuals with a diagnosis of malignancy in remission • For the first five individuals on the list of malignancy, and first five individuals diagnosed with malignancy in remission (Facility indicated only one individual with diagnosis of malignancy, Individual #275: o Most recent annual medical assessment o Most recent quarterly medical review o Las six months IPNs by the medical provider, specifically addressing evaluation of the malignancy diagnosis. o All consultation reports, specific to the management of malignancy o Most recent ISP and, or IPN documenting review of malignancy o Most recent IRRF	

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		The Facility provided a spreadsheet indicating one newly diagnosed individual with diagnosis of active malignancy, Individual #275, and a spreadsheet indicating no cases of malignancy in remission. For Individual #275: • Most recent annual medical summary documented diagnosis of malignancy in one out of one examples (100%) • Most recent annual medical summary documented a comprehensive medical plan for malignancy in one out of one examples (100%) • There was documentation provided in one out of one examples (100%) documenting clinically appropriate follow-up with medical specialists, for the diagnosis of malignancy • There was evidence the IDT had reviewed the diagnosis of malignancy in one out of one examples (100%) Following are some comments and specific concerns regarding the example reviewed: • Individual #275: The Individual was diagnosed and treated for breast cancer in 2010. The most recent annual medical summary, dated 7/25/2014, provided a comprehensive overview for the diagnosis of breast cancer, and treatment, indicating that the Individual was in clinical remission. On 7/31/2014, the Individual was transferred to the local acute care Facility, and diagnosed with metastatic breast cancer. Review of the clinical documents provided indicated the following: Evaluation by an oncologist on 3/24/2014, and there was no signs of recurrence. The action plan for this consultation was to have a follow-up in 12 months, and routine mammogram • Evaluation by general surgery for breast cancer on 11/13/2013, and there was no evidence of recurrence by the general surgeon. The Individual followed-up by surgery in April 2014; however, because of positioning issues, secondary to spasticity, a mammogram could not be obtained. • The Individual had a mammogram completed with in the past 12 months, 8/12/2013, which was reported to be negative. • There was evidence of significant review by the IDT of the recurrence and metastasis of malignancy, based on review of the 8/27/2014 IDT meeting minutes. Summary: Based on the documents provided for review, the Facility ensured appropriate follow-up with medical consultants to address the one case of malignancy diagnosed at the Facility.	

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		Clinical Management of pneumonia To assess the Facility's management of pneumonia, the Monitoring Team requested the following information: • Alpha list of all individuals who developed pneumonia during this reporting period • List of all individuals who developed at least three or more episodes of pneumonia during the past five years • For the five individuals with the highest incidence of recurrent pneumonia, and with at least one episode of pneumonia that occurred during this reporting period: o Most recent annual physician's summary o Most recent quarterly medical review o Most recent IRRF assessment o All medical provider's IPNs documenting initial assessment and follow-up of pneumonia o All diagnostics, and consultations, specific to the most recent episode of pneumonia o Medical provider's IPN, and other evidence documenting the etiology of recurrent pneumonia, and steps taken to help reduce or mitigate recurrent pneumonia The Facility provided a list of 20 individuals who were diagnosed with pneumonia from 2/1/2014 through 7/31/2014 (4% of the 479 individuals at the Facility). The Facility provided a list of 14 individuals who were known to have three or more episodes of pneumonia during the past five years. Review of this list indicated that five of the 14 individuals (36%) developed an episode of pneumonia during this reporting period; of the 14 individuals with recurrent pneumonia, 11 (79%) were provided enteral tube feeding, and three (21%) were provided oral feeding. The following is a review of the Monitoring Team's findings from review of the last five individuals on the list of individuals with recurrent pneumonia (Individuals #783, #666, #523, #192, and #621): • Recurrent pneumonia or aspiration pneumonia was listed as a diagnosis on two out of five examples (40%). • A clinically rational medical action plan to help mitigate the recurrent pneumonia was documented on the annual medical assessment in two out of five examples (40%). • There was documented evidence that the medical provider regularly assessed the individual for recurrent pneumonia, and reviewed and	

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		assessed efficacy of prescribed supports and services for recurrent pneumonia, in two out of five examples (40%). • In five out of five examples (100%), the IRRF clearly delineated all necessary supports and services to help mitigate the risks associated with recurrent pneumonia. • In five out of five examples (100%), the medical provider assertively managed the acute case of pneumonia, through resolution. The following are some comments and concerns for four of the five examples reviewed: • Of the five individuals reviewed, who had recurrent pneumonia, the medical providers only documented recurrent pneumonia, or related condition, on the active problem list in 40% of the examples. Review of the documents provided for each of the individuals that did not include recurrent pneumonia or related condition on the active problem list, and assessed quarterly (individuals #666, #783, #and #621), indicated that two of the three individuals had not had an episode of pneumonia for more then 12 months. Individual #621 was noted to have had an episode of pneumonia in 2011 and in 2009; Individual #666, had three episodes of pneumonia in 2013, but did not have recurrent pneumonia, or a related condition documented on the active problem list. It should be noted, however, that in all five cases the IRRF clearly documented risks associated with pneumonia, including rating of a high risk for aspiration and a clear plan delineated to help mitigate pneumonia. It was noted by review of the medical QA data, delineated in Section L.3, that Facility-acquired pneumonia had decreased by 50% in fiscal 2014, compared to fiscal 2013. As delineated in Sections L.2 and L.3, the Facility maintains a robust process to track, trend, and develop action plans to address episodes of pneumonia at the Facility. Summary: Based on the Monitoring Team's review of the Facilities management of pneumonia, the Monitoring Team determined that the Facility has developed mechanisms to address pneumonia at the Facility. <u>Clinical management of fractures</u> The Facility reported five individuals as sustaining a fracture during this reporting period. To assess the Facility's clinical ability to manage fractures, the Monitoring Team requested the following information: • Alpha list of all individuals who sustained a fracture during the reporting period • Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures	

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		• For the first two and last three individuals on the list of fractures (Individuals ##634, #448, #700, #415, and #204): 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 five fractures (Individuals #634, #448, #700, #415, and #204): • Long bones: 1 • Nose: 1 • Digits: 2 • Ankle: 1 The following is a summary of the Monitoring Team's findings for the document reviewed for Individuals #634, #448, #700, #415, and #204: • In five out of five examples (100%) the medical provider conducted a prompt initial triage for reported fractures. • In five out of five examples (100%) the medical provider regularly followed the Individual through full resolution of the fracture. • In five out of five examples (100%) the medical provider obtained necessary diagnostics, and prompt consultation for the assessment and treatment of fracture. • In five of five cases (100%), the medical provider assessed the individual for osteoporosis, and prescribed pharmacological treatment as necessary. • In zero out of five cases (0%), the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture. The Monitoring Team did not identify documented evidence of the medical provider's comprehensive review of possible underlying medical, behavioral, or medication issues that may have precipitated the fractures. • In two out of five cases (40%), the IRFF documented a comprehensive assessment of all risk factors for fall and fracture. Individuals #700 and #203	

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		were the only IRRF assessments noted to have been updated to reflect the current fracture. • There was one example, Individual #415, who was identified as having 14 falls, as a significant risks for fracture; however, there was no indication that the medical provider, in collaboration with other professionals, assessed the efficacy of prescribed supports and services to help prevent falls and fractures. Summary: Medical providers provide assertive triage, appropriate clinical management, and follow-up through resolution of fractures; however, there was no evidence to indicate there was a clinically robust review for possible contributing factors leading to fractures. Also, for the one individual with known risk factors of 14 falls, there was no documented evidence that the medical provider, in collaboration with other professionals, routinely assessed supports and services to help mitigate the risk of falls. Falls and fractures are serious issues, that can be life altering, and many individuals with developmental disabilities have underlying medical, behavioral, and medication risk factors; these issues must be comprehensively reviewed following a fall or fracture. <u>Management of chronic care conditions:</u> To assess the Facility's management of chronic medical conditions, the Monitoring Team selected osteoarthritis as the chronic care conditions to assess, and requested the following documents, for the first five individuals on a list of osteoarthritis: • Medical providers IPNs, specific to routine follow-up for the chronic condition • All diagnostics, obtained in past 12 months, specific for the chronic condition • All consultations, for past 12 months, specific for the chronic condition • Most recent IRRF • Most recent annual medical assessment • Quarterly medical review, specific to the chronic condition The Facility did not provide a list of individuals with a diagnosis of osteoarthritis. Instead, the Facility provided a sample of four individuals. Because osteoarthritis is a very common medical condition, the Monitoring Team is concerned that the Facility did not provide a list of individuals with this diagnosis. Assessment of documents reviewed: • A diagnosis of osteoarthritis was documented on the active problem list in four out of four examples (100%) • A clinically appropriate medical action plan was documented on the annual medical summary in three out of four examples (75%). The action plan for Individual #137 was limited.	

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		• There was evidence that the medical provider routinely assessed osteoarthritis throughout the year, outside the scope of the annual medical summary, in zero out of four examples (0%). • Necessary diagnostics were obtained to determine diagnose osteoarthritis, determine the extent of osteoarthritis, and for periodic assessment of worsening in two out of the four examples (50%). Given the significance of the clinical issues associated with Individuals #137 and #772, additional diagnostic assessments should have been considered, or the clinical rationale for not obtaining additional diagnostics documented. • The IRRF delineated all risks associated with the diagnosis of osteoarthritis, all necessary supports, and monitoring parameters for osteoarthritis, in zero out of four examples (0%) The following are some comments and concerns, regarding some of the issues identified, following review of the documents: • Individual #177: Was identified as having osteoarthritic changes of the cervical spine, following x-ray assessment for possible subluxation, on 7/15/2013, and was diagnosed with osteoarthritis of the hip and knee in 2007. The individual was evaluated for the "mild" osteoarthritis of the knee and hip by orthopedic specialists, who recommended conservative therapy. There is evidence that the medical provider performed an annual physical assessment, and had assessed the individual for pain. In addition, the medical provider recommended to the IDT to monitor for specific signs and symptoms of worsening degenerative joint disease. • Individual #137: The Monitoring Team noted that on an integrated progress note by the medical provider, dated 4/1/2013, the medical provider documented the results of an x-ray of the cervical spine, and indicated there "there is an acute fracture dislocation, osteophyte anteriorly, as well as fusion at the C5 through C6" area of the vertebrae; however, review of the x-ray report, dated 3/29/2013, of the cervical spine stated "there is no acute fracture or dislocation." The Monitoring Team recommends that the Facility reconcile this issue. Although there was evidence of extensive follow-up for degenerative conditions of the spine, there was no evidence of orthopedic consultation for degenerative changes of the hip; furthermore, given the individual's significant gait issues, more assertive assessment for osteoarthritic, and other conditions, should be considered; for example, assessment of the lower extremity would be warranted. In addition, the medical provider indicated on the IRRF that the Individual had "mild" degenerative changes of the hips; however, no supports were indicated. X-ray findings, functional decline, and subjective impression of pain do not always correlate, and the Facility should ensure the routine	

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		assessment of pain, discomfort, and functional decline. The annual medical summary, dated 3/5/2014, did not include an action plan that defined how pain would be assessed; did not indicate the need for additional evaluation for osteoarthritis of other joints; and did not assess how functional decline would be assessed. The Monitoring Team was concerned that initial x-rays of the spine, dated 3/27/2013, indicating possible central stenosis, and other serious conditions, did not result in referral to the specialist until April 2014. Furthermore, despite the medical consultant's assessment that the Individual's spine condition was not severe enough to warrant surgery, there was no evidence that the Facility had developed specific monitoring parameters for worsening degenerative spine disease and pain. The Monitoring Team did note that the medical provider pursued the etiology of the gait abnormality with a neurologist, who after consideration of medications and of other diagnostics that included an MRI of the brain, determined that Parkinson's disease was the most likely etiology. • Individual #772: The Facility provided a copy of an x-ray of the lumbar and thoracic spine, and bilateral hips, dated 8/1/2014. The spine x-ray was limited because of body habitus, but did indicate "degenerative changes"; and the hip x-rays indicated "congenital dysplastic hips". The medical provider documented an IPN for the x-rays, and stated "we will continue the current plan of treatment for degenerative joint disease; no further workup is needed". The most recent IRRF did not comment on the degenerative conditions. The most recent annual medical summary was dated 7/25/2014, which was prior to the x-ray findings, did indicate osteoarthritis, but did not specify the specific joints involved. The medical action plan for both osteoarthritis and degenerative spine disease included specific recommendations to the IDT to assess for functional decline and pain, and that follow-up x-rays would be obtained. The Monitoring Team is concerned that following the "limited" x-ray results of the spine, that indicated degenerative changes, no further work-up was entertained, or the clinical rationale for not pursuing further evaluation documented. Furthermore, both medical conditions should have been well documented on the IRRF. Summary: The Monitoring Team is concerned that only four individuals were provided as examples of individuals with a diagnosis of osteoarthritis; there was lack of assertive clinical follow-up; and there was lack of integration of osteoarthritis on the IRRF assessment. Osteoarthritis is a common and serious medical condition that can progress to functional decline, and manifest pain, which can result in behavioral exacerbation. The Facility must enhance its assessment, management, and routine follow-up of osteoarthritis. <u>Conclusion:</u>	

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		The Monitoring Team is extremely impressed by the many clinical improvements noted for Section L.1, and the Facility is near substantial compliance. Furthermore, the Monitoring Team compliments the medical providers, medical director, nursing staff, support staff, and Facility leadership for the marked improvements that have taken place during this reporting period. The Facility demonstrated exemplary follow-up to acute medical conditions; ensured comprehensive review of the qualifying condition for DNR orders; ensured appropriate management for pneumonia, acute management of fractures, and management of malignancy; ensured influenza vaccination was provided; and provided assertive preventative health care management by ensuring assertive screening for prostate and breast cancer. Substantial compliance was not determined because of significant issues identified with the screening, diagnosing, and overall management of osteoarthritis, and because there was no evidence of a comprehensive review, that included the medical provider, in determining the underlying cause of fractures. Both of these issues are essential, within the context of a development disability facility. Osteoarthritis is a very common medical condition in the general public. The Medical provider must document a review of possible contributing factors for fracture, including underlying medical conditions, maladaptive behavior issues, and medication usage.	
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; the process must involve non-Facility physician case review and facilitate performance improvement. 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 the medical director. To assess the Facility's ability to conduct clinical performance audits, the Monitoring Team reviewed the following documentation: • Assessments, graphs, summaries, action plans, and quality assurance (QA) reports for Internal and external medical audits for round nine • Clinical pathway tools • Clinical pathway audits for round nine • All QA/QI follow-up to action plans for the clinical performance audits, and the medical audits for round nine • Statement by external physician documenting findings and recommendations for round nine of the medical audits <u>State-mandated external medical audit</u> A physician who was external to the Facility conducted round nine of the external	Substantial Compliance

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		medical reviews on 3/28/2014. Specific clinical indicators assessed for this review included diabetes, osteoporosis, and pneumonia. The clinical records of 19 individuals were randomly selected by a computer software program, and used for the review process. For round 9, there were six practicing medical providers at the Facility, and all six medical providers were assessed through the external medical audits. External medical reviews were divided into two components: • External medical audits, which required 80% or greater for medical providers to be considered successful. • Medical management audits, which required 80% or greater for medical providers to be considered successful. The outcome of the external medical reviews for round nine was as follows: • Six out of six (100%), of the medical providers achieved a score of 80% or higher for the medical audit indicators. • Three out of four medical providers (75%) received a score of 80% or greater for medical management audits. Only four of the six medical providers reviewed were assessed for medical management audits, because two of the six medical providers did not treat individuals with the medical management audit indicators assessed for this audit period. For the three medical management audit assessments: • Diabetes had a cumulative score of 100% for all medical providers. • Osteoporosis had a cumulative score of 87.5 % for all medical providers. • Pneumonia had a cumulative score of 65.5% for all medical providers. The medical conditions assessed for round nine differed from those reviewed in round eight, so a direct comparison cannot be made. 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 36 essential, non-essential, and medical management action plans were developed for the six medical providers. At the time of the Monitoring Team's on-site compliance review, 35 out of 36 action plans (97%) were completed, per review of the Action Plan Follow-Up by QA report, found in the presentation book. Review of the 15 medical management elements, that covered all three diagnoses assessed for round nine of the medical audit process, indicated there were no examples of questions to determine if the provider assessed for the underlying etiology of a	

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		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. Furthermore, there was no evidence that medical management questions included evaluating physician performance against national benchmarks and, if not meeting national benchmarks, documenting the clinical rationale for not meeting the benchmark. The summary report developed by the external physician was based solely on the findings of the medical review process. The external reviewing physician delineated seven areas that needed improvement, and seven areas of strength; the Monitoring Team agreed with several of the documented strengths, and areas that require improvements. For example: • Areas needing improvement: o Need to update active problem list, and preventative flow sheet more frequently o Recognition that functional status, ADLs, and fall risk deserve more attention o Need for enhanced documentation following procedures and outpatient visits • Areas of strength: The Monitoring Team concurs with these three findings, and is complimentary for the sound process that the Facility has developed that enables medical providers the ability to establish this exceptional continuity of care practice. o Care plans contained detailed analysis of current problems with greater consideration given to the psychiatric issues and weight problems. o Integrated progress notes were presented in a logical format. o Referral notes sent to specialists during initial resident visit included in-depth report of previous history and reason for the consultation. The Monitoring Team did not identify evidence to concur with the following strengths, as reported by the external physician: • The medical staff provided comprehensive coordination of care with consultants, outpatient facilities, and other living center health professionals. As	

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		noted in Section L.1, the Monitoring Team did not identify meaningful integration of medical care, within the context of the interdisciplinary team process • The medical staff with support from pharmacist conducted careful review of resident medications, and subsequent changes to produce better treatment outcomes. While the Monitoring Team concurs with the physicians addressing the pharmacists' recommendations, as reported in Section N.5, of this report, the medical providers were not assertively assessing and reporting adverse drug reactions. Summary: The Monitoring Team concurs with the external medical auditor's list of areas that need improvement and many, but not all the strengths identified. As with previous compliance visits, the Monitoring Team did not identify further development of the State's external medical management component of the medical audit process. The State's external medical audit process must be enhanced by including additional medical management audit tools to assess the most common, and most serious medical conditions that occur in people with intellectual disability; and should incorporate data elements that assess clinical performance, against National standard of care benchmarks. To address this issue, and overcome barriers to substantial compliance, the Facility developed the "Clinical Performance Audits" system. <u>Clinical performance audits</u> To enhance the Facility's assessment of medical providers' clinical performance, the Facility developed a Facility specific assessment process, called clinical performance audits; this is a different, and independent, process from the DADs internal reviews. The Facility has been working on developing and implementing this process for the past four compliance review visits, and during this compliance review period, the Facility enlisted an external physician to conduct the clinical performance audits, at the same time that the DADS external medical audit process was completed. The associated policy indicates that the clinical performance audits will be conducted by an external physician. This process included the use 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	

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		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. Subsequent to the last compliance review, the Facility continued to develop two additional clinical pathways, for a total of 15 clinical pathway audit tools; the clinical performance audit policy, dated 8/27/2014, 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 15 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 • Anemia • Unintentional weight loss The clinical performance audit tools are comprehensive, and utilize national benchmarks, to help assess, and ensure that medical providers are utilizing nationally recognized standard of care practice, as well as including specific indicators, as related to the Facility specific practice standard. For example, the clinical pathway used to assess the clinical performance practice for diabetes assessed the following, in addition to many other clinical outcome parameters: • Blood pressure less then 130/80 • LDL less then 100, or less then 75 if known coronary arter disease with diabetes • Albumin-creatinine ration less than 2.5 for men and 3.5 for women • Presence of retinopathy • Presence of neuropathy	

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		The same reviewing physician who completes the State's external medical audits also completes the clinical performance audits. Each review period, three clinical indicators are chosen, from the current 15 clinical audit tools, 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 a clinical performance audit, for each of the five medical providers who were practicing medicine at the Facility on 3/28/2014. This audit assessed clinical performance in the areas of Down syndrome, chronic kidney disease, and degenerative spine disease. The physician who conducted the external medical audit also conducted the clinical performance audit. Each of the three medical conditions, assessed by the associated clinical pathway was provided a total compliance score, based on the averages of the collective score by the medical providers; compliance rate per diagnosis of: • Down Syndrome: 66.7% • Chronic kidney disease: 78.6% • Degenerative spine diseases: 77.5% • Total compliance rating: 74.2% Each of the five medical providers were assessed on their clinical performance for each of the three clinical pathways assessed, and provided a clinical performance result: • Medical provider #1: 81.3% total compliance • Medical provider #2: 86.7% total compliance • Medical provider #3: 83.3% total compliance • Medical provider #4: 45.6% total compliance • Medical provider #5: 83.3% total compliance • Overall compliance: 76.04% total compliance To address identified deficiencies, the Facility developed action plans, and followed up on action plans through full implementation of the action plan, by each medical provider. For the clinical performance audits completed on 3/28/2014, there were a total of 20 action plans developed for identified deficiencies, and at the time of this compliance visit, 20 out of 20 action plans (100%) were completed. The Monitoring Team noted that since the Facility fully implemented the clinical performance audits, as well as its medical quality assurance process, as delineated in	

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		Section L.3 of this report, the Facility mortality rate has significantly improved; there were a total of nine deaths reported for fiscal year 2013, and two deaths reported for fiscal year 2014, which was also associated by improved morbidity, as delineated in Section L.3 of this report. <u>Mortality Review Process:</u> Since the last compliance review, two deaths had occurred at the Facility. At the time of the Monitoring Team's compliance review two of the two deaths had Clinical and Administrative Death Reviews completed. On 8/28/14, the Monitoring Team met with the Medical Director, Primary Care Providers, CNE, QA Nurses, and the Medical Records Director. The Facility continued to maintain and improve its comprehensive tracking systems for recommendations resulting from the Clinical and Administrative Death Review Committees. A review of the recommendations stemming from these committees' recommendations found they were tracked, completed, and followed through to resolution as specified in the established timelines for each relevant discipline. In addition, the QA Nurses continued to conduct follow-up reviews of actions taken in response to the recommendations from each death review to verify they were carried out through to resolution. The Monitoring Team's review of the Clinical and Administrative Death Review Recommendation Tracking data indicated that the recommendations were appropriate in relation to the findings in the documents supplied for review. General findings for the two deaths reviewed included: • Of the two deaths reviewed, the average age was 61 years (ages varied from 56 to 66 years of age). • Zero of two (0%) deaths had an autopsy completed. • Two of two (100%) deaths had Unusual Incident Investigations completed. • Two of two (100%) decedents had Do Not Resuscitate (DNR) orders signed prior to illness and at the time of death. • Two of two (100%) deaths occurred in a local hospital. • Two of two (100%) deaths were from natural causes. • Two of two (100%) decedents were fed by enteral tube. • The cause of individuals' deaths, as determined by the Texas Department of Health Services, Vital Statistics Unit Certificates of Death, are listed in the chart below: 1. Primary Cause of Death: Pneumonia 2. Cause of Death: Sepsis and Aspiration Pneumonia (Certificates not yet	

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		available) The Facility had fully implemented a new process for conducting mortality reviews, that included the use of a standardized form to help ensure that not only the direct cause of death is reviewed, but possible contributing factors leading to the death, and overall morbidity of the Individual. In addition, the Facility developed a clinically relevant electronic database to track and trend data elements specific to the administrative death review and clinical death review. For example, the database generates a mortality trend report that documents the number of deaths, date of death, primary and secondary causes of death. Additional data elements that are tracked, and trended include if the individual had a do not resuscitate order (DNR), and if the individual was enrolled in a hospice program. The Facility plans to continue to enhance the report process by including additional data elements, such as the primary medical provider and the place of death. To help reduce bias, the medical director completes the medical summary, instead of the individual's primary medical provider. The Facility has developed a process to initiate specific action plans for identified deficiencies, following a mortality review. For example, following the mortality review meeting on 8/15/2014, the mortality review committee developed three action plans to address system issues, that included: • Enhance the infection control database for tracking of sepsis, and for the medical director to monitor outcome data every three months, and provide clinical intervention to address increased frequency of sepsis at the Facility. • Enhance the mortality database to include a report correlating the underlying chronic medical conditions with the death; this will enable the Facility to correlate chronic medical conditions with the death of an individual, and be able to initiate and monitor corrective action. • Enhance the mortality database to trend age of death to the average age of individuals living at the Facility. The Monitoring Team attended a clinical mortality review committee meeting. The Monitoring Team noted that the committee had utilized the new standardized mortality review form, and conducted a comprehensive and clinically appropriate review of the immediate cause of death, identified all possible contributing factors to the death, and identified unrelated, albeit relevant, clinical issues specific to the general morbidity of the Individual. Furthermore, the Facility developed appropriate action plans to address issues identified within the context of the mortality review committee meeting. <u>Conclusion:</u> The Facility had continued to enhance its mortality review process by developing and	

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		implementing a comprehensive mortality and morbidity review form; developed and implemented a database to track and trend relevant database elements associated with mortality and morbidity; conducted a robust, effective mortality review meeting, and developed appropriate action plans to address issues identified within the context of the mortality review committee meeting. The Monitoring Team compliments the Facility for its development and implementation of a robust mortality review process. There had been no appreciative improvements made with the State's medical audit process, and the Monitoring Team has the same concerns as at the time of the last compliance visit. This State audit process had not developed additional medical management audit tools to address common and serious medical conditions, such as cerebral palsy, other neurodegenerative conditions, and degenerative spine disease, among others. In addition, the medical management component does not rely on outcome data, based on national benchmarks. Over the past two years, however, the Facility developed its own process to assess clinical performance of medical providers known as Clinical Performance Audits that are designed to help assess clinical performance of medical providers at the Facility, and improve overall level of care. To assess efficacy of care, the Clinical performance audit process utilizes national benchmarks to assess clinical outcomes, and the medical director uses the outcome data to develop corrective action plans, as necessary. In addition, the process included a comprehensive electronic database, which was developed by the Facility. The Monitoring Team compliments the Facility for development and implementation of a robust and efficacious process to help assess clinical performance, and determined that the Facility is in substantial compliance with Section N.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 action; and monitors to ensure that remedies are achieved.	Provision L3 requires the Facility to implement a quality assurance (QA) process for medical services. This process included the following components: • Internal Medical Provider quality assurance audit process for round nine. • Clinical performance audits for round nine • Medical quality assurance data-base printout <u>Internal medical reviews</u> Round nine of the internal medical reviews was conducted on 6/13/2014, 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 audit indicators assessed for this review, Round nine, included diabetes, osteoporosis, and pneumonia. The clinical records of 19 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:	Substantial Compliance

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		• Essential audit elements, which required a Facility determined score of 80% compliance, as a passing score
		• Medical elements, which required a Facility determined score of 80% compliance, as a passing score
		• The outcome of the internal medical reviews for round nine was as follows:
		• Six out of six medical providers (100%) received a score of 80% or greater for medical audits.
		• Four out of the four medical providers (100%) who were assessed by medical management audits, received a score of 80% or greater.
		• For the three medical management reviews
		  o Diabetes had a cumulative score of 100% for all four medical providers.
		  o Osteoporosis had a cumulative score of 86.4% for all four medical providers.
		  o Pneumonia had a cumulative score of 68% for all four 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 34 action plans were assigned to the medical providers, and at the time of this compliance review 25 out of 34 (74%) 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, in Section L2 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.
		
		<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 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
		  o Urinary tract infections, October 2013 and January 2014	

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		○ Medical follow-up, December 2013 ○ Diabetes, 6/18/2014 ○ Pneumonia, 6/27/2014 • Observation of electronic medical QA database functionality • Clinical indicators: ○ Diabetes Mellitus ○ Osteoporosis ○ Developmental Disability Healthcare Screening ○ Neuromotor/Musculoskeletal ○ UTI ○ Pneumonia ○ Medical Consultation Follow-up ○ Mortality Review ○ Chronic care ○ Preventive care health screening 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 the efficacy of action plans. 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 regularly updates 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 contained 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	

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		• Mortality Review • Chronic care • Preventive care health screening • Sepsis Also, as reported in the last compliance report, the Facility enhanced its process by developing and implementing a preventative care health screening indicator, and as a result of an action plan for a recent mortality review, an indicator for sepsis was developed. All 11 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 Another example of the Facility's clinical indicators, the 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	

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		The clinical indicator for developmental disability healthcare also assesses if the medical director provided specific screening for common developmental disabilities, including: • Cerebral palsy • Tuberous Sclerosis • 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; the medical director 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, sepsis, 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 by the medical director. During the reporting period, database elements and trends data were reviewed by the Facility for eight of the 11 clinical indicators: diabetes, urinary tract infections, pneumonia, medical follow-up, osteoporosis, preventive health, neuromotor and degenerative conditions, medical follow-up, and mortality review. The Monitoring Team reviewed all eight trends analysis reports, and found them to be equally as comprehensive and clinically relevant. The following is a summary of one of the eight trends analyses completed by the medical director, and reported on the healthcare trends report--Diabetic Trend Analysis Report, 6/18/2014: • Medical services met with residential services, nursing, dietary, and education and training to review the diabetes database on 6/17/2014. • Average HbA1C was 6.55, similar to 2013, and well within treatment range • Sixteen out of 20 individuals (80%) were at goal with diabetic management.	

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		• Retinopathy, neuropathy, and microalbuminuria were noted in under 10% of individuals with diabetes. • Ten percent of individuals with diabetes had peripheral neuropathy. • All individuals with diabetes were prescribed an ACE inhibitor for renal protection • 80 percent of individuals with diabetes had an LDL level of 100 or less. • There was an analysis of the five individuals not at therapeutic goal, and for four out of five (80%), it was determined that although their A1C was not at the ADA recommended level of 7 or less, the individuals' clinical issues warranted higher A1C control, to prevent hypoglycemia; and one out of five was found to be within goal following the trend analysis meeting. • The Facility reviewed its previous action plans that were implemented for diabetes, and as a result the Facility determined that less frequent monitoring of A1C levels was warranted for well-controlled individuals. • Two new action plans were developed: o Initiate a biannual diabetes education fair. This activity is currently scheduled, and an event occurred on July 2014. o Improve the Facility's exercise programs. The Facility was currently developing a process to enhance physical activity for individuals at the Facility. o The Facility's QA/QI department is tracking the development and implementation of both action plans. Specific to outcomes, the Monitoring Team reviewed the incidences of mortality, pneumonia, and urinary tract infections. Since implementing its robust medical QA process, as well as other processes, such as the clinical performance audits delineated in Section L.2 of this report, there has been marked improvement in all three areas: • Urinary Tract Infections: o January 2014: 12 o August 2014: 4 • Facility acquired pneumonia o Fiscal 2013: 44 o Fiscal 2014: 22 • Mortality o Fiscal 2013: 9 o Fiscal 2014: 2 Conclusion: Because the Facility utilizes the same process for both the internal and external medical audit process, the Monitoring Team has the same concern as stated in Section L.2, for the	

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		internal medical audit process. To specifically address Section L.3, the Facility's continued to enhance its data-based Quality Assurance Process by implementing two new clinical indicators, and by implementing action plans to address identified system issues. The quality assurance process is robust and clinically effective, as determined by significant reduction in mortality, pneumonia, and urinary tract infections. The Monitoring Team compliments the staff for its diligence in developing, and implementing this process, and continues substantial compliance for Section L.3.	
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: • RSSLC Policy: Physician Annual Medical Assessment, dated 8/5/2014 • RSSLC Policy: Physician Quarterly Review, number 126, revised 7/15/2014 • RSSLC Clinical Pathway for Standard of Care and Documentation, not dated: o Osteoporosis o Diabetes Mellitus o Dyslipidemia o Constipation o Hypertension o Down Syndrome o Cerebral Palsy o Degenerative Spine Disease • RSSLC Policy: Integrated Clinical Services Policy, dated 8/6/2014 • DADS Policy, Medical Services, number 1/00A, dated 1/21/2011 The following are some concerns, and comments regarding some issues identified, upon the Monitoring Team's review of current medical policies, procedures, and guidelines. Review of Medical Services Policy: The Monitoring Team noted that the definition of the advanced practice registered nurse indicated that the nurse "acts independently and/or in collaboration with other health care professionals". There was no comment regarding supervision by a licensed physician, registering with the medical board, and the nurse practice agreement. These issues are essential elements that should be incorporated into the policy. The policy stated, "all active and chronic problems will be reviewed every quarter". To ensure standard of care practice, the policy did not specify the extent of the review, and should include requirements for a focused physical assessment and review of necessary diagnostics. The Monitoring Team noted, upon review of osteoarthritis, in Section L1,	Noncompliance

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		that the Facility did not follow its policy by not reviewing chronic care conditions quarterly. Review of Physician Quarterly Review Policy: The policy outlines the Facility's expectation to ensure all chronic care conditions are assessed, at least quarterly, and will help to enable enhanced continuity of care among medical and nursing services. The Monitoring Team was unable to determine the effectiveness of this policy, as it had only recently been developed and not substantially implemented. As indicated in Section L.1, there were many quarterly assessments not provided for review. Review of Integrated Clinical Services Policy: The Integrated Clinical Services Policy dated 8/6/14 requires clinical services to "show integration through the ISP process and procedures established from the clinical services," and provides guidance and required actions (with reference to RSSLC Policy F04 that guides the ISP process). Review of Clinical Pathways: • Cerebral Palsy: The Monitoring Team recommends that the Facility add statements to address increase risk for constipation, degenerative spine disease, osteoarthritis, and restrictive lung disease. • Degenerative Spine Disease: The Facility should consider including limitations of x-rays, CT scans, and standard diagnostics used to evaluate degenerative spine disease, and associated myelopathy, pain, and discomfort; and emphasize the important of having a standardized measure to assess for functional decline. • Hypertension: The pathway appears complete. • Diabetes Mellitus: The Pathway appears complete. • Dyslipidemia: The Pathway appears complete. • Osteoporosis: The Pathway appears complete. The Monitoring Team compliments the Facility for further developing clinical pathways that are used as guidelines and include clinical indicators. The Facility continues to need to refine some policies and to ensure it is following its policies. For example, it requires but had not yet ensured implementation of quarterly assessments of chronic medical conditions, such as osteoarthritis. Therefore, the Monitoring Team determined noncompliance for Section L.4. The Facility must have policies and, or procedures in place for all clinical activities performed by the Facility, and must have substantially implemented all policies and procedures.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Section M Self-Assessment, Updated: 8/12/14 2. RSSLC Section M Action Plan, Updated: 8/11/14 3. RSSLC Section M Presentation Book 4. Texas Department of Aging and Disability (DADS), Policy: Nursing Competency Based Training Curriculum Guidelines, Date: March 2014 5. DADS Policy, 001.2, Date: 4/4/14, 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. RSSLC Policy: G06, Admitting/Moving Individuals – Community Movement, including Community Move Personal Property Inventory Checklist and Assessment Template Check Sheet for Community Living Discharge Planning, Revised: 7/7/14 8. RSSLC Health Care Services, Skin Integrity Committee Meeting Process, Date: 6/5/14 9. RSSLC Policy: I.34, Providing Health Care Services – Medication Variances, Revised: 2/27/12 10. RSSLC Policy: A-2, Nursing Services, Medication Administration Observation Guidelines, Revised: December 2013 11. RSSLC Policy: A-3, Nursing Services, SSLC Medication Variance Guidelines, Date: 1/24/12 12. RSSLC list of other new or revised policies, procedures, and/or other documents addressing the provision of nursing care since the last compliance review: 13. RSSLC Policy I.14 – Health Care Services, Requesting Non-traditional Supplements, Revised: 3/25/14 14. RSSLC Policy I.16 – Health Care Services, Monitoring Episodes of Acute Illness/Use of Sedation, Revised: 5/2/14 15. RSSLC Policy I.18 – Providing Health Care Services, Actions During and Following a Medical Emergency (4444), Revised: 5/2/14 16. RSSLC Policy I.24 – Health Care Services, Using Enteral Feeding Pumps, Using Enteral Feeding Pumps, Revised: 3/19/14 17. RSSLC Policy D.25 – Safety and Environmental Management, Completing/Routing Fall Evaluation Form, Revised: 6/6/14 18. RSSLC Policy D.8 – Safety and Environmental Management, Completing/Routing Client Injury Report, Revised: 5/2/14 19. RSSLC Policy B.2 – Nursing Services, Physician Quarterly Orders, Revised: 7/2/14 20. RSSLC Policy E.17 Direct Support Services, Completing Incident Information Reports, Revised: 5/2/14 21. RSSLC Policy J.01 – Behavior Intervention, Use of Restraint, Revised: 8/12/14 22. RSSLC Nurse Competency Based Training Curriculum Guidelines, Revised: March 2014 23. RSSLC Medication Variance Form, Revised: 4/7/14 24. RSSLC Post Hospital/ER/LTAC/Nursing Assessment Form 25. RSSLC Hospital Discharge Form, Revised: December 2013 26. RSSLC Medical Monitoring Form, Revised: 3/27/14 27. RSSLC Standardized Nursing Abbreviations List, May 2014

	28. RSSLC Enteral Feeding Record, Revised: April 2014 29. RSSLC New Controlled Substance Dispensing Process, 7/1/14 30. RSSLC Wound Assessment/Wound Care Observation Form, 6/6/14 31. RSSLC Nursing Education Training Outline for All New and Ongoing Topics Since the Last Compliance Review 32. RSSLC List of Individuals Admitted to the Infirmary for the Last Year 33. RSSLC Nursing Department Meeting Schedule for Week of 8/24/14 34. RSSLC Nursing Department Staffing Schedules and Staffing Patterns for last six months 35. RSSLC Nursing Staffing Patterns for Infirmary and Residential Units by Shifts for last six months 36. RSSLC Nursing Staffing Reports and Analysis for the last six months 37. RSSLC Nursing Overtime Hours by Nurse, January 2014 through June 2014 38. RSSLC Number of Filled and Unfilled Nursing Positions 39. RSSLC RN Case Managers' Caseload by Unit 40. RSSLC Nursing Department Administration and Nurse Managers Meeting Minutes, January 2014 through June 2014 41. RSSLC Quarterly Infection Control Committee Meeting Minutes, for the last six months 42. RSSLC Infection Control Database for all Types of Infection Report, January 2014 through June 2014 43. RSSLC Infection Control Data Summary for the last six months 44. RSSLC Monthly QA/QI Council Meeting Minutes Regarding Section M, April 2014 and July 2014 45. RSSLC Nursing Plan of Improvement Meeting Minutes January 2014 through August 2014 46. RSSLC List of Nursing Monitoring/Auditing Tools 47. RSSLC Nursing Monitoring Tools Analyses and Corrective Action Reports for the last six months 48. RSSLC Quarterly Pharmacy and Therapeutics Committee Meeting Minutes for the last six months 49. RSSLC Skin Integrity Committee Meeting Minutes for the last six months 50. RSSLC Medication Variance Reports for the last six months 51. RSSLC Medication Administration Observation Reports, for the last six months 52. RSSLC Summary of Emergency Equipment and Automated External Defibrillator (AED) Checklist Reports for the last six months 53. RSSLC Emergency Response Committee Membership 54. RSSLC Quarterly Emergency Medical Response Committee Meeting Minutes, 4/16/14 and 7/16/14 55. RSSLC List of Location of Emergency Equipment and Automated and AEDs Campus-wide 56. RSSLC Mock Medical Emergency Drill Reports for the last six months 57. RSSLC List of Staff Responsible for Conducting, Reporting, Tracking and Analyzing Mock Medical Emergency Drills 58. RSSLC Monthly Mock Medical Emergency Drill Trend Analysis for last six months 59. RSSLC Competency Training and Development (CTD) Due/Delinquent List for Cardiopulmonary Resuscitation (CPR) Basic and CPR for Healthcare Providers, Printed 8/18/14 60. RSSLC Monthly Infection Control Committee Meeting Minutes for Reviewing and Revising Infection Control Policies and Procedures, January 2014 through May 2014 61. RSSLC Training Curricula for Infection Control with Training Material 62. RSSLC Monthly Antibiograms and Epidemiology Reports for last six months 63. RSSLC Competency Training and Development (CTD) Infection Control Due/Delinquent List, Printed:

	8/4/14 64. RSSLC Percentage of Individuals Current with Tuberculosis Screening 65. RSSLC Percentage of Employees Current with Tuberculosis Screening 66. RSSLC Percentage of Individuals Current with Influenza Vaccinations 67. RSSLC Percentage of Employees Current with Influenza Vaccinations 68. RSSLC Percentage of Employees Current with Hepatitis B Vaccinations 69. RSSLC Clinical Morning Report Minutes, 8/26/14 70. RSSLC Grand Round Meeting Minutes, 8/27/14 71. RSSLC Pre-Hospital Discharge Meeting Minutes, 8/24/14 72. RSSLC List of Hospital/Emergency Room Visits for the last six months 73. RSSLC List of Individuals' Health Risk Ratings 74. Sample Review of Comprehensive Records for 10 Individuals #468, #499, #66, #716, #527, #395, #107, #173, #737, and #350 75. Sample Review of Community Placement Nursing Summaries and Discharge Packets for Four Individuals #799, #625, #306, and #771 76. Sample Review of Currently Active Skin Integrity Issues for Four Individuals #429, #743, #423, and #523 77. Sample Review of Ten Most Recent Reported Medication Variance Reports for Individuals #215, #391, #153, #241, #415, #718, #527, #72, #259, and #553 78. Sample Review of Records of Five Individuals who had Recent Urinary Tract Infections (UTIs) for Individuals #619, #395, #320, #669, and #296 79. Sample Review of Records of Five Individuals who had Recent Reportable Infectious/Communicable Diseases for Individuals #678, #623, #745, #465, and #675 80. Sample Review of Five Recently Hospitalized Individuals #140, #103, #477, #618, and #354 81. Sample Review of Records of Three Hospital Weekend Phone Contacts for Individuals #140, #84, and #403 82. Sample Review of Seven Post-hospitalization Reports for individuals #340, #782, #649, #465, #149, #140, and #429 83. Sample Review of Diabetic Teaching for Individual/Family Members Sheets and Integrated Progress Notes for Individuals #680 and #530 84. Sample Review of Physician's Orders and Vital Sign Sheets for Oxygen for Individuals #661 and #360 **People Interviewed:** 1. Sherene Green-Blaber, 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. Rose Nnake, RN, RN Case Manager Supervisor 8. Wickliff Fawibe, RN, Skin Integrity Coordinator 9. Alice Bruner, RN, Infection Control Nurse 10. Antonio Crescini, RN, Assistant Infection Control Nurse

	11. Deloris Milligan, RN Nurse Manager, Trinity 12. Irma Bernas, RN, Nurse Manager, San Antonio 13. Deborah Brewer, RN, Nurse Manager, Leon 14. Franca Uzuegbu, RN, Nurse Manager, Three Rivers 15. Amanda Hogan, RN, Nurse Manager, Four Rivers 16. Wilma Parker, RN, Quality Assurance (QA) Nurse 17. Robyn Partridge, RN, Quality Assurance (QA) Nurse 18. Numerous RN Case Managers, Staff RNs, LVNs, and Direct Support Professionals **Meetings Attended/Observations:** 1. Review of Section M Presentation Book and other nursing related documents with Nursing Administration and Management Staff the Week of 8/24/14 2. Clinical Morning Report Meeting, 8/26/14 3. Infection Control Committee Meeting, 8/26/14 4. Skin Integrity Dressing Change Observations for Individuals #743, 8/26/14 5. Long Term Acute Care Facility (LTAC) with Hospital Liaison Nurse Regarding Individual #306, 8/26/14 6. IDT Meeting Regarding Individual #306, 8/26/14 7. Medication Administration Observations and Medication Room Survey in Trinity A, 8/26/14 8. Grand Rounds for Individual #737, 8/27/14 9. Skin Integrity Committee Meeting, 8/27/14 10. Skin Integrity Dressing Change Observations for Individual #523, 8/27/14 11. Pre-Hospital Discharge Meeting for Individual #84, 8/28/14 12. Medication Administration Observations and Medication Room Survey in Three Rivers, 8/28/14 13. Numerous Impromptu Meetings with Nursing Administration and Management Staff throughout the Week of 8/24/14
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. ▪ The monitoring/audit tools the Facility used to conduct its Self-Assessment included: Data analyses of nursing vacancies and staffing levels for nursing over time and infection control, skin integrity, emergency response, nursing monitoring tools, medication variances, with narrative explanations for items assessed for each Provision. These data provided sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. ▪ Compliance Nurse, 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 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. The Section M Presentation Book included supporting documentation that verified the information used in the Self-Assessment. ▪ 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, analyses of infection control, and skin integrity data. ▪ 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 continued to appear relevant to achieving compliance. The Facility defined in detail and sequentially the provision-specific actions, outcomes, and processes for improvement it expected to achieve as a result of these Action Steps, as well as how accomplishments will be measured. The Facility developed and implemented a detailed sequential plan to accomplish the priorities. Action Steps documented the dates they were completed and projected dates for completion for those that were still in process.
	Summary of Monitor's Assessment: The Facility's Self-Assessment stated they were in substantial compliance with Provisions M.1, M.2, M.3, M.4, M.5, and M.6. The Monitoring Team concurs with their findings for Provisions M.2, M.4 and M.6. Provisions M.1, and M.3 showed significant progress and had self-identified and self-initiated corrective actions for such deficiencies. This was evidenced by progressive improvement found by the Monitoring Team's review of records, interviews with responsible nursing staff, and through observations. For example: A CAP was implemented for PCP Notification to ensure the nursing staff documented their assessments in the Integrated Progress Notes on individuals' acute change in health status from baseline, as well as the information communicated to the PCPs. If this and other self-initiated corrective actions put in place are continued and show effectiveness the Facility could be found in substantial compliance at the next review. However, Provision M.5, which is an integrated process for the Integrated Risk Rating Form and Integrated Health Care Plan, needs continued improvement in collaboration with other disciplines. Provision M.1: The Facility's Self-Assessment stated they were in substantial compliance with this Provision but the Monitoring Team did not concur. This Provision contains multiple requirements. Review of this Provision showed that the positive practices found in previous compliance reviews were maintained and additional improvements were made. The Nursing Department continued to maintain a stable and highly motivated nursing staff, and to track, trend and analyze Infection Control and Skin Integrity data.

	The Infection Control, Skin Integrity and Emergency Response Committees continue to be to show integration and active participation with other relevant disciplines. The Nursing Department continued to self-identify and self-initiate corrective action where areas of deficiencies were found. However, a few areas continue to need improvements, which were suggested for the various requirements in order to achieve substantial compliance for the entire Provision, as indicated in the report. Provision M.2: The Facility's Self-Assessment stated they were in substantial compliance with this Provision and the Monitoring Team concurs. The positive practices found in previous compliance reviews were maintained and additional improvements were made. Most notable was the RN Case Managers' collaboration with the medical staff on completing Quarterly Assessments to ensure continuity of care. Provisions M.3: The Facility's Self-Assessment stated they were in substantial compliance with this Provision but the Monitoring Team did not concur. The positive practices found in previous compliance reviews were maintained and additional improvements were made. However, there remained the need for continuous improvement to ensure Acute Care Plans were consistently followed through to resolution with resolution notes documented in the Integrated Progress Notes and on the care plan. The RN Case Managers need to ensure that all relevant information is contained in the Community Placement Transition Packets and that all training provided to the agency providers is listed on the In-service Training Sheets. Provision M.4: The Facility's Self-Assessment stated they were in substantial compliance with this Provision and the Monitoring Team concurs. The Nurse Educator continued to maintain 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. It was positive to find that the Nurse Educator provided training in collaboration with other disciplines. Provision M.5: The Facility's Self-Assessment stated they were in substantial compliance with this Provision but the Monitoring Team did not concur. This Provision showed minimal progress since the last compliance review. The RN Case Manager Supervisor and RN Case Managers continued to work collaboratively with other responsible disciplines to make improvements. It was apparent the Integrated Risk Rating Form and Integrated Health Care Plan 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: The Facility's Self-Assessment stated they were in substantial compliance with this Provision and the Monitoring Team concurs. This Provision 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.	Monitoring Team Findings: The Facility's Provision M.1 Self-Assessment stated they were in compliance with this Provision, but the Monitoring Team did not concur. However, most of the requirements for this Provision 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 addressed various areas of compliance. These requirements included: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical emergency drills and the emergency response system. Additional information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions M.2, M.3, and M.5 reports. Information and recommendations regarding nursing documentation on restraint usage is included above in Provision C.5 of the report. Information and recommendations regarding nursing stemming from the death review process are reported above in Provision L.2. Staffing: At the time of the compliance review the census was reported as 335 individuals residing at the Facility. The Nursing Department reported there was a total of 157 allocated nursing positions, of which 88 Registered Nurses (RNs) and 60 Licensed Vocational Nurses (LVNs) were filled. There were six vacant RN positions and three vacant LVN positions. The Infirmary continued to have four available beds. The Facility did not use agency contract nurses to supplement staffing. Since the last compliance review, the Nursing Department implemented 12 hour shifts for nurses in the Three Rivers and Four Rivers Units to ensure 24 hour nursing coverage. This was a significant improvement since previously there were no dedicated nurses in these units on the 10-6 shifts. Rather, the campus nurses provided coverage for these units on an a per needed basis. Additionally, Four Rivers provided a dedicated Sick Call Nurse, Monday through Friday, to assist the Physician. The Monitoring Team's independent review of the Nursing Department's Summary Addressing Minimum Staffing Patterns for Nursing Reports for all units/Infirmary, daily by shifts, monthly, and longitudinally for the last six months showed the Facility did not fall below the minimum established staffing patterns/ratios. The Facility used a pulling system	Noncompliance

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		and/or overtime/compensatory hours if the minimum staffing/ratios were not met. The Monitoring Team's independent review of the Nursing Department's monthly summaries/analyses of the Number of Overtime and Compensatory Hours by Nurses Reports, for the last six months showed the Nursing Department continued to use and evaluate the use of overtime and compensatory hours to ensure adequate staffing coverage. The Nursing Administration/Management and Specialty Nursing positions remained stable. The only significant change was that the Assistant Nursing Educator took the position as the Infection Control Nurse. 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. <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 January 2014 through June 2014. The Nursing Plan of Improvement Committee continue to meet monthly or more often when needed with the Nursing Administrative/Management staff (Compliance Nurse, Infection Control Nurses, Skin Integrity Coordinator, Hospital Liaison Nurse, Case Manager Supervisor, Nurse Educator, and Nurse Managers) responsible for conducting the monthly monitoring/auditing of designated tools and the QA Nurses who conduct inter-rater reliability checks. Monitoring/auditing data completed the previous month was reviewed for any changes and needs for corrective actions. The Nursing Department continued to follow the procedure for monitoring tools according to the QA Audit Process to track compliance. The Monitoring Team independently reviewed the monthly Nursing Monitoring Tools and Protocol Auditing Tools and supporting documentation for January 2014 through June 2014. The monthly percentage of compliance with the tools is shown in the chart below:	

Monitoring Tools	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	Overall Percentage
Urgent Care/ER/Hospitalizations	83%	84%	94%	100%	98%	100%	93%
Medication Administration Observations	100%	100%	100%	DC'd	DC'd	DC'd	100%
Annual Nursing Assessments	97%	99%	98%	DC'd	DC'd	DC'd	100%

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Quarterly Nursing Review	N/A	N/A	N/A	N/A	96%	98%	98%
Skin Integrity	94%	100%	95%	95%	100%	100%	97%
Protocol Tools							
Antibiotic Therapy	80%	90%	100%	100%	100%	DC'd	94%
Pre-Post Sedation	95%	92%	81%	81%	95%	89%	89%
Constipation	93%	100%	93%	DC'd	DC'd	DC'd	95%
PCP Notification	85%	88%	81%	73%	73%	88%	81
Urinary Tract Infections	N/A	94%	90%	84%	81%	88%	88%
Falls or Suspected Falls	N/A	N/A	N/A	97%	87%	92%	92%
Seizures	N/A	N/A	N/A	N/A	N/A	96	N/A

The above monitoring/audit data contained a monthly description of the tools used; size of sample per tool; total number of records audited; number of tools that met compliance of 80% or greater; and identified trends. For tools that fell below the established threshold of 80% compliance recommendations for corrective action was made. For tools with identified trends that fell below the established threshold for compliance Corrective Action Plans (CAP) were initiated.

The following monitoring/audit tools were discontinued because they had met compliance of greater than 90% over an extended period of time of three months, i.e., Medication Administration Observation, Annual Nursing Assessments, Antibiotic Therapy, and Constipation. The following new monitoring/audit tools were added, i.e., Quarterly Nursing Assessments and Falls or Suspected Falls. A CAP was initiated and remained active for the PCP Notification Audit Tool.

A summary, January 2014 through June 2014, of inter-rater reliability checks performed between the internal nursing staff and the QA Nurses showed the following levels of agreement:

- Urgent Care/ER/Hospitalization = 100% level of agreement, January 2014 through June 2014
- Quarterly Nursing Review = 100% compliance, April 2014 through June 2014
- Skin Integrity = 98% compliance, January 2014 through June 2014
- Medication Administration Observation = 100%, January 2014 through March 2014
- Annual Nursing Assessment = 100%, January 2014 through March 2014

Although it was reported that inter-rater reliability checks were performed monthly on each tool monitored/audited, a summary for the level of agreement was not provided for review.

In order for this section of the Provision to be determined in substantial compliance all monitoring/audit tools must consistently achieve the established compliance score of 90% or

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		greater over an extended period of time according the Facility's QA Audit Process. <u>Clinical Morning Report Meeting:</u> The Monitoring Team attended the meeting on 8/26/14. The Facility continued the integrated Clinical Morning Report meetings, which followed a formalized agenda for conducting the meetings. The on call physician reported on calls received during the off-hours regarding changes in individuals health status. 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 8/26/14 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, RN Case Manager Supervisor, and Nursing Managers were responsible for following up on nursing issues with the responsible nursing staff. <u>Grand Rounds Meeting for Individual #737:</u> The Monitoring Team attended the Grand Rounds Meeting on 8/27/14 for Individual #737, 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 #737's clinical course regarding severe pica behaviors. The team discussed the history/background of the behaviors, potential underlying causes for the behavior, current management plan, and elicited further strategies for management and treatment. The team summarized action plans and provided recommendations for strategies to manage and treat Individual #737's severe PICA behaviors. The Grand Rounds Meetings continued to serve 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>Pre-Hospital Discharge Planning Meeting for Individual #84:</u> The Monitoring Team attended the IDT Pre-Hospital Discharge Planning meeting for Individual #84 on 8/28/14. The meeting was well attended by all relevant disciplines. Individual #84 is a 50 year old male home who was admitted to the hospital on 8/1/14 for recurrent Urinary Tract Infection. The Hospital Liaison Nurse summarized Individual #84's hospital course. The date of discharge was pending because of the infection that required a longer course of antibiotic; however, discharge was expected to be the next week. A diagnosis of acute renal failure was made and G and J Tube leakage was identified. The potential need for changes in medications, treatments, and equipment upon discharge as well as other changes in supports and services were discussed. Risk ratings based on the	

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		hospitalization were discussed. High risk ratings were determined for several conditions. The Pre-Hospital Discharge Planning Meeting results and recommendations were to be submitted to Individual #84's IDT for further review and follow-up. <u>Availability of Pertinent Medical Records:</u> There was no difficultly with the availability of records and documents requested for onsite and offsite review. However, at the last compliance review, there was an issue identified with filing the Hospital Liaison Nurse's Integrated Progress Notes. A CAP was put in place to address this issue. Since the last compliance review, the actions taken for the CAP appeared to be effective and the issue was resolved. A revision to the Recordkeeping Policy was proposed to include language to clarify who was responsible for ensuring the records of individuals who were in the hospital were in the Medical Records Department per policy so the records were accessible to the Hospital Liaison Nurse and other staff. The nursing staff now have computer access campus-wide and have begun typing their Integrated Progress Notes, which has significantly improved the quality and legibility of the notes. <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 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: • Conducted orientation classes for nursing new hires on the Protocol for Hospitalization, Transfers, and Discharges. From January 2014 through July 2014, conducted eight orientation classes. • Participated and performed chart audits in collaboration with the Infirmary nurses for post hospital discharge for individuals' who were admitted to the Infirmary. Audited 61 charts from January 2014 through July 2014. • Performed chart audits for 61 individuals from January 2014 through July 2014, for hospitalized individuals for the inclusion of complete and appropriate filling of documentation. • Daily, updated hospital transfers, admission, and discharge information into the AVATAR database. • Attended the Hospital Discharge Planning Meetings every Friday from January 2014 through July 2014. Prepared and presented discharge summaries for all meetings. The Hospital Discharge Planning meetings were attended by several relevant disciplines,	

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		including clinicians on the IDT, the Hospital Liaison Nurse, and the Skin Integrity Coordinator, who reviewed/discussed individuals' current and future need for supports and services during hospitalization and upon discharge from the hospital. • Attended the Clinical Morning meetings every Tuesday and Thursdays along with the Interdisciplinary Team (IDT) and prepared reports and provided updates to the IDT on individuals' health status who were currently hospitalized. • Collaborated with the RN Case Manager Supervisor/Nurse Managers to ensure that nursing issues/recommendations/action plans made by the Medical Director and team at the end of each Clinical Morning Report meeting were carried out and followed up on as indicated. • Served as a backup to the Physical Nutritional Management Team (PNMT) Nurse. Performed and completed the documentation for PNMT Nurse Post-Hospitalization Assessments/Evaluations conditions requiring such assessments/evaluations. • Performed Medication Administration Record reconciliation with the RSSLC Medication Profile List on individuals admitted to the hospital from January 2014 through July 2014. • The Campus nurses maintained contact with the hospitals and/or LTAC facilities over the weekends and on holidays. • Attended and participated in the Nurse Managers Morning Meetings. • Attended and participated in Clinical and Administrative Death Review Committee Meetings. The Monitoring Team verified the completion of Post-hospitalization Reports through review of a sample for recently discharged Individuals #340, #782, #649, #465, #149, #140, and #429, 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. The Monitoring Team verified the completion of Weekend Telephone Contacts of Review for Records for three hospital weekend phone contacts by the Campus Nurses for Individuals #140, #84, and #403. The documentation in the Integrated Progress Notes of weekend contacts by the Campus Nurses for the above individuals provided substantive information regarding their health status, as required by hospitalization policy and nursing protocol. <u>Facility's Self-Assessment Urgent Care/ER/ Hospitalization Monitoring/Audit Reports:</u> At the last compliance review, there was an issue identified with filing the Hospital Liaison Nurse's Integrated Progress Notes. A CAP was put in place to address this issue. Since the last compliance review, the actions taken with the CAP appeared to be effective and the issue was resolved. The results of the nursing monitoring/audit results, January 2014 through June	

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		2014 showed significant improvement as reflected in the chart below:	

January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	Overall Percentage
83%	84%	94%	100%	98%	100%	93%

The Monitoring Team independently reviewed the records of recently hospitalized individuals using an Urgent Care/ER/Hospitalization Monitoring Tool comparable to the Facility's for the required hospital related documentation. Sample Review included the following five recently hospitalized Individuals #140, #103, #477, #618, and #354 and found:

- Of the required items reviewed the Monitoring Team found an overall 86% compliance, which was less than the overall 93% compliance reported in the Self-Assessment. The items that fell below 100% compliance are reflected in the data below.
- Three of five (60%) records showed there was documentation in the Integrated Progress Notes showing that the PCP Notification Protocol was followed related to the circumstances/reasons that led to urgent care visit/emergency room visit/hospitalization.
- Five of five (100%) records showed there were pre-transfer physical assessment SOAP notes (including a full set of vital signs, the chief/complaint/presenting problem, and a systems review including skin assessment, as appropriate) of acute medical problem(s) documented in the Integrated Progress Notes.
- Five of five (100%) records showed the Hospital Transfer Forms were completed and filed in the Integrated Progress Note section of the record.
- Five of five (100%) records showed there were pre-transfer diagnoses documented on the Hospital Transfer Forms.
- Five of five (100%) records showed there was documentation on the Hospital Transfer Forms that the medical providers and/or the nurses telephoned the receiving facility to notify them of the individuals' transfer and health status.
- Five of five (100%) records showed the dates, times and methods of transfer were documented on the Hospital Transfer Forms and in the Integrated Progress Notes.
- Five of five (100%) records showed when individuals were admitted to the hospital; the Hospital Liaison Nurse included current diagnoses of the individuals' problems, the type of treatment received and clinical status during the visitations, any discharge planning, including any special needs.
- Five of five (100%) records showed there was documentation in the Hospital Liaison Reports and/or Integrated Progress Notes that the Hospital Liaison Nurse (or designated back-up) visited hospitalized individuals daily or made phone contacts.
- Two of two (100%) records showed for individuals that were hospitalized over the weekends and/or holidays contained documentation in the Integrated Progress Notes that the Campus Nurses made telephone contacts with the hospital for hospitalized

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		individuals. • Five of five (100%) records showed upon individuals' discharge from the urgent care visits/emergency room visits/hospitalization there was documentation that nursing assessments (RN Post Hospital Assessment Forms) were completed by an RN within two hours and included subjective information, a full set of vital signs with oxygen saturation levels, physical assessment with skin assessments, nursing diagnoses/nursing problem as per assessment findings. • The Facility provided PNMT Nurse Post Hospital Assessments/Evaluations for zero of three (0%) records of individuals in this sample who were hospitalized for conditions, such as aspiration pneumonia, respiratory concerns, gastrointestinal issues, skin integrity issues, fractures, and seizures. However, as reported in Provision O2 for Sample O.1, eight of eight individuals were seen following hospitalization, resulting in documentation for a total of eight of 11 (73%). • Five of five (100%) records showed there was documentation for hospital discharge summaries, lab, diagnostics and other related reports in the records. If not, there was documented effort to obtain the discharge summaries. • Five of five (100%) records showed individualized Acute Care Plans were initiated upon discharge and admission to the Infirmary. • Two of five (40%) records showed there was documentation that the ACPs were carried out according to plans through to resolution. Examples of concerns identified in reviewing post-hospitalization records are as follows: • Individual #354 was admitted on 7/31/14, for two episodes of vomiting coffee ground emesis with a positive gastroccult for blood. Individual #354 was diagnosed and treated for moderate esophagitis and discharged and admitted to the Infirmary on 7/31/14. An ACP was initiated within 12 hours of discharge from the hospital, which was sufficiently individualized to address moderate esophagitis. There was documentation in the Integrated Progress Notes that the plan was carried out as described until Individual #354 was transferred back to the dorm on 8/1/14. There was documentation that ACP was to be continued in his dorm. However, there were no further Integrated Progress Notes provided for review after returning to his dorm. Therefore, it could not be determined whether the plan was continued through to resolution or that these notes were not provided for off-site review, as requested. However, the ACP was documented as being resolved on 8/7/14. • Individual #477 was admitted to the hospital on 7/21/14, for respiratory distress, fever, and tachycardia. Individual #477 was diagnosed and treated for acute asthma. Individual #477 was discharged on 7/23/14 with a discharge diagnosis of resolved asthma and was admitted to the Infirmary. An ACP was initiated within 12 hours of discharge from the hospital, which was sufficiently individualized to address the resolved asthma and was followed through to resolution during the Infirmary admission. Upon	

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		transfer to the dorm a complete physical assessment was performed and documented in the Integrated Progress Notes. An ACP was initiated to resolve asthma and Medical Monitoring Form with instructions was initiated for 72 hours for medical monitoring. The Direct Support Professional completed the Medical Monitor Forms every hour for 72 hours. After the 7/23/14 notes there was no further nursing documentation indicating the ACP was carried out through to resolution. Therefore, it could not be determined whether the plan was continued through to resolution or that these notes were not provided for off-site review, as requested. • Individual #103's Integrated Progress Notes on 7/5/14 (Saturday) at 1555 documented that the Direct Support Professional reported the individuals had a swollen left foot. The nurse completed an assessment of the left foot and ankle and found mild swelling reported as 1+ pitting edema. The nurse placed Individual #103 on Sick Call to be seen the next morning. Based on Individual #103's diagnosis of cerebral palsy diplegia, history of venous stasis edema of the lower extremities that required treatment with compression stockings, and the unilateral edema of the left ankle, the RN should have suspected the potential for developing a deep venous thrombosis (DVT) and completed a more thorough circulatory assessment that included, such assessments as checking the lower extremities pulses (popliteal, dorsalis pedis and posterior tibial), capillary refills, temperature of the legs, pain and/or tenderness in the calves, perhaps by checking the Homan's sign (the sign is positive when pain is elicited with dorsiflexion of the foot) and/or Lowenberg's sign (the sign is positive when pain is elicited when a blood pressure cuff is placed around the calf and inflated to 80 mmHg). Neither was an orthopedic assessment completed on the left ankle for a possible fracture. Perhaps, if more thorough/definitive circulatory and orthopedic assessments were performed to rule out DVT and/or fracture of the left ankle, the RN could have promptly contacted the on call physician and medical attention would have been provided on 7/5/14 as opposed to placing Individual #103 on sick call to be seen the following day. DVTs can result in developing pulmonary emboli, which can be life threating. On 7/6/14, Individual #103 was examined in sick call. The physician's assessment found mild pitting edema in the left lower extremity, lower leg, ankle and foot. Peripheral pulses were palpable but weak in the lower extremities with poor vascular circulation in both feet. The physician ordered a venous ultra sound to rule out DVT of the left leg and an x-ray to rule out a fracture of the left ankle. The venous ultrasound showed DVT. Consequently, upon the results of the ultrasound, Individual #103 was immediately sent to the hospital and admitted on 7/6/14. Individual #103 was diagnosed and treated for DVT. Individual #103 was discharged with a diagnosis of DVT on 7/12/14 and admitted to the Infirmary. An ACP for DVT was initiated upon admission to the Infirmary. However, the ACP did not include instructions to complete circulation assessments of the lower extremities every shift and per necessary (PRN) monitoring of vital signs, or the physician's orders to apply compression stocking, and to keep legs elevated. Although	

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		the physician's orders for compression stocking and to keep legs elevated were not included in the plan, there was documentation in the Integrated Progress Notes that these orders were carried out; nonetheless, it is essential that physician's orders be documented in the plan to ensure staff using the plan are aware. Individual #103 remained in the Infirmary from 7/12/14 to 7/15/14, and then she was transferred back to her dorm. The ACP was continued with orders for 72 hours medical monitoring. On 7/17/17 an ISPA meeting was conducted where risk ratings were reviewed and need for supports and services were discussed. Individual #103 was rated at high risk for circulatory. A review of the Integrated Progress Notes 7/12/14 through 7/17/14 found that Individual #103 was monitored every shift but the assessments for circulation of the lower extremities were not consistently performed; and assessments for DVT were not thoroughly performed when circulation was assessed. The last Integrated Progress Note reviewed was on 7/17/14, which ended the 72 hours of medical monitoring. However, the note stated the problem was not resolved. The ACP did not contain a date for resolution. Therefore, it could not be determined whether the plan was continued through to resolution or that these notes were not provided for off-site review, as requested. • Three individuals were admitted to the hospital for conditions that required PNMT Nurse Post Hospital Assessments/Evaluations, Individuals #618 and #345 for gastrointestinal conditions and Individual #477 for a respiratory condition. The Facility did not provide documentation of completion of those assessments, and the Monitoring Team could not determine whether those had been completed. Based on the Monitoring Team's independent findings for the five individuals who were recently hospitalized the previous positive practices were maintained and improvements were made since the last review; however, several areas need continuous improvement. The Nursing Department should consider making the following improvements: • Notify the Primary Care Providers of assessment findings any time individuals have an acute change of condition from baseline, including weekends/holidays, and provide them with a thorough description of assessment findings as well as documenting in the Integrated Progress Notes what was communicated to the Primary Care Providers. It should be up to the Primary Care Provider to decide if the acute change in condition should be referred to next day sick call or should receive immediate attention. • Provide nurses training on assessing the circulatory system for DVTs. • Ensure that ACPs are followed through to resolution with documentation in the Integrated Progress Notes and on the ACPs when problems are resolved. • Ensure that PNMT Nurse Post Hospital Assessments/Evaluations are completed for the required conditions. Refer to Provision M.3 for additional information regarding compliance with Acute Care Plans and Protocols.	

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		Skin Integrity Coordinator Activities: Since the last compliance review, the Skin Integrity Coordinator had resigned and been rehired and began working after orientation in March 2014. Since being rehired the Skin Integrity Coordinator had continued to make significant improvement in the assessment and management of skin integrity issues and wound care in collaboration with the Nurse Educator, Infection Control Nurses, Nurse Managers, Hospital Liaison Nurse, other Facility disciplines, external wound care specialist, and hospitals/LTAC Facilities. A summary of improvements made in skin integrity activities was provided through interview with nursing administration/management staff, observations, and review of documents. Activities reported by the Skin Integrity Coordinator: • Conducted 11 bimonthly, and when needed, Skin Integrity Committee Meetings between March 2014 and July 2014. The main issues discussed were for individuals with Stage IV pressure ulcers and two individuals with chronic wounds Stages IV pressure ulcers, which were healed in June 2014. One chronic wound that was scheduled for surgery improved with the new wound treatment without surgery. The Skin Integrity Committee Meeting Process was implemented to identify the core members, which included: Skin Integrity Coordinator, Physician or designee, Dietitian, RN Case Managers, Habilitation Staff, Infection Control Nurses, QA Nurses, and Pharmacist. Attendance was more consistent than found in prior reviews. • Updated current Skin Integrity Database to add wound tracking and trend reports that showed monthly, quarterly, and yearly wound counts, types of wounds, location of bodily wounds, and units where the individuals resided. The database also tracked recommendations and wound healing progress. • From March 2014 through June 2014 the Skin Integrity Coordinator met with other disciplines to discuss analysis and trending for underlying causes that contribute to pressure ulcers. The respective disciplines identified planning and treatment for such issues as nutrition, positioning, and the frequency for checking and changing individuals who were incontinent to prevent/reduce the incidences of pressure ulcers. • Implemented random joint rounds facility-wide to observe Wound Dressing Procedures for proper technique. The Joint rounds included the Skin Integrity Coordinator, Nurse Managers, Nurse Educator, and the Infection Control Nurses. Five joint Wound Dressing Change Observations were observed from June 2014 through July 2014. The dressing change procedures observed were at 100% compliance with the nurses following preparation and proper technique as trained. • Reviewed 22 Acute Care Plans for Skin Integrity issues between March 2014 and July 2014 and made revisions on three plans. • Attended seven ISP Meeting between March 2014 and July 2014. The main points discussed were the individuals with chronic wounds who required wound care referrals to outside facilities with wound care physicians in area hospitals.	

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		• Attended 30 Clinical Morning Meetings from March 2014 through July 2014. The Skin Integrity Coordinator discussed updates for individuals with skin integrity issues with input from other disciplines. <u>Facility's Self-Assessment Skin Integrity Data:</u> The Facility's Self-Assessment Skin Assessment Monitoring data, January 2014 through June 2014, reported that the nursing staff completed 30 internal audits during the date range and the quality assurance staff completed six external audits during the date range. The data showed overall 97.65% compliance by the internal audits, overall 88.64% compliance by the external audits, with 98.18% level of agreement between the internal and external audits. The Facility's Pressure Ulcer and Number Pressure Ulcer/Wound Data Reports, March 2014 through June 2014, is showed in the chart below:	

Month	March 2014	April 2104	May 2014	June 2014
Number of Individuals with Pressure Ulcers during the month	1	1	0	1
Number of Pressure Ulcers acquired in the Facility	1	1	0	0
Number of Pressure Ulcers acquired outside the Facility	0	0	0	1
Number of Pressure Ulcers – Stage I	0	0	0	1
Number of Pressure Ulcers – Stage II	1	1	0	0
Number of Pressure Ulcers – Stage III	0	0	0	0
Number of Pressure Ulcers – Stage IV	0	0	0	0
Number of Pressure Ulcers – Unstageable	0	0	0	0
Number of Pressure Ulcers – Suspected Deep Tissue Injury	0	0	0	0

<u>Skin Integrity Committee Meetings:</u>
Since the last compliance review, the Facility policy for the Skin Integrity Committee had been revised: RSSLC Health Care Services, Skin Integrity Committee Meeting Process, Date: 6/5/14.
The Facility had developed and implemented a Skin Integrity Committee Meeting Process to ensure that the committee meetings consistently analyzed and trended skin integrity data for underlying causes of skin breakdown. The Skin integrity Committee meets twice monthly. The Skin Integrity Coordinator was to classify individuals with integrity problems or pressure ulcers and present to the committee. The Skin Integrity Coordinator in collaboration with the Skin Integrity Committee discussed skin integrity data for underlying causes that contributed to skin breakdown and prevention. The Skin Integrity Coordinator along with the Committee focused on more in-depth analyses and trends for underlying causes that contributed to pressure ulcers acquired at the Facility and at outside facilities by individuals.

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		The Monitoring Team verified the improvements made in the Skin Integrity Committee Process by reviewing the Skin Integrity Meeting minutes July 2014 through August 20, 2014. The minutes included a print out of the status of healing for each identified skin integrity issue/pressure ulcer and a trend analysis of skin integrity data by month, quarter, and year, wound counts, types of wounds, location of bodily wounds, and units where the individuals resided. These minutes showed significant improvement in the analysis and trending of skin integrity issues/pressure ulcers. The Monitoring Team attended the Skin Integrity Committee Meeting on 8/27/14. All core committee members attended the meeting and actively participated. The Skin Integrity Coordinator projected onto a screen and provided hard copies to the committee of the monthly data for each skin integrity issues/pressures ulcer. Each individual with skin integrity issues/pressure ulcers was reviewed regarding the status of their healing and treatment regimens. The Skin Integrity Coordinator elicited discussion from the committee for changes and/or additional treatments for individuals who continued to have active skin integrity issues/pressure ulcer. A copy of the monthly trend analysis was provided for further review, discussion, and disposition. This meeting was substantive and showed a more in-depth analysis of underlying causes contributing to skin integrity issues/pressure ulcer and recommendations for preventative measures. <u>Monitoring Team's Observation Wound Dressing Changes:</u> Since the last compliance review, the Skin Integrity Coordinator in collaboration with the Infection Control Nurses, Nurse Educator, and Nurse Managers had put in place a procedure for accurately measuring the size and condition of wounds and for wound dressing changes to ensure that proper techniques were followed and biohazard waste was disposed of properly. They had procured portable carts to use to hold dressing changing materials. The carts had a top surface for clean supplies and the bottom surface for waste material. A red biohazard kick bucket with biohazard bags was procured to use during the dressing change procedure. The nursing staff were instructed to ensure that individuals were provided perineal care before providing dressing changes for such wounds. The nurses were instructed to assemble all necessary wound care assessment and dressing change materials prior to providing dressing changes. The Monitoring Team, accompanied by the CNE, Skin Integrity Coordinator, Infection Control Nurses, and Nurse Educator, observed wound care assessments, care, and dressing changes for Individuals #743 and #523. The wounds were accurately measured, prescribed wound care was provided, proper techniques were followed for dressing changes, and waste materials were disposed of properly; however, the nurses required some prompting by the accompanying nursing staff. After the dressing changes the nursing staff met with the nurses performing the dressing changes to critique their performance. The Skin Integrity	

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		Coordinator, Infection Control Nurses, and Nurse Educator agreed that they needed to continue to conduct dressing change observations with the nursing staff until they were comfortable with the new procedure for changing dressings, and the Monitoring Team agreed. Individual #306 was transitioned to the A Peace of Mind Care Group on 6/1/14. On 8/10/14, the agency Case Manager contacted the Facility's Director of Admission/Discharge Department and informed her that Individual #306 had been hospitalized with an allergic reaction to Bactrim used to treat a boil on her foot that had caused her skin to peel. On 8/14/14, the Case Manager reported Individual had third degree burns and an infection. On 8/16, the case manager reported that skin grafts were done on her feet. After discharge from the hospital, and the individual was readmitted to the Infirmary. The IDT met to discuss her condition, establish a plan of care, and assess if the Facility could meet her medical needs for second/third degree burns. The IDT determined her medical need could be better served in a hospital. Consequently, on 8/22/14, Individual #306 was transferred to the hospital. On 8/26/14, the Monitoring Team, accompanied by the CNE, Hospital Liaison Nurse, and Skin Integrity Coordinator, visited Individual #306 in hospital. By the warm reception the Hospital Liaison and Skin Integrity Coordinator received by the hospital Wound Care Nurse and Nursing Supervisor, it was evident they had established a positive rapport with the hospital staff. The Wound Care Nurse gave a detailed report on Individual #306's health status and wound healing. The Hospital Liaison and Skin Integrity Coordinator visited Individual #306 in her hospital room accompanied by the hospital Wound Care Nurse and Physical Therapist. The Physical Therapist provided an update on the physical therapy plan of care and response to therapy regarding ability to stand and a concern regarding what was considered temporary contracture of the left knee. The floor nurse continued to provide an update on her health status. The hospital Speech Pathologist had completed a bedside swallow evaluation. The diet texture was downgraded to ground texture with thickened liquids. A Modified Barium Swallow test was scheduled. The Direct Support Professionals (DSPs) were with Individual #306 to assist with personal care needs. Individual #306 was receiving pain medication. The Skin Integrity Coordinator examined the second/third degree wounds on the buttocks and lower extremities. All wounds appeared to be clean, dry, and healing. From the visit it appeared that the hospital was providing Individual #306 with care sufficient to meet her health care needs. Upon return to the Facility from the visit, the Monitoring Team, CNE, Hospital Liaison Nurse, and Skin Integrity Nurse attended an IDT meeting where the Hospital Liaison Nurse and Skin Integrity Coordinator reported on Individual #306's health status. The IDT discussed future needs for supports and services. For additional information regarding Individual #306's transition to the community and readmission to the Facility refer to Section T of the report. Refer to Provision M.3 for information ACPs for individuals with active pressure wounds.	

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		The Facility's Self-Assessment for Infection Control Activities provided the following data: • From January 2014 through June 2014, the Infection Control Nurses reviewed Infection Control Forms (ICFs) and ACPs for completion. The following criteria were used to generate and follow up on acute illnesses, documentation for monitoring the effectiveness of antibiotic therapy, documentation of side effects of medications, documentation of instructions for the DSPs, documentation for in-service to staff, and notification of the Infection Control Nurses: o 276 of 276 (100%) ICFs were completed. o 276 of 276 (100%) ICFs had ACPs completed. o 276 of 276 (100%) ACPs included interventions for infection control. • The Antibiotic Nursing Protocol Audit results, January 2014 through June 2014, showed:	

Nursing Protocol Audit Tools	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	Overall percentage
Antibiotic Therapy	80%	90%	100%	100%	100%	DC'd	94%
Urinary Tract Infections	N/A	94%	90%	84%	81%	88%	88%

• The Infection Control Nurses conducted 60 audits for hand washing/glove use and standard precautions to prevent infection and monitored skills assessments performance by new employees from January 2014 through June 2014 with 100% compliance in six of six months.
• The Environmental Review Team conducted monthly inspections for all environmental issues in the months of February 2014, April 2014, May 2014, and June 2014. Five of five areas inspected found no infection control issues.

Infection Control Nurse/Infection Control Committee 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 verifying the Self-Assessment data, as well as other documents when requested. Other activities included:
• The Infection Control Nurses worked collaboratively with the Skin Integrity Coordinator, Nurse Educator, and Nurse Managers to develop and implement a process for training and observation of wound dressing changes to ensure that proper techniques were followed and biohazard waste materials were properly disposed of according to biohazard waste disposal requirements. In conjunction with the Skin Integrity Coordinator, Nurse Educator and respective Nurse Managers began Wound Dressing Observations using a standardized observation form. Additional training/coaching was provided to the nurses observed to ensure that proper techniques for dressing changes were followed and the biohazard wastes were properly disposed.

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		• The Infection Control Nurses in collaboration with the Nurse Managers developed and implemented a new system for isolation carts with isolation instruction cards. Several portable carts were stocked with all of the necessary isolation supplies that can be readily transported to locations where needed when isolation is ordered. • The Infection Control Nurses reviewed and reported Individuals' and employees' tuberculosis skin testing and influenza vaccination status: o Individuals' were reported to be 100% current with tuberculosis skin testing/screenings. There were no individuals reported that had converted tuberculosis skin tests in 2014. Seven individuals who had converted in prior years were current in their follow-up screenings. o Individuals influenza vaccinations were reported as 100% completed. o Employees' tuberculosis skin testing and/or chest x-ray/screenings were reported at 99.53% completed. There were no reported employee converted tuberculosis skin tests. o Employees' influenza vaccinations were reported at 26.02% completed. The 2014-2015 seasons for receiving influenza vaccination had not started. o Employees' who received Hepatitis B vaccination series were reported at 10.53%. Although Hepatitis B vaccinations were not required to for employment, these vaccinations were offered to employees. • The Infection Control Nurses prepared monthly Antibiograms and provided the information to the medical staff and to the Pharmacy and Therapeutics Committee. • The Infection Control Committee in collaboration with the Medical Director and medical staff implemented a Pneumonia Post Hospital Monitoring and Infection Control Data List. The Pneumonia Post Hospital Monitoring consisted of dates when individuals were discharged from the hospital. The Primary Physicians' followed up initially, within three to five days later, then in two weeks, and then one month post pneumonia. The Infection Control Nurse Data List used for monitoring consisted of all of the factors that could be implemented to prevent pneumonia. This information was sent to the Primary Physician, Medical Director, CNE, and NOO with recommendations. For additional information regarding the tracking of aspiration pneumonia/pneumonia data refer to Section L.2, L.3 and Section O. for the effectiveness of the pneumonia action plan. • The Infection Control Committee along with the Trinity staff, Medical staff, and dietary staff continued to carry-out the action plan implemented in September 2013 to decrease Urinary Tract Infections (UTIs), specifically on this unit where medically fragile individuals live. The Committee continued to discuss possible reasons for episodes of UTIs and discussed way of prevention. Moving forward, it was recommended that the action plan for the UTI process be implemented campus-wide. Refer to Section L.2 and L.3 for additional information regarding the effectiveness of the UTI action plan. • The Infection Control Committee recommended reducing the different types of sanitizing wipes used by the Facility by using a multipurpose wipe that would be available in the	

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		warehouse. The Oxivir TB Wipes were considered a multipurpose wipe. These wipes provide general virucide, bactericide, tuberculocide, and fungicide sanitation. • The Infection Control Policy and Procedure Committee began reviewing and revising Infection Control Policies and Procedures for 2014, which were updated on the shared drive. The Pandemic Respiratory Infectious Disease Readiness Plan became part of the Infection Control Policies and Procedures on the shared drive. To date 44 Infection Control Policies and Procedures had been reviewed and revised. <u>Summary of Infection Control Nurses Integration with other disciplines/departments included:</u> • Attended the Clinical Morning Meetings on Tuesdays and Thursdays. • Attended the Grand Rounds Meetings. • Attended the Skin Integrity Committee Meetings weekly. • Taught Infection Control Measures at New Employee Orientation in collaboration with CTD. • Attended IDT meetings when infection control issues needed addressed. • Attended the Safety Committee Meetings monthly. • Attended Pharmacy and Therapeutics Committee Meetings Quarterly. • Attended the Environmental Readiness Team monthly meeting rounds on campus. • Attended Pre/Post-hospital Discharge ISP meetings on individuals with infectious issues. <u>Infection Control Nurse Training Activities:</u> • The Infection Control Nurses continued to teach Infection Control Measures at New Employee Orientation and at annual refresher training in collaboration with CTD. • The CTD Course Delinquency List, printed 8/4/14, indicated there were four incumbent delinquent employees for Infection Control annual refresher training and six new hires that had not yet completed the infection control training. The Facility should ensure that all employees are current in infection Control annual refresher training. • The Infection Control Nurses provided additional in-service training on infection control issues 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 Blood Draw Procedures for Immuno Compromised Individuals training was provided to the Nursing staff in Trinity Unit on 1/21/14. o Shingles training was provided to all staff in Leon A Dorm on 1/27/14. o Hepatitis A, B, And C and Standard Precautions training was provided to Trinity Unit Direct Support Professionals on 1/23/14. o Universal Precaution training was provided to all San Antonio Unit staff on 2/21/14.	

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		○ Methicillin-Resistant Staphylococcus aureus (MRSA) training was provided to the Trinity C Dorm Direct Support Professionals on 3/13/14, to the Trinity B Dorm Direct Support Professionals on 3/13/14 and 6/20/14, to all Trinity D Dorm staff on 5/6/14, and to the Trinity A Dorm Direct Support Professionals on 6/30/14. ○ Proper Handling of Biohazard Waste training was provided to Trinity Unit Nursing staff on 4/9/14. ○ Genital Herpes training was provided the all staff on San Jacinto Unit on 4/17/14. ○ Conjunctivitis training was provided to Direct Support Professionals in Leon D Dorm on 5/19/14. ○ Conjunctivitis training was provided to all staff in Trinity A, B, and D Dorms on 5/27/14. ○ Clostridium difficile training was provided to the Infirmary Nursing Staff and Direct Support Professionals on 5/30/14. ○ Handling of Bio-hazard Waste was provided to all Nurse Managers, Infirmary Nurses, and Campus Nurses on 6/5/14. ○ Oxivir TB Wipes/RSSLC Policy E11, Direct Support Services, Meal time Procedure, revised 5/12/14, training was provided to all unit nursing staff and Direct Support Services staff on 6/30/14. For addition training activities refer to Provision M.4. <u>Infectious and/or Communicable Disease Data Reports:</u> 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. The Infection Control Nurses continued to audit hand washing, conduct random observations of staff for competency and compliance with infection control precautions and prevention measures, and in-service staff on universal and contact precautions, as well as specific infections occurring in specific units/Infirmary, as verified by the monitoring team in review of the report above for training activities. <u>Infection Control Committee Meetings Minutes:</u> 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 Monitoring Team independently reviewed the Infection Control Committee meeting	

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		minutes for 3/4/14, 6/10/14, and 8/26/14, as well as attending the Infection Control Meeting on 8/26/14. 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 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. Updates were provided by various Direct Support Services staff regarding environment issues related to infection control. The minutes reflected the activities reported above under Infection Control Committee Activities. 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 that several activities were provided by the Nurse Educator. The Monitoring Team's review of documents and interview with the Nurse Educators showed the following diabetic activities were provided: <u>Diabetic Health Fair:</u> The Monitoring Team's independent review of Diabetic Activities found the positive practices continued to be maintained as found in the previous: • The Nurse Educator facilitated the biannual Diabetic Education Fair for all individuals and family members in collaboration with other disciplines. The target audience was the 20 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 when they out on visits outside the Facility. There were booth displays from different disciplines, such as Nutrition Services, Pharmacy, Dental, Habilitation Therapy, Residential/Recreation, Medical, and Nursing Departments. • The Monitoring Team independently reviewed Individuals #680 and #530's completed and signed Diabetic Teaching for Individual/Family Members Form for outside/home	

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		visits and accompanying Integrated Progress Notes. The information was sufficient to assist individuals and their families in managing their diabetic care while on leave from the Facility. <u>Review of Physician's Order and Vital Sign Sheets for Oxygen:</u> The Monitoring Team requested Physician's Orders and Vital Sign Sheets for individual who required oxygen. Two individuals, Individuals #661 and #360, required oxygen. It was positive to find that both individuals had Physician's Orders for oxygen that included the parameters for administration and the frequency for checking oxygen saturation levels. A review of these individuals' August 2014 Vital Sheets showed that oxygen saturation levels were consistently monitoring according to Physician's Orders. <u>Mock Medical Emergency Drills and Emergency Response Activities:</u> The Monitoring Team's independent review found that the Facility continued to maintain the positive practices identified in previous reports. There was evidence found through 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: • 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 Quarterly Emergency Medical Response Committee consistently met as scheduled. • The Emergency Medical Response Core Committee member and/or designee consistently attended all scheduled committee meetings. • The Monitoring Team reviewed Emergency Medical Response Committee Meeting minutes for 4/16/14 and 7/16/14. The meeting followed a standardized agenda. 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 full body mannequin was used for conducting Mock Medical Emergency Drills and used various scenarios throughout the facility. The working order and placement of emergency equipment of was reviewed and discussed. An annual service agreement contract was signed for three years with a new company for Automated External Defibrillators AEDs equipment and service. The company checks and maintains the AEDs and the pads to ensure they do not expire. 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,	

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January 2014 through June 2014, found, that 100% of the scheduled drills were completed, and data were analyzed and trended by shift, unit/location, and overall. Data were represented in tabular and graphic form with narrative explanations that report no identified deficiencies. Since the last compliance review, the narratives added a summary of the various scenarios used in conducting the drills. The Monthly Mock Medical Emergency Drill Reports were sent to Incident Management Meetings (IMM) after the 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 chart below shows the status of completed Mock Medical Emergency Drills completed January 2014 through June 2014:

Month	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	Total
Scheduled	31	31	31	31	31	31	186
Completed	31	31	31	31	31	31	186
Passed	31	31	31	31	31	31	186
Percent Passed	100%	100%	100%	100%	100%	100%	100%
Percent completed	100%	100%	100%	100%	100%	100%	100%

- The Nursing Department collaborated with Competency Training and Development (CTD) to track the results of realistic mock medical emergency drill scenarios to establish further need for guidance in training and management of real life medical emergencies and emergency response. Scenarios using the full body mannequin were choreographed to establish training for real life medical emergencies and emergency response. This was a positive finding. The staff needs to continue to practice realistic drills for all potential medical emergencies to ensure all staff are comfortable and proficient in executing the scenarios.
- The Monitoring Team's review of internal nursing audits and longitudinal monthly Emergency Equipment/Automated External Defibrillators (AEDs) Checklist and Emergency Walkthrough Checklist Report analysis for the Facility, January 2014 through June 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
January	100%	100%	100%	100%	100%	100%	100%
February	100%	100%	75%	100%	75%	100%	100%
March	100%	100%	100%	100%	100%	100%	100%
April	100%	100%	100%	100%	100%	100%	100%
May	100%	100%	100%	100%	100%	100%	100%
June	100%	100%	100%	100%	100%	100%	100%

The Monitoring Team independently verified the above data by conducting random

#	Provision	Assessment of Status	Compliance
		observations and reviews of the emergency equipment and AEDs and monthly Emergency Equipment/Automated External Defibrillators (AEDs) and Emergency Walkthrough Checklists in Trinity and Three Rivers Units. • The CTD's Due/Delinquency Training Lists, printed 8/18/14, indicated five employees were delinquent for August 2014, to date, in Basic CPR, and no Health Care Providers were delinquent. The Facility should continue to ensure that all required employees are current with Basic CPR training. If this section of the Provision were a standalone item, it would be considered in substantial compliance. The Facility's Self-Assessment stated they were in substantial compliance with this Provision but the Monitoring Team did not concur. The Monitoring Team's review of this Provision found that the Facility continued to maintain the positive practices identified at the last compliance review and showed overall significant improvements in all required items for this Provision. The Nursing Department had self-identified and self-initiated the following improvements in order to achieve substantial compliance with this Provision: • Notify the Primary Care Providers of assessment findings any time individuals have an acute change of condition from baseline, including weekends/holidays, and provide them with a thorough description of assessment findings as well as documenting in the Integrated Progress Notes what was communicated to the Primary Care Providers. It should be up to the Primary Care Provider to decide if the acute change in condition should be referred to next day sick call or should receive immediate attention. • Ensure that ACPs are followed through to resolution with documentation in the Integrated Progress Notes and on the ACPs when problems are resolved. • Ensure that nurses consistently inform the primary care provided of assessments for acute changes in health status and document in the Integrated Progress Notes the information provided. • The Nurse Managers, Skin Integrity Nurse and Infection Control Nurse should continue to provide over-the-shoulder observations to ensure that all responsible nurses follow proper techniques for dressing changes and proper disposal of biohazard waste materials. • The Emergency Response Committee recently procured a full body mannequin to use for conducting mock medical emergency drill using realistic scenarios but more drill practice is needed to ensure competency in completing the various scenarios. The nursing staff should receive additional training on assessment for DVT. It was apparent from reviewing the IPN that the assessment performed for the cited individual was not adequate to rule out DVT, particularly based on the individual's history of venous insufficiency of the lower extremities.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The Facility has continued to make and maintain significant improvements in procedures and in quality of services, and it is approaching substantial compliance with the requirements of this provision.</td><td></td></tr>
<tr><td>M2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.</td><td>
<u>Monitoring Team Findings:</u>
The Monitoring Team verified 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>RN Case Manager Supervisor and RN Case Management Activities:</u>
Since the last compliance review, the RN Case Manager Supervisor and RN Case Managers continued to maintain the positive practices reported in the last compliance period and made the following improvements:

The RN Case Manager Supervisor continued to conduct monthly quality reviews on the revised Comprehensive Nursing Review/ Quarterly Nursing Record Review/Physical Assessments for the current format and accuracy, including immunizations, current medical diagnoses, end of life screening, and nursing diagnoses related to high and medium risk conditions to ensure all required assessments were completed according to policy.
The RN Case Manager Supervisor continued to review the Annual Nursing Assessment and Quarterly Nursing Review Monitoring Tools completed by the nurse auditors and the QA Nurse auditors for compliance and inter-rater reliability.
The Annual Nursing Assessment Monitoring Tool was discontinued (DC'd) in April 2014 because greater than 90% compliance had been achieved and sustained over a three month period. The Quarterly Nursing Review Monitoring Tool began being audited in May 2014. The results of the audits January 2014 through June 2014 are shown in the chart below:
<table>
<tr><td>Nursing Monitoring Tools</td><td>January 2014</td><td>February 2014</td><td>March 2014</td><td>April 2014</td><td>May 2014</td><td>June 2014</td><td>Overall Percentage</td></tr>
<tr><td>Annual Nursing Assessments</td><td>97%</td><td>99%</td><td>98%</td><td>DC'd</td><td>DC'd</td><td>DC'd</td><td>100%</td></tr>
<tr><td>Quarterly Nursing Review</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>96%</td><td>98%</td><td>98%</td></tr>
</table>

The RN Case Manager Supervisor continued to review tracking of Annual Nursing Assessments for timely completion and filing in the ISP folder within 10 days prior to the ISP meetings.

</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		• The RN Case Manager Supervisor continued to provide RN Case Managers with ongoing topics relevant to case management responsibilities. For additional information on training refer to Provision M.4. • The RN Case Manager Supervisor provided coaching and retraining of the RN Case Managers for completing proper filing in the ISP folder for annual nursing assessments within the mandated timeframe. According to the Self-Assessment, compliance for submitting reports timely was greater than 94%. • The RN Case Manager Supervisor developed and implemented a RN Case Manager Orientation Training Module. • The RN Case Manager Supervisor in collaboration with the Medical Director developed and implemented in June 2014, a joint Nursing and Physician Quarterly Review process to ensure the quality/accuracy, and completeness of both disciplines Quarterly Reviews, to ensure continuity of care. Reportedly, this had improved both disciplines Quarterly Reviews. However, the Monitoring Team was not provided with examples to review. <u>Monitoring Team's Independent Review of Recently Completed Comprehensive Nursing Assessments and/or Reviews/Quarterly Nursing Record Reviews/Quarterly Physical Assessments</u>: The Monitoring Team independently reviewed the most recently completed Admission, Annual Comprehensive Nursing Assessments and/or Quarterly Nursing Reviews and Quarterly Physical Assessments of a sample selected from the Facility's At Risk List for individuals identified at high risk for health conditions from each unit for 10 Individuals #486, #499, #66, #716, #527, #395, #107, #173, #737, and #350. The Monitoring Team reviewed these assessments for assessment items required by the Comprehensive Nursing Assessments and/or Review/Quarterly Nursing Record Review/Quarterly Physical Assessments Policy and found: • Ten of 10 (100%) Admission, Annual Comprehensive Nursing Reviews, and or Quarterly Nursing Reviews were completed according to mandated timelines. • For combined Admission, Annual Comprehensive Nursing Reviews, and/or Quarterly Nursing Reviews, an overall compliance score of 95% was found. A compliance score of 96% was found for two admission nursing assessments. A compliance score of 95% was found for five Annual Nursing Assessments. A compliance score of 94% was found for three Quarterly Nursing Assessments. There were no trends identified where required items fell below 80% compliance. Based on the Monitoring Team's independent review of the above nursing assessment, the Nursing Department had continued to maintain the positive practices identified in the last compliance review and had continued to make improvements to the nursing assessment process. The only concern identified for which the RN Case Manager Supervisor should	

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		continue to address included: On rare occasions nursing assessments were completed several days in advance of the required timelines. While it is important for nursing assessments to be completed timely, the nursing assessments should not be completed so far in advance that changes occurring near the end of the quarter are not included in the nursing assessment, i.e., changes in health status, tertiary care, medications, consults, and lab/diagnostic tests. The Facility's Self-Assessment stated they were in substantial compliance with this Provision and the Monitoring Team concurs. Refer to Provision M.5 and Section I, Provision I.1 and I.2 for additional information regarding the IRRFs and IHCPs processes.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	<u>Monitoring Team's Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.3's Presentation Book; review of documents requested; meetings/interviews with Program Compliance Nurse, Nurse Educator, 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 in substantial compliance with Provision M.3 and the Monitoring Team did not concur with their findings. <u>Unit Nurse Managers and Infirmary Director Activities:</u> Since the last compliance review, the Nurse Managers/Infirmary Director had continued to maintain the positive practices reported in the last compliance and made the following improvements: • Began conducting joint rounds with the Skin Integrity Coordinator, Infection Control Nurses, and Nurse Educator to make Wound Care and Dressing Change Observations. • Collaborated with the Infection Control Nurses to develop and implement a new system for isolation carts with isolation instruction cards. Several portable carts were stocked with all of the necessary isolation supplies that can be readily transported to locations where needed when isolation is ordered. • Developed and implemented a new Sick Call Note for the nurses to use for documenting assessment findings and other relevant information for the PCP's review when individuals were sent to sick call. • Four Rivers now had a Sick Call nurse Monday through Friday to assist the PCP. • Developed and implemented a standard content for Integrated Progress Note to use for documenting PCP Notification documentation, when applicable, to ensure PCPs are consistently provided nursing assessment information when individuals have an acute change from baseline health status. This was part of the PCP Notification CAP. • Implemented 12-hour shifts on Three Rivers and Four Rivers Units to ensure 24 hour	Noncompliance

#	Provision	Assessment of Status	Compliance
		nursing coverage. • The nursing staff now have computer access campus-wide and have recently begun typing their Integrated Progress Notes, which has significantly improved the quality and legibility of the notes. Refer to Provision M.1, Quality Assurance Activities for the status of compliance with the various Nursing Monitoring and Nursing Protocol Care Tool Audits, and Provision M.4 for training activities. <u>Monitoring Team's Review of Acute Care Plans and Associated Documents for Recent and/or Active Pressure Ulcers:</u> At the time of the compliance review, the Facility had two active and two resolved pressure ulcers for Individuals #523, #743, #429, and #423, and overall there was found significant improvement in the quality and content of the Acute Care Plans as reflected below: • Four of four (100%) individuals had Skin Integrity-Pressure Ulcer Acute Care Plans (ACPs) provided for review. • Four of four (100%) individuals' baseline data was sufficient to describe what led up to the necessity for a Skin Integrity-Pressure Ulcer ACP. • Four of four (100%) individuals had Skin Integrity-Pressure Ulcer ACPs initiated upon identification of the pressure ulcers. • Four of four (100%) individuals' goals were measurable and observable to achieve the desired outcome of the plan. • Four of four (100%) Skin Integrity-Pressure Ulcer ACPs were individualized sufficiently for nursing interventions and treatment orders to meet the individuals' health care needs. • Four of four (100%) Skin Integrity-Pressure Ulcer ACPs included criteria for treatment per relevant nursing protocols. • Four of four (100%) Skin Integrity-Pressure Ulcer ACPs specified the frequency of the nursing interventions and treatment orders to be performed and documented. • Four of four (100%) Skin Integrity-Pressure Ulcer ACPs included infection control interventions. • Three of four (75%) individuals' Skin Integrity-Pressure Ulcer ACP included collaboration with the PNMT. • Four of four (100%) individuals Skin Integrity-Pressure Ulcer ACP included instructions for the DSPs. • Four of four (100%) individuals had Skin Integrity-Pressure Ulcer ACP's DSP Instruction Sheets signed by the Home Manager/Charge/DSPs. • Four of four (100%) individuals' Skin Integrity-Pressure Ulcer ACPs were reviewed/revised at least weekly and/or there were changes in nursing interventions and/or treatment orders for the pressure ulcer. • Four of four (100%) individuals' Integrated Progress Notes showed the ACPs were	

#	Provision	Assessment of Status	Compliance
		carried out as instructed. Although not consistently included on the plans per se, relevant nursing protocols were followed, e.g., Pain. • Two of two (100%) individuals' Skin Integrity-Pressure Ulcer ACPs included the dates they were resolved. Two individuals' pressures ulcers were determined resolved on 8/28/14 by the Skin Integrity Coordinator; however, the nursing staff had not had an opportunity to write a resolution note in the Integrated Progress Notes. Two individuals' pressure ulcers were not yet resolved. Based on the Monitoring Team's independent review of the above items, an overall 98% compliance was achieved. <u>Monitoring Team's Review of Acute Care Plans and Associated Documentation for Recent and/or Active Infections.</u> The Monitoring Team independently reviewed a sample of five Acute Care Plans (ACPs) and supporting documentation for active/recent Urinary Tract Infections (UTIs) selected from the various units for Individuals #619, #395, #320, #669, and #296, and found: • Five of five (100%) Integrated Progress Notes showed the Primary Care Provider was notified according to the PCP Notification Protocol at the onset of signs and symptoms of the Urinary Tract Infections, as applicable. Some individuals may be asymptomatic and were diagnosed and treated by the PCP with Urinary Tract infections based on urinalysis results, at which time the nurse was made aware through the Physician Orders. • Five of five (100%) ACPs were initiated within 12 hours of diagnoses of Urinary Tract Infections. • Five of five (100%) ACPs had baseline data sufficient to identify the clinical data that led up to the necessity for care plans. • Four of five (80%) ACPs had goals sufficient to identify the desired outcomes of the urinary tract issues for which the care plans were design to resolve. • Four of five (80%) ACPs that required antibiotic therapy included Individual Infection Control Forms completed and sent to the Infection Control Nurses. • Five of five (100%) ACPs were individualized care plans sufficient to meet needs of the individuals' Urinary Tract Infection. • Four of five (80%) ACPs incorporated relevant protocols in the plan, e.g., Antibiotic Therapy, Urinary Tract Infections, and Pain. • Five of five (100%) plans included how frequently interventions were to be completed, by whom, and where documented. • Five of five (100%) plans included relevant preventative measures. • Three of four (75%) ACPs showed documentation that the plans were reviewed/revised every seven days and/or per necessary (PRN). One ACP was too recently implemented to have been reviewed/revised within seven days. • Four of five (80%) ACPs documented that DSPs were trained on the DSP Instruction Sheets. The DSP Instructions Sheets were individualized sufficient to meet individuals'	

#	Provision	Assessment of Status	Compliance
		health care needs that were applicable to individuals' specific Urinary Tract Infections. • Four of five (80%) ACPs had signature sheets verifying DSPs were trained on each shift. • Four of five (80%) Integrated Progress Notes showed documentation that ACPs/Urinary Tract Infection Protocols were consistently carried out, with rare exception, according to plans. • Three of three (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. Based on the Monitoring Team's independent review of the above ACPs for Urinary Tract Infections and accompanying Integrated Progress Notes, 89% compliance was found for the items reviewed, which was consistent with the Self-Assessment findings. It was evident the Nursing Management and the Infection Control Nurses continued to put forth significant effort to improve the quality and completeness of the ACPs related to infections, including the incorporation of relevant nursing protocols into the plans and in the Integrated Progress Notes. The Integrated Progress Notes showed the ACPs were consistently carried out, with rare exception, on all shifts according to the plans. The Monitoring Team independently reviewed a sample of five Acute Care Plans (ACPs) and supporting documentation for active/recent active/recent Reportable Infectious/Communicable Diseases for Individuals #678, #623, #745, #465, and #675, and found: • Four of Five (80%) Integrated Progress Notes showed the Primary Care Provider was notified according to the PCP Notification Protocol at the onset of signs and symptoms or there was documentation regarding signs and symptoms of the acute changes in individuals' health status from baseline that led to the referral to sick call. • Five of five (100%) ACPs were initiated within 12 hours of the diagnoses of Reportable Infectious/Communicable Diseases. • Four of five (80%) ACPs had baseline data sufficient to identify the clinical data that led up to the necessity for care plans. • Four of five (80%) ACPs had goals sufficient to identify the desired outcomes of the Reportable Infectious/Communicable Diseases for which the care plans were design to resolve. • Five of five (100%) ACPs that required antibiotic therapy included completed Individual Infection Control Forms and were sent to the Infection Control Nurses. • Three of five (60%) ACPs were individualized care plans sufficient to meet the needs of individuals' Reportable Infectious/Communicable Diseases • Three of five (60%) ACPs incorporated criteria for treatment per relevant nursing protocols in the plan, e.g., Antibiotic Therapy, Pain, and other related nursing protocols. • Five of five (100%) plans included how frequently interventions were to be completed, by whom, and where documented.	

#	Provision	Assessment of Status	Compliance
		• Five of five (100%) ACPs included relevant preventative measures. • One of five (20%) ACPs showed documentation that the plans were reviewed/revised every seven days and/or per necessary (PRN). • Four of five (80%) ACPs documented that DSPs were trained on the DSP Instruction Sheets. The DSP Instructions Sheets were individualized sufficient to meet individuals' health care needs that were applicable to individuals' Reportable Infectious/Communicable Diseases. • Four of five (80%) ACPs had signature sheets verifying DSPs were trained on each shift. • Five of five (100%) Integrated Progress Notes showed documentations that ACPs and applicable Nursing Protocols were consistently carried out, with rare exception, according to plans. • Four of five (80%) ACPs contained documentation when the plans were resolved. • Five of five (100%) Integrated Progress Notes showed documentation of resolution notes Based on the Monitoring Team's independent review of the above ACPs for Reportable Infectious/Communicable Diseases and accompanying Integrated Progress Notes, 81% compliance was found for the items reviewed. The Integrated Progress Notes showed the ACPs did not include all of the interventions that should have been included according to criteria for treatment of relevant nursing protocols; documentation in the Integrated Progress Notes showed they were consistently carried out, with rare exception, on all shifts. Items of concern that fell at 80% and/or below Included: • Individual #678's ACP for MRSA did not clearly identify that the wound culture of MRSA was related to the abdominal surgical wound for removal of a foreign object. The baseline data did not clearly describe the infection that Individual #678 would be free of after the treatment of antibiotic therapy. The ACP did not include the wound care treatment recommended by the Skin Integrity Coordinator and ordered by the PCP, nor the assessment of the size, description, or status of healing of the abdominal surgical wound, and did not incorporate the criteria for treatment per nursing protocols for assessment and management of Pica and pain. However, a review of the Integrated Progress Notes showed these items were consistently, with rare exception, assessed and documented according to the relevant nursing protocols. If the ACPs are to be meaningful to direct individuals' care, they should include all of the necessary assessments, interventions, frequency, and documentation required to effectively meet individuals' health care needs. • Individual #675's ACP for Herpes Zoster (Shingles) did not incorporate the criteria for treatment per the Nursing Protocol for Pain. Shingles pain can be excruciating. Therefore, it is important to incorporate the criteria for treatment per the Nursing Protocol for Pain assessment and management in the ACPs for Herpes Zoster. However, a review of the Integrated Progress Notes showed pain assessment and management was consistently documented according to the Nursing Protocol for Pain. • ACPs were not consistently reviewed/revised every seven days and/or PRN.	

#	Provision	Assessment of Status	Compliance
		<u>Comprehensive Nursing Review/Nursing Physical Assessments and Community Living Discharge Placement (CLDP) Packets:</u> Since the last compliance review, the RN Case Manager Supervisor met with the Transition Specialist and clarified that two packets were generated for individuals transitioned to community, the CLPD packet and the Transition Packet. The Facility had made several improvements to the CLDP Process: • Revised RSSLC Policy G06, Admitting/Moving Individuals, Community Movement, 7/7/14 • Developed and implemented an Assessment Template Cheat Sheet for the Community Living Discharge Plan, 11/2013 • Developed and Implemented Community Move Personal Property Inventory Checklist, 3/31/14 • Developed and implemented an In-service Record for Nurse to Nurse Report/Documentation Hand Over for Community Movement Checklist. The Checklist included a space to date and sign the signatures/titles of both the Facility RN Case Manager and the Provider Agency Case Manager/Nurse to verify that the required transition information and training was provided. The Transition Packet contained all of the individuals' forms required to be sent to the agency providers, per policy. • According to the Self-Assessment from March 2014 through June 2014, three random audits were completed for CLDP. The overall results showed that the requirements for CLDP were met by 100% compliance. <u>The Monitoring Team's Review of Transition Community Living Discharge Packets:</u> The IDT meets and the QIDP is responsible to put together a packet of information for discharge. Regardless of who is responsible for specific items, the packets need to contain adequate and accurate information, and there must be documentation that the training of nurses and DSPs is completed (including topic and, if appropriate, competency testing) as well as of the supports the individual needs (including medical equipment). The Monitoring Team independently reviewed four Transition Packets provided using the Facility's In-service Record for Nurse to Nurse Report/Documentation Hand Over for Community Movement Checklist for recent transitions to the community for Individuals #799, #625, #306, and #771, and found: • Four of four (100%) Transition Packets included copies of active and inactive problem lists. • Two of four (50%) Transition Packets included RSSLC Physician's orders, e.g., Diet Orders, Quarterly Orders for nursing treatments/care, routine laboratory and diagnostic tests, and specific specialty consultations. • Two of four (50%) Transition Packets included copies of current medication profiles. • Three of four (75%) Transition Packets included Annual Integrated Risk Rating Forms.	

#	Provision	Assessment of Status	Compliance
		• Two of four (50%) Transition Packets included copies of the most recent Integrated Health Care Plans with nursing specific instructions/interventions and direct care staff instructions for all identified medium and/or high-risk conditions. • Two of four (50%) Transition Packets included copies of routine laboratory test results/diagnostic reports. • Zero of four (0%) Transition Packets included Immunization Records. • Three of four (75%) Transition Packets included Medical Summaries. • One of four (25%) Transition Packets included a copy of the most recent medical examination. • Four of four (100%) Transition Packets included a copy of the most recent dental examination. • Four of four (100%) Transition Packets included Medical Summaries for CLDP. • Three of four (75%) Transition Packets included Comprehensive Nursing Review/Nursing Physical Assessments completed within 45 days prior to transition into the community. • Two of four (75%) Transition Packets included copies of height/weight reports/graphs. • Three of three (100%) Transition Packets included MOSES and DISCUS assessments, as applicable. • Four of four individuals did not require Transition Packets to include copies of Seizure Records, as applicable. • Four of four individuals did not require Transition Packet Nursing Summaries for restrictive interventions, as applicable. • Two of three (67%) Transition Packets included Special Considerations (CPAP, Oxygen, Glucometer, Seizure precautions, fragile bone precautions, falls, etc.), as applicable. • Four of four (100%) Transition Packets included competency-based training tests. • One of four (25%) Transition Packets included In-service Sheet that listed the topic for which training was provided and the signature/titles of agency provider staff trained. • Two of two (100%) Transition Packets included pending consultations/appointments/scheduled procedures, as applicable. • Two of four (50%) Transition Packets included medical equipment the individual's currently uses/depends upon. Based on a review of the above items included on the Facility's In-service Record for Nurse to Nurse Report/Documentation Hand Over for Community Movement Checklist, an overall 57% compliance was found as required to be included in the Transition Packets. This percentage of compliance was inconsistent with the Self-Assessment results. Numerous documents were not found in the Transition Packets, as reflected in the above data. The items on the checklist that had significantly missing documents and/or documentation included: • None of the Transition Packets contained Immunization Records; also missing for some	

#	Provision	Assessment of Status	Compliance
		individuals were copies of Physician's Orders, recent medical examination, routine laboratory test results/diagnostic reports, and consultations. Two of the Integrated Health Care Plans did not include the Direct Support Professionals Instructions Sheets. One of the Comprehensive Nursing Review/Nursing Physical Assessment's was missing the Nursing Physical Assessment. • Although the Transition Packets included signed and dated In-service Sheets showing that the agency providers were trained, only one of the In-service Sheets listed the topics that were trained. Therefore, it could not be determined whether all required training was provided. • Individuals #306 and #625 were diagnosed with diabetes and required twice a day blood sugar finger sticks. Monitoring blood sugar levels through finger stick is critical in managing diabetes, particularly when individuals are on sliding scales for insulin that is determined based on their blood sugar levels, as well as assessing for hypoglycemia and hyperglycemia. These individuals' Date of The Move Checklists did not show their personal Glucometers were sent with them. Reportedly, there was considerable delay in Individual #306 receiving the Glucometer. • Individual #799 was rated at medium risk for falls and at high risk for fractures. According to the Occupational Therapy/Physical Therapy assessment Individual #799 required the use of a Velcro belt and close stand-by assistance with transfer and ambulation. However, the CLPD Nursing Assessment did not include Special Considerations for fall prevention measures. In order to achieve compliance with the In-service Record for Nurse to Nurse Report/Documentation Hand Over for Community Movement Checklist, the RN Case Manager in conjunction with the RN Case Managers should consider the following improvements: • Monitor/check the Transition Packets before individuals move to ensure all the necessary information is included and that all agency providers are trained on all relevant topics. Further, consideration should be given to listing all topics that were trained on the In-Service Sheets. • Ensure all Special Considerations (CPAP, Oxygen, Glucometer, Seizure precautions, fragile bone precautions, falls, etc.), as applicable, are included in the move. It is essential to ensure that individuals diagnosed with diabetes that require routine blood sugar fingers sticks have Glucometers sent with them on the day of the move. For additional information regarding CLDP refer to Section T of the report. The Monitoring Team did not concur with the Facility's Self-Assessment that they were in substantial compliance with this Provision. Although it was positive to find that numerous processes had recently 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	

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		should move toward substantial compliance at the next compliance review. There needs to be improvement in the nursing responsibilities for Community Living Discharge Placements as noted above. 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 verified 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 interviews with the Nurse Educator. Ample supporting documentation was provided in the Presentation Book for Provision M.4 with additional documentation provided onsite, which further verified 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. As the Monitoring Team found in past compliance reviews, 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 Educator demonstrated that she was 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 Educator also provided competency-based training materials used and training records for the trainings reported. RSSLC provided a list of new or revised policies, procedures, and/or other documents addressing the provision of nursing care since the last compliance review. Revised policies, procedures, and/or other documents included: • Policy I.14 – Health Care Services, Requesting Non-traditional Supplements, Revised: 3/25/14 • Policy I.16 – Health Care Services, Monitoring Episodes of Acute Illness/Use of Sedation, Revised: 5/2/14 • Policy I.18 – Providing Health Care Services, Actions During and Following a Medical Emergency (4444), Revised: 5/2/14 • Policy I.24 – Health Care Services, Using Enteral Feeding Pumps, Using Enteral Feeding Pumps, Revised:3/19/14 • Policy D.25 – Safety and Environmental Management, Completing/Routing Fall Evaluation Form, Revised: 6/6/14 • Policy D.8 – Safety and Environmental Management, Completing/Routing Client Injury	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Report, Revised: 5/2/14 • Policy B.2 – Nursing Services, Physician Quarterly Orders, Revised: 7/2/14 • Policy E.17 Direct Support Services, Completing Incident Information Reports, Revised: 5/2/14 • Policy J.01 – Behavior Intervention, Use of Restraint, Revised: 8/12/14 • Nurse Competency Based Training Curriculum Guidelines, Revised: March 2014 • Medication Variance Form, Revised: 4/7/14 • Post Hospital/ER/LTAC/Nursing Assessment Form • Hospital Discharge Form, Revised: December 2013 • Medical Monitoring Form, Revised: 3/27/14 • Standardized Nursing Abbreviations List, May 2014 • Enteral Feeding Record, Revised: April 2014 New policies, procedures and/or other documents included: • New Controlled Substance Dispensing Process, 7/1/14 • Wound Assessment/Wound Care Observation Form, 6/6/14 <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 Training Activities:</u> • Since the last compliance review, there were no changes to the new nurse orientation, refresher training, and annual certification of nursing skill competencies. The Nurse Educator continued to evaluate the competency of all new and tenured nursing staff, including their nursing skills/knowledge in following nursing policies, procedures, processes, protocols, and guidelines. Hence, the Nurse Educator continued to monitor, evaluate and retrain the nursing staff as needs were identified. • The Nurse Educator continued to utilize the state mandated and standardized Nurse Education Hand Book for all new nursing orientation and annual refresher training. All trainings were competency based using formalized lesson plans from the Nurse Educator Hand Book. • The Nurse Educator continued to retrain and monitor nurses on the use of the 23 Nursing	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Protocol Cards in the assessment and management of individuals/ care, documentation, and use of protocols sufficient to address the health status of individuals served.
• The Nurse Educator continued to make rounds, evaluate, and follow up with new nurses after nursing orientation, sharing words of encouragement, answering questions, and making sure they were comfortable in their new roles.
• 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 Physical Assessment
o Mosby's Physical Examination Course (RNs)
o ICF – I/DD: Understanding the Survey Process
o Social Medical Use for Nurses
o Nursing Competency Based Training Curriculum to include physical assessments
• The chart below lists additional trainings conducted since the last compliance review, including training topics and percentages of nurses trained. Trainings were ongoing for those classes that had not achieved 100% completion.
<table>
<tr><th>Training Topics</th><th>Percentage of Nurses Trained</th></tr>
<tr><td>The Nurse Educator conducted competency-based in-service training for all RSSLC nurses on the new/revised</td><td>99% of all nursing staff completed the training</td></tr>
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#	Provision	Assessment of Status			Compliance
			policies/Forms as listed above.		
			In-service training for the Nurse Managers on: Nursing services competency/skill On-Job Training (OJT), nursing competency-based training curriculum, and the role of a preceptor.	100% of the Nurse Managers were trained on the importance of OJT	
			State mandated health physical assessment for registered nurses (RNs) only	98% of the RNs received this training	
			The Nurse Educator conducted campus-wide training on the State Supported Living Center (SSLC) revised Medication Variance Report.	100% of nurses were trained on the revised report	
			In-service training was provided on SSLC Policy I.18: Actions during and following a medical emergency.	98% of the nurses were trained on this policy	
			Ongoing new nursing orientation training for all new hires, on new/revised state and facility policies, procedures, processes, guidelines, and protocols using formalized lesson plans and competencies in the mandated SSLC Nurse Educator Hand Book. Also included in the new hire trainings was ICF – I/DD: Understanding the survey process and the Board of Nursing statement on the social medical use for nurses.	100% completion was accomplished for all new hire trainings	
			Completing/routing Client Injury Reports (CIR) and the revised policy on requesting non-traditional supplements. Reporting of unusual incidents, allegations, non-serious injuries, policies on: Completing incident information, completing/routing fall evaluation forms.	98% of nursing staff completed this training	
			Plan of Improvement competency-based training for all nurses on 23 Nursing Protocol Cards.	98% of the nurses competed this training. Training was ongoing until 100% completion	
			PCP Notification and Documentation in the Integrated Progress Notes (IPNs).	98% of the nurses competed this training. Training was ongoing until 100% completion	
			Safe and secure medication administration practice/administration/documentation in	98% of the nurses competed this training. Training was ongoing until	

#	Provision	Assessment of Status			Compliance
			the Medication Administration Record (MAR)	100% completion	
			Revised Physician Quarterly Orders Policy	98% of the nurses competed this training. Training was ongoing until 100% completion	
			Wound Care/Perineal Care Training to include standard precautions to avoid cross contamination, documentation of wound care including: length, width, depth, description of exudate by type, amount, and odor, and wound care observation form.	98% of the nurses competed this training. Training was ongoing until 100% completion	
			Emergency Response/Urgent Care/Hospitalization, Immunization Record, responding to Weight Loss/Gain, and the revised Nursing Abbreviation List.	98% of the nurses competed this training. Training was ongoing until 100% completion	
			Revised Nurse Competency-based Curriculum Guidelines and New Control Substance Dispensing Process.	98% of the nurses competed this training. Training was ongoing until 100% completion	
			Death Review Recommendations competency-based training to all licensed nurses.	98% of the nurses competed this training. Training was ongoing until 100% completion	
			Competency-based training on the following Policies and Procedures: Providing Acute Care, Actions During and Following a Medical Emergency (4444), Physician Quarterly Orders, Responding to Weight Loss/Gain, Notification of the physician, dietitian, and social worker by telephone or electronic mail of any problems involving the individual's weight, including but not limited to: Weight loss or gain of 3% in one week or 5% in one month, 7.5% in one quarter, or 10% in six months.	99% of the nurses competed this training. Training was ongoing until 100% completion	
			Care Plan Development with emphasis of training on the review and revision of the Acute Care Plans (ACPs) as treatment regimen changes.	98% of the nurses competed this training. Training was ongoing until 100% completion	
			The Nurse Educator continued to train newly hired RN Case Managers on the MOSES and DISCUS assessments.	100% of the RN Case Managers completed their annual MOSES and DISCUS assessment training.	

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Medication Administration for Individuals with Dysphagia	100% of the nursing staff completed this training
Mosby's Physical Assessment Class – Chapters 17 and 13 Abdominal and Chest and Lungs respectively for RNs.	98% of the RNs completed this training. Training was on going until 100% completion

- Observing and Reporting Clinical Indicators: The Nurse Educator continued to conduct competency-based training on the state mandated Observing and Reporting Clinical Indicators for Individual's Change in Status at CTD during new employee orientation.
- RN Case Management: The Nurse Educator continued to train the newly hired RN Case Managers on MOSES and DISCUS during new nurse orientation. To date, 100% of the RN Case Managers had completed their annual MOSES and DISCUS assessment training. Additional training conducted by the RN Case Manager Supervisor for the RN Case Managers is reported in Provisions M.2, M.3, and M.5.
- Infection Control: The Infection Control Nurses continued to conduct training for infection control measures in CTD for new employees, including new nurses, as well as conducting special training when required for local and/or systemic outbreaks of infectious/communicable diseases. Additional training conducted by the Infection Control Nurses is found in Provision M.1. Reportedly the CNE, NOO, Infection Control Nurses, Nurse Educator, and Medical Director recently attended the DADS/DSHS State Supported Living Centers Infection Control Seminar on Clostridium difficile infection in Austin Texas.
- Skin Integrity: The Skin Integrity Coordinator conducted competency-based training on wound assessment, management and documentation classes for new nurses in orientation. The Nurse Educator, Infection Control Nurses, Skin Integrity Nurse, and Nurse Managers provided direct over the shoulder observations of nursing staff during wound and perineal care to ensure the correct techniques are followed at all times to prevent cross contamination and the spread of infections. Additional training conducted by the Skin Integrity is found in Provision M.1

Nursing Education Integration with Other Disciplines:

- Medication Administration for nurses for Individuals with I/DD: To date, 100% of all RSSLC nursing staff were trained on the state mandated Medication Administration for Individuals with Dysphagia, which was jointly taught by Habilitation Therapy, Physical Nutritional Management Team (PNMT) Nurse, and the Nurse Educator.
- Diabetic Health Fair: The Nurse Educator facilitated the biannual Diabetic Education Fair for all individuals and family members in collaboration with other disciplines. The target audience was the 20 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 when they on leave outside the Facility. There were

#	Provision	Assessment of Status	Compliance
		booth displays from different disciplines, such as Nutrition Services, Pharmacy, Dental, Habilitation Therapy, Residential/Recreation, Medical, and Nursing Departments. • Cardiopulmonary Resuscitation (CPR): To date, all nursing staff were current in CPR for Healthcare Providers. • Competency Training and Development (CTD): The Nurse Educator continued to participate in the CTD performance training meetings, which included other disciplines. The degree of adherence to the nursing protocols was reported in the other appropriately related Provisions. Care was consistent, with rare exception, with nursing protocols for antibiotic therapy, urinary tract infections, 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 Book, staff interviews, direct onsite observations of nursing care, and review of documents to verify that the Nursing Department had continued to maintain positive practices toward the development and implementation of nursing policies, procedures, processes, protocols and training.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	Monitoring Team's Findings: The Facility's Section M Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs. The Facility reported the 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 and 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. RN Case Manager Supervisor's Training Activities with the RN Case Managers: • The RN Case Manager Supervisor provided competency-based training for RN Case Managers on 3/13/14 on the IHCP audit findings. The RN Case Managers were also trained on including the Nursing Protocol Cards in the IHCPs. This training was ongoing. The Case Manager Supervisor continued to meet with individual RN Case Managers needing further training.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The RN Case Manager Supervisor attended three IDT "15-Day" Pre-ISP meetings on 5/21/14 that discussed history, current supports, current status, and discrepancies of completed assessments prior to the ISP. <u>The Monitoring Team's Independent Review of Individuals' IRRFs and IHCPs:</u> The Monitoring Team reviewed 10 of the most recently completed IRRFs and IHCPs for specific risk conditions for Individuals #486 for constipation/bowel obstruction, #499 for cardiac disease, #716 for aspiration, #66 for mild neurofibromatosis, #173 for urinary tract infection, #737 for constipation/bowel obstruction, #107 for skin integrity, #527 for cardiac disease, #395 for weight, and #350 for cardiac disease, and found: • Ten of ten (100%) individuals had comprehensive interdisciplinary assessments completed. • Seven of ten (70%) individuals' IRRF assessments were adequate to support risk level determinations. • Seven of ten (70%) individuals' IRRF assessments provided information that helped plan how to address risks. • Nine of ten (90%) individuals had IHCPs developed to address risks. • Six of nine (67%) IHCPs met individuals' needs identified by the interdisciplinary assessments. • Six of nine (67%) IHCPs included preventative interventions sufficient to minimize the conditions of risk. • Nine of nine (100%) IHCPs were integrated into individuals' ISPs. • Six of nine (67%) IHCPs showed adequate integration among all appropriate disciplines. • Five of nine (56%) IHCPs had appropriate functional and measurable objectives sufficient to measure the efficacy of the plans. • Eight of nine (89%) IHCPs identified appropriate clinical indicators to be monitored and the frequency. • Nine of nine (100%) IHCPs contained Direct Support Professional Instruction Sheets for which the specific risk ratings were reviewed. • Six of nine (67%) IHCPs' Direct Support Professional Instruction Sheets were signed for the specific risk ratings reviewed. • Additional examples of findings included the following: o Individual #716: Clinical data regarding cleft palate and hair lip was not included in risk rating for aspiration. These conditions had the potential to interfere with swallowing that could lead to aspiration. o Individual #66: A medium risk rating was added at the ISP for Mild Neurofibromatosis, a genetic disorder. The IRRF made recommendations for annual follow-up MRIs and other assessments but did not develop and implement an IHCP for Mild Neurofibromatosis. o Infection #468: IHCP contained proactive interventions for constipation,	

#	Provision	Assessment of Status	Compliance
		including realistic and measurable objectives, and sufficient clinical indicators and frequency for monitoring were included. o Individual #716: The diet plan was incorrect. It listed regular texture but puree texture was ordered. The Monitoring Team found minimal improvement in the IRRF and IHCP process since the last compliance review. The overall compliance of the above risk conditions reviewed found 79% 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 notably missing in IRRFs and IHCPs and which need improvement included: • As was found in previous compliance reviews, according to review of the ISP sign-in sheets, often the physician, psychiatrist, and dietitian did not attend. It was of concern that the dietitian did not attend ISPs for individuals where there were individuals identified at high and/or medium risk for weight conditions. • 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 did not consistently include criteria for treatment according to relevant Nursing Protocols in the IHCP for managing the acute episodes. 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 accordance with current, generally accepted professional standards of care	<u>Monitoring Team's Findings:</u> The Monitoring Team verified 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; interviews with Nurse Managers; review of documents requested both offsite and onsite; review of the Medication Variance Committee Meeting Minutes, Pharmacy and Therapeutics Committee Meeting Minutes; Medication Administration Observations and Medication Rooms surveys; and review of Medication Variance data. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6 and the Monitoring Team concurs with their	Substantial Compliance

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	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.	findings. <u>Medication Administration Policies, Procedures, and Guidelines:</u> The following policies were reviewed: • RSSLC Policy: I.34, Providing Health Care Services – Medication Variances, Revised: 2/27/12 • RSSLC Policy: A-2, Nursing Services, Medication Administration Observation Guidelines, Revised: December 2013 • RSSLC Policy: A-3, Nursing Services, SSLC Medication Variance Guidelines, Date: 1/24/12 • RSSLC New Controlled Substance Dispensing Process, 7/1/14 <u>Medication Administration Training Activities:</u> • Refer to Provision M.4 for details of the training. <u>Medication Variance Committee Meeting Minutes:</u> The Monitoring Team independently reviewed the monthly Medication Variance Committee meeting minutes January 2014 through June 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 Medication Variance Committee Meetings follow a set agenda that included addressing old business for follow-up issues, as well as new business. Each discipline presented their monthly medication variance data for review, discussion and disposition. Based on the findings of the committee, recommendations were made for changes, improvements, and/or systemic corrective actions, as required by policy. For example in the 6/2/14 minutes it was noted that: • In May 2014, a medication variance was found in one unit during shift-to-shift count of controlled substance regarding a missing plastic bag for Lorazepam that could not be accounted for. The nurses involved received counseling from their Nurse Manager. On 6/2/14, a Corrective Action Plan (CAP) was implemented to ensure that both shifts (incoming and outgoing) nurses will count all narcotics prior to the end of shift in assigned homes. The completion date was projected for 7/12/14 and remained active according to the CAP documentation provided and reviewed by the Monitoring Team. In addition, a new controlled substance dispensing process was implemented on 7/1/14. • In May 2014, another unit had a reported medication variance that resulted in the misidentification of a nonresident who was given a resident's medication at school. It was determined that the nurse did not take an identifying picture and information to	

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		correctly identify the resident. The committee generated another CAP to implement a newly developed identification process for individuals' off-campus medication administration. However, when the CAP was sent to the QA Director the CNE was told that it did not meet the criteria of a CAP; it was an action plan. Consequently, the action taken was printing and placing in each individual's Medication Administration Record a recent large color photograph, including their name, date of birth, and RSSLC number matching the information on the individual's Medication Administration Record. The above examples demonstrated that the Medication Variance Committee took corrective action when indicated, as required by policy. Information generated from the Medication Variance Committee was submitted to the quarterly Pharmacy and Therapeutics Committee for further review, discussion and disposition when indicated. For additional information regarding the Pharmacy and Therapeutics Committee refer to Section N, Provision N.8. <u>Medication Variance Database Reports:</u> The Facility continued to have a robust comprehensive Medication Variance Database, with analysis 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, discipline 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 2014 through June 2014 that had been aggregated, analyzed, trended, along with remedial actions taken to mitigate medication variances and storage issues. The Monitoring Team compared the total number of medication variances reported from July 2013 through December 2013 to those reported from January 2014 through June 2014 and found a significant decrease in the number of medication variances reported, i.e., a reduction from 216 to 131 or 85 less reported or approximately a 40% reduction, as showed in the charts below: The total number of medication variances reported for July 2013 through December 2013 showed:	

July 2013	August 2013	September 2013	October 2013	November 2013	December 2013	Total

#	Provision	Assessment of Status	Compliance

20	25	59	63	25	24	216

The total number of medication variances reported for January 2014 through June 2014 showed:

January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	Total
39	16	21	23	20	12	131

The medication variance data from January 2014 through June 2014 reported the overall number and percentage of medication variances by discipline showed:

- Pharmacy committed 63 medication variances or 47%
- Nursing committed 52 medication variances or 40%
- Medical committed 13 medication variances or 10%
- Dental committed 2 medication variances or 2%
- Other (not determined by discipline) committed 1 or 1%

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. As the data above showed, all departments were reporting their medication variances, as required by policy. This was evidenced through review of the Medication Variance and Pharmacy and Therapeutics Committee meeting minutes and supporting documentation, Medication Variance Database, and the Monitoring Team's medication administration observation, medication room survey and review of Medication Administration Notebooks, and Control Substance Logs. This was a positive finding because it demonstrated that 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's Self-Assessment of Medication Administration and Documentation, Medication Room Survey, and Medication Administration Record Audits:</u>
The Monitoring Team independently reviewed the Facility's Self-Assessment of Medication Observations, Medication Room, and Medication Administration Record Audits against the supporting documentation supplied for review and found:

- Data analysis for the Medication Administration and Documentation audits for the months of January 2014 through March 2014 showed the percentage of compliance in the chart below:

Monitoring Tool	January 2014	February 2014	March 2014	Overall Percentage
Medication Administration	100%	100%	100%	100%

#	Provision	Assessment of Status	Compliance

and Documentation				

In April 2014, the Plan of Improvement Committee recommended the discontinuation of the Medication and Documentation Tool due to the level of compliance consistently reached of 97% or greater for the past six months, October 2013 through March 2014. Medication Administration Observation continued to be observed monthly for compliance by unit Nurse Manager.

- The results for percentage of compliance for 70 Medication Administration Record Audits, 181 Medication Administration Observations, and 129 Medication Room audits from January 2014 through June 2014 showed the monthly percentage compliance in the chart below:

Monitoring Tools	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	Overall Percentage
MAR Audits	100%	96%	96%	100%	100%	89%	97%
Medication Administration Observations	100%	100%	100%	100%	100%	100%	100%
Medication Room Survey Audits	100%	100%	100%	100%	100%	100%	100%

- Inter-rater reliability checks with the QA Nurses and internal nurses on Medication Room Survey and MAR Audits were completed January 2014 through June 2014 and reviewed in the Plan of Improvement Committee Meetings with the following results:
  - There was a 98% to 99% level of agreement between the QA Nurses and internal nurses for these audits.

<u>Monitoring Team's Review of the Ten Most Recent Medication Variance Reports:</u>
The Monitoring Team's review 10 of the most recent Medication Variance Reports and supporting documentation provided by the Facility for Individuals #215, #391, #153, #241, #415, #718, #527, #72, #259, and #553 found continued 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 and severity index, and were reviewed by the respective supervisors.
- Ten of 10 (100%) reports showed that the respective supervisors documented appropriate corrective actions.
- Seven of 10 (70%) reports were dispensing errors committed by the pharmacy technician and were Category A that did not require the notification to the physician of the medication variances. The notification to the physician was not applicable due to a filling variance by the pharmacy.
- Three of 10 (30%) Medication Variance Reports were for Nursing Services.

#	Provision	Assessment of Status	Compliance
		• Ten of 10 (100%) reports were incorporated into the Medication Variance Database, and after an analysis, were 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 and Review of MARs:</u> • The Monitoring Team conducted random Medication Room Surveys, and reviewed MARs and Control Substance Logs found in the medication rooms in the Trinity and Three Rivers units, using the state's standardized Audit Tool. The findings were consistent with the Facility's findings reported. However, numerous individual MARs were loose in the MAR Notebooks where the holes were torn. This was discussed with the Nurse Manager and CNE. The CNE will procure mending materials to repair the torn holes and will instruct the nursing staff to immediately repair the MAR sheets when they are found torn to prevent the MAR sheets from falling out and causing medications to be missed. • The Monitoring Team randomly reviewed the August 2014 Universal Signature Sheets for Trinity and Three Rivers Units, which found they were current for nurses who administer medications, with their printed names, signatures, and titles. <u>Monitoring Team's Medication Administration Observations:</u> The Monitoring Team, accompanied by the CNE and Unit Nurse Managers, conducted oral and enteral nutrition medication administration observations in Trinity A on 8/25/14 at the 4:00 pm medication pass and oral medical observation in Three Rivers on 8/28/14 at the noon medication pass. • The nurses observed administering oral/enteral medication were observed using the standardized Medication Administration Observation Guidelines' criteria for safe medication administration practices. The observation found that the nurses consistently adhered to the guidelines, with one minor exception, i.e., the nurse in Trinity A required momentary prompting by the Nurse Manager to tell an individual the name and purpose of the medications received. However, this momentary omission may have been due to the nurse's distraction when explaining to the Monitoring Team the purpose of the medication. • The Direct Support Professionals consistently assisted the nurses during the medication pass by bringing one individual at a time to receive medications. Privacy was consistently provided. • The Monitoring Team reviewed the Physician's Orders, PNMPs, and Medication Administration Records for the individuals reviewed and found: Medications were administered as prescribed, the PNMPs were current and contained Medication	

#	Provision	Assessment of Status	Compliance
		Administration Instructions, and medications were administered for August 2014, to date, and were consistently initialed as administered. The medication administration observations completed by the Monitoring Team were consistent with the reported quality assurance data for mediation administration observations over the last six months. On the morning of 8/26/14, the Monitoring Team Physician, accompanied by the QA Nurse, went to the Infirmary to request records. While waiting for the records he observed one of the Infirmary nurses initialing medications that had been administered earlier that morning. He informed the Monitoring Team Nurse of this practice. The Monitoring Team Nurse informed the CNE of this information, who further investigated the situation with the Infirmary Director and QA Nurse. The CNE confirmed that the nurse was initialing medication long after they were administered. The CNE stated that the nurse was given Level I disciplinary action because of initialing medications administer after they were passed. In addition, the NOO implemented a corrective action plan with the nurse for documenting medications on the MAR immediately when they were administered. This was considered an isolated incident and should not negate compliance with this Provision since the Infirmary Director took prompt corrective action with the nurse. 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 8/12/14 2. RSSLC Action Plan 8/11/14 3. RSSLC Presentation Book 4. RSSLC Pharmacy Policy and Procedure Manual, Adverse Drug Reactions, revised on 8/28/2013 5. RSSLC Policy (no number), Adverse Drug Reactions revised, 8/24/2014 6. For Individuals #144, #192, #621, #44, #613, #151, #217, #530, #568, #738, #296, and #223: a. Last two medication orders of each month during this reporting period b. Pharmacy documentation of a review for allergies, interactions, required diagnostics, appropriate indication, and dose c. Current medication list 7. Quarterly Drug Regimen Review (QDRR) schedule for past six months, and pending six months 8. List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date 9. Average daily census 10. Alpha list of individuals who were prescribed a neuroleptic and have diabetes 11. Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension 12. Alpha list of individuals who were prescribed a benzodiazepine 13. Alpha list of all individuals with diagnosis of osteoporosis 14. For Individuals #239, #142, #424, #787, #377, #426, #12, #239, #751, #465, #402, and #268: 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) h. Evidence that the medical providers reviewed the pharmacists' recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale 15. For Individuals #787, #278, 3723, #530, and #404: 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

	16. For Individuals #278, #561x2, #714, and #140x2: a. Emergency Medication Monitoring database printouts, documenting the pharmacist's 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 17. Pharmacy and Therapeutic Committee (P&TC) meeting minutes dated 7/15/2014, 7/16/2014, and 5/28/2014 18. Graph of all chemical restraints used during the reporting period 19. For Individuals #513, 714, #82, #140, and #76: a. Most recent two QDRRs b. Most recent psychiatric assessment c. Current medication list d. Most recent ISP, or related document, documenting review for the use of polypharmacy 20. Monthly Polypharmacy Panel Meeting minutes for August 2013 through January 2014 21. List of all individuals on polypharmacy 22. For Individuals #330, #368, #513, #475, and #787 a. Most recent two QDRRs b. Most recent IRRF c. Current medication list d. Most recent psychiatric assessment e. Most recent annual medical assessment 23. Alpha list of all individuals on benzodiazepines 24. For Individuals #153x3, #72, #500, #227, #618, #177, #783, and #686: *a.* SPDI (single patient drug intervention) report *b.* Copy of associated medication order *c.* Documentation of pharmacist's review of the order *d.* Clinical evidence for the medical provider following up on the recommendation, or alternative rationale 25. For Individuals #561x2, #302, #80, #524, #151, #714, #239, #723, #760, and #758, all MOSES and DISCUS assessments completed during this compliance period 26. Staff training record for adverse drug reporting (ADR) 27. Completed ADR reporting forms for Individuals #645, #537, #679, #202, #618, #302, #512, #160, #559, and #726 28. 2013-2014 Drug Utilization Evaluation (DUE) schedule 29. Copy of all completed DUEs for this reporting period 30. Medication Variance Committee meeting minutes February 2014 through July 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 #546, #140, #268, #48, #463x2, #192, #535, #66, and #787: 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 34. All pharmacy documentation, and communication related to mediation variance, for this reporting period **People Interviewed:** 1. Anto Parambil, Pharmacy Director **Meetings Attended/Observations:** 1. None
	Facility Self-Assessment: Following its review of the Self-Assessment for Section N, the Monitoring Team noted that: • The Facility did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. • The monitoring tools did not include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment did not identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, but only provided overall percentage of compliance. • The Monitoring Team determined that the Facility's monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. This was evident by the lack of consistency among the various sections reviewed for this Provision. ▪ It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools; however, based on self-assessments for the past three compliance reports, the outcome of the self-assessment appeared consistent. The Facility determined that it was in substantial compliance with Sections N1, and N.3 through N.8. The Monitoring Team concurs with the Facility with its assessment of substantial compliance for Sections N.1, N.4, and N.6 through N.8, and the Facility's assessment of noncompliance with Section N.2; however, the Monitoring Team disagrees with the Facility regarding Sections N.3 and N.5. and determined noncompliance. 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 Action Plans for Provisions N1, N4, N6, N7, and N8 listed actions for maintenance of compliance. • The Facility did not identify areas of need/improvement. Nonetheless, action steps were in process for Sections N3 and N5 that could move the Facility toward compliance.

	Summary of Monitor's Assessment: The Facility has continued to make significant improvements towards substantial compliance with Provision N. There has been marked improvements in the documentation of QDRRs, as well as with the review of benzodiazepines, anticholinergics, and polypharmacy usage. The Monitoring Team determined continued compliance for Sections N.1, N.4, and N.6 through N.8; however, noncompliance was determined for Sections N.2, N.3, and N.5. The following is a summary of some of the Monitoring Team's specific comments and concerns, following it's review for Provision N: Section N.1: The Facility continued to provide necessary review of new medication orders, and the Monitoring Team determined that the Facility maintained substantial compliance with Provision N.1, of the Settlement Agreement Section N.2: The Monitoring Team is extremely complementary to the pharmacy department, and the clinical pharmacist for their significant improvements in completing QDRRs. Each QDRR reviewed was noted to be comprehensive, and clearly delineated issues related to medication usage. The Monitoring Team noted, however, that the MOSES and DISCUS assessment used by the pharmacist were not regularly completed by the prescribing medical provider. It is essential that the clinical pharmacist review the prescribing medical provider's comments, and diagnosis on the MOSES and DISCUS assessment reports. Furthermore, there was no indication that that the psychiatrist reviewed the QDRRs, when the QDRR included review of psychotropic medications. Section N.3: The Facility has made substantial improvements with its assessment of benzodiazepine, anticholinergic, and polypharmacy review by the pharmacists, and the pharmacists' review of metabolic syndrome and stat chemical restraint usage. The Monitoring Team did, however, note areas that needed continued improvement; these included, but were not limited to, ensuring that metabolic risk factors are carefully assessed by the clinical pharmacists, including those risk factors, such as blood glucose levels, that are normalized because of current treatment; ensuring that common and serious risks associated with anticholinergic, polypharmacy, and benzodiazepine usage are well documented by the clinical pharmacist; and developing a mechanism for the psychiatrist to document a formal post chemical restraint assessment. Section N.4: The Facility ensured that pharmacists completed a SPDI report for individuals identified as having drug-drug interactions or other clinical concerns regarding the prescribing of drugs. The medical providers addressed the pharmacist's recommendations in a substantial majority of cases. The medical provider indicated review and acceptance of the pharmacist's recommendations that were documented on the QDRRs; however, there were no examples of the psychiatrist documenting review and acceptance of the pharmacist's recommendations. The Monitoring Team will continue substantial compliance; however, the Facility must ensure that the psychiatrists document their review of the QDRRs and acceptance of the pharmacist's recommendations, or provide clinical rationale for not following the pharmacist's recommendations. Section N.5: The Facility did not obtain more frequent clinical assessments to assess for dyskinesia, when clinically indicated. Furthermore, the medical provider did not routinely complete the medical provider's

	component of the MOSES and DISCUS assessments. Section N.6: The Facility does have a mechanism in place to identify, report, and assess ADRs; however, the Monitoring Team is very concerned that the numbers of reported ADRs had significantly decreased since the previous compliance report, and that in most cases (90%) the pharmacist was the reporting professional. The P&TC meeting minutes indicated concern over the small number of ADRs reported, which reflected a meaningful review of the ADR process, and the Monitoring Team is complimentary of the P&TCs vigilance in attempting to ensure ADRs are reported. Given the number of medications prescribed at this Facility, the Facility should be identifying more then 20 ADRs within a reporting period. The Monitoring Team will continue compliance at this time; however, continued compliance will require that the ADR process be enhanced to ensure that direct care, nursing, and medical provider staff are carefully assessing individuals for signs and symptoms of adverse drug reactions, and promptly reporting them as ADRs. Section N.7: The Facility maintained an effective DUE process that enabled scheduled DUEs to be developed per request of the medical staff, developed unplanned DUEs that were based on institutional need, had a process to monitor for FDA advisories, and is prepared to develop and implement DUEs for FDA product warnings. Section N.8: The Facility had continued to implement its medication variance process, and ensured a robust reporting process, conducted efficacious Medication Variance Committee meetings, and addressed 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.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing	Provision N.1 requires that a pharmacist review all new medication orders to ensure that the medication is for a clinically appropriate indication; evaluate all diagnostics necessary for safe administration of the medication; evaluate efficacy of the drug; ensure that the dose is clinically appropriate; and ensure that there were no contraindications, such as allergies, and drug-drug interactions. The pharmacist utilizes the WORx drug safety computer program when reviewing all medication orders. The WORx program is an automated process that assesses for possible drug-drug interactions and known allergies, and prompts the pharmacist to review necessary diagnostics. To document the pharmacist's review of new medication orders, the pharmacist completes a checklist, which is stamped on each new medication order. The stamp includes notation for appropriate indication, evaluation of labs, assessment for allergies, and dose. To assess continued compliance with Section N.1, the Monitoring Team reviewed copies of the last two medication orders of each month during this reporting period, for a total of 12 new medication	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	orders. In addition, the following information was reviewed for each example provided (Individuals #144, #192, #621, #44, #613, #151, #217, #530, #568, #738, #296, and #223): • Pharmacy documentation that a review for allergies, interactions, required diagnostics, appropriate indication, and dose • Current medication list The following is a summary of the Monitoring Team's findings: • The pharmacist reviewed all new medication orders for potential allergies, interactions, appropriate doses, necessary diagnostics, and indications in 12 out of 12 examples (100%). • The Monitoring Team reviewed the medication order for potential drug interactions with the medications listed on the current medication list, and in 12 out of 12 examples (100%), the Monitoring Team identified no evidence of drug-drug interactions. • There were no examples requiring the initiation of a single patient drug intervention report (SPDI). • There were no new medication orders that required specific monitoring, such as drug levels, EKG, or ophthalmology examination. Summary: The Facility continued to provide necessary review of new medication orders, and the Monitoring Team determined that the Facility maintained substantial compliance with Section N.1.	

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
		• For the following examples from the alpha lists above (Individuals #239, #142, #424, #787, #377, #426, #12, #239, #751, #465, #402, and #268)
		  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
			Noncompliance

#	Provision	Assessment of Status	Compliance
		○ Most recent annual physician summary ○ Most recent psychiatric assessment ○ Most recent IRRF ○ Evidence that the medical providers reviewed the pharmacist's recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale <u>Timely Completion of QDRRs</u> The Facility reported that because of a clinical pharmacist requiring unexpected time away, the Facility was delayed in completing 62 QDRRs within the designated completion date, according to the QDRR schedule. Upon learning of the scheduling issue, the Facility hired a temporary clinical pharmacist to assist in completing QDRRs. At the time of this review, the Facility reported that all QDRRs were current, and the Facility's clinical pharmacist had returned from time away. <u>Review of Completed QDRRs</u> The following is a summary of the Monitoring Team's findings of the document review for the selected sample (Individuals #239, #142, #424, #787, #377, #426, #12, #239, #751, #465, #402, and #268; the QDRR for Individual #239 was not provided, so this example was not included in the review): • Eight examples required a review of polypharmacy, and eight out of eight examples (100%) included a review of polypharmacy. • The pharmacist indicated a review for the usage of benzodiazepines in 11 our of 11 examples (100%). • The pharmacist assessed Laboratory tests in 11 out of 11 examples (100%). • Metabolic syndrome was appropriately assessed, when clinically indicated, in in 11 out of the 11 examples (100%). • The QDRR indicated review by the medical provider in 11 out of 11 examples (100%). • The QDRR indicated review by the psychiatrist in zero out of the seven examples (0%) that required review by the psychiatrist. • The MOSES and DISCUS included as part of the assessments for the QDRRs indicated significant deficiencies, and the reader is referred to the specific comment on MOSES and DISCUS assessments, below. • The QDRR clearly delineated the appropriateness for all drugs prescribed in 11 out of 11 examples (100%). • The QDRR clearly delineated effectiveness of all drugs prescribed in 11 out of 11 examples (100%). • The QDRR clearly delineated potential drug-drug interactions for all of the prescribed medications in 11 out of 11 examples (100%). The following are some concerns and comments for the examples reviewed for this Section:	

#	Provision	Assessment of Status	Compliance
		• Individual #239: The 3/15/2014 QDRR provided a pharmacist's recommendation to replace solifenacin with bethanechol, and to consider the addition of lisinopril. Both recommendations were accepted by the treating medical provider; however, the Facility provided a medication list dated 3/14/2014, and did not provide a current medication list; therefore, the Monitoring Team had no evidence that medication changes were made, per the pharmacist's recommendations, and there was no supporting documentation to indicate the medication changes, or clinical rationale for not making the medication changes. The MOSES assessment, dated 5/15/2014, which was documented for the current QDRR, indicated that the Individual had gait imbalance; however, the medical provider documented "this assessment is of dubious validity given, for example, that the rater scored the item "gait imbalance/unsteady", when the fact is the patient has no lower extremities". The pharmacist reviewing this MOSES assessment documented "scored 2 for gait imbalance, 1 for slowed movement, and 1 for tremor which may be pseudo-parkinsonism related effects associated with quetiapine used for treatment of MDD in this patient. Therefore the addition of benztropine 0.5 mg per day may be an option for relief of these EPS symptoms". The lack of reference to the medical provider's statement raises question of whether the pharmacist read the medical provider's assessment, and considered the clinical consequences of an inaccurate assessment. The Monitoring Team compliments the medical provider for identifying this inaccurate assessment. The Monitoring Team also noted that the pharmacist had made several recommendations within the body of the QDRR report and, under the heading "recommendations", included a comment stating "note recommendations above". Because recommendations were made, and because there was a statement instructing the medical provider to read the recommendations that were delineated in the body of the QDRR report, this will not affect compliance; however, including a list of noted recommendations under the heading "recommendations" may reduce the potential to overlook a recommendation and, therefore, lead to enhanced compliance by the medical provider, and may enable an efficient means to assess if recommendations were, in fact, completed. • Individual #142: There was no indication that the medical provider reviewed the QDRR, dated 6/9/2014. • Individual #787: The psychiatrist signed the QDRR form, dated 4/30/2014, on 7/15/2014, and did not indicate if the recommendations were accepted or not, nor if not accepted, document a rationale for not accepting the recommendations. Furthermore, the psychiatrist did not sign the QDRR dated 7/30/2014. The only medication list provided was dated 7/7/2014, and it did not include changes recommended on the 4/30/2014 QDRR. • Individuals #377 and #268: The Facility did not provide a medication list for the Monitoring Team to complete it's assessment. • Individual #239: The Facility did not provide a QDRR for review. MOSES and DISCUS assessments are used by the pharmacist to aid in determining if side effects are present, or not present. As documented above, for Individual #239, the pharmacist reviewed, and	

#	Provision	Assessment of Status	Compliance
		based a clinical recommendation on, the result of a MOSES assessment, without taking into consideration the medical provider's comment stating "this assessment is of dubious validity given, for example, that the rater scored the item "gait imbalance/unsteady", when the fact is the patient has no lower extremities". Because the medical provider is required to formulate a diagnosis and medical action plan based on the results of the MOSES and DISCUS assessment, and because the medical provider may not concur with the nurse's assessment, it is paramount that the pharmacist also review the medical provider's comments,] and diagnosis when assessing for side effects by the MOSES and DISCUS assessment tool. Of the ten DISCUS and 12 MOSES assessments provided for this document request, six out of ten DISCUS assessments (60%), and seven out 12 MOSES assessment (58%) were completed by the medical provider. The Monitoring Team had commented on the importance of this issue on previous compliance reports, and had discussed the clinical relevance of the clinical pharmacists review of the medical provider's comments, when completing the QDRRs. For the examples of DISCUS and MOSES assessments that were not completed by the medical provider, the pharmacists should document on the QDRR that the assessment was not completed, and ensure that the MOSES and DISCUS used for the QDRR are updated and completed by the medical provider. Summary: The Monitoring Team is extremely complimentary to the pharmacy department and the clinical pharmacist for their significant improvements in completing QDRRs. Each QDRR reviewed was noted to be comprehensive, and clearly delineated issues related to medication usage. The Monitoring Team noted, however, that the MOSES and DISCUS assessments used by the pharmacist were not consistently completed by the prescribing medical provider. Furthermore, there was no indication that that the psychiatrist reviewed the QDRRs, when the QDRR included review of psychotropic medications. It is essential that the clinical pharmacist review the prescribing medical provider's comments and diagnosis on the MOSES and DISCUS assessment reports and document when important information is not available for pharmacy review. Because of the stated issues, the Monitoring Team determined noncompliance for Section N.2.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and	Section N.3 requires the Monitoring Team to 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: <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 medication and had a diagnosis of diabetes or hypertension, and reviewed the following documents to assess the Facility's monitoring of metabolic syndrome (Individuals #787, #278, 3723, #530, and #404). • Most recent QDRR • Most recent IRRF	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Current medication list • Most recent six months laboratory data • Most recent annual medical assessment • Most recent psychiatric assessment • Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome The following is a summary of the documents reviewed for metabolic syndrome, for the five examples provided (Individuals #787, #278, 3723, #530, and #404): • Five of five QDRRs (100%) indicated specific review for metabolic syndrome on the QDRR report. • Two out of five QDRRs (40%) assessed clinically appropriate risk factors to evaluate for metabolic syndrome. The assessments did not take into consideration diagnosed and treated risk factors, such as diabetes, and hypertension that was well controlled, or medications that were prescribed that would normalize abnormal lab values, such as lisinopril, fish oil, and simvastatin. • In zero out of five examples (0%), the IRRF documented the associated risk for metabolic syndrome. • In one out of five examples (20%), the QDRR commented on the associated risk of being on a neuroleptic medication, and associated known risk for metabolic syndrome. The following are some examples of the Monitoring Team's findings from the sample, specific to the management of metabolic syndrome: • Individual #723: The most recent QDRR, dated 5/15/2014, indicated that the individual was not at risk for metabolic syndrome; however, the individual was treated with insulin for diabetes, lisinopril for hypertension, and atorvastatin for dyslipidemia. The individual has three conditions resulting in positive risk factor for metabolic syndrome, albeit well controlled by medication. • Individual #530: The most recent QDRR, dated 7/30/2014, indicated that the individual was not at risk for metabolic syndrome; however, the individual was treated with insulin for diabetes, lisinopril for hypertension, and simvastatin and fish oil for dyslipidemia. The individual has three conditions resulting in positive risk factor for metabolic syndrome, albeit well controlled by medication. • Individual #782: The most recent QDRR was dated with a QDRR review date of 9/13/2014, and signed by the medical provider, but not by the pharmacist, on 9/5/2014 (thus, the signature was dated prior to the review date of the QDRR); these were after this compliance visit was completed. The QDRR indicated that the individual was not at risk for metabolic syndrome; however, the individual was diagnosed and treated for diabetes, dyslipidemia, and morbid obesity, with the following drugs: fish oil, insulin, lisinopril for hypertension, and niacin. The individual has three conditions resulting in positive risk factor for metabolic syndrome.	

#	Provision	Assessment of Status	Compliance
		Summary: The Facility did not clearly identify risk factors associated with metabolic syndrome, and did not clearly delineate risks of metabolic syndrome on the IRRF. <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. The following documents were reviewed for the six stat chemical restraints administered (Individuals #278, #561x2, #714, and #140x2): • Emergency Medication Monitoring database printouts, documenting the pharmacist's review of the stat chemical restraint usage. • QDRRs • Post chemical restraint IPN by the psychiatrist • Post chemical restraint documentation by the pharmacist In addition, the Monitoring Team reviewed: • P&TC minutes, dated 7/16/2014 • Graph of all chemical restraints used during the reporting period To assess the Facility's review of stat chemical restraint usage, the Monitoring Team reviewed the pharmacist's review, which was documented on the Facility's Stat Chemical Restraint Database and the post chemical restraint clinical review form, and the psychiatrist's review, which was documented on a post chemical restraint IPN. The documents provided for review, were not organized in a way that lead to an effective review by the Monitoring Team. Documents provided to the Monitoring Team were not collated by individual, nor were multiple IPNs by the psychiatrist and primary medical provider arranged in any specific order. The Monitoring Team was able to review six post chemical restraint clinical review forms but did not locate any IPNs labeled as specific to post chemical restraint. Psychiatrists' IPNs were included, but in no cases did they completely delineate a form, or specific document, for post chemical restraint assessment. Pharmacists consistently reviewed Stat Chemical Restraints for this sample: • In six out of six examples (100%), the pharmacist documented a review of scheduled psychotropic medications and whether the scheduled medication dose, formula, or schedule should be changed to help minimize the need for stat chemical restraint. • In six out of six examples (1000%), the pharmacist documented if side effects occurred following the stat chemical restraint. • In six out of six examples (100%), the pharmacist documented if the indication for the stat chemical restraint was appropriate.	

#	Provision	Assessment of Status	Compliance
		• In six out of six examples (100%), the pharmacist documented if drug and dose used for the stat chemical restraint were clinically appropriate. • In six out of six examples (100%), the pharmacist documented if currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint. Psychiatrists did not consistently document a comprehensive review of Stat Chemical Restraints for this sample. For each of these components that should be reviewed, the Monitoring Team identified documentation of review through review of all available documents, including multiple IPNs, not from a specific post chemical restraint assessment. • In six out of six 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 three out of six examples (50%), the psychiatrist documented if side effects occurred following the stat chemical restraint. • In three out of six examples (50%), the psychiatrist documented if drug and dose used for the stat chemical restraint were clinically appropriate. • In three out of six examples (50%), the psychiatrist documented if currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint. • In two out of six examples (33%), 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 two out of six examples (33%), the psychiatrist documented review and determination if the behavioral support plan was effective or not effective. <u>Systems Review of Stat Chemical Restraint Usage:</u> P&TC meeting minutes, dated 7/16/2014, stated "the clinical pharmacist reviewed eight emergency stat medication orders for the 12 month rolling period and found the medications to be administered appropriately"; the graphs for stat chemical restraints indicated that seven stat medications were administered since 3/1/2014. The Monitoring Team was unable to clearly determine if a total of eight, or a total of seven stat chemical restraints were administered during this reporting period, but data reported for Section C identify eight uses. Summary: The pharmacist conducted a post chemical restraint assessment, for six chemical restraints that were administered for this compliance review period.. The psychiatrist did not document a specific post chemical restraint assessment to address a clinical review of effectiveness of current scheduled psychotropic medications, effectiveness of current behavioral support plan, and adverse affects, appropriateness, and efficacy of the stat chemical restraint; it should be noted that there were some	

#	Provision	Assessment of Status	Compliance
		examples of the psychiatrist documenting some of the necessary components of a post chemical restraint assessment, on various psychiatry IPNs. The psychiatrist must document a specific post chemical restraint assessment that can be efficaciously reviewed by the IDT. Given that the documents provided for review were unorganized, the Monitoring Team was unable to ensure a comprehensive review of the usage of stat chemical restraints. <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 dated 7/15/2014 • List of all individuals on polypharmacy • For the first five individuals on the list of polypharmacy (Individuals #513, 714, #82, #140, and #76): o Most recent two QDRRs o Most recent psychiatric assessment o Current medication list o Most recent ISP, or related document for the use of polypharmacy The Facility assesses the appropriateness of polypharmacy usage of four, or more 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; review of the meeting minutes for P&TC meeting minutes, dated 7/15/2014, 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 meeting on 7/15/2014 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 psychotropic polypharmacy each month, and indicated a rational explanation for the decrease from 62 individuals on psychotropic polypharmacy in February 2014 to 50 individuals on psychotropic polypharmacy in June 2014. The following is a summary of the documents reviewed for polypharmacy for Individuals #513, 714, #82, #140, and #76: • In five out of five examples (100%) 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	

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		polypharmacy combination. • In three out of five cases (60%), the QDRR documented whether the dose for the specific polypharmacy agents was appropriate or not appropriate. • In three out of five cases (60%), the QDRR documented clinically justifiable recommendations for continued use, along with the clinical rationale for continued use or consideration for alternative treatments. • In three out of five cases (60%), the pharmacist documented the efficacy, or lack of efficacy, for the use of polypharmacy. The following are some specific comments and concerns, following review of the five examples: • Individual #140: The QDRR, dated 5/20/2014, did not document efficacy, alternative treatments, or appropriateness of medications used; the IRRF did not address common and serious interactions and side effects of the polypharmacy usage. • Individual #82: The IRRF did document risks associated with polypharmacy; however, the QDRR did not address appropriateness, efficacy, and alternative treatments, specific to the prescribed polypharmacy. Summary: The Facility conducted effective polypharmacy review panel meetings that regularly discuss individuals who are prescribed psychotropic polypharmacy. Individuals prescribed psychotropic polypharmacy are reviewed at least every six months at the polypharmacy review panel. The Pharmacist documents a review of polypharmacy on the QDRR, and risks associated with polypharmacy usage on the IRRF; however, common and serious side effects, effectiveness of polypharmacy, alternative therapy to polypharmacy, and appropriateness of polypharmacy were documented by the pharmacist in less then 80% of the QDRRs reviewed. <u>Benzodiazepine Usage:</u> The Monitoring Team reviewed the following documents to assess the Facility's review of benzodiazepine use: • Alpha list of all individuals on benzodiazepines • For the first five individuals on a list of benzodiazepines used for psychiatric indication (Individuals #330, #368, #513, #475, and #787): 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 #330, #368, %513, #475, and #787:	

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		• In five out of five cases (100%), the QDRR documented the use and indication for the use of the benzodiazepine.
		• In three out of five cases (60%), the QDRR documented risks associated with the use of the benzodiazepine. The Monitoring Team could not identify on the IRRF or QDRR documentation of common and more serious adverse reaction to benzodiazepines for individuals #330 and #368.
		• In five out of five cases (100%), 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.
		
		The Facility did not provide P&TC meeting minutes documenting a systems review of benzodiazepines usage. The Facility did provide a document stating that the Facility will review benzodiazepine usage as part of the DUE process, twice per year, starting September 2014.
		
		Summary:
		The Facility provides a pharmacist's review of benzodiazepine usage, per the QDRR process. The Monitoring Team strongly recommends that all serious and common potential side effects be well delineated within the context of the IRRF. The Facility reported it will begin a biannual systems review of benzodiazepine usage, beginning in September 2014.
		
		<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 #76, #160, #513, #529, and #546):
		  o Most recent two QDRRs
		  o Current medical list
		  o Most recent medical, and psychiatric annual reviews
		  o Most recent MOSES and DISCUS assessments
		• P&TC Meeting Minutes for October 2013 and January 2014	

#	Provision	Assessment of Status	Compliance
		Review of clinical documents 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 five out of five cases (100%), the QDRR documented whether the dose of the anticholinergics drugs 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. • In five out of five cases (100%), the pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics. The Facility did not provide graphical data or data analysis of the Facility's review of anticholinergic usage at the level of a systems review. The Facility did provide a document stating that the Facility will review anticholinergic usage as part of the DUE process, twice per year, starting September 2014. Summary: The Facility ensures that the pharmacy conducts a comprehensive clinical review of anticholinergic usage when completing QDRRs. The review of anticholinergics is comprehensive, and clinically rationale. The Facility did not conduct a systems analysis of anticholinergic usage; however, the pharmacy director provided documentation stating that the Facility will begin conducting semiannual systems review of anticholinergic usage, beginning with the September 2014 DUE process. <u>Conclusion:</u> The Facility has made substantial improvements with its assessment of benzodiazepine, anticholinergic, and polypharmacy review by the pharmacists, and the pharmacists' review of metabolic syndrome and stat chemical restraint usage. The Monitoring Team did, however, note areas that needed continued improvement; these included, but were not limited to, ensuring that metabolic risk factors are carefully assessed by the clinical pharmacists, including those risk factors, such as blood glucose levels, that are normalized because of current treatment; ensuring that common and serious risks associated with anticholinergic, polypharmacy, and benzodiazepine usage are well documented by the clinical pharmacist; and developing a mechanism for the psychiatrist to document a formal post chemical restraint assessment. Because of the noted deficiencies, the Monitoring Team determined that the Facility was not in substantial compliance with Section N.3.	
N4	Commencing within six months of the Effective	To assess the pharmacist's clinical recommendations, and clinical appropriateness of the medical providers' responses to the recommendations, the Monitoring Team assessed the QDRRs from	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	Section N.2 for Individuals #142, #424, #787, #377, #426, #12, #239, #751, #465, #402, and #268 and requested the following information for the first two single patient drug intervention reports (SPDI) for Individuals #153x3, #72, #500, #227, #618, #177, #783, and #686: • SPDI report • Copy of associated medication order • Documentation of pharmacist's review of the order • Clinical evidence for the medical provider following up on the recommendation, or alternative rationale Review of the QDRRs indicated the following: • There were eight QDRRs that required review by a psychiatrist (Individuals #142, #424, #787, #377, #426, #12, #239, #751, #465, #402, and #268). Of the eight QDRRs that required review by the psychiatrist there was documentation for zero (0%) that the psychiatrist reviewed the QDRR form. The psychiatrist did not sign or indicate acceptance of the pharmacist's recommendations on the completed QDRR. • The QDRR indicated review by the medical provider in 10 out of the 11 examples (91%). The medical provider did not sign the QDRR for Individual #239. Review of the SPDIs indicated the following: • In 11 out of 11 examples (100%), the pharmacist documented a SPDI report. • Ten out of 11 SPDI examples (91%) indicated that the medical provider either accepted the pharmacist's recommendations or provided clinical rationale for not following the pharmacist's recommendations. For Individual #618, there was no evidence that the medical provider followed specific recommendations by the pharmacist, or otherwise communicated with the pharmacist regarding the SPDI report. • There was supporting documentation that appropriate clinical action was taken for ten out of 11 SPDIs (91%). For Individual #618, there was no evidence that the medical provider followed specific recommendations by the pharmacist, or otherwise communicated with the pharmacist regarding the SPDI report. • The medical provider completed an SPDI report form to communicate a response to the pharmacist in four out of 11 examples (36%). For the seven examples that did not include a completed SPDI report form, there was documented evidence, by the pharmacists on the SPDI report form, that the medical provider communicated a specific response to the pharmacist in five out of seven examples (71%). Thus, there was documented evidence of communication from the medical provider to the pharmacist in nine of 11 examples (82%). o There was no documented evidence that the medical provider communicated directly with the pharmacist to address the SPDI for Individuals #618 and #175. <u>Conclusion:</u> The Facility ensured that pharmacists completed a SPDI report for individuals identified as having	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>drug-drug interactions or other clinical concerns regarding the prescribing of drugs. The medical providers addressed the pharmacist's recommendations in a substantial majority of cases. The medical provider indicated review and acceptance of the pharmacist's recommendations that was documented on the QDRRs; however, there were no examples of the psychiatrist documenting review and acceptance of the pharmacist's recommendations. The Monitoring Team will continue substantial compliance; however, the Facility must ensure that the psychiatrists document their review of the QDRRs, and acceptance of the pharmacist's recommendations, or provide clinical rationale for not following the pharmacist's recommendations.</td><td></td></tr>
<tr><td>N5</td><td>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.</td><td>To assess if the Facility performed clinically appropriate monitoring for dyskinesia caused by dopaminergic drugs, the Monitoring Team reviewed MOSES and DISCUS assessments provided for Section N.2 of this report for Individuals #239, #142, #424, #787, #377, #426, #12, #239, #751, #465, #402, and #268. In addition, the Monitoring Team requested a list of all individuals who had either a dose decrease or initiation of a dopaminergic drug, and for the first ten individuals on that list, all MOSES and DISCUS assessment completed during this reporting period; the Facility provided a total of 11 examples (Individuals #561x2, #302, #80, #524, #151, #714, #239, #723, #760, and #758).

Review for More Frequent Monitoring of Dyskinesia: For the 11 examples provided, the Monitoring Team identified the following:
<table>
<tr><th>Individual</th><th>Date Med Change</th><th>Date MOSES</th><th>Date DISCUS</th><th>More Frequent Monitoring</th></tr>
<tr><td>#561</td><td>4/29/2014</td><td>None</td><td>6/30/2014</td><td>No</td></tr>
<tr><td>#561</td><td>4/15/2014</td><td>4/16/2014 (baseline)</td><td>6/30/2014</td><td>No</td></tr>
<tr><td>#302</td><td>4/15/2014</td><td>4/16/2014 (baseline); 5/13/2014 (not completed by medical provider); 8/19/2014</td><td>4/16/2014 (baseline); 5/13/2014 (not completed by medical provider)</td><td>No</td></tr>
<tr><td>#80</td><td>4/23/2014</td><td>7/14/2014</td><td>7/14/2014</td><td>No</td></tr>
<tr><td>#524</td><td>4/23/2014</td><td>6/12/2014 (annual)</td><td>4/14/2014; 6/12/2014</td><td>No</td></tr>
<tr><td>#151</td><td>4/29/2014</td><td>4/23/2014</td><td>4/23/2014; 7/11/2014</td><td>No</td></tr>
<tr><td>#714</td><td>4/29/2014</td><td>3/4/2014</td><td>3/4/2014</td><td>No</td></tr>
<tr><td>#239</td><td>5/9/2014</td><td>5/15/2014</td><td>5/15/2014</td><td>Yes</td></tr>
</table>
</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>
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<tr><td>#723</td><td>6/12/2014</td><td>6/23/2014 (not completed by medical provider)</td><td>6/5/2014 (not signed by medical provider)</td><td>No</td></tr>
<tr><td>#760</td><td>6/18/2014</td><td>7/8/2014</td><td>7/8/2014</td><td>Yes</td></tr>
<tr><td>#758</td><td>7/10/2014</td><td>7/30/2014</td><td>7/11/2014; 7/30/2014</td><td>Yes</td></tr>
</table>

Completion of MOSES and DISCUS Assessments:
• From Section N.2, of this report, the Monitoring Team reviewed the provided DISCUS assessment for Individuals #142x2, #239, #424, #787, #426x2, #239, #465, and #402, for a total of ten DISCUS assessments.
o The medical provider completed the physician component of the DISCUS assessment in six out of ten examples (60%).

• From Section N.2, of this report, the Monitoring Team reviewed the provided MOSES assessments for Individuals #239, #142, #424, #787, #377, #426, #239, #751, #465, #402, and #268x2, for a total of 12 MOSES assessments.
o The medical provider completed the physician component of the MOSES assessment in seven out of 12 examples (58%)

Conclusion:
The Facility did not obtain more frequent clinical assessments to assess for dyskinesia, when clinically indicated. Furthermore, the medical provider did not routinely complete the medical provider's component of the MOSES and DISCUS assessments. For these reasons, the Monitoring Team determined that the Facility was not in substantial compliance with Section N.5.
</td><td></td></tr>
<tr><td>N6</td><td>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.</td><td>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 8/24/2014, was reviewed.

<u>ADR Policy</u>
The Facility's Pharmacy Policy and Procedure Manual, Adverse Drug Reactions revised on 8/24/2014 was reviewed. The policy was updated to include the Facility's practice of retraining nursing staff, primary care providers, and staff pharmacists, on the ADR process.

<u>Staff Training:</u></td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		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 copies of minutes of the P&TC meetings held 5/28/2014 and 7/16/2014, each of which included an analysis of the ADRs reported. The P&TC meeting minutes commented that the Facility was reporting fewer ADRs, then in the past, and that direct care, nursing, and medical staff needed to enhance monitoring for ADRs; the Monitoring Team compliments the Facility for identifying this issue and taking action to enhance reporting of ADRs. 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, for a total of ten examples. The following is a summary of the findings of this review of reported ADRs (Individuals #645, #537, #679, #202, #618, #302, #512, #160, #559, and #726): • The ADR reporting form was fully completed in ten out of ten examples (100%). The Monitoring Team recognized that only 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 of ten examples (100%). • The medical provider component of the ADR reporting form was completed in ten out of ten examples (100%). • The medical provider signed the ADR report form in ten out of ten examples (100%). • The pharmacist provided comments regarding the ADR in ten out of ten examples (100%). • Nine out of ten ADR reports (90%) indicated that the pharmacist identified the ADR, and only one ADR (individual #302), was reported by a non-pharmacist. The Monitoring Team is concerned that other professionals, who are responsible for closely monitoring for adverse drug effects, are not regularly reporting on ADRs. Review of the ADRs provided indicate that the medical provider or nurse should have identified the ADR prior to the pharmacist's identification of the issue while conducting a QDRR at a much later date. For example, Individual #645 was identified by the pharmacist review of having had urticaria The urticaria should have been identified and reported as an ADR by either a nurse, direct care staff, or medical provider. Summary: The Facility does have a mechanism in place to identify, report, and assess ADRs; however, the Monitoring Team is very concerned that the numbers of reported ADRs had significantly decreased since the previous compliance report, and because in most cases (90%) the pharmacist was the reporting professional. The P&TC meeting minutes indicated concern over the small number of ADRs reported, which reflected a meaningful review of the ADR process, and the Monitoring Team is	

#	Provision	Assessment of Status	Compliance
		complementary for the P&TCs vigilance in attempting to ensure ADRs are reported. Given the number of medications prescribed at this Facility, the Facility should be identifying more then 20 ADRs within a reporting period. The Monitoring Team will continue compliance at this time; however, continued compliance will require that the ADR process be enhanced to ensure that direct care, nursing, and medical provider staff are carefully assessing individuals for signs, and symptoms of adverse drug reactions, and promptly reporting them as ADRs.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	To assess the Facility's development and provision of drug utilization evaluations (DUEs) the Monitoring Team requested the following information: • Complete DUE schedule for 2013-2014, to include all DUEs provided and pending • Copies of all DUEs provided during the reporting period <u>DUE Schedule:</u> The Monitoring Team reviewed the 2014 DUE schedule and noted that the Facility completed two of the seven planed DUEs, and is on schedule to complete the remaining DUEs, per the Facility's schedule. The Facility conducted, and completed two unplanned DUEs during this reporting period. • Completed scheduled DUEs included a clinical review of Clozapine, and Clobazam. • Completed unplanned DUEs included an in-service on the use of cranberry juice, and interaction with medications, and a clinical review of warfarin. The DUE schedule also indicated that no DUEs were developed secondary to an FDA alerts. The Monitoring Team noted that the FDA did not issue warnings during this reporting period, that would directly relate to the prescribing of drugs at this Facility. Furthermore, during the Monitoring Team's on-sigh review, the director of pharmacy informed the Monitoring Team that it continues to monitor for FDA advisories, and when an advisory that is relevant to the Facility, the pharmacy department would conduct a DUE. The Facility provided copies of the following DUEs, that were completed during the reporting period: • Clobazam • Phenobarbital • Anticholinergic review • Benzodiazepine review The Monitoring Team noted that the DUEs that were developed and completed for Clozapine, warfarin, and Clobazam, included an excellent review of drug utilization, and meaningful clinical information was well delineated in each DUE report. The Monitoring Team was impressed with the Facility's development of a DUE for drug interaction with cranberry juice.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Summary: The Facility maintained an effective DUE process that enabled scheduled DUEs to be developed per request of the medical staff, developed unplanned DUEs that were based on institutional need, and has a process to monitor for FDA advisories, and is prepared to develop and implement DUEs for FDA product warnings. For these reasons, the Monitoring Team determined that the Facility will remain in substantial compliance with Section N.7.	
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 March 2014 through July 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 #546, #140, #268, #48, #463x2, #192, #535, #66, and #787): 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 one scanned document was blurred and could not be read). Review of the medication variance report forms indicated the following for Individuals # 546, #140, #268, #48, #463x2, #192, #535, #66, and #787: • 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, which 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 March 2014 through August 2014, which showed 100% of the meetings were conducted as scheduled. The Committee was chaired by the pharmacy director. Prior to the committee meetings the responsible disciplines reviewed and analyzed their medication variance data for the number and type of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		medication variances, as well as for systemic variances, developed strategies, and corrective actions 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 P&TC meeting for further review, discussion, and disposition. <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 incidence of variances. The Monitoring Team was provided with medication variance data for 2/1/2014 through 7/31/2014, and the Monitoring Team noted that the data had been aggregated, analyzed, trended, along with remedial actions taken to mitigate medication variances and storage issues. Review of the data for quarter three, 2014: Type of Variance | QTR 3, 2014 Transcribing | 2 Other | 5 Dispensing | 32 Prescribing | 8 Administrating | 15 Documentation | 2 Total Variances | 64	

#	Provision	Assessment of Status	Compliance
		The Facility reported the severity index for the report range 2/1/2014 through 7/31/2014, indicating a total of 95 variances (A severity category of C indicates that the medication was either inadvertently given, or a prescribed medication was not given to the individual). Category / Number A: 68 B: 4 C: 24 D: 0 E: 1 Summary: The Facility had continued to provide its medication variance process, and ensured a robust reporting process, conducted efficacious Medication Variance Committee meetings, and addressed 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-8/12/14 2. RSSLC Action Plan-Sections O and P- 8/11/14 3. Presentation Books for Sections O and P 4. RSSLC Policy K.01 Physical and Nutritional Management (rev: 5/15/14) 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: 6/6/2014) 8. RSSLC Policy K.08 Developing Pathways to Oral Intake (rev: 7/7/14) 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. RSSLC Policy D.25 Reporting Fall Incidents (rev: 6/6/14) 13. Record or partial record review: a. Sample O.1: Individuals #84, #192, #340, #429, #442, #523, #649 and #666 • Sample O.2: Individuals #106, #325, #463, and #621 • Sample O.3: Individuals #73, #159, #169, #173, #352, #500, and #553 • Sample O.4: Individuals #57, #109, #125, #138, #142, #169, #173, #180, #259, #268, #302, #384, #386, #413, #458, #477, #484, #501, #512, #515, #525, #526, #551, #589, #597, #661, #666, #701, #753, #789, and #791 14. 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 (QA) reports, including subsequent corrective action plans. 15. 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 (including 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 16. List of current PNMT members, including PNMT Coordinator/Lead, designated and non-designated members 17. PNMT members and PNMT back up curriculum vitas 18. PNMT members' state licenses 19. PNMT minutes since the last review; minutes should include signatures of attendees 20. Caseloads of PNMT dedicated and non-dedicated members 21. 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 22. Continuing Education completed by PNMT members and back ups for the past 12 months 23. QA reports/matrix since the last compliance review 24. List of referrals to the PNMT since the last compliance visit 25. List of individuals on PNM caseload since the last compliance visit 26. PNMT RN post hospitalization assessments completed since the last compliance visit. 27. PNMT assessment template

	28. PNMT Action Plan template 29. PNMP format 30. PNM NEO orientation covering the following elements: (include, agenda, handouts, curriculum and performance check offs) (only if changed from previous visit) • Lifting and Transfers; • Positioning (Alternate, wheelchair, and bathing/showering); • Adaptive Equipment; • PNMP orientation and implementation; • Safe Mealtime strategies; and • Basics of Dysphagia. 31. List of new employees since last compliance visit and evidence that they have received all PNM related trainings 32. 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) 33. Facility documentation showing categories of staff requiring annual refresher training, numbers of staff requiring training, and numbers of staff who have successfully completed training; 34. PNM Monitoring Tool template; 35. Summary of last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 36. Minutes of the clinical morning report of 8/26/14 **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. DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meetings Attended/Observations:** 1. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 8/12/14 and Action Plan dated 8/11/14. 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. The activities presented in the Self-Assessment did consistently correlate with the Settlement Agreement Monitoring Tool. 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 consistently provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. However, analysis was noted when the PNMT reviewed inter-rater reliability of PNM monitoring; therefore, this could be used as a template moving forward. The Facility rated itself as being in compliance with Provision O.1, O.3, O.4, O.5, and O.6. This was consistent with the Monitoring Team's findings of compliance with Provision O.1, O.3, and O.5 but inconsistent with the Monitoring Team's finding of noncompliance with O.4 and O.6. 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 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 in substantial 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 Facility PNMT revised the needed polices and now had a sustainable system that was fully implemented for resolution of systemic issues/concerns. All areas related to PNM were now effectively tracked and analyzed. Per interview with the PNMT, this information was brought to the clinical meetings in the morning and shared with the PCPs as well as the QIDPs. Information was also shared as part of the QA/QI Council. 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. Provision O.3: This provision was determined to be in substantial compliance. PNMPs contained all the required components in the areas of dining, medication administration, bathing, personal care, and lifting/transfers. PNMPs across the various locations (i.e., MARs and "Me" books) were consistently and appropriately updated. 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, while this had resulted in improvement, it was still not at the level needed to represent consistent 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. Provision O.6: This provision was determined to be not in compliance. 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. A proportionate number of monitors were focused on all areas in which PNM difficulties were likely to be provoked. Also noted upon review of the monitoring data was the inclusion of all three shifts in the monitoring process. A total of 3,561 monitoring forms were completed from January 2014 to June 2014. The concern noted was that although substantial retraining of staff had occurred, the acquired data showed compliance and implementation of plans as being significantly higher than what was noted by the Monitoring Team. These disparities in scores again bring into question the reliability and/or effectiveness of RSSLC to identify and intervene when plans are not implemented. 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 clear treatment plans as it relates to oral motor therapy. Information regarding medical necessity and potential for oral intake was not consistently present in the IRRF and IHCP.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the	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 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 four 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 31 individuals observed in homes and day programs throughout the 24-hour day.	Substantial Compliance

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	individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	This provision was determined to be in Substantial 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 Facility PNMT revised the needed polices and now had a sustainable system that was fully implemented for resolution of systemic issues/concerns. All areas related to PNM were now effectively tracked and analyzed. Per interview with the PNMT, this information was brought to the clinical meetings in the morning and shared with the PCPs as well as the QIDPs. The regular agenda for this morning meeting included a topic for PNMT Report, usually provided by the PNMT Nurse. Review of minutes of the clinical morning report of 8/26/14, for example, confirmed that PNMT reports were made; these could include actions to be taken and notice of need for the IDT to meet. Information was also shared as part of the QA/QI Council. <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	

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		anesthesia; ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking 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; ▪ 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	

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		but did not address the review of the monitoring process based upon the findings of the inter-rater checks. 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. <u>Core PNMT Membership</u>: RSSLC had a Physical and Nutritional Management Team (PNMT). The PNMT focused on clinical issues and assessment and served as a resource to the IDT. Evidence of 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: • 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 <u>Consultation with Medical Providers and IDT Members</u> For four of four individuals in Sample O.2 (100%), 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 four of four individuals in Sample O.2 (100%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities. The PNMT held joint meetings in which recommendations from the PNMT were shared with the IDT. <u>Qualifications of PNMT Members</u> 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.	

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		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 ▪ The SLP and the OT attended: Dysphagia: From Assessment to Discharge ▪ RD attended: Early enteral Nutrition ▪ RN attended: Head to Toe Assessment PNMT Meetings From 4/1/14 to 7/16/14, of the 16 weeks, the PNMT met 16 of 16 weeks (100%). This resulted in evidence that the team met at least weekly. All core members of the PNMT were present for at least 88% of the meetings. Attendance was as follows: • Qualified Intellectual Professional (QIDP): 96% • Occupational Therapist (OTR): 96% • Speech Language Pathologists (SLP): 88% • Physical Therapist (PT): 88% • Registered Dietitian (RD): 92% • Consulting MD: 88% • Registered Nurse (RN): 92% Sixteen of 16 PNMT meeting minutes reviewed (100%) include documentation of appropriate topics: a) referrals; b) review of individual health status; c) PNMT actions; and d) follow-up. PNMT minutes reviewed showed integrated clinical collaboration between all disciplines contained within the team. The collaboration of the team was substantiated through observation of the PNMT meeting on 8/27/14. The Facility PNMT did have a sustainable system that was fully implemented for resolution of systemic issues/concerns. A 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	

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		such issues (e.g., Medical Morning meeting, QA/QI meeting). Since the last compliance visit, RSSLC revised policy D.25 "Reporting Fall Incidents" addressed the fall quality assurance process. Since 4/25/14 fall incidents became part of the agenda on the facility daily Incident Management Meeting (IMM). Each reported fall incident was presented and discussed for the home IDT to follow up. The Fall Evaluation Form was faxed to the Habilitation personnel for data entry and follow up. This data was then tracked and trended for analysis and corrective action and shared at the QA/QI Council meeting. Additional improvements noted with regards to the overall PNM system included the PNMT utilizing various databases (osteoporosis, pneumonia, body weight, and skin integrity) and collaborating with other disciplines to obtain a better overview of PNM-related systemic issues. Policy K.1 Physical and Nutritional Management was revised to include an episode tracking system to allow for trending and analysis. The database focused on fractures, choking, and emesis. The data tracking, trending and analysis were presented and discussed at various venues including the IDT meetings, clinical morning report meetings, medical quality assurance meetings, and QA/QI Council meetings, for the development of action plans.	
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	<u>Identification of PNM risk</u> Two hundred and ninety seven out of 335 Individuals were identified as having PNM related issues. The remaining 38 individuals were not identified as having PNM issues. 297 of 297 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"). Six of eight individuals in Sample O.1 (75%) 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). An example of an inaccurate risk score was Individual #442 who was identified as being	Noncompliance

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	management problems to identify the causes of such problems.	at a low risk of choking and medium risk of falls. Individual #442's mobility presented with impaired balance, abnormal gait, decreased awareness of surroundings and 16 falls in the past twelve months, but risk for this individual was only listed as medium risk. Individual #442's mealtimes were characterized by rapid eating pace, overstuffing, and a choking event on 6/12/14, yet the Individual was only listed as being at low risk. Based on the information provided, the Monitoring Team felt that the risk scores did not accurately reflect the risk score. Other individuals not included as part of the sample but noted to have inaccurate risk scores as it related to falls included: • Individual #72 had 24 falls over the past six months but was not rated as being at a high risk for falls. • Individual #174 had nine falls over the past six months but was only rated as being at a low risk for falls. • Individual #561 had 11 falls over the past six months but was only rated as being at a low risk for falls. • Individual #718 had 12 falls over the past six months but was not rated as being at a high risk for falls. <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. 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%) in Sample O.1 were seen within five days of their change in status or by the PNMT Nurse within five days of their return from the hospital (but note that in an additional sample not related to PNMT issues, as reported in Provision M1, the Facility did not provide documentation that the PNMT nurse assessed individuals following hospitalization, resulting in documentation being provided for a total of eight of 11, or 73%). Another method in which the PNMT was made aware of changes in status was through participation by the PNMT RN in the clinical morning report 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.	

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		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> Four of four 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 provided assessment upon return from the hospital in an effort to identify any concerns noted with PNM. Results of the assessment were discussed at the PNMT 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 Four of four 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 four individuals' records who were referred to the PNMT (Sample O.2), the comprehensiveness of the PNMT assessment components were as follows: • Four of four (100%) contained date of referral by the IDT. This information was contained within the PNMT assessment. • Four of four (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 history. This information was contained as part of the PNMT RN Assessment as well as the PNMT assessment. • Four of four (100%) identified the individual's current risk rating(s), including	

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		the current rationale. This information was contained within the IRRF, and Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Four of four (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. • Four of four (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.). • Four of four (100%) contained assessment of musculoskeletal status as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Four of four (100%) contained evaluation of motor skills as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Four of four (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Four of four (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. These were provided through the completion of Head of Bed (HOB) assessments as part of the PNMT referrals/reviews or through evidence of evaluation of general posture as part of the Habilitation Assessment, and PNMT RN Assessment. • Four of four (100%) contained evaluation of current adaptive equipment. This information was contained within the PNMT Assessment, Habilitation Assessment as well as the PNMT minutes. • Four of four (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. • Four of four (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. • Zero of four (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.	

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		• Four of four (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation as indicated. • Four of four (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting • Four of four (100%) contained evidence of review/analysis of lab work. • Four of four (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. • Four of four (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. • Four of four (100%) contained oral hygiene status. This information was contained within the Habilitation Assessment, and PNMT evaluation. • Four of four (100%) contained evidence of observation of the individuals' supports at their home and day/work programs. • Four of four (100%) contained evidence that the PNMT conducted hands-on assessment and/or review. • Four of four (100%) 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. • Four of four (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Four of four (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. • Zero of four (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. • Four of four (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (e.g. revision of the individual's PNMP). • Four of four (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.	

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		• Four of four (100%) contained signatures with dates. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u> For zero of four 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 #621 had a recommendation to check residuals every four hours to rule out high residuals, but this was not included as part of the IHCP. In order to move towards substantial compliance, RSSLC must ensure that IHCPs are updated in a timely manner to include recommendations by the PNMT. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In four of four individuals' plans reviewed (100%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. • In two of two individuals (100%) for whom Head of Bed Elevation (HOBE) assessments were conducted or reviewed, the HOBE recommendations were integrated into individuals' plans. • In two of four 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 the "PNMT/IDT Discharge Plan". This form contained recommendations, needed action plans, person responsible and due dates. This form was not utilized for Individuals #106 and #324 and therefore the facility would be unable to determine if recommendations were completed in a timely manner. • In four of four 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 four 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 four of four individuals' plans reviewed (100%), the plans defined triggers. • In four of four individuals' plans reviewed (100%), the frequency of monitoring	

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		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. This information should be contained within the PNMT assessment as well as integrated as part of the IHCP. <u>PNMT Follow-up and Problem Resolution</u> With regard to plan implementation for individuals in Sample 0.2: • In two of four individuals' documentation reviewed (50%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days of the plan's finalization, or sooner as needed. The PNMT-IDT discharge plan that identified the steps to be taken by the IDT post PNMT discharge was not consistently used but, when utilized, there was evidence of IDT completion of recommendations in a timely manner. • In two of four individuals' plans reviewed (50%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provided an explanation for any delays and a plan for completing the action steps. Examples of issues with follow up, documentation, and resolution included: • Individual #324 did not have evidence that the PNMT recommendation for a team to meet to discuss methods to improve oral hygiene was completed. • Individual #106 did not have evidence that the PNMT recommendation to ensure that medications following morning bath as an aspiration precaution. • Individual #463 did not have evidence that nursing was in-serviced regarding proper G-tube syringe technique. • Individual #621 did not have evidence that any of the PNMT recommendations were implemented. It should be noted that all of the above areas were marked on the PNMT/ISPA discharge form as being completed but as stated above, there was no evidence provided to back up these statements and no process in place in which the PNMT reviews the actual completion of the action plan. In order for the Facility to move toward substantial compliance, the Monitoring Team recommends the IDT meet in a timely manner upon completion of the task to review the	

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		overall plan of care and make any revisions based upon the findings of the consult. The PNMT should then follow up, beyond just the statement by the IDT that the action step was completed, to review a sample of the actual evidence substantiating the claim. <u>Individuals Discharged from the PNMT</u> For individuals discharged by the PNMT in Sample O.2: ▪ Four of four individuals (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ Four of four individuals' (100%) discharge summaries/action plans provided objective clinical data to justify the discharge. ▪ Zero of four individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. ▪ Zero of four 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 pneumonia 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 IHCP, and criteria for referral back to the PNMT integrated as part of the IHCP. 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	This provision was determined to be in substantial compliance. PNMPs contained all the required components in the areas of dining, medication administration, bathing, personal care, and lifting/transfers. PNMPs across the various locations (i.e., MARs and "Me" books) were consistently and appropriately updated. <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 Habilitation Department was present at 100% of the meetings.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	Ten of twelve PNMPs from Samples O.1 and O.2 (83%) 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. <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 nine of nine 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' 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. • Four individuals had feeding tubes with no oral intake. Four of four (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth.	

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		• 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 eight of eight PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In eight of eight PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In eight of eight 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 five of five individuals (100%) 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. 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 months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u> Staff did not consistently engage in safe mealtime or positioning practices, as indicated by the following: Per observations conducted by the Monitoring Team, 17 of 31 individuals' (55%) dining plans/PNMPs in Sample O.4 were implemented as written. Although implementation was still not at the level needed to ensure consistent safe practice, this did represent an improvement of approximately 30% since the last review. Examples of dining plans not implemented included but were not limited to: • Individual #458 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 less than 5 minutes • Individual #109 and #753 were not provided with cues to alternate liquids and solids after every few bites.	Noncompliance

#	Provision	Assessment of Status	Compliance

Based on observations by the Monitoring Team, examples of positioning plans not being implemented included:

- Individual #484 was observed slid down in bed, therefore not receiving the needed head of bead elevation as determined in the PNMP to prevent reflux.
- Individual #173's was leaning severely to the right and slumped forward while being providing enteral nutrition resulting in increased abdominal compression and increased risk of reflux.

It should be noted that based upon review of Sample O.2's PNMT assessments, there was a pervasive issue as it related to turning individuals on their sides when experiencing emesis. This information was contained on the PNMP but was not consistently noted or implemented. Based upon the review of PNMT minutes and evaluations for individuals in Sample O.2, zero out of four individuals (0%) had documentation that verified individuals were placed on their side when emesis was noted. This was noted despite a correlation being drawn between emesis and aspiration pneumonia.

Staff did a very nice job in talking the individuals through the process and ensuring the transfer was done in a safe manner. Transfers were improved and observations noted:

- Two of two individuals' transfer plans (100%) were implemented as written.

During one of one observations of medication administration (Sample O.4) (100%), the nurse followed procedures in the PNMP. The nurse reviewed the PNMP prior to the administration of the medication and ensured that all adaptive equipment was utilized as indicated.

One of one (100%) individual's (Sample O.4) oral hygiene plans were implemented as written.

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

	# Asked	# Correct	% Correct
Positioning:			
How do you know the individual is in the correct position in their wheelchair/bed?	6	4	67%

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Mealtimes:			
For what reason does the individual have thickened liquids?	8	8	100%
For what reason does the individual eat a modified texture?	8	7	88%
What is the reason for the individual using a specific utensil?	8	6	75%
If the individual receives enteral nutrition, how do you determine if he/she is in the correct position?	5	5	100%

Knowledge exhibited by staff continued to show improvement, which also resulted in improved (although not yet satisfactory) implementation compared to previous visits. In order to move towards substantial compliance, RSSLC must ensure staff consistently follow the plans as indicated.

#	Provision	Assessment of Status	Compliance
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	This provision was remained in Substantial Compliance. All staff, new and existing, received both foundational as well as individual specific training. Greater than 98% 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. <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 The large majority of staff successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs. As of July 15, 2014, 616 of 619 (100%) of staff had completed the Core Competency training. Per RSSLC training records, for the 6 month time period between 1/1/14 and 6/30/14, 79 of 82 (96%) new staff recently participated in the trainings and completed the core competency NEO trainings.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		PNM Core Competencies for Current Staff As of the last compliance visit, 619 staff still required their PNM related training to be verified through competency based check offs. As of this review, 619 of 619 staff requiring verification (100%) had successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs to ensure all staff had completed the foundational skills training now required for new employees. Seventy three of 73 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	

#	Provision	Assessment of Status	Compliance
		• Arjo Bathing • Use of Draw Sheet and Changing • Mechanical Lift • Two-Person Manual Lift • Gait Belt Use • Augmentative/Alternative Communication (AAC) <u>Annual Refresher Training</u> As of 6/30/14, staff that requires training had completed annual refresher competency-based training and performance check-offs within the last 12 months. ▪ Lifting People: 897 staff (99%) had completed their annual lifting class. ▪ Preventing Aspiration: 929 staff (100%) 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 O.2 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 have a clear process in place. For two of two individual's (Sample O.1) staff (100%) assigned to individuals #106 and #649, there was evidence of exchange of the information included in the PNMP prior to the provision of services. For Individuals #106 and #649, 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. 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:	

#	Provision	Assessment of Status	Compliance
		• Individuals #84 and #523'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) had been revised and included the frequency of the monitors for individuals at risk as well as the areas in which the monitors are expected to be completed (i.e., bath, meal, oral care). The monitoring policy included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk • Identification of monitors and their roles and responsibilities • Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician • Inter-rater reliability schedule Monitoring tools included adequate indicators to determine whether or not "staff 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.	Noncompliance

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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

Thirty seven of 37 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 January 2014 to June 2014 provided information as follows:

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014
6-2 shift	504 (77%)	493 (67%)	471 (72%)	344 (73%)	331 (66%)	334 (62%)
2-10 shift	131 (20%)	192 (26%)	159 (23%)	107	146 (29%)	186 (34%)
10-6 shift	19 (3%)	56 (7%)	18 (3%)	23 (4%)	26 (5%)	21 (4%)
Compliance Monitors	654	741	648	474	503	541
Assist Equip	51 (8%)	42 (6%)	45 (7%)	33 (7%)	35 (7%)	31 (7%)
Positioning	134 (20%)	161 (22%)	91 (15%)	97 (20%)	81 (16%)	100 (18%)
Meal	174 (27%)	196 (26%)	209 (34%)	102 (22%)	177 (35%)	158 (29%)
Snack	15 (2%)	28 (4%)	25 (4%)	18 (4%)	20 (4%)	22 (4%)
Med Adm	93 (14%)	92	96	83	45 (9%)	49 (9%)

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		(12%)	(16%)	(18%)		
Oral Care	58 (9%)	76 (10%)	44 (7%)	29 (6%)	27 (5%)	37 (6%)
Bathing	63 (10%)	41 (6%)	39 (6%)	23 (5%)	32 (6%)	32 (6%)
Lifting/Transfer	38 (6%)	49 (7%)	36 (6%)	19 (4%)	18 (4%)	21 (4%)
Communication	28 (4%)	56 (8%)	63 (10%)	70 (15%)	68 (14%)	91 (17%)
% Compliance	96%	96%	94%	96%	88%	88%
Passed	626	710	607	456	442	477
Failed	28	31	38	18	61	64
6-2 shift	19	14	21	14	39	32
2-10 shift	8	16	17	3	21	32
10-6 shift	1	3	0	1	1	0

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 3,561 monitoring forms were completed from January 2014 to June 2014. Also noted upon review of the monitoring data was the inclusion of all three shifts in the monitoring process.

Since the last visit in March 2014, the HT director and PNMP Coordinator Supervisor analyzed the monitoring performance of each monitor. From the HT Director and Supervisor interviewing each monitor and comparing how they would each score the tool; areas were identified that contributed to the overall inaccuracy of the monitoring system. Areas noted were that monitors were giving credit after correcting the staff and a variance in expectations. Counseling was provided by the Director and Supervisor to each monitor in an effort to improve validity of scores.

<u>Monitoring for Individuals in Samples</u>
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 four of four 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 every two weeks
- Moderate risk: Monitored once monthly

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		Additionally, the PNMT provided a level of monitoring for identified indicators (e.g., vomiting) for a period of one to 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, 1129 of the expected 1129 monitoring sessions (100%) per policy or the individuals' assessments and/or plans were completed timely. Individuals were 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 six months, issues regarding implementation were noted on 240 of the 1129 monitoring forms. A sample of five was drawn from the 240 forms. Of these, documentation of adequate follow-up was provided on the form for five of five (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 implementation percentage provided by RSSLC was approximately 88% while the Monitoring Teams finding suggested a much lower rate of 55%. 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.	
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 four 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. This area had not shown improvement even though the Director Of HT had a workshop in March 2014 with the QIDPs that focused on the inclusion of the effectiveness of the	Noncompliance

#	Provision	Assessment of Status	Compliance
		PNMP in the monthly review 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, many times through collaboration with the PNMT if there was a need to implement and/or revise a trigger sheet. Zero of ten trigger sheets (0%) were completed correctly. Two of 10 trigger sheets (20%) were reviewed at a minimum daily by the appropriate shift RN. Issues with the Aspiration Trigger Sheet included: • The trigger sheets 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 sheets was inconsistent. • The trigger sheets contained multiple triggers per data point. For example Individual #324 had gagging, formula in the mouth and hiccups all listed in one row. This resulted in difficulty determining what trigger occurred when marked. All of the issues listed above regarding the trigger sheets were noted to be pervasive.	
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.	As of 7/15/14, there were 58 individuals (17%) at RSSLC who received enteral nutrition. <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. Eight of eight 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. Eight of eight 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.	Noncompliance

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		No individuals admitted since the last review received enteral nourishment; therefore, no individuals were reviewed to determine the medical necessity of the feeding tube within 30 days. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> Three of seven individuals (43%) 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 OT/PT assessment and as part of any external consults such as a Modified Barium Swallow Study (MBSS). Examples of issues noted with the assessment process included: • Individual #553 was recommended to have a MBSS on 7/1/14 but there was no evidence that this had occurred. • Individuals #500, #352, #73, and #159 did not have assessment information integrated as part of the IRRF. RSSLC did not consistently provide treatments or strategies to help move the individual along the pathway to oral intake. Examples included: • Individual #553 was recommended to have a MBSS on 7/1/14 but there was no evidence that this had occurred. • Individual #169 was identified as being a candidate for return to oral intake on 6/4/14 but as of the review, had not been provided with the appropriate treatment. Two of three 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 (67%) had a comprehensive plan outlining the treatment or return to PO process. Two of three individuals' plans to return to oral eating or improve oral eating were based on the results of the IDT's discussion (67%), but zero of three (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. Two of three individual's plans to return to oral eating (67%) 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 zero of three (0%) individuals' current status in the IPNs. Missing was an overall treatment plan that included all of the following components:	

#	Provision	Assessment of Status	Compliance
		• 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 increasingly 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 to Individual's plans resulting from Oral Motor Therapy were recommended or needed; therefore, there was no need for the IDT to meet and review interventions.	

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-Sections O and P-8/12/14 2. RSSLC Action Plan-Sections O and P- 8/11/14 3. Presentation Books for Sections O and P 4. RSSLC Policy K.01 Physical and Nutritional Management (rev: 5/15/14) 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: 6/6/2014) 8. RSSLC Policy K.08 Developing Pathways to Oral Intake (rev: 7/7/14) 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. RSSLC Policy D.25 Reporting Fall Incidents (rev: 6/6/14) 13. Record or Partial Record Reviews: a. Sample P.1: Individuals #84, #192, #340, #429, #442, #523, #649 and #666. This 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. b. Sample P.2: Individuals #17, #120, #470, #593, #700, and #765. This consisted of six 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. 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: a. Who use wheelchair as primary mobility; b. With transport wheelchairs; c. With other ambulation assistive devices, including the name of the device; d. With orthotics and/or braces; e. Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution; f. Who have experienced a falling incident during the past three (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury 16. OT/PT assessments template 17. Wheelchair seating, PNM clinic assessment templates and related documentation, and 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

	People Interviewed: 1. Ping Law OTR Habilitation Therapies Director 2. David Taylor OTR, PNMT OT 3. Jean Cuevo PNMT PT and PNMT Lead **Meetings Attended/Observations:** 1. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon) 2. QA/QI Council 8/26/14
	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 activities presented in the Self-Assessment were based on separate auditing tools (OT/PT Assessment Audit & Outcome Audit). These monitoring/audit tools 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 P.3 and not in compliance with Provisions P.2, and P.4. 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. In addition, ongoing processes for maintenance of compliance were identified for Provisions P.1 and P.3. 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. Provision P.1: The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. Results in the data provided by RSSLC from audits of assessments continued to show the presence of all the needed assessment components. Therefore, the finding of substantial compliance continues.

	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 95% 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 not to be in compliance. Based on review of the RSSLC PNMP Training and Monitoring Policy- K.07, the policy addressed all shifts and all areas in which OT/PT supports were likely to be needed and areas that were likely to provoke PNM related issues. Adaptive equipment and wheelchairs were largely in good repair and a system was in place to ensure they remained so. The concern noted was that although substantial retraining had occurred, the percentage regarding the implementation of the PNMPs remained significantly higher as identified by RSSLC's monitoring forms than what was noted by the Monitoring Team during observations. These disparities in scores again bring into question the reliability and/or effectiveness of monitoring in identifying and intervening when plans are not implemented.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. Based upon interview with the HT director, the assessments continued to be comprehensive and the need for skill acquisition remained a focal point. As part of RSSLC's self-assessment, the Habilitation Therapies Department continued to audit assessments to ensure they were completed in a timely and comprehensive manner. Results in the data provided by RSSLC continued to show the presence of all the needed assessment components.	Substantial Compliance
P2	Within 30 days of the integrated	**OT/PT Interventions**	Noncompliance

#	Provision	Assessment of Status	Compliance
	occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	For individuals receiving OT/PT supports and services, 14 of 14 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 14 of 14 individuals in Samples P.1 and P.2 (100%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. Primary integration was in the form of discussion and review of the PNMP. **Direct OT/PT Interventions** The records of individuals in Sample P.2 were reviewed resulting in the following findings: • One of six individuals' direct intervention plans (17%) 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 five individuals' plans were implemented timely as the Facility did not provide OT/PT treatment plans that indicated the referral date and treatment start date.. • For six of six individuals' records (100%) reviewed, the current OT/PT assessment/note identified the need for direct intervention with rationale. • For one of six individuals' records (17%) 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 five individuals were provided with measurable objectives as no OT/PT treatment plans 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. **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. Fourteen of 14 ISP annual meetings (100%) had a member from either OT or PT present to represent the disciplines. Eleven of 14 ISPs or ISPAs from Samples P.1 and P.2 (79%) integrated the OT/PT	

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		interventions. The ISP or ISPA did not consistently describe the supports based on the rationale provided in the therapy assessment. Integration was primarily in the form of PNMP review and acceptance. Examples of non-integration included: • Individuals #593, #765 and #470 did not have information related to OT/PT services and/or status mentioned as part of the ISP. In eight of the fourteen ISPs or ISPAs reviewed (57%), skill acquisition programs that had been recommended in the OT/PT assessment were present. One of six individuals receiving direct OT/PT Services (Sample P.2) (17%) was 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. For individuals with PNMPs, for 0 of 14 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. It should be noted that the HT director in May 2014 met with the QIDPs to discuss the	

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		need to review the effectiveness of the PNMP as part of their monthly review but positive outcomes from this training had not been seen in the reviewed sample.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	The requirements for this section were discussed in detail with regard to Provision O.5. Indirect plans are inclusive of the PNMPs since OT/PT is covered substantially in the PNMP. As with Provision O.5, this provision remained in Substantial Compliance. All staff, new and existing received both foundational as well as individual specific training. Greater than 98% 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 any changes in the plan.	Substantial Compliance
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.	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. A proportionate number of monitors were noted to be focused on all areas in which PNM difficulties were likely to be provoked. A total of 3,561 monitoring forms were completed from January 2014 to June 2014. Also noted upon review of the monitoring data was the inclusion of all three shifts in the monitoring process. The concern noted was that although substantial retraining had occurred, the accuracy of the monitoring was lacking. The implementation percentage provided by RSSLC was approximately 88% while the Monitoring Teams finding suggested a much lower rate of 55%. These disparities in scores again bring into question the reliability and/or effectiveness of RSSLC to identify and intervene when plans are not implemented. **<u>Monitoring System</u>** 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. A proportionate number of monitors were focused on all areas in which PNM or OT/PT difficulties were likely to be provoked. A total of 3,561 monitoring forms were completed from January 2014 to June 2014. Also noted upon review of the monitoring data was the inclusion of all three shifts in the monitoring process. PNMP Training and Monitoring Policy K.07 (revised 6/6/14) 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. This set frequency was in addition to any needed monitoring that occurred as a result of an IDT or PNMT meeting. The Facility did have comprehensive OT/PT policies that substantially included the	Noncompliance

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		needed components. The policies included the following elements: • Define the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; • Identify monitors and their roles and responsibilities; • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Includes re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requires that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identifies the frequency of assessments; • Defines how individuals' OT/PT needs will be identified and reviewed; and • Sets forth documentation expectations for individuals receiving direct services • Define a formal schedule for monitoring to occur. For 14 of 14 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 order/consult was sent to the home therapist. For 14 of 14 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 156 of 157 (99%) individuals for whom adaptive equipment was noted to be in disrepair or needing replacement between the dates of 4/1/2014 to 7/1/2014, equipment was repaired or replaced within 30 days unless justification was provided, or unless the issue impacted 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.	

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SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment, 8/12/2014 2. RSSLC Action Plan, 8/11/2014 3. RSSLC Presentation Book, August 2014 4. RSSLC Policy (no number): Dental Procedure, Radiation Policy, dated 12/20/2013 5. RSSLC Policy (no number): Dental Procedure, Staff Responsibilities Policy, dated 1/21/2014 6. RSSLC Policy (no number): Dental Procedure, Oral Hygiene Care Plan, dated 8/1/2013 7. RSSLC Policy (no number): Dental Procedure, Oral Care, dated 8/1/2013 8. RSSLC Dental Procedure: Suction Toothbrush Policy, and procedure, revised 3/14/2014 9. RSSLC Dental Policy and Procedures: Suction Toothbrush Policy and Procedure, revised 3/14/2014 10. RSSLC Dental Procedure: Process for Enrollment in Suction Tooth brushing Program, dated 1/1/2014 11. RSSLC Dental Procedure: Quality Assurance Policy, dated 7/30/2014 12. RSSLC Dental Procedure, Sedation for Dental Treatment, Pre-operative Evaluation, dated 8/1/2013 13. List of all staff of all dental office staff, and: a. Name of staff, and title b. Indicate if full time or part time c. Average number of direct care hours provided each week d. Caseload (number of Individuals under the direct care of each dentist) e. Documentation of all DD dentistry continuing education during the past 12 months 14. Alpha list of all individuals who the Facility has identified as not being current with dental radiography 15. Alpha list of all individuals who have <u>not</u> had preventive dental x-rays (or alternative to bitewings) within the past 24 months 16. For Individuals #678, #508, #155, #596, and #377: 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 a dental IPN or x-ray report 17. Oral health care plans for the first and than every fifth individual listed on the current name key, for a total of ten examples (Individuals #678, #377, #465, #634, #273, #694, #604, #9, #23, and #31) 18. Evidence that oral health care treatments were routinely assessed at the living area, such as oral hygiene spot checks 19. List of individuals with treatment oral healthcare plans (OHCP) 20. For Individuals #77, #477, #31, #350, and #672: a. List of all pending restorative treatments b. Date when the underlying condition requiring the restorative treatment was first identified

	c. Date when the restorative treatment was completed, or date of pending treatment d. Documentation why restorative treatment has not been completed e. Copy of the most ISP or related document, indicating the IDTs awareness of the need for restorative treatment 21. Copy of last six months and next six months appointment schedule for annual dental examinations 22. 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: a. Name b. Date of previous year's annual dental examination c. Scheduled date for most recent dental examination 23. For Individuals #678, #377, #465, #634, #273, #694, #604, #9, #23, and #31: 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 24. List of individuals who were not current with scheduled dental hygiene 25. Number TIVA hours per month available at the Facility 26. Number of individuals who have been provided TIVA services each month, for this reporting period 27. Alpha list of all individuals who require TIVA for dental services 28. Alpha list of all individuals who were provided TIVA for dental services during the past 12 months 29. For Individuals #678, #508, #155, #426, #16, #470, #751, #791, #379, #770: 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) 30. 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). a. Date that TIVA was provided b. Date pneumonia was diagnosed/treated/or person hospitalized 31. 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 32. Alpha list of all individuals who are provided suction tooth brushing 33. Alpha list of all individuals identified as needing suction tooth brushing, but not currently receiving suction tooth brushing 34. For Individuals #465, #16, #470, #551, #719, #791, #463, #388, #251, #666: a. Copy of the most recent assessment results used to evaluate efficacy of suction tooth brushing 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 tooth brushing

	d. Documentation assessing the efficacy of the use of suction toothbrush 35. List of all dental QA indicators used to assess efficacy of dental treatment, and potential adverse outcome secondary to dental services 36. 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 37. Dental QA monitoring tool 38. Dental services QA data analysis report, 2/1/2014 through 7/31/2014 39. Oral hygiene ratings assessed during this reporting period 40. Spreadsheets of missed dental appointments that occurred during this reporting period 41. Alpha list of all individuals who received oral sedation for dental appointments 42. Minimizing pretreatment chemical restraint committee meeting minutes dated 4/7/2014, 6/6/2014, 6/30/2014, and 7/14/2014 43. Copy of dental schedule for past, and future six months period **People Interviewed:** 1. Carol Heath, Dental Director **Meetings Attended/Observations:** 1. Observations of Individuals #542, #19, #162, #749, and #680
	Facility Self-Assessment: Following its review of the self-assessment for Section Q, the Monitoring Team noted that the Facility: • Did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. The Self-Assessment did not give information other than that the audits met timeframes, sample size requirements, and if in compliance or not in compliance. There was not information on the findings if any actions plans were established to address findings. • The monitoring tools did not include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment did identify the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, and overall percentage of compliance. • The Monitoring Team could not determine that the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. • It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. The Facility's self-assessment stated that the Facility was in compliance with Sections Q.1, and not in substantial compliance with Section Q.2. Monitoring Team concurs with the self-assessment of noncompliance for Section Q.2; however, disagreed with the Facility self-assessment of substantial compliance for Section Q.1, and determined that the Facility was not in substantial 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, complete and ongoing, or not started**.** • The Facility identified one area of needed improvement. 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. Although identifying Section Q.1 as in substantial compliance and not identifying an area needing improvement, several action steps were still reported as in process. Some of these address issues identified by the Monitoring Team as being useful for improving care. For example, an action step to capture necessary data for restorative appointments could include the date at which a need for restorative care was identified, thus providing a way for the Facility to track timeliness of care. • The actions provided a set of detailed steps likely to lead to compliance with the requirements of this Section. Actions steps were sequential and clearly stated. A good example was the set of actions for minimizing pre-treatment sedation.
	Summary of Monitor's Assessment: The Facility continued to make significant progress towards substantial compliance for Section Q.1. It was obvious to the Monitoring Team that the dental office developed and implemented many new strategies to enhance documentation practice, which in turn demonstrated the Facility's provision of high quality dental service. The documents provided indicated that annual dental examinations, dental hygiene, provision of restorative treatments, application of suction tooth brushing, and the provision of oral health care at the living area, clearly met substantial compliance; however, there was no evidence provided to support the living area, or dental office's effort to triage, manage, and follow-up on dental emergencies. There was improvement in provision of dental imaging, but the Facility did not provide clinical rationale for not adhering to the ADA's recommendations for dental imaging studies. The Facility should also ensure that the IDT is informed of when dental services are not provided as necessary, such as failure to obtain dental imaging studies and other dental support services, so that the IDT can help develop mechanisms to overcome barriers that prevent dental services. The IRRF assessment should document relevant risks associated with dental services, including risks associated with the usage of suction tooth brushing. The Facility has continued to move closer to compliance with Section Q.2. The Facility developed a robust database mechanism to help ensure effective tracking and trending of past and future dental appointments, developed an effective process to track missed dental appointments, and developed a committee process to evaluate the Facility's usage of pre-treatment sedation. Compliance, however, will require that the Facility develop and implement processes to trend missed dental appointments and develop strategies to help reduce missed dental appointments; develop a policy that clearly delineates its process to help reduce the need for pre-treatment sedation; ensure that all individuals who require pre-treatment oral sedation have been identified; develop individualized plans to help reduce the need for pre-treatment oral sedation; track and trend outcome data, to determine efficacy of the program; develop a process to analyze dental QA data, and develop action plans for data elements that were determined not to be in compliance; and develop a process to analyze adverse outcome events following dental sedation, and when necessary, develop action

	plans to help reduce adverse outcomes. For these reasons, the Monitoring Team determined that the Facility is not in substantial compliance with Section Q.2.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	To assess the Facility's ability to provided necessary oral health care assessments and treatments, the Monitoring Team assessed dental administration; the provision of routine, restorative, and emergency oral health care; dental hygiene; oral hygiene provided by the living area, 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 dental director, who provides 20 hours of direct care. • The Facility's full time dentist resigned from the Facility, and the Facility is currently recruiting a new dentist. • The Facility has two full time dental hygienists who each provide 30 hours of direct care and ten hours of administrative activities. • The Facility documented that it has two-full-time dental assistants, who provide a total of 50 hours of direct care and 30 hours of administrative activities. • There was evidence that the Facility's professional dental staff were involved in continuing dental education. 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 addition, the dental director participated in an additional 12 hours of continuing education on general dentistry-related conditions and techniques. Summary: At the time of this compliance review, the Facility had a vacancy of one full-time dentist; however, the Facility was in the process of assertively recruiting a new dentist. The	Noncompliance

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		Facility maintained two full time dental hygienists and two dental assistants. Dental Imaging To assess if the Facility provides dental imaging at the level of generally acceptable standard of care, the Monitoring Team requested the following documentation: • Alpha list of all individuals who the Facility has identified as not being current with dental radiography • Alpha list of all individuals who have not had 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, and #377: 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 The Monitoring Team was provided a document stating "for those who have not completed x-rays, there are no IDT minutes or specific plans for x-rays". Per previous compliance reports, the Monitoring Team expected documented evidence indicating that the IDT was made aware of individuals who were delinquent with dental radiography, for noncompliance or other reasons, and to delineate a plan to address the delinquent issue. The Facility provided a list of six individuals who were delinquent with dental radiography (Individuals #551, #719, #179, #343, #395, and #737) but did not provide supporting evidence that that the IDT was made aware of the delinquency, and there was no plan to either ensure compliance, or delineation of a clinical rationale for not obtaining the dental imaging studies. 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 taken 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	

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		Lubbock (sic) State Supported Living Center will be in the category: Recall patient with periodontal disease." • The policy was not updated since the last compliance report. As per the last compliance report, 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; it was not clear to the Monitoring Team whether there had been a review to ensure whether this policy/procedure accurately reflected operational procedures and standards at RSSLC. Also, the Monitoring Team disagrees that the 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. The Monitoring Team was provided a document indicating that 328 out of 334 (98%) individuals were current with dental radiographic studies, based on the Facility's determination of clinical need for dental radiographs. Review of documentation of x-rays, and x-ray plan for first five individuals on the list of all Individuals who have had dental x-rays (Individuals #678, #508, #155, #596, and #377) showed: • Five out of five examples (100%) documented the results from the dental x-ray. • Five out of five examples (100%) indicated the specific type of dental x-ray obtained. • Two out of five examples (40%) indicated the type and date of the last set of x-rays for preventive dental care. The Monitoring Team has the following concern: • Individual #678: Dental radiographs were obtained on 1/14/2014, and the integrated progress note for the same day indicated that the individual was high risk for caries; however, despite being high risk for caries, and recently diagnosed with caries, the Facility's X-ray Plan indicated that follow-up x-rays would not be obtained for 24 months. The ADA recommendation for an individual with risk for caries is six to 12 months. • Individual #155: Dental radiographs were obtained on 4/24/2014, and an integrated progress note for the same day indicated that the Individual had poor oral hygiene, poor periodontal tissue, heavy plaque, heavy bleeding, and dental caries on two teeth; however, despite being high risk for caries, the Facility's X-ray Plan indicated that follow-up x-rays would not be obtained for 24 months.	

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		The ADA recommendation for an Individual with risk for caries is six to 12 months. • Individual #596: Dental radiographs were obtained on 10/23/2013, and a progress note dated the same date indicated that the Individual had required multiple tooth extractions; however, despite being high risk for caries, and recently diagnosed with caries, the Facility's X-ray Plan indicated that follow-up x-rays would not be obtained between 18 and 24 months. The ADA recommendation for an Individual with high risk for caries is six to 12 months. Summary: The Facility has made significant improvements with documenting the dental imaging status of individuals, both on the dental database and on integrated progress notes. The Facility did not obtain dental imaging studies, per recommendations by the ADA, or provide clinical rationale for not obtaining dental imaging studies, for Individuals at risk for dental carries and periodontal disease. The Facility's procedure for dental x-rays was not updated since the last compliance visit; as it continues to refer to an alternate developmental center, the Monitoring Team could not determine whether it accurately reflects policy and procedure at RSSLC. <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 # 448: 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 provided a list that contained only one dental emergency; however, the date of that indicated it occurred prior to the March 2014 compliance visit and more than six months prior to the current compliance visit. The Facility reported no dental	

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		emergencies during the current review period. Therefore the Monitoring Team did not assess the Facility's management of dental emergencies. <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: • RSSLC Policy: Dental Procedure, Staff Responsibilities Policy, dated 1/21/2014. • RSSLC Policy: Dental Procedure, Oral Hygiene Care Plan, dated 8/1/2013. • RSSLC Policy: Dental Procedure, Oral Care, dated 8/1/2013. • RSSLC Policy: Dental Procedure, Suction Toothbrush Policy, and procedure, revised 3/14/2014. • Oral health care plans for the first and than every fifth individual listed on the current name key, for a total of ten examples (Individuals #678, #377, #465, #634, #273, #694, #604, #9, #23, and #31). • Evidence that oral health care treatments were routinely assessed at the living area, such as oral hygiene spot checks. • List of individuals with treatment oral healthcare plans (OHCP) Review of dental office procedures, and policies: • The Dental Procedure, Staff Responsibilities Policy, dated 1/21/2014, delineated dental office, and living area, responsibilities for the provision of oral hygiene and oral healthcare. • The Dental Procedure, Oral Hygiene Care Plan (OHCP), dated 8/1/2013, stated that the dental clinic would develop, and review the oral healthcare plan annually. The procedure also delineated the specifics of what information the OHCP would include, such as the current oral healthcare statues, use of dental appliances, and barriers to oral hygiene. • The Dental Procedure, Oral Care, dated 8/1/2013, delineated the dental office's responsibility in providing living area staff with instruction on oral hygiene care, and annual training of residential coordinators on the OHCPs. The procedure also stated that the dental office will monitor the effectiveness of oral hygiene for each individual at each dental office visit, and provide instruction for necessary corrective action, such as retraining of the individual, direct support professional, or residential coordinator, as appropriate. Review of the oral healthcare plan, and documentation of oral healthcare assessments for Individuals #678, #377, #465, #634, #273, #694, #604, #9, #23, and #31, indicated: • The OHCP for Individual #465 indicated that because of significant medical issues, completed assessment and optimal oral health care is not possible at this time; however, the OHCP and annual dental summary specified a specific plan to	

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		help provide limited oral health care for this Individual. The Monitoring Team compliments the dental office for its assertiveness in helping this Individual achieve some benefit from oral hygiene efforts, given the individual's limitations to comprehensive oral hygiene. • The most recent dental examination indicated that oral healthcare was at the level of fair or better in seven out of 10 (70%) examples. For three Individuals #273, #694, and #23 with reported poor oral hygiene, there was evidence documented in the dental progress note and the integrated progress note that oral hygiene was unacceptably poor, and indication that re-training of staff on the OHCP would occur. For example, the annual dental summary, and an integrated progress note, for all three examples, clearly delineated the dental office's effort to inform the living area staff of the need to enhance oral hygiene, and documented retraining of living area staff on the OHCP. The Monitoring Team compliments the dental office for its diligence with following up on poor oral health care issues. • The Facility provided documentation that the provision of oral hygiene was assessed during this reporting period in ten out of ten (100%) examples. The Facility provided a list of all individuals who reside at the Facility that indicated the date when a OHCP was assessed by a dental professional, and if the individual or staff implementing the OHCP was determined to be successful or not successful. In only two incidences were staff not successful in implementing the OHCP (Individuals #458 and #680), and in both occasions, staff training was provided. The Monitoring Team observed the following individuals at the living area and noted that there was no gross debris, no glistening plaque, and no overt dental discomfort for Individuals #542, #19, #162, #749, and #680. Summary. The Monitoring Team compliments the Facility for enhancing its documentation practice that demonstrates the provision of high quality oral hygiene efforts by the living area staff and dental office professionals. The Facility's new process for documenting integrated progress notes, and comprehensive documentation of oral healthcare plans, is exceptional. <u>Restorative dental care:</u> To assess effectiveness of the Facility's provision of restorative dental care, the Monitoring Team requested the following documents for Individuals #77, #477, #31, #350, and #672: • List of all pending restorative treatments	

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		• 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 The Facility provided datasheet, that was dated 8/28/2014, indicating a total of five individuals (Individuals #77, #477, #31, #350, and #672) were pending restorative treatment, and that all restorative treatments would be completed by 9/18/2014. Of the five individuals, four were initially diagnosed with a need for restorative treatment on or after 7/17/2014, and one individual (#672) was initially diagnosed on 6/17/2014. In five out of five examples (100%), restorative dental treatment has been scheduled within a reasonable period. The Monitoring Team reviewed the dental progress notes, annual dental summary, and most recent integrated dental progress notes for Individuals #77, #477, #31, #350, and #672, and noted documentation of a comprehensive dental examination, identification of necessary restorative care, and effective communication to living area staff of the individuals' oral heath care issues. The Facility provided a datasheet of all individuals who were identified by the Facility as requiring restorative treatment, and had their restorative treatment completed by the time of this compliance review. The datasheet did not provide the specific date when the dental condition requiring restoration was initially diagnosed; therefore the Monitoring Team was unable to determine the time frame between identifying the need for restorative treatment and having the restoration completed. Summary. The Monitoring Team determined that the Facility provides restorative treatments, as clinically indicated to Individuals at the Facility. Although not required for substantial compliance, the Facility may consider ensuring that the initial date when the need for restorative treatment is included on the dental database that tracks restorative treatments. <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	

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		dental examinations • As of the day prior to the Monitoring Team's 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 o Scheduled date for most recent dental examination • The Monitoring Team used the same sample selection and documents obtained for its assessment of oral hygiene (Individuals #678, #377, #465, #634, #273, #694, #604, #9, #23, and #31) 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 (98%) 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. For Individuals #678, #377, #465, #634, #273, #694, #604, #9, #23, and #31: • Ten out of ten (100%) examples included a current oral hygiene care plan that delineated the individual's oral health support needs. • Ten out of ten (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 nine out of nine (100%) examples. The health status of Individual #465 did not permit dental x-rays from being obtained. • A complete annual dental examination was provided within 12 months from the previous complete dental examination in nine out of the nine examples (100%). The health status of Individual #465 did not permit the completion of a complete oral health care examination. • There was a dental IPN associated with the annual dental examination in ten out of the ten examples (100%). The Monitoring Team compliments the Facility for its enhanced documentation practice of integrated dental progress notes. • A cancer screening was completed in nine out of nine examples (100%). The	

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		health status of Individual #465 did not permit the completion of a complete oral cancer screening. • Periodontal assessment was documented in nine out of the nine examples (100%). The health status of Individual #465 did not permit the dental professional from completing a comprehensive assessment of periodontal issues. • Three out of ten annual dental examination reports (30%) indicated poor oral hygiene, at the time of the examination, and as reported above, under the heading oral hygiene, the dental office documented, provided extensive notification to the living area, and provided additional in-service opportunities on the provision of oral hygiene to living area staff. Review of the dental schedule indicated that at the time of the Monitoring Team's on-site review, all Individuals were current with their annual dental assessment. Summary: The Monitoring Team noted significant improvement with the provision of annual dental assessments, as well as enhanced communication of oral health care issues to living area staff. The Monitoring Team is complimentary of the dental office's effort to assertively assist individuals with oral health care needs. <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 ten individuals who were provided TIVA anesthesia (Individuals #678, #508, #155, #426, #16, #470, #751, #791, #379, #770): o Copy of TIVA records associated with the most recent use of TIVA anesthesia o Copy of all nursing notes associated with post anesthesia monitoring of the individual, following TIVA, once back at the living area (or infirmary) • List of all individuals who were provided TIVA anesthesia during the past six months, and who were diagnosed/treated/and or hospitalized for pneumonia	

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		(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. <u>Allocation of TIVA services</u> The Facility provided documented evidence that it maintained a list of all individuals who require TIVA for dental services, on a database called Candidates for TIVA. The list indicated a total of 132 individuals require TIVA for all oral health care services. The Facility provided a documented entitled Individuals Utilizing Intravenous Sedation and Oral Sedation, for the time period 2/1/2014 through 8/29/2014. This document indicated that a total of 88 TIVA opportunities were provided to individuals during the six-month reporting period. The Facility provided a table and graph indicating the amount of TIVA hours required by the Facility. The Facility indicated that seven individuals required TIVA every six months, 78 individuals required TIVA every 12 months, nine individuals required TIVA every 12-18 months, 12 individuals required TIVA every 18-24 months, two individuals required TIVA every 2 years, and 27 individuals required TIVA on an as needed basis. The Facility indicated, on the table outlining the amount of TIVA required at the Facility, that a total of 284 TIVA hours is required to provide the necessary TIVA to individuals who require TIVA, and that the Facility has 336 hours of TIVA services scheduled. The Facility provided documentation that "no one has had TIVA deferred due to lack of available TIVA dates". The Facility identified nine individuals who require TIVA or intubation anesthesia for dental services, but because of underlying general medical conditions, they are not candidates for either TIVA or intubation anesthesia. Because the Facility reported that a total of 132 individuals require TIVA for dental services. Based on a minimum TIVA allotment of two TIVA opportunities per year per individual, and because the Facility schedules a total of 336 hours of TIVA per year, the Monitoring Team determined that the Facility provides adequate quantity of TIVA opportunities to meet the needs of Individuals who require TIVA for dental services.	

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		Review of clinical documentation related to treatments that included administration of TIVA (Individuals #678, #508, #155, #426, #16, #470, #751, #791, #379, #770): • In ten out of ten cases (100%), the anesthesiology records were completed, and documented all necessary monitoring parameters, during the dental procedure. • In ten out of ten 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 ten out of ten (100%) examples. • In ten out of ten cases (100%), the nurse performed, and documented, pre-sedation assessment • In ten out of ten cases (100%), the dental office provided post-sedation orders, or other specific documentation that delineated monitoring parameters. Summary The Monitoring Team compliments the Facility for provided adequate quantity of TIVA services, and for comprehensive pre-anesthesia, intra-anesthesia, and post-anesthesia monitoring of individuals who undergo TIVA, for their dental services. <u>Suction Tooth brushing</u> To assess the Facility's process for providing suction tooth brushing, the Facility requested the following documentation: • Alpha list of all individuals who are provided suction tooth brushing • Alpha list of all individuals identified as needing suction tooth brushing, but not currently receiving suction tooth brushing. • RSSLC Policy: Dental Procedure, Suction Toothbrush Policy and Procedure, revised 3/14/2014. • RSSLC Dental Procedure, Process for Enrollment in Suction Tooth brushing Program, dated 1/1/2014 • For the first ten individuals on the list of those who are provided suction tooth brushing (Individuals #465, #16, #470, #551, #719, #791, #463, #388, #251, and #666): o Copy of the most recent assessment results used to evaluate efficacy of suction tooth brushing for the individual o Copy of most recent oral health rating scale o Copy of the most recent ISP, and/or IDT minutes specific to the use of suction tooth brushing o Documentation assessing the efficacy of the use of suction toothbrush	

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		The dental director informed the Monitoring Team that all individuals who have been identified as requiring suction tooth brushing have been provided suction tooth brushing. The Facility provided the Monitoring Team with a spreadsheet document indicating 86 individuals as having suction tooth brushing protocol in place. Also, the spreadsheet clearly documents the indication for the use of suction tooth brushing, diet texture, and if the individual is cooperative or not cooperative with the application of the suction tooth brush. Review of dental policies and procedures: • Review of the RSSLC Dental Procedure, Process for Enrollment in Suction Tooth brushing Program, dated 1/1/2014, indicated that the Facility has an effective mechanism to provide on-going evaluation for individuals who may require suction tooth brushing in the future. • Review of RSSLC Policy: Dental Procedure, Suction Toothbrush Policy and Procedure, revised 3/14/2014, indicated that the Facility maintains a standardized protocol that delineates the application of suction tooth brushing, and delineates the dental office's responsibility for staff training of the use of suction tooth brushing. The Monitoring Team assessed the Facility's periodic assessment of oral health hygiene at the living area under the heading "oral health care at the living area," above, and determined that the Facility effectively assesses the provision of oral hygiene at the living area. The Monitoring Team review of the examples of individuals who were provided suction tooth brushing (individuals #465, #16, #470, #551, #719, #791, #463, #388, #251, #666) indicated: • The individual support plans (ISPs) for ten out of ten examples (100%) indicated the use of suction tooth brushing. • The ISP documented the rationale and associated risks of suction tooth brushing in in zero out of ten examples (0%). • The annual dental examination documented oral health care as fair or better in 8 out of ten examples (80%). • Ten out of ten examples (100%) included documented evidence that the dental office had assessed the provision of suction tooth brushing by direct care staff. • There was an oral health care plan documenting the use of a suction toothbrush in ten out of ten (100%) examples. • The Monitoring Team did not assess the incidence of pneumonia for these examples, but will assess this issue at subsequent reviews. Although suction tooth brushing is provided to help reduce the incidence of pneumonia, the	

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		application of suction tooth brushing may be implicated in pneumonia, and the Facility must have an assessment mechanism to track this issue. Summary: The Facility maintained a process to provide suction tooth brushing, and implemented a policies and procedures that helped to ensure that individuals were provided suction tooth brushing, as needed in the future. The Facility incorporated suction tooth brushing as part of oral health care plans, and as part of the IRRF assessments. The Facility ensured that dental office professionals assessed the provision of suction tooth brushing. To help ensure continuity of care, the ISP should include specific risks and benefits associated with suction tooth brushing. Conclusion: The Facility continued to make significant progress towards substantial compliance for Section Q.1. It was obvious to the Monitoring Team that the dental office developed and implemented many new strategies to enhance documentation practice, that in turn demonstrated the Facility's provision of high quality dental service. The documents provided indicated that annual dental examinations, dental hygiene, provision of restorative treatments, application of suction tooth brushing, and the provision of oral health care at the living area, clearly met substantial compliance; however, the Facility did not provide clinical rationale for not adhering to the ADA's recommendations for dental imaging studies. As the Facility reported no dental emergencies, the Monitoring Team did not assess the living area's or dental office's effort to triage, manage, and follow-up on dental emergencies. The Facility should also ensure that the IDT is informed of when dental services are not provided as necessary, such as failure to obtain dental imaging studies and other dental support services, so that the IDT can help develop mechanisms to overcome barriers that prevent dental services. The IRRF assessment should document relevant risks associated with dental services, including risks associated with the usage of suction tooth brushing.	
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	To assess compliance issues for Section Q.2, the Monitoring Team reviewed the Facility's processes related to dental Quality Assurance (QA), issues related to scheduling of dental services, and programs to reduce the need for dental pre-treatment sedation. <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	Noncompliance

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	the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	• 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 • RSSLC Dental Procedures, Quality Assurance Policy, dated 7/30/2014 During the on-site interview with the dental director, the Monitoring Team was informed that the Facility had not develop a dental QA process to assess the efficacy of dental treatments, but did develop and implement a process to assess potential adverse outcome following dental treatments. During this compliance review, the Monitoring Team observed the Facility's database system that helps track adverse outcome following dental procedures. The database is an elaborate system that links actual dental office visit with the Facility's databases that monitor pneumonia diagnosis, falls, seizures, and injuries. Furthermore, the Facility is continuing to enhance the database to link dental visits to reported injurious maladaptive behavior. The Monitoring Team determined that the Facility's process to monitor adverse outcome following dental office visits was effective as a quality assessment tool, and supports the Facility's further development to include associated maladaptive behaviors. Review of the RSSLC Dental Procedures, Quality Assurance Policy, dated 7/30/2014, indicated that the Facility conducts weekly and monthly assessments of randomly selected individuals to assess missed appointments, poor oral hygiene, refused appointments, oral hygiene care plans, oral cancer screening. Although data had been collected on adverse outcome following dental sedation, including falls, seizures, pneumonias, and injuries, the Facility had yet to develop a process to analyze the data and to develop strategies to address adverse outcomes. The Facility provided a copy of its Dental QA Monitoring Tool, that outlined 18 essential elements, which included those items that were monitored by the Facility's internal (dental office staff) and external (Facility's QA department staff) dental audit process. In addition, the Facility provide a copy of its Dental Services QA Data Analysis Report for date range 2/1/2014 through 7/31/2014. The data analysis report indicated that a total of 32 individual audits had been completed during this reporting period, and all 18 of the audit tool assessments were evaluated. For the July 2014 dental QA analysis, compliance scores ranged from a low of 0% compliance (assessment to ensure that desensitization plan was in place for individuals identified as needing desensitization) to 100% compliance; an overall compliance rating was determined to be 84% by the Facility's QA department's analysis, and 91% for the dental office's analysis. There were no data analyses or action plans provided for database elements that were determined to be noncompliant.	

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		The Facility provided documentation of all oral hygiene ratings that were assessed during this reporting period; however, there was no data analysis provided. Summary: The Facility has significantly improved its dental quality assurance process; however, the Facility did not provide data analysis, action plans for data elements that were determined not to be in compliance, and assessment of efficacy of action plans. Although the Facility did not yet analyze data collected for adverse outcome following dental sedation, the Monitoring Team is most complimentary to the Facility for its development and implementation of a comprehensive, and effective mechanism to track adverse outcome following dental sedation. <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 (i.e., not enough TIVA days; another individual required that particular TIVA appointment for a dental urgency, etc.)	

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		• 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 The Facility provided spreadsheets for missed appointments by reason missed that occurred between 1/1/2014, and 6/30/2014, that indicated that 373 individuals had missed their dental appointment for the following reason: • Maladaptive behavior: 34 out of 373 total missed appointments (9.1%) • Dental clinic issues: 57 out of 373 total missed appointments (15.3%) • Equipment issues: 2 out of 373 total missed appointments (0.5%) • Furlough of the individual: 17 out of 373 total missed appointments (4.6%) • Illness of the individual: 31 out of 373 total missed appointments (8.3%) • Weather related issues: 70 out of 373 total missed appointments (18.8%) • Failed medical clearance: 5 out of 373 total missed appointments (1.3%) • N/A attended appointment 2 out of 373 total missed appointments (0.5) • No reason entered 41 out of 373 total missed appointments (11.0%) • Not NPO 1 out of 373 total missed appointments (0.3%) • No consent for treatment 6 out of 373 total missed appointments (1.6%) • Staffing issues 4 out of 373 total missed appointments (1.1%) • Transportation issues 1 out of 373 total missed appointments (0.3%) • Unknown reason 102 out of 373 total missed appointments (27.3%) The Facility provided an additional spreadsheet entitled "Missed Appointment Reason Counts", for 1/1/2014 through 8/26/2014, that indicated 453 individual had missed their dental appointment for reason including: • No shows: 198 out of a total of 453 missed appointments (43.7%) • Cancellations: 224 out of a total of 453 missed appointments (49.4%) • Refusals: 29 out of a total of 453 missed appointments (6.4%)	

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		• No reason: 2 out of a total of 453 missed appointments (0.4%) The Facility provided a document that stated, "No TIVA appointments have been missed due to TIVA issues, other than illness of the individual that requires deferral". There was no analysis provided for missed appointments, and there were no action plans to help reduce the number of missed appointments provided for review. During this compliance review, the Monitoring Team assessed the dental office's database for scheduling dental appointments, and determined that the Facility maintained an electronic database that can track past and future dental appointments. The Facility did not have an updated policy that delineated its updated database tracking mechanism. Summary: The Facility developed and implemented a database system that can track past and future dental appointments, developed an effective process to determine missed dental appointments, and tracked specific reasons for missed appointments. Per review of annual dental summaries for Section Q.1 of this report, and review of the dental schedule, individuals benefited from annual dental assessments that are completed prior to the annual ISP meeting. The Facility should develop and implement a policy to delineate its dental scheduling process; develop a process to analyze missed dental appointments; and develop action plans to address system issues for missed dental appointments, when necessary. <u>Review of Programs to Reduce Need for Pre-treatment sedation</u> To assess the Facility's process for reducing the need for pre-treatment sedation for dental services, the Facility reviewed the following documents: • The Monitoring Team requested policy and procedures for the administration of pre-treatment oral sedation, and was provided the Dental Procedures, Sedation for Dental Treatment, Pre-operative Evaluation, dated 8/1/2013. The procedure did not delineate the Facility's process for providing programs to help reduce the need for pre-treatment sedation. • Alpha list of all individuals who require pre-treatment oral sedation for dental services; the Monitoring Team was provided a document that stated "There is not an alpha list of all the individuals that require oral sedation. The use of oral sedation seems to be too variable to make such a list useful. We can provide a list of all those who received oral sedation".	

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		• Alpha list of all individuals who received oral sedation for dental appointments. The Facility provided an alpha list of 63 individuals who received pre-treatment oral sedation for dental service that were provided during this review period. • Minimizing pretreatment chemical restraint committee meeting minutes dated 4/7/2014, 6/6/2014, 6/30/2014, and 7/14/2014, that indicated that the Facility had developed a committee structure to comprehensively review the Facility's current practice, and that had proposed changes to the Facility's practice, of providing pre-sedation. • The Facility did not provide copies of specific programs to reduce the need for pre-treatment sedation, and did not provide trends analysis to assess the efficacy of programs to reduce the need for pre-treatment sedation. Summary: The Facility has begun a process to develop programs to help minimize the need for pre-treatment sedation; however, the Facility did not provide supporting evidence necessary to determine the efficacy of its efforts in developing such programs. The Facility should develop a policy that clearly delineates its process to help reduce the need for pre-treatment sedation; ensure that all individuals who require pre-treatment oral sedation have been identified; develop individualized plans to help reduce the need for pre-treatment oral sedation; and track and trend outcome data, to determine efficacy of the program. Conclusion: The Facility has continued to move closer to compliance with Section Q.2. The Facility developed a robust database mechanism to help ensure effective tracking and trending of past, and future dental appointments, developed an effective process to track missed dental appointments, and developed a committee process to evaluate the Facility's usage of pre-treatment sedation. Compliance will require that the Facility develop and implement processes to trend missed dental appointments and develop strategies to help reduce missed dental appointments; develop a policy that clearly delineates its process to help reduce the need for pre-treatment sedation; ensure that all individuals who require pre-treatment oral sedation have been identified; develop individualized plans to help reduce the need for pre-treatment oral sedation; track and trend outcome data, to determine efficacy of the program; develop a process to analyze dental QA data, and develop action plans for data elements that were determined not to be in compliance; and develop a process to analyze adverse outcome events, following dental sedation, and when necessary, develop action plans to help reduce adverse outcomes. For these reasons, the Monitoring Team determined that the Facility is not in substantial compliance with 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 8/11/14 2. RSSLC Action Plan 8/12/14 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 Policy K.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. RSSLC-Behavioral Health and Speech Language Collaboration Procedures (2/14/14) 9. Record reviews for the following samples: a. Sample R.1: Individuals #149, #232, #465 #497, #552, and #777 b. Sample R.2: Individuals #60, #332, #561, #736 and #787 c. Sample R.3: Individuals ##160, #302, #447, and #655 d. Sample R.4: Individuals #264, #448, #462, and #669 e. Sample R.5: Individuals #160, #179, #254, #502 and #679 10. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 11. A list of people with Alternative and Augmentative Communication (AAC) devices 12. AAC evaluation and Speech Language assessment template 13. Monitoring tools template for AAC and SLP programs 14. List of individuals receiving direct speech services, and focus of intervention 15. Positive Behavior Support Plans (PBSPs) for sample individuals 16. Communication assessments for sample individuals 17. Communication programs for sample individuals **People Interviewed:** 1. Brandie Rabe MS, CCC-SLP 2. Ping Law PT Director of Habilitation Therapies 3. Carolyn Elliot MS-CCC-SLP 4. DCPs (San Antonio, Trinity, Leon, Three Rivers and Four Rivers) **Meetings Attended/Observations:** 1. Mealtimes and Transitions (Four Rivers, Three Rivers, Trinity, San Antonio, Leon)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 8/11/14 and Action Plan dated 8/12/14. 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. 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 Form, the Speech Communication Outcome Audit form and the Integrated Progress Note Efficacy Monitoring Audit form. • This monitoring/audit tools 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. • 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 rated itself as being in compliance with Provisions R.1 and R.2 and not in compliance with Provisions R.3, and R.4. This was consistent with the Monitoring Team's findings of substantial compliance with Provision R.1 and noncompliance with R.3 and R.4 but inconsistent with the Monitoring Team's finding of noncompliance with R.2. 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. Additionally, direct and Indirect programs continued to need to be expanded to those Individuals who are most in need and integrated as part of the ISP.

	Provision R.1: This provision remained 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, six were licensed Speech-Language Pathologists (SLP). This represented an increase of one SLP due to RSSLC transitioning the previous SLP assistant position to another full time SLP positioning. Among them, five SLPs were dedicated to communication and one SLP was 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. A positive note was the increased collaboration between the SLP and Behavior Supports in addressing undesired behaviors. 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. A process was now in place in which communication was monitored as part of the PNMP monitoring but, as reported in Provisions O.6 and P.4, 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 training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the	Samples for this section are as follows: Sample R.1: Consisted of six 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. 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.	Substantial Compliance

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	implementation of programs.	This provision was found to remain 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. <u>Staffing</u> 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, six are licensed Speech-Language Pathologists (SLP). Among them, five SLPs are dedicated to communication and one SLP is dedicated to dysphagia. These staffing numbers represent a change since the last review as RSSLC has transitioned a SLPA positing into a SLP thus representing an increase of one SLP since the last review. 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 <u>Qualifications:</u> Six of six positions for SLPs (100%) for which documents were provided to the Monitoring Team were filled by licensed SLPs. • Six of six SLPs (100%) were licensed to practice in the state of Texas. • Six of six SLPs (100%) had evidence of ASHA certification. <u>Continuing Education:</u> 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: • Texas Assistive Technology Network Conference • Low Tech AAC Options	

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		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 involving behavioral supports or interventions.	Assessment Plan: The Facility had a reasonable plan to screen/assess all individuals and, based on priority need, assess individuals who would benefit from the use of alternative or augmentative communication systems. RSSLC provided assessments for all new admissions in lieu of providing screenings. Individuals at a minimum are provided with a Communication Assessment annually if they receive direct or indirect communication supports, and all others will be provided with assessments if there was a change in status, IDT request or at a minimum will be provided with an assessment every 5 years. Assessments Provided Six of six individuals in Sample R.1 (100%) were provided a communication assessment per policy and/or Master Plan. Ten of ten individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission. For six of six individuals in Sample R.1 (100%), assessments/updates were dated as	Noncompliance

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		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. <u>Communication Assessment:</u> Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows: • Eleven of 11 individuals' Communication assessments (100%) were signed and dated by the clinician upon completion of the written report. • Eleven of 11 individuals' Communication assessments (100%) were dated as completed at least 10 working days prior to the annual ISP; • Eleven of 11 individuals' Communication assessments (100%) included diagnoses and relevance of impact on communication; • Eleven of 11 individuals' Communication assessments (100%) included individual preferences, strengths, and needs • Eleven of 11 individuals' Communication assessments (100%) included medical history and relevance to communication • Eleven of 11 individuals' Communication assessments (100%) listed medications and discussed side effects relevant to communication; • Nine of 11 individuals' Communication assessments (82%) provided documentation of how the individual's communication abilities impacted his/her risk levels; • Eleven of 11 individuals' Communication assessments (100%) 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); • Eleven of 11 individuals' Communication assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; • Eight of 11 individuals' Communication assessments (73%) included discussion of the expansion of the individuals' current abilities. • Nine of 11 individuals' Communication assessments (82%) provided a discussion of the individuals' potential to develop new communication skills; • Eight of 11 individuals' Communication assessments (73%) assessed AAC or	

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		Environmental Control (EC) needs, including clear clinical justification; and rationale as to whether or not the individual would benefit from AAC or EC. • Eleven of 11 individuals' Communication assessments (100%) offered a comparative analysis of health and functional status from the previous year • Eleven of 11 individuals' Communication assessments (100%) gave a comparative analysis of current communication function with previous assessments. • Seven of 11 individuals' Communication assessments (64%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. • Nine of 11 individuals' Communication assessment (82%) 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; • Eleven of the 11 individuals' Communication assessments (100%) supplied a monitoring schedule. • Seven of 11 individuals' Communication assessments (64%) 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. • Eleven of 11 individuals' Communication assessments (100%) made a recommendation about the appropriateness for community transition. • Six of 11 individuals' Communication assessments (55%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. In order to obtain substantial compliance, RSSLC must improve their ability to identify objectives and or methods to improve the individual's ability to communicate. Communication Dictionaries are useful tools to bridge existing communication gaps but do little to promote the expansion of their skills. Additionally, more input should be given with regards to how the strategies provided in the assessment can better be integrated throughout the individual's day, thus allowing for maximum generalization of skills. <u>SLP and Psychology Collaboration:</u> 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.	

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		• 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 the 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 Policy K.06.2. The Behavioral Health and Speech Language Collaboration Procedures was fully implemented and included the following components: • Before updating or revising a Behavioral assessment, the SLP will be notified. • A conference will be set up between the BA and the SLP. • 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. • As part of the review, communication strengths, deficits and barriers to communication will be discussed. • 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.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP</u> Based on review of the ISPs for individuals in Samples R.1 and R.2 the following was noted: • In seven of 11 ISPs reviewed (64%) for individuals with communication needs an SLP attended the annual ISP planning meeting, or the team provided adequate justification. • Ten of 11 ISPs reviewed (90%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. • Communication Dictionaries for ten of ten individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. • Zero of eleven ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. • Six of 11 ISPs reviewed (55%) contained skill acquisition programs to promote functional communication. The primary concern continued to focus on the expansion of communication. Many	Noncompliance

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		times, the response to individuals who had decreased communication was to have a communication dictionary without any trials to determine, or SAPs to potentially improve upon, existing skills. Many times it was noted as part of the assessment that recommendations were made for SAPs during the previous year but were never included as part of the ISP and therefore never initiated. Examples of this were Individuals #332 and #502 who were recommended to have a SAP on choice making and AAC development respectively. <u>Development And Implementation Of Functional Individual-Specific Assistive Communication Systems</u> For ten of ten individuals in Sample R.1 for whom the IDT directed a revision in the communication dictionary (100%), the communication dictionary was revised within 30 days. Of the 335 individuals at RSSLC, the Facility identified 165 who have severe speech and language disorders. Of those 165 individuals, the Facility reported that 136 individuals (82% of those with severe speech and language disorders, and 41% of the total population) were provided with communication supports. This number reflected both communication dictionaries and Skill Acquisition Programs. Thirty-five of these individuals had low or high tech AAC devices. In order to obtain substantial compliance, RSSLC must ensure all individuals who are identified as having decreased communication capabilities are provided with the needed supports. 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 three of four individuals (75%) were portable. • AAC systems for four of four individuals (100%) were functional. • For two of four individuals (50%), 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. <u>General Use AAC Devices:</u>	

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		Observations were completed in four homes and to determine the presence and use of general AAC devices. Findings included the following: • Four of four homes (100%) had general use AAC devices present in the common areas. In four of four homes, (100%), general use AAC devices were operational. • Fourteen of 14 general use AAC devices (100%) noted contained clear directives on how staff should use these devices. • Fourteen of 14 general use AAC devices (100%) noted had a clear function within that setting/situation. • Two of 14 general use AAC devices noted (14%) 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 them. Concerns noted regarding the use of AAC devices continued to be that the implementations of common areas devices as well as individual devices were virtually nonexistent. 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: • Three of five individual's direct intervention plans (60%) 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. Individuals receiving direct Speech Services (Sample R.2) were not provided with comprehensive progress notes that contained each of the indicators listed below. • For three of five individuals' records (60%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For three of five individuals (60%), 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 device and/or goal to the individual. There was no evidence that the therapist	

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		reported on a monthly basis how the goal would support communication for the individual in their daily activities. • For zero of five individuals (0%), 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. A pervasive issue noted was that there was not a clearly developed treatment plan that outlines not only the expected frequency and schedule of treatment but the underlying relevance and functionality of the chosen program and/or treatment. Treatment plans or the initiation or intent to initiate a plan was often missing or vaguely supported as part of the ISP. <u>Indirect Communication Supports:</u> Programs for individuals in Sample R.5 who received indirect communication supports were reviewed and found: • Two of five individuals' indirect plans (40%) (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 clear evidence for the remaining three individuals from Sample R.5 of an anticipated start date; therefore, the Facility would be unable to determine if the plan was implemented in a timely manner • For five of five individuals' records (100%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For zero of five individuals in Sample R.4 (0%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. It should be noted that Individuals #179, #254, #502, and #679 were 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 for any of these individuals that this was integrated into the ISP and implemented. Zero of five 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 five individuals (0%) contained information	

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		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 five individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of five individuals (0%) identified consistency of implementation. • Quarterly documentation for zero of five individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. A potential way that RSSLC may want to consider to address these issues would be to have the QIDP review the SAP/Indirect Support as part of their monthly review for relevance and continued function. <u>Staff Interviews</u> Four of eight staff interviewed (50%) 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. <u>Competency-Based Training and Performance Check-offs:</u> Staff was provided with Core Competency training during new employee orientation in which AAC was a component. Staff also received another class titled "Use of AAC and Maintenance" which addressed AAC components. All staff were 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. One hundred and thirty three of 145 new employees since March 2014 (92%) had completed NEO core communication competencies for foundational skills and performance check-offs. <u>Individual-Specific Competency-Based Training</u>	

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		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 four individuals in Samples R.4 had received training related to Communication SAPs and programs. Two of four (50%) individual's (Sample R.4) 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. In order to obtain substantial compliance, RSSLC must ensure that the training of all staff that were required to assist the individual with their communication program has been provided and clearly documented.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	<u>Policy and Procedure</u> The monitoring system consisted of monthly PNMP monitoring that included communication. These were generally conducted by the PNMPCs to check for availability, condition, and working order. RSSLC 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. Evidence of this monitoring was noted for the three individuals from Sample R.4. <u>Monitoring of Implementation of Communication Supports</u> Compliance Monitoring forms for implementation of communication supports the last six	Noncompliance

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		months for three individuals from Sample R.4 were reviewed and the following was found: • For three of three individuals (100%), monitoring of communication supports was outlined in the assessment. • For zero of three individuals (0%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. For example, Individual #448 was not provided with monthly monitoring by the QIDP. In order to obtain compliance, RSSLC must ensure that all communication supports are reviewed and monitored to ensure supports are being utilized and implemented as recommended.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RSSLC Self-Assessment (8/12/2014) 2. RSSLC Action Plan (8/11/2014) 3. RSSLC Presentation Book for Section S 4. Documents that were used as part of the document review process included the following. • For Provision S.1, ISPs, related assessments, and Skill Acquisition Plans (SAPs) were reviewed for Individuals #74, #101, #243, #309, #530, #596, #630, #655, #753, and #795. • For Provision S.1, the content and composition of SAPs were reviewed for Individuals #74, #101, #243, #309, #530, #596, #630, #655, #753, and #795. • For Provision S.2, the facility tracking spreadsheets for assessment report submissions was reviewed. • For Provisions S.1 and S.3.a, SAPs and data collection forms were reviewed for Individuals #74, #101, #243, #309, #530, #596, #630, #655, #753, and #795. • 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. Approximately 25 direct care staff in the following residences and day treatment areas: Lavaca, Leon, Nueces, Pecos, San Antonio, Sabine, and Trinity. **Meeting Attended/Observations:** 1. The following residences and day treatment areas: Lavaca, Leon, Nueces, Pecos, San Antonio, Sabine, 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.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RSSLC from 8/25/2014 through 8/29/2014. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that no Provision of Section S was in substantial compliance with the Settlement Agreement. Information obtained during the site visit reflected that almost all areas related to Section S either suggested no improvement or reflected substantial declines. • Skill acquisition programs (SAPs) typically did not reflect needs identified in assessments or the ISP. • The components of skill acquisition programs were often insufficient to ensure that training could be conducted consistently or in a manner likely to provide meaningful improvements in skills and abilities. • Substantial declines were noted in the provision of functional engagement. • Documentation reflected that skill acquisition data frequently were recorded incorrectly and that skill acquisition programs were often not implemented according to the schedule in the program instructions. • Community outings had dropped by more than 50%. 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.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Historical Perspective During the May 2010 site visit, RSSLC had just implemented a series of efforts to improve the quality of skill acquisition programs. In October 2010, a limited sample revealed task analysis 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 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. In March 2014, however, minimal progress was noted. Current Site Visit For the August 2014 site visit, the parties agreed to conduct reduced monitoring. The Facility reported in the Self-Assessment, as well as on-site, that substantial limitations continued to exist in relation to Provision S.1. This included weaknesses in skill assessments, SAP content and implementation, and the provision of functional engagement. In order to assess the accuracy of the Facility's assessment, a sample of 10 individual's was selected for the review of assessments and SAPs. This sample included Individuals #74, #101, #243, #309, #530, #596, #630, #655, #753, and #795.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Use of Assessment Information in Planning Skill Acquisition Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training. The table below reflects the status of assessments in relation to the sampled SAPs.	

	5/2010	3/2014	8/2014
Skill acquisition plans are implemented to address needs identified in:			
ISP	0%	20%	20%
Adaptive skill or habilitative assessment	0%	20%	10%
Psychological assessment	0%	20%	0%
Skill acquisition plans are chosen in an individualized manner.	0%	20%	20%
Skill acquisition plans are related to the individual's preferences.	0%	20%	30%

Based upon the information submitted by the Facility, it was not evident that assessments were consistently used in the development of SAPs for the majority of individuals living at the Facility. Furthermore, there was no indication of substantive improvement in the use of assessments in comparison with the previous site visit.

- ISPs for only two of 10 SAPs (20%) reflected evidence to support the reviewed SAP.
- Functional Skill Assessments (FSAs) for only one of 10 SAPs (Individual #753, 10%) reflected needs addressed in the reviewed SAP. Records did reflect that each individual had been provided with skill assessment by means of the FSA. In 90% of the reviewed SAPs, however, it was not evident that the FSA had been effectively used in the development of skill acquisition programs.

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

Teaching New Skills
In a review of the 10 individuals in the sample, it was noted that the SAPs lacked many of the essential components of a skill acquisition program. The table below reflects the status of the sampled SAPs.

#	Provision	Assessment of Status	Compliance

	5/2010	3/2014	8/2014
Plan reflects development based upon a task analysis	0%	0%	0%
Behavioral objective(s)	0%	0%	40%
Operational definitions of target behavior	0%	44%	40%
Description of teaching conditions	0%	11%	20%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%
Relevant discriminative stimuli	0%	33%	30%
Specific instructions	0%	11%	30%
Opportunity for the target behavior to occur	0%	56%	80%
Specific consequences for correct response	0%	100%	60%
Specific consequences for incorrect response	0%	89%	70%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	20%
Documentation methodology	0%	0%	20%

Based upon the information gained in the review, the Facility achieved modest progress in six of 12 areas (50%), remained unchanged in two of 12 areas (17%), and regressed in four of 12 areas (33%). The Facility was fully successful in no elements (0%).

Engagement, activities, and informal skill acquisition training

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
Trinity C	1.00	2.00	2.00	100%
Trinity C	4.00	6.00	5.00	83%
Trinity C	0.00	1.00	0.00	0%
Trinity D	0.00	2.00	0.00	0%
Trinity D	1.00	1.00	1.00	100%
Trinity D	1.00	2.00	0.00	0%
San Antonio	8.00	19.00	4.00	21%

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Leon</td><td>4.00</td><td>10.00</td><td>4.00</td><td>40%</td></tr>
<tr><td>Lavaca</td><td>4.00</td><td>9.00</td><td>3.00</td><td>33%</td></tr>
<tr><td>Sabine</td><td>4.00</td><td>3.00</td><td>2.00</td><td>67%</td></tr>
<tr><td>Pecos</td><td>2.00</td><td>4.00</td><td>1.00</td><td>25%</td></tr>
<tr><td>Pecos</td><td>2.00</td><td>10.00</td><td>3.00</td><td>30%</td></tr>
<tr><td>Nueces</td><td>2.00</td><td>10.00</td><td>3.00</td><td>30%</td></tr>
<tr><td>Nueces</td><td>2.00</td><td>2.00</td><td>2.00</td><td>100%</td></tr>
<tr><td>Lavaca</td><td>2.00</td><td>7.00</td><td>1.00</td><td>14%</td></tr>
<tr><td>Sabine</td><td>3.00</td><td>10.00</td><td>3.00</td><td>30%</td></tr>
<tr><td colspan="4">Total percentage of individuals functionally engaged</td><td>35%</td></tr>
<tr><td colspan="4">Percentage of locations with 50% or greater functional engagement</td><td>31%</td></tr>
<tr><td colspan="4">Total percentage of individuals functionally engaged (March 2014)</td><td>58%</td></tr>
<tr><td colspan="4">Percentage of locations with 50% or greater functional engagement (March 2014)</td><td>42%</td></tr>
</table>

Observations revealed that across all settings 35% of observed individuals were functionally engaged. Furthermore, slightly less than one-third (31%) of all environments observed reflected at least 50% engagement.

Based upon information obtained from the Facility, as well as observations and document reviews, it was reflected that the Facility had experienced substantial declines in the level of functional engagement provided.</td><td></td></tr>
<tr><td>S2</td><td>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.</td><td>For the August 2014 site visit, the parties agreed to conduct reduced monitoring.

Based upon a review of assessment practices in Provisions K.5, K.6, and K.7, as well as Provision 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.

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.</td><td>Noncompliance</td></tr>
<tr><td>S3</td><td>Within three years of the Effective Date hereof, each Facility shall use the information gained from the</td><td></td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and</td><td>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.

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, 10 SAPs and the latest data recording forms for each were reviewed. The 10 individuals included in the sample were Individuals #74, #101, #243, #309, #530, #596, #630, #655, #753, and #795.

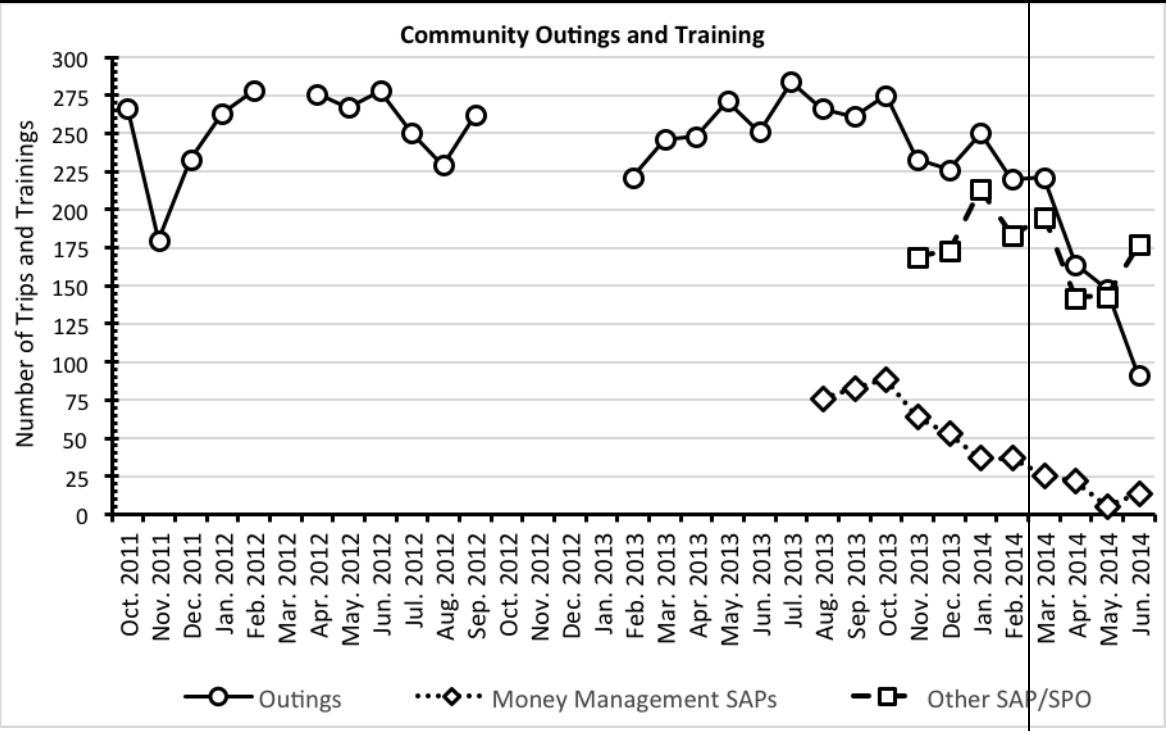
The table below reflects the results of the review.

<table>
<tr><th>Element</th><th>Percent Correct</th></tr>
<tr><td>Data recording forms present</td><td>40%</td></tr>
<tr><td>Individual information is correct</td><td>90%</td></tr>
<tr><td>Data current</td><td>50%</td></tr>
<tr><td>Plan is implemented according to the specified schedule.</td><td>0%</td></tr>
<tr><td>Data recorded correctly</td><td>0%</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, 10 ISPs and SAPs (Individuals #74, #101, #243, #309, #530, #596, #630, #655, #753, and #795.) 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>90%</td></tr>
<tr><td>SAP is not excessively difficult or technical.</td><td>90%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		SAP can be implemented in relevant environments. 90% **Functional** SAP addresses specific needs from formal assessment. 10% SAP targets skills useful for the individual. 50% Specific issues noted regarding functionality included the following. • Only one of the 10 sampled SAPs (10%) addressed specific needs reflected in formal assessments. • Five of the 10 sampled SAPs (50%) targeted skills that would likely be useful for the individual. Concerning practicality, none of the reviewed SAPs was overly sophisticated or required expertise a DSP was unlikely to possess. In the one case in which a SAP was determined to be impractical, the determination resulted from weaknesses in assessment or instructions. Based upon information presented by the Facility, it was evident that little progress had been made toward providing training that was practical. Furthermore, considerable weaknesses remained regarding SAP documentation. 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.	The current review included a sample of 10 SAPs submitted by the Facility. This sample included Individuals #74, #101, #243, #309, #530, #596, #630, #655, #753, and #795. None of the sampled SAPs included indications of potential implementation in the community. Tracking data maintained by the Facility, as documented in the graph below, reflected that efforts to provide skill acquisition training had declined in recent months. It therefore did not appear that the Facility had a comprehensive plan for providing community instruction when developing the SAPs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		 During the current site visit, information provided by the Facility indicated that employment both on and off campus remained relatively stable. Although stable, employment in the community remained low, as only one individual was provided community employment.	

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: 08/12/2014 2. Richmond State Supported Living Center Action Plans, updated: 08/11/2014 3. Section T Presentation Book materials 4. Richmond State Supported Living Center Settlement Agreement presentation, August 2014, Round 8 5. DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013 6. RSSLC Policy G.06 Admitting/Moving Individuals: Most Integrated Setting Practices, Revised 7/07/2014 7. RSSLC Policy G.6 Admitting/Moving Individuals: Community Movement, Revised 7/07/2014 8. RSSLC Policy G.5 Admitting/Moving Individuals: Recommending and Choosing a Provider for Community Movement, Revised 01/31/14 9. RSSLC Policy G.6.1 Admitting/Moving Individuals: Post Move Monitoring, Revised 7/07/2014 10. RSSLC Policy G.14 Admitting/Moving Individuals: CLDP Grand Rounds, effective 08/30/2013 11. DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 12. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 13. Since last on-site review, a list of all individuals who have been referred for placement 14. 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" 15. Since last on-site review, a list of all individuals who have died after moving to community living 16. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 17. For the last twelve months, a list of individuals who were reported to have been assessed for placement 18. Potentially Disrupted Community Transition Documentation for Individuals #165, #238, #366, and #746 19. Individual Support Plans (ISPs) including assessments for seven Individuals: Individuals #243, #501, #530, #596, #630, #655, and #753 20. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #243, #501, #530, #596, #630, #655, and #753 21. Documentation of Living Options Action Plans implementation for Individuals ##86, #144, #149, #184, #302, #324, #349, #487, #503, #582, #723 and #758 22. ISP Addenda (ISPA) to rescind referral and related documentation for Individual #712 23. Community Placement Report (CPR), dated Monday August 25, 2014 24. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 25. Minutes of Self-Advocacy meetings for the last six months 26. RSSLC Annual Report: Obstacles to Community Transition, Fiscal Year 2013, dated November 2013

	27. Completed Community Living Discharge Plans (CLDPs) for Individuals #625, #711, and #799 28. Partial CLDPs (in progress) and Transition Specialist documentation for Individuals #66, #120, #600 and #770 29. Pre Move Site Reviews for Individuals #238, #306, #410, #569, #625, #711, and #799 30. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plans for Individuals #306, #410, #569, #625, #711, and #799 31. Transition Related Activities Quality Assurance Auditing Process, dated December 9, 2013 32. QA/QI Review Process for Transition Related Activities, dated December 9, 2013 33. Completed Post Move Monitoring (PMM) checklists for Individuals #35, #238, #306, #366, #410, #569, #625, #711, #746, #748, #771 and #799 **People Interviewed:** 1. Terri Carter, Admission/Placement Coordinator (APC) and Post Move Monitor 2. Aarti Narsinghani, Placement Coordinator 3. Andrea Lewis, Transition Specialist 4. LaTonya Akorede, Transition Specialist 5. Georgette Brown, QA Director **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #680 and #745 2. Pre-ISP meeting for Individual #497 3. ISPA meetings for Individuals #306 and #711
	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 self-assessment rating did not substantially rely on data collected through the Facility's QA/QI processes. The CLDP Monitoring Tool was occasionally referenced, but the ISP Monitoring Tool was not. 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. In order to improve its Self-Assessment for use in achieving compliance, the Monitoring Team again suggests 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. 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. 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 this provision, but it did report it had achieved some level of compliance for the following Provisions: T1C, which addresses the timely implementation of the CLDP when a referral is made; T1c1, which requires the Facility to specify actions to

	be taken to implement the CLDP in coordination with provider staff; T1c2 which requires the Facility to specify the SSLC staff responsible for CLDP actions, and the timeframes in which such actions are to be completed; T1c3, which requires the CLDP to be reviewed with the individual, and LAR as appropriate, to facilitate their decision-making; T1e, which addresses the adequate identification of pre and post move supports in the CLDP and the Facility's actions to ensure their presence prior to transition; and T1h, the issuance of the Community Placement Report. The Monitoring Team concurred with Facility findings of substantial compliance for Provisions T1c, T1c2, T1c3 and T1h, but did not concur with self-assessment of compliance with Provisions T1c1 and T1e. 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. As no PMM visit was observed during this monitoring visit, this Provision was not rated. For Provision T3, no compliance rating is required. For Provision T4, the Facility provided no rating as it indicated 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 ongoing implementation 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 Facility had also revised its policies to ensure routine IDT review of PMM visits, and enhanced certain quality management procedures internal to the APC's office, which the Monitoring Team commends. The Post-Move Monitor (PMM) position was vacant at the time of the visit, which might have affected timeliness of completing PMM checklists. Other specific findings are detailed below: **For Provision T1**, seven individuals had transitioned to community living and there were 17 active referrals. The Department of Admissions and Placement staff, including a Placement Coordinator, 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. The

	Monitoring Team was particularly concerned with the failure of the IDTs to identify and address in a substantive manner the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences. Even when obstacles were identified, the minimal strategies developed to address them were seldom implemented or monitored. CLDPs did not yet 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 T1c, 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 were not as consistently completed in a timely manner as in the past. RSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDPs, particularly because the CLDPs did not yet provide adequate monitoring parameters for the Post-Move Monitor to reference. There had been turnover in the Post-Move Monitor position and it was currently vacant. 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	<u>Transition Staffing:</u> Staffing devoted to transition included the Admissions/Placement Coordinator (APC), a Placement Coordinator, a Post-Move Monitor, and two Transition Specialists funded through the state's Money Follows the Person project. The Facility also continued to have a Transition QIDP position whose responsibilities had included writing the CLDP, scheduling trainings with SSLC staff, individuals, LARs and family members, and providing technical assistance to IDTs. There had been some staff turnover during this six months in the Transition QIDP and Post-Move Monitor positions. The Post-Move Monitor position remained vacant at the time of the monitoring visit, but interviews were underway to fill it. <u>Transition Outcomes During Last Six Months</u>: • Community Transitions: The number of community transitions showed a	Noncompliance

#	Provision	Assessment of Status	Compliance
	transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	decreasing trend. o There were seven transitions to community living in the six months since the last monitoring visit. With 335 individuals currently living at RSSLC, this represents an annualized rate of approximately four percent of the population. This number of transitions was a decrease over the last two previous monitoring periods for which 11 and 15 individuals had transitioned. o The Monitoring Team was unable to fully assess whether the transition process took more than 180 days for these seven individuals, as the CPR and other reporting in the document request did not provide the actual date of referral. o The number of community referrals indicated a slightly increasing trend. Twelve referrals had been made in the past six months, according to the Community Placement Report, as compared to 11 in the prior six month period. o Seventeen individuals were on the active referral list (approximately five percent of the current population at RSSLC). o Four of the 17 (24%) individuals had been on the referral list more than 180 days. • Individuals requesting placement, but were not referred: There were seven individuals reported to have requested community transition, but were not referred. Six of the seven (86%) were not referred due to LAR choice, while one was not referred due to Behavioral Health/Psychiatric Needs. • Rescinded Referrals: There was only one rescinded referral reported since the last review due to medical reasons, which appeared to have been well-documented by the IDT. • Returns from Community Placement o One individual had very recently returned to the Facility, on at least a temporary basis, from a community placement as a result of a serious injury. This number of individuals who returned to the SSLC after a failed community placement indicated a stable trend over the previous two monitoring site visits. The Facility had been taking assertive action since it became aware of the injury. • Deaths Following Community Placement o Since the last onsite review, there had been no deaths of an individual who had moved from RSSLC to the community. • Other Adverse or Unexpected Outcomes o The Facility reported eight adverse or unexpected outcomes during this past six months for four individuals who had transitioned during the past year. For two of the individuals, the type of disruption was listed as	

#	Provision	Assessment of Status	Compliance
		provider issues, and for the remaining two there were emergency room visits. It was not evident the Facility adequately reviewed and/or provided a sufficient response to these incidents. For example, Individual #366 had three emergency room visits related to behavioral circumstances, which met the Facility's criteria for IDT review, but no review was conducted. Two of the ER visits were on the same day, but the behaviors were severe enough that an IDT review would have been appropriate in any event. See also Provision T2a related to post-move monitoring for Individual #746. <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 revised policies and added tracking and quality assurance processes around CLDP and Post-Move Monitoring. <u>Conclusion:</u> This provision was found to be not in compliance. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 and F2ab); education for community awareness (see Provision T1b2); and transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not yet be said to be effectively assisting and encouraging individuals to move to the most integrated setting.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two 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 Provision T1b or any of the other cells under T1b. DADS had issued DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members	Noncompliance

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		make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spells out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and Facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. • The policy did not mention the Settlement Agreement requirement that action be taken prior to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. The policy listed two reviews of CLDPs to be undertaken, one at the Facility and one at State Office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no mention of need for the IDT to use the CLDP to ensure supports are in place. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences. • To move in the direction of substantial compliance, the Monitoring Team recommends the DADS policy be reviewed for consistency with the metrics submitted by the Monitors and with the content of the monitoring reports. The Facility had recently revised RSSLC Policy G.6 Admitting/Moving Individuals: Most Integrated Setting Practices, as of 7/07/2014. Policy G.6 was part of a more	

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		comprehensive set of policies related to the Most Integrated Setting that expanded on and localized DADS Policy 018.2. The Monitoring Team had noted at the time of the last monitoring visit that this latter policy 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 most recent version corrected this omission. In addition, it clarified Facility expectations that the IDT would review each PMM visit. Conclusion: 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.	Status of Process and Training on ISP Development: 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 an individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individual's 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. Protections, services, and supports: DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of Section F: F1d, F2a1, and F2a3. As noted above in Section F of this report, substantial compliance was not found for Provisions F1d, F2a1, and F2a3. As documented in Provisions F1d, F2a1 and F2a3, the Monitoring Team found the IDT still failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. Therefore, substantial compliance was not found for Provision T1b1. Identification of and Plans to Overcome Obstacles to Transition: RSSLC gathers obstacle information through the ISP process, and then categorizes these using a list of DADS-approved obstacles separated into two categories as defined in	Noncompliance

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		Exhibit A to the statewide Policy #018.2. The first category, obstacles to referral, included: • Individual's reluctance for alternate placement • LAR's reluctance for alternate placement • Medical needs requiring 24-hour nursing services/frequent physician monitoring • Behavioral health/psychiatric needs requiring frequent monitoring by psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff • Evaluation period (Ch55/46B only) • Court will not allow placement (Ch55/46B only) • Lack of funding The second category, obstacles to transition, included: • 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 specialized mental health supports • Need for environmental modifications to support the individual • Need for meaningful employment or supported employment • Individual/LAR indecision • Medicaid/SSI funding • 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 community living were still not yet consistently addressed by the IDTs in the ISPs. The Monitoring Team reviewed seven recent ISPs. One referral was made at the time of the ISP. Of the six ISPs reviewed which did not make a referral, none evidenced proficiency in identification and addressing of obstacles. The obstacles cited for all six (100%) was LAR choice, but in no case was a comprehensive and individualized plan developed to address the concerns. Of these six ISPs in this sample, none (0%) included an action plan to address/overcome identified obstacles that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles.) The Monitoring Team also observed ISP annual planning meetings for Individuals #680 and #745 during the monitoring visit. It was observed the IDTs were making an effort to identify and address obstacles, but were not yet proficient in this process. For example, Individual #680 was an articulate young adult with many skills and talents whose LAR was firm in her refusal to consider a community living option due to a life-threatening	

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		injury the individual had sustained while living at home. At the heart of her concerns was her sense the individual lacked maturity and ability to make good judgments regarding risky behaviors. While the IDT members worked in a concerted manner to encourage the LAR, they did not help her to formulate a longer term vision for the individual's life, to develop a sense of what it would take for her to feel reasonably confident in the future as to the individual's maturity, judgment and safety in a community setting or develop any specific measurable goals or indicators that would satisfy her not-unreasonable concerns. It appeared highly likely the LAR would be open to a longer term approach and to working with the IDT and the individual to clearly define the obstacles and a concrete plan for each of them. It was also noted the Facility was unable to provide any documentation regarding implementation of the individual's Living Options Action Plans for the last year. In addition to the findings above, at the time of the last monitoring visit, the Monitoring Team reviewed the ISPs for 12 individuals for the living options obstacles and Action Plans and found these were also typically minimal, not individualized and not measurable. During the present visit, to ascertain the level of implementation of these plans for the past six months, the Monitoring Team reviewed any ISPA, any documentation related to any community education and awareness activities and, if held, any updated ISP or ISP Preparation documents. Very little implementation of even these minimal plans had taken place. See Provision F1e for details regarding this lack of implementation. <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 seven 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. As reported above and in Provisions T1b2 and F1e, the Facility was not yet undertaking assertive action to assist individuals to develop and articulate these preferences in a planned manner. Efforts at the individual level remained minimal. 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 actively participating in them. <u>Conclusion:</u> This provision was found to be not in compliance.	

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	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices: In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria: An Individualized Plan For Each Individual: 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 six (0%) recently completed ISPs for which a referral was not made 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 Provision T1b1. The Facility did not yet succeed in developing individualized plans for community education and awareness, nor, as reported in Provision Tib1 and F1e, in implementing even the minimal plans that had been developed. An Annual Provider Fair: The Facility had held its most recent semiannual Provider Fair on May 23, 2014, a weekday. Attendance included 86 individuals, 106 staff and 3 family members. The Facility did not provide a written analysis of the outcomes of this activity. It did note it planned to continue to alternate weekend and weekday Provider Fairs in order to accommodate families and LARs with options based on their schedules. 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 February and May 2014. 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. As has been recommended in the past, and in light of the lack of implementation of Living Options Action Plans described in Provision F1e, the Facility 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	Noncompliance

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		awareness for individuals. The Monitoring Team reviewed the CLOIP Worksheets for six recent ISPs; for the seventh individual in the sample, the CLOIP form provided was not for that individual, For these individuals, two (33%) were visited by the CLOIP Service Coordinator. The other four were not visited per LAR request. 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 was not yet a consistent, formalized process in place at the Facility to fashion provider tours as a part of an individualized community living awareness and education plan. The Facility reported it had piloted and was planning a policy change to increase the individualization of the tour process, which was expected to go into effect in September, 2014. Specific findings regarding community tours for this past six month period 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 four CLOIP tours had been scheduled or held. The Monitoring Team requested attendance documentation for these tours, which indicated that a total of 16 individuals had taken such tours in the last six months. This did not appear to provide sufficient opportunities for the 335 individuals residing at the Facility to obtain enough experience about community living to form an opinion or participate in informed decision-making. The Monitoring Team remained 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. The Monitoring Team did note the Facility's creative approach in developing a virtual tour available on its intranet. While this could be an effective tool for some individuals living at the Facility, for most individuals it should be seen as an adjunct to the actual experience of touring community homes and work sites. • <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 previously 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.	

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		• Size of tours: The number of individuals attending a single tour may have a significant impact on the learning experience for the participants, as well as the ability of staff to gauge individuals' reactions and respond appropriately to facilitate learning. For the most part, the size of tours at the Facility, when they occurred, appeared to be conducive to both individual learning and assessment of responses. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the most integrated setting. At the time of the last monitoring visit, the Transition QIDP had recently begun completing a form entitled Community Tour Documentation that asked how the individual reacted to the tour and for any staff comments about the program for the purpose of assessing individuals' reactions and preferences. The Monitoring Team requested this documentation for the six months since the last visit, but the Facility was not able to locate any such material, which it indicated may have been due to turnover in the Transition QIDP position. The Monitoring Team notes these data should be transmitted to the IDT, including families and LARs, to provide them with feedback about individuals' reactions and possible preferences regarding community living options. As such, it should be expected the IDT would have copies of the documents and of its review and consideration. Opportunities Are Provided To Visit Friends Who Live In The Community: No specific documentation was provided that indicated opportunity for individuals to visit with friends who had moved to the community. Education Provided In Various Venues: The Facility had continued to hold self-advocacy meetings for adults and youth, generally on a bimonthly basis. The APC's office was working with the HRO to provide some educational opportunities about community living, including having obtained some materials that would allow participants in the group to think about what their ideal home would look like, and the plan to have a former member return to talk about the positive experiences of that individual's recent transition. APC staff also made a presentation about community living options to the RSSLC Self-Advocacy in May 2014. 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 only nine staff participating in such activities,	

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		including tours and visits. Staff also had the opportunity to attend the semi-annual Provider Fair, with 86 staff attending in May 2014, and the annual LA In-service Training held on February 11, 2014, with 92 staff in attendance. The Facility also continued to include training regarding community integration and the *Olmstead* decision in new employee orientation on a regular basis. The web-based virtual tour noted above may also be particularly helpful to staff serving as IDT members to educate themselves on the availability of different community living options <u>Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories:</u> There was no evidence presented at this juncture as to individuals and families having been provided with opportunities to learn about success stories related to transition from RSSLC, as the Facility continued to consider how to best address privacy concerns in this area. However, it was reported that one individual, a former active member of the Facility's Self-Advocacy group, who had transitioned in the past six months was expected to attend some Self-Advocacy meeting in the future to share positive experiences. <u>Conclusion:</u> 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	<u>Assessment Practices Pursuant to Transition and Discharge Policies and Procedures:</u> The Facility did not provide any information in response to the document request for a description of how it assesses an individual for placement and no changes were reported from previous practices during the monitoring visit. The Facility also provided a list that indicated it had assessed 337 individuals for placement in the past year, pursuant to the procedures prescribed in this section. For most individuals on the list, however, unless a referral for transition took place, it remained true that the assessment process was limited to the annual ISP meeting.	Noncompliance

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	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.	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: • 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. • 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. • As described in Provision F1e, each discipline's ISP assessment needed to include an opinion/recommendation regarding community living. For seven recently completed ISPs, the Monitoring Team reviewed a total of 51 discipline-specific assessments. Of these, 36 (71%) included a determination and recommendation as to whether the individual could be served in a less restrictive setting. In many cases , however, 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. Only four of the 51 discipline-specific assessments (8%) provided a substantive and individualized statement and recommendation in this regard. • 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. Conclusion: 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 meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service	CLDP Policy and Process: The Department of Admissions and Placements was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. The Transition QIDP was designated to implement this responsibility. The statewide CLDP format and template had been slightly revised on 06/01/2014.	Substantial Compliance

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	in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	<u>Timeliness of Development and Implementation of CLDP:</u> The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. The Facility reported it initiated the Profile section of the CLDP within 24 hours of a referral. The Monitoring Team reviewed a sample of three completed CLDPs (Individuals #625, #711, and #799) and four CLDPs in progress (Individuals #66, #120, #600 and #770) for referrals made during the past six months. Overall, the Monitoring Team found that documentation of ongoing implementation continued to be frequent and detailed: • Three of the three (100%) completed CLDPs included adequate documentation to show that they were updated throughout the transition planning process over the past six months. • Three of four (75%) CLDPs in progress included adequate documentation to show that they were being updated throughout the transition planning process. For one individual (Individual #66), who was referred for transition in April 2014, the Facility did not provide a completed CLDP Profile, although there was evidence of transition activity otherwise. The Monitoring Team reviewed an updated Community Placement Report (CPR), updated on Monday, August 25, 2014 covering the previous six months. Thirteen of the 17 (76%) current referrals were within the 180 days allowed in the current policy. The Monitoring Team was unable to further assess whether the transition process took more than 180 days for these seven individuals, as the CPR and other reporting in the document request did not provide the actual date of referral; however, for the sample of three CLDPs reviewed for transitioned individuals, all (100%) had transitioned within 180 days. The Monitoring Team has noted several times in the past that the CPR does not provide accurate dates upon which it can measure timeliness from the point of referral until transition. This remained true for this monitoring visit. The Monitoring Team again suggests this be remedied for the purposes of clarity. The information provided in the document request for the CLDPs in progress was also not sufficiently clear to gauge timeliness, as the actual CLDP form was included for only two of the four. The other two included the completed Living Options Addenda, but it was not clearly stated what the original referral date was. For example, the Monitoring Team noted that the Living Options Addendum for Individual #770 indicated a referral date of 01/23/2014, but the CLDP in progress indicated the original referral date was 7-13-2011. As a result, it was not possible to rely with certainty on the Living Options Addenda reviewed to evaluate timeliness. The two Transition Specialists were 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	

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		and deliberations. This continued to appear to be a successful approach in achieving transitions in a timely manner. The APC's office had also developed a tracking list of action steps that need to be implemented once a referral is made in order to track progress and facilitate follow-up with IDTs to ensure timely actions when necessary, as previously recommended. Development of CLDP in coordination with the LA: A review of completed CLDPs indicated that four of four (100%) evidenced that the plan was developed in coordination with the responsible LA. In addition to participation in the referral meeting, the LA attended the CLDP meetings and completed the Continuity of Care-Move Site Review Instruments for the Community Living Discharge Plan as further described in Provision T1e below. Conclusion: While the Monitoring Team was unable to fully evaluate compliance with the timeliness of implementation of the CLDP due to lack of sufficient data for review, it would appear that the Facility was maintaining substantial compliance 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. Coordination with the LA in the development of the CLDP did not appear to be of significant concern at this time. As has been noted in previous monitoring reports, there did remain concerns related to the adequacy of the CLDPs that were developed, primarily in the failure by the IDTs to adequately identify the appropriate essential and nonessential supports for each individual. These deficiencies are described in more detail in Provisions T1c1, T1c2, and T1c3 below.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	Actions that Need to be taken by the Facility Specified: None of three 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. The Monitoring Team understands that not all six of these bulleted items will apply to every individual; however, there should be some indication that all six were at least considered by the IDT and placement coordinator in the development of every CLDP. • 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)	Noncompliance

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		• 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 three CLDPs reviewed. As reported in Provision M3, signed and dated In-service Sheets were available in nursing Transition Packets reviewed for four individuals indicating the agency providers were trained, but only one of the In-service Sheets listed the topics that were trained. Therefore, it could not be determined whether all required training was provided. The Facility had continued to implement some level of competency-based written tests to test provider staff understanding of basic information about each individual. 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. Such specific training may have prevented a regrettable lapse in ensuring adequate supports for Individual #306 were provided. In that instance, the Facility did not ensure a glucometer was made available to the provider home at the time of transition, as specified. The only specific documentation of training provided was a multiple choice test that asked if the individual had a diagnosis of diabetes, but did not address any actions the home would need to take to ensure her health in this regard or what equipment would be needed. 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 be pro-actively and effectively applied for other disciplines as well. For example, the Monitoring Team noted one occasion in which behavioral staff from the Facility interacted with a provider behavioral consultant following significant disruptions to the Individual #746's transition. Given the individual's history, a more proactive pre-transition collaboration may have been advisable. <u>Coordination of CLDP with provider staff:</u> A review of completed CLDPs indicated provider staff were typically involved throughout the CLDP process. In three of three (100%), there was documentation of training of provider staff, visits by the individual to the provider sites and the individual's	

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		responses, and provider staff attendance at the CLDP. The Monitoring Team was again pleased to see the Facility's continued to provide an increased level of in-service training and competency testing for provider staff, but again encourages the Facility to further enhance this training in terms of its content. Conclusion: This provision was found to be not yet in compliance.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The parties requested reduced monitoring due to history of compliance ratings and the Monitoring Team agreed. A brief review of three CLDPs indicated the following: • Responsible staff identified for needed actions: For three of three (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 three of three (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 three completed CLDPs and four CLDPs in process, for a total of seven to assess compliance with this provision. For seven of seven (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 assessment of needs and supports within 45 days prior to the individual's leaving.	Timeliness of Assessments: The Facility continued to review CLDP assessments and to make assignments for any updates, revisions or Action Plans that needed to be made to an individual's current assessments, as described in RSSLC Policy G.14 Admitting/Moving Individuals: CLDP Grand Rounds, effective 08/30/2013. 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. Adequacy and Comprehensiveness of Assessments: Assessments were still not being consistently well integrated into a comprehensive assessment in a manner that allowed for the CLDP to adequately reflect the needs and	Noncompliance

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		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. See also Provision T1e. <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. RSSLC should continue its efforts toward developing 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 be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	<u>Identification of Pre and Post Move Supports</u>: In none of the four completed CLDPs reviewed (0%) was there identified a comprehensive set of pre and post move supports, in measurable/observable terms, to be implemented. This was also found to be true for the CLDP for Individual #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: 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	Noncompliance

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		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. The Monitoring Team was encouraged to observe a continued emphasis placed on the identification of clinical indicators in the medical summaries to be used as monitoring parameters to be included in the CLDP. It would be advisable for the other disciplines to provide similar monitoring parameters, particularly as these are critical for an effective and accurate PMM process. Otherwise, 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: • None of three 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. • As reported in Provision M3, the Monitoring Team independently reviewed four Transition Packets provided using the Facility's In-service Record for Nurse to Nurse Report/Documentation Hand Over for Community Movement Checklist for recent transitions to the community for Individuals #799, #625, #306, and #771, and found an overall 57% compliance based on a review of items included on the Facility's In-service Record for Nurse to Nurse Report/Documentation Hand Over for Community Movement Checklist, was found as required to be	

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		included in the Transition Packets. Numerous documents were not found in the Transition Packets, as reflected in the above data. • Individual #306 had a diagnosis of Diabetes, Type 2 and required glucose checks in the morning and at hour of sleep. A support was developed in the CLDP for the individual to have glucose monitored on this schedule. The CLDP did not indicate whether the Facility or the provider would provide the equipment for monitoring, nor did it indicate any parameters for the glucose measurement or any actions provider staff should take based on the results. A glucose monitor was not included in the list of items the Facility would deliver on the day of move, nor was there an expectation defined for observing for the glucose monitor in the Pre-Move Site Review or the PMM Checklist. • An IDT meeting was held during the monitoring visit to review the status of Individual #771, who had transitioned on 6/25/14. This meeting was held after the Program Compliance QIDP made a visit to the individual's community home, shortly after another individual from RSSLC (Individual #306) was hospitalized and returned to the Facility. The Program Compliance QIDP noted several concerns, including a change in psychotropic medication that had taken place. It was noted by the IDT that there had been considerable discussion at the CLDP meeting about not making changes in these medications without very careful consideration due to past difficulties in finding an appropriate regimen. The Monitoring Team reviewed the CLDP and did not find this referenced, nor did any support provide such a precaution. Additional circumstances of concern are discussed further in Provision T2a. <u>LA Continuity of Care Process:</u> The Monitoring Team reviewed documentation for seven individuals who had transitioned to the community in the last six months and was able to find six (86%) LA Continuity of Care Pre-Move Site Review Instruments in the packets provided. The document was not included in the document request material for Individual #238, which may have been an oversight. Five of the six (83%) available for review were completed within the required timeframe and included the required DADS QRS report as an attachment. The LA Continuity of Care Pre-Move Site Review Instrument for Individual #771 was not completed until three days after the transition date. <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 seven individuals who had transitioned in the past six months. Each appeared to have been completed in a timely	

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		manner and included a visit to each service provision site. The Monitoring Team had selected a sample of three CLDPS to review more extensively to assess thoroughness in addition to timeliness, including the Pre-Move Site Reviews, for Individuals #625, #711 and #306. The findings 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. In at least one instance, the Pre-Move Site Review documented an activity was completed, but it had not been. For Individual #771, the Pre-Move Site Review indicated the LA Continuity of Care Site Review was completed on 5/29/2014, the same day as the Pre-Move Site Review. The completed LA document indicated it did not take place until 6/12/2014. There were additional apparent discrepancies in the Pre-Move Site Review for this individual, in that it indicated in-service training was "Completed June 11, 2014" but the individual transitioned on June 9, 2014. • 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. <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, but 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. The Monitoring Team recommends an additional layer of review and scrutiny by the QA Department be given to CLDPs before approval and to the subsequent PMM over the course of the next six months.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the	<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	Noncompliance

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	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.	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. At the time of this monitoring visit, the Facility continued tracking the timeliness of the 45-Day assessments from the various disciplines using a revised Transition Checklist. It also continued to implement the CLDP Grand Rounds, which was 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. Additional QA procedures internal to the APC's office related to ensuring the development of CLDPs had been further enhanced since the last monitoring visit. These new processes included a Day of Move Checklist, which was intended to ensure the presence of supports that were required to be in place at that time, including, for example, the transfer of belongings and equipment. <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 Provision T1e. The Facility continued to use the Section T Monitoring which included the CLDP tool, the PMM tool and the Alternate Discharge tool. The Facility had initiated implementation of the CLDP tool, with eight having been completed thus far. It remained 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. <u>Conclusion:</u> This provision was found to be not in compliance. The quality assurance processes for this Section continued to evolve. The Monitoring Team encourages the Facility to continue to evaluate outcome and process indicators for implementation that will address the deficiencies in Provisions T1c, T1c1, T1d and T1e. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility	

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		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. • Given concerns related to the adequacy of the CLDP, the Monitoring Team again strongly suggests the Facility continue to focus and expand efforts within the Quality Assurance Department in conjunction with the Department of Community and Family Relations to improve the quality of all of the processes involved in the CLDP, consistent with the findings and recommendations in this report, including the continued 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.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance	<u>Facility Annual Obstacles Report:</u> The Facility had provided an updated Annual Report: Obstacles to Community Transition, Richmond State Supported Living Center, Fiscal Year 2013 for review at the time of the last monitoring visit. 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> DADS issued an Annual Report: Obstacles to Community Referral and Transition. It included data as of 8/31/13 from all 13 Facilities and a statewide summary. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 6 obstacles to referral categories and 12	Noncompliance

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	from other agencies or the legislature.	obstacles to transition areas used in FY13. • DADS included a list of 14 initiatives it was continuing to support. • The report included attachments with each of the Facilities' annual reports. • The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the monitoring team's reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • Transition obstacles data: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. State office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, state office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The monitoring team believes that this information should be included in the report. • DADS strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. During recent discussion with state office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set	

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		of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition). • 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). <u>Conclusion:</u> This provision was found to be not in compliance.	
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	<u>Issuance of the Community Placement Report:</u> 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, August 25, 2014, for six months ending on that same date, 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 <u>Conclusion:</u> The finding of substantial compliance stands. The Monitoring Team noted some changes in process and format of the report, including a much lengthier, and likely more accurate, listing of individuals whose ISPs were held during the timeframe covered by the CPR and were not referred solely due to LAR Choice. It also included a list of 64 individuals who were not referred due to other reasons, ranging from Individual Choice to Medical Issues to Behavioral Psychiatric Issues and others. These were helpful data to have readily available. It was also noted that referral dates were no longer listed for community placements or rescinded referrals, which made the CPR less useful in assessing the status of timeliness. The Facility may want to consider resuming the inclusion of those dates.	Substantial Compliance

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	Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Policies and Procedures related to Post-Move Monitoring: The Facility continued to use the PMM Checklist dated December 2013. It had also made revision to its local policies intended to strengthen to its PMM processes, as discussed below. Staffing: There was a single Post-Move Monitor position at RSSLC, which would appear to be adequate for the numbers of transitions. At the time of the last monitoring visit, the APC was continuing to complete PMM responsibilities, but a newly hired Post-Move Monitor was in orientation at the time and expected to begin work shortly after the monitoring visit concluded. This new staff person was only on the job for several months before leaving the position. In the interim, several members of the Department of Admissions/Placements staff had been completing the PMM responsibilities. Interviewing was currently underway to re-fill this position. Review of PMM Checklists: The Monitoring Team reviewed PMM Checklists for 13 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 not being as consistently completed in a timely manner as in the past. This may have been the result of turnover in the Post-Move Monitor position. Of the 24 PMM visits due during this time period, 21(88%) were made within the required timeframes, ranging from one day to one week in terms of the delay. In addition, Individual #746 was to have an extended 90 day PMM period due to significant behavioral concerns that required disruptions in the stability of his community home, as described further below regarding the implementation of required supports. This PMM period was to have begun in June, 2014. The Facility did not include this in its tracking log provided for review, nor were any additional PMM Checklists beyond the initial 90-Day period provided in the document request. • 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).	Noncompliance

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		• Use of Standard Assessment Tool: In each case, the PMM visits were documented using the prescribed standardized tool, the Post-Move Monitoring Checklist revised in December 2013. The Post-Move Monitor also gathered documentation of the completion of supports 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 Monitoring Team found the PMM process was not yet as vigilant in this regard as necessary. For example: • Individual #771 had a support to receive an additional eight ounces of fluid at each meal due to constipation. The documentation obtained by the Post-Move Monitor for the 45-Day PMM visit included Fluid Intake Charts that provided a direction the individual should have eight ounces of water daily. This was not noted by the Post-Move Monitor, nor was the fact that for the entire month of July 2014 the Fluid Intake Charts documented water intake only for the hours from 8:00 AM to 3:00 PM. • The Service Delivery Logs for Individual #771 gathered at both the 7-Day and 45-Day included a number of notations the individual was not sleeping well at night and was frequently yelling and crying. The CLDP called for the individual to be monitored for "psychotic behaviors, hallucinations, agitations associated with the diagnosis of Schizophrenia." Both the 7-Day and 45-Day PMM Checklists indicated only that the individual had not been observed to have any hallucinations or psychotic behaviors. The PMM Checklists did not otherwise note the sleeping issues and apparent frequent agitation. The IDT reviewed the 7-Day Checklist and did not address this concern. The 45-Day Checklist had not been reviewed. Facility's Efforts to Ensure Supports are Implemented: The Post Move Monitor maintained a file with materials to verify the implementation of supports as well as to document follow-up in some instances, but the process was not yet consistently implemented nor was it sufficient to ensure supports were implemented. Examples included: • As described in Provision T1e, Individual #306 had a diagnosis of Diabetes, Type 2 and required glucose checks in the morning and at hour of sleep. A support was developed in the CLDP for the individual to have glucose monitored on this schedule. The CLDP did not indicate whether the Facility or the provider would	

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		provide the equipment for monitoring, nor did it indicate any parameters for the glucose measurement or any actions provider staff should take based on the results. A glucose monitor was not included in the list of items the Facility would deliver on the day of move, nor was there an expectation defined for observing for the glucose monitor in the Pre-Move Site Review or the PMM Checklist. At the 7-Day PMM visit, the Post-Move Monitor indicated the support had not been implemented and noted the provider had not received the glucose monitor from the Facility. The Post-Move Monitor Follow-up Activities indicated the Facility did not deliver this vital equipment to the provider until 7/4/14, nor was there any follow-up to verify the provider was implementing the support at all. • Individual #746 was to have an extended 90 day PMM period due to significant behavioral concerns that required disruptions in the stability of his community home, as described further below regarding the implementation of required supports. This PMM period was to have begun in June, 2014. The Facility did not include this in its tracking log provided for review, nor were any additional PMM Checklists provided in the document request or the Potentially Disrupted Community Placement packet of materials. The Monitoring Team was unable to verify whether the Facility had acted to ensure adequate supports were provided during this extended PMM period. <u>ISPA meetings following PMM visits</u>: IDT review of PMM visits was no longer required as a matter of routine as per the statewide MIS Policy 018.2, but was to occur only if there was a concern. The Monitoring Team noted that RSSLC Policy G6.1, revision date 7/07/2014, clarified and localized an expectation that the IDT would meet after each PMM visit for review. The Monitoring Team urges the IDT to evaluate each PMM visit carefully and in detail in order to ensure that important issues are not overlooked as described above for Individual #771. <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 pre and post-move supports, as described in Provision T1e. The IDT should also clearly state the necessity to interview and observe for staff compliance and knowledge in addition to the paper review of a training roster. When staff interview is indicated, the IDT must also provide some criteria for the Post-Move Monitor to use in assessing whether provider staff have adequate knowledge of the specific supports. <u>Conclusion:</u> This provision was found to be not in compliance. Continuing deficits in the process remain as described above.	

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T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	Observation of Post-Move Monitoring Visit: No PMM visit was held during this monitoring visit; therefore this provision was not rated. The scheduled PMM visit was canceled as a result of the individual returning to the Facility after a significant injury and hospitalization.	Not Rated
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		Not Rated
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals:	Number and Categories of Alternate Discharges: In response to the document request, RSSLC reported there were no alternate discharges during the past six months.	Not Rated

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	(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: **Documents Reviewed:** 1. Richmond State Supported Living Center (RSSLC) Self-Assessment, updated 08/12/2014 2. Richmond State Supported Living Center Action Plans, updated 08/11/2014 3. Section U Presentation Book materials 4. Richmond State Supported Living Center Settlement Agreement presentation, August 2014, Round 8 5. DADS Policy 019: Guardianship, effective 3/7/2012 6. DADS Policy 057: Self-Advocacy, effective 5/30/2012 7. RSSLC Policy C.3: Guardianship, dated 3/7/2012 8. RSSLC Policy C.18: Self-Advocacy, effective 7/20/2012 9. RSSLC Policy F.1: Scheduling Annual Personal Support Meetings, dated 8/2/2011 10. The most recent prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and a LAR to render such a decision, dated Monday, August 25, 2014 11. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 12. Over the six (6) months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates 13. Individual Rights Assessment (IRA), Form 6614, dated September 2012 14. ISPs for Individuals #243, #501, #530, #596, #630, #655, and #753 15. Completed IRAs for Individuals #243, #501, #530, #596, #630, #655, and #753 16. 30-Day ISPs and Assessments for Individuals ##85, #153, #395, and #795 17. Self-Advocacy Minutes for the past six months **People Interviewed:** 1. Veronica Humphrey, Human Rights Officer (HRO) 2. Georgette Brown, Quality Assurance (QA) Director **Meetings Attended/Observations:** 1. ISP annual planning meetings for Individuals #680 and #745
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The Monitoring Team reviewed the RSSLC Self-assessment., which indicated the Facility was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. For Section U, in conducting its self-assessment, the Facility had not used monitoring/auditing tools to any significant level, although there continued to be a review of a sample of ISPs for several indicators. While the Monitoring Team commends the Facility for its efforts to utilize data in its self-assessment, it must be reiterated that there must be a clear outcome basis and a careful choice of indicators for the data to be useful in evaluation. An example was provided when the Monitoring Team last reviewed this section in

	August 2013 that highlighted an inherent conflict in the findings of the Facility's self-assessment. A similar issue was again apparent in the review of the current self-assessment. For example, to evaluate compliance with Provision U1, the Facility indicated it had reviewed ten ISP documents to assess whether IDTs discussed the individuals' capacity to communicate ability to make decisions. The self-assessment found that zero of 10 (0%) ISPs included such discussions. At the same time, to evaluate compliance with Provision U2, ten ISP documents were reviewed to assess whether the IDTs also discussed the individuals' needs related to guardianship, but those findings indicated 100% included such a discussion. As was reported previously, there was an obvious conflict, in that guardianship needs cannot be adequately discussed if that does not include a discussion of the individuals' capacity to communicate their ability to make decisions. A finding that 100% of the IDTs discussed guardianship was not a positive outcome indicator when 0% discussed the ability to communicate in the decision-making process. The State and Facility are encouraged to develop meaningful and consistent outcome indicators to self-assess this Section. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. The Facility did appropriately include several broad steps to be implemented in the future, including training QIDPs on the new IRA and its inclusion in ISP, implementing the new IRA, conducting an audit of random ISPs to identify that new IRA is being included in ISP, and analyzing data for corrective action. These Action Plans could be improved in the future by providing further operational detail.
	Summary of Monitor's Assessment: This Section was not yet in compliance. This Section was last reviewed by the Monitoring Team in August, 2013, as the parties had agreed that this would not be monitored at the March 2014 visit. There had been little action or progress in this Section since the last time it was reviewed, with the exception of the creation of an electronic database for tracking guardianship requests and prioritization. This was a helpful management tool that will take on additional importance once the Facility implements a standardized tool, process. and/or methodology for IDTs to use to assess and prioritize the need for a Legally Authorized Representative (LAR), an advocate, or other assistance an individual might need in decision-making. Specific findings for each provision are as follows: **Provision U1:** This provision was found to be not yet in compliance. The Facility did maintain a list of individuals without a guardian, but not all individuals on the list had yet been assigned a priority. The Monitoring Team remained concerned that DADS policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized tools, process and/or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate, or other assistance an individual might need in decision-making. Facility IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria or process. This remained the most significant barrier to achievement of substantial compliance for this Section. As part of undertaking an effective and appropriate large-scale effort to solicit guardians, RSSLC must ensure it has an appropriate assessment process, tool and/or methodology in place to determine the actual need for guardianship. In the past several reports, it

	was noted that DADS State Office reportedly was developing a policy on consent to supplement the one it had issued on guardianship. This was essential, because until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. **Provision U2:** This provision was found to be not in compliance. It was reported no guardians had been obtained during the past six months, but 56% of the individuals living at RSSLC had previously been adjudicated incompetent. The Facility's Guardianship Committee had met on two occasions since the last monitoring visit, but the minutes did not reflect significant ongoing actions and deliberations. The Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. These data were not adequately reflected in the ongoing minutes and provided little follow-up information from one meeting to the next. The Facility continued to need to ensure it had an appropriate methodology in place to determine the actual need for guardianship.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	<u>Policies and Procedures related to functional capacity to give consent and/nor need for LAR:</u> No new DADS policies had been issued related to this provision. DADS Policy 019: Guardianship, effective 3/7/2012, addressed the development and maintenance of a prioritized guardianship list as required. The Monitoring Team had expressed concern in previous reports that the policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized process, methodology, or tools IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. The Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance needed to be provided as to how, and how often, a need for guardianship should be periodically reviewed. In the past several reports, it was noted that DADS State Office reportedly was developing a policy on consent to supplement the one it had issued on guardianship. This was essential, because until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. Since the Monitoring Team last reviewed this Section in August 2013, DADS State Office had issued a draft Individual Rights Assessment (IRA) that included questions related to an individual's capacity to make decisions, and the Monitors jointly provided comments to State Office on that draft document. No policy changes, proposed methodology for implementation or training requirements accompanied the draft IRA, all of which would	Noncompliance

#	Provision	Assessment of Status	Compliance
		be needed to implement an effective and comprehensive approach to the SA requirements. Maintenance of Prioritized List: The Facility maintained a Prioritized List of certain individuals who did not have a current guardianship imposed. A new electronic database had been created for tracking guardianship requests and prioritization. This was a helpful management tool that will take on additional importance once the Facility implements a standardized tool, process, and/or methodology for IDTs to use to assess and prioritize the need for an LAR, an advocate, or other assistance an individual might need in decision-making. The Monitoring Team reviewed the provided Prioritized List for timeliness of updates to the list and the prioritization process: • Timeliness of Updating Process: The SA requires the prioritized list to be updated semiannually. The priority list was reported to be updated as new admissions and/or discharges occurred. It was last updated Monday, August 25, 2014. • Prioritization Criteria: The Facility used three criteria for prioritization for individuals who had not been adjudicated incompetent, which did not appear to be fully consistent with the criteria in DADS Policy 019. The list provided indicated there were six individuals in Priority I, which was defined as individuals without Family/Correspondent to advocate for them; 19 individuals assigned Priority II, or individuals with family/correspondents that do not routinely and/or regularly visit or attend meetings to advocate for them; and, 16 individuals in Priority III, individuals with an involved family correspondent. The remaining individuals were not assigned a priority, either because they had previously been adjudicated incompetent and/or because the IDT had not yet assigned a priority level. A second list, also dated Monday, August 25, 2014, entitled Individuals without a Priority Identified/No LAR, contained 62 names. This list did not include individuals who had been previously adjudicated incompetent but did not have a current LAR due to a lapse or death of the LAR. It may be helpful to the Facility to track this latter group of individuals, as well as to consider whether individuals whose designated guardians are either deceased or do not intend to renew their guardianship require a higher priority than, for example, those whose guardianship lapse is a temporary status related to the filing process. Assessment of Functional Capacity to Render a Decision: RSSLC indicated it did not yet have a standardized process, methodology, and/or tool to assess functional capacity. During the past six months, the IDTs had addressed the ability of an individual to provide informed consent using IRA form (Form 6614), dated September 2012, which was administered in conjunction with the completion of an ISP.	

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		Seven of seven (100%) recently completed annual ISPs included an IRA, but for 30-Day ISP meetings reviewed for four individuals, only two (50%) included a completed IRA in the final documentation provided. Form 6614 included an expanded section for assessing an individual's ability to provide informed consent, but it was not predicated on any objective or standardized criteria related to decisional capacity, nor were the IDTs using it in a thoughtful manner. The decision to place someone on the prioritized list therefore remained without a sound basis for the most part. • For the seven annual ISPs, findings related to the completion of the IRA and the discussion of decisional capacity by the IDT included : o For one of seven reviewed (14%) the IDT concluded the individual was able to give, or participate in giving, informed consent in any of the six areas listed in the IRA. For Individual #630, the IDT determined the individual was able to give informed consent in the areas of Programming, Transfer/Placement, and Financial. While the Monitoring Team was encouraged that at least one IDT did not make a blanket determination of incapacity, there was no specific basis offered for any of the determinations, whether in the positive or the negative, in the way of an individualized assessment of the individual's decision-making capacity. The IDTs still needed guidance and training on an appropriate methodology to guide and to justify its decision-making processes around informed consent. This was further evidenced, for example, by the fact that Individual #630 continued to have a money management restriction even though it was determined the individual was capable of informed consent in the financial area. There was no documentation the individual had given consent for this restriction. • Observations made by the Monitoring Team of the ISP meetings held during the site visit indicated that for neither of two individuals (0%) did the IDT undertake any substantive discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent. <u>Conclusion:</u> This Provision was found to be not yet in compliance. The Facility did maintain a list of individuals who did not have a guardianship imposed, but the determination of need was not predicated on any formal or standardized process or tool. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility will need to prescribe an assessment process, methodology, and/or tool rooted in objective evidence-based principles of decisional capacity, and further, require the IDTs receive	

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		sufficient training and oversight to ensure they implement the process thoughtfully and carefully.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	Policies and Procedures related to obtaining LARs for individuals in need: No changes had been made to DADS or local Facility policies regarding processes to obtain LARs since the previous monitoring visit. Facility Efforts to Obtain LARs: RSSLC reported no new LARs had been obtained for individuals living at the Facility during past six months. Facility activities related to supporting decision-making for individuals during the past six months included: • Guardianship Committee: The Facility had a Guardianship Committee as called for in DADS Policy 019 and in RSSLC Policy C.3: Guardianship. The Committee had met twice since the previous monitoring visit and also held a meeting during this visit. Meeting participation appeared to have been somewhat limited, particularly for individuals and community members. The Monitoring Team reviewed the minutes for the meetings held in June and July 2014. It appeared these meetings continued to be largely informational, as reported in the report of the compliance visit of August 2013. The Committee had not been reviewing individuals' needs or requests for guardians or advocates in the past six months. • Advocacy Program: An Advocacy Program was not yet in place. In past reviews, the Facility indicated it was awaiting the final promulgation of the statewide policy on the topic before initiating a response. • Self-Advocacy Program: Although not a requirement for substantial compliance for this provision, the Monitoring Team wants to highlight the self-advocacy group's activities at RSSLC. The Facility continued to provide support for self-advocacy. The HRO was designated as the Self-Advocacy Coordinator and was responsible for providing support for the Self-Advocacy program, which typically met twice a month. One meeting did focus on the right of individuals to manage their own money and how they might receive assistance to do so. The Facility might consider also offering the self-advocacy group an opportunities for specific training regarding the ability to give informed consent. • Other Activities of the HRO/ Guardianship Coordinator: The HRO continued to provide training about guardianship and advocacy at new employee orientation on a monthly basis. Conclusion: This Provision was found to be not yet in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility need to prescribe an assessment process, methodology, and/or tool rooted in	Noncompliance

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		objective evidence-based principles of decisional capacity and, further ensure the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully. The Guardianship Committee should be provided with training regarding the assessment process as well to facilitate their appropriate review of referrals made as a result. The Facility may also want to consider including appropriate outcome measures and indicators related to this Provision in its QA/QI processes.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RSSLC Self-Assessment 8/12/14 2. RSSLC Action Plans 8/11/14 3. Presentation Book for Section V 4. Provision Action Information 5. DADS Policy 020.1 Recordkeeping Practices 3/5/10 6. RSSLC Policy A.6 Recordkeeping 6/23/14 7. RSSLC Policy A06.1 Individual Notebooks 1/29/14 8. List of DADS Policies revised since last visit 9. List and copy of each new/revised Facility Policy relevant to Requirements of the SA 10. 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. 11. List titled Revised Policies, date range 2/1/14-8/22/14, sorted by Competency-Based and In-service 12. Active Record Order & Guidelines 7/23/14 13. Table of Contents for Master Record 7/29/14 14. Guidelines for Monitoring Active Record 7/29/14 15. Guidelines for Monitoring of Individual Notebook 7/7/14 16. Guidelines for Use of the V-Tool 6/13/14 17. Checklist for Minimum Documents Included in Master Record 12/6/13 18. Virtual Client Folder Structure 8/12/14 19. Active Record and Individual Notebooks—Monthly Audit (Internal/External Record Monitoring) description of process 7/31/14 20. Overflow—Monthly Audits description of process 2/17/14 21. Master Records Monthly Audit description of process 7/30/14 22. Settlement Agreement Cross-Referenced with ICF-MR Standards Section V (referred to in this report as Section V monitoring tool) 23. Description of the process for selecting records for each of the types of audits 24. Guidelines or definitions for use in doing records audits 25. Record Audits, including emails regarding corrective actions for 10 audits per month, conducted June 2014 for Individuals #56, #70, #112, #174, #253, #300, #388, #603, #619, and #776, July 2014 for Individuals #29, #76, #91, #137, #324, #437, #530, #551, #568, and#723, and for August 2014 for Individuals #202, #322, #332, #384, #387, #463, #537, #626, #641, and #663 26. Quality Assurance Monthly Report for Section V, June 2014 27. Tables of monthly data on level of compliance for "Provisions 1, 3, and 4" by Section V monitoring tool question, Internal and External audits, 8/1/13-7/31/14 28. Trend Analysis Report on Section V, Provisions 1, 3, and 4 8/1/13-7/31/14 29. Graphs of data on Appendix D compliance in Observation Notes from audits 3/1/14-8/25/14

	30. Active Record, Individual Notebook, and Master Record for Individual #350 31. Active Treatment Notebook, Individual Notebook, and Active Record Corrections Follow-Up for Individual #619 32. ISP Attendance Tracking Log for meeting dates of 4/1/14-8/25/14, alphabetically by individual 33. Table of annual assessments filed 10 days prior to meeting (annual ISP planning meeting) for meeting dates of 4/1/14-6/30/14, totaled by month by assessment 34. Share Drive list of assessments for Individual #181 35. List of assessments required for ISP annual meeting for Individual #745 36. Integrated Progress Notes (IPNs) by Medical staff for Individual #429 **People Interviewed:** 1. Group interview of Wanda Hartensteiner, Medical Records Director, and Unified Records Coordinators (URCs) Susan Steamer and Eileen Holmes 2. Andrea Faniel, Sherita Flowers, Kaylan Henderson, and Lester Shelton; and Director of Quality Assurance Georgette Brown. 3. Group interview of Leroy Thompson (QIDP Coordinator), Angela Hernandez (Program Compliance QIDP), Dameyon Landrum (QIDP Educator), Ashley Smith (Services Coordinator), and QIDPs Clara Ebot, Crystal Hill, and Chundra Smith **Meetings Attended/Observations:** 1. Integrated Support Plan (ISP) Annual Planning Meetings for Individuals #680 and #745 2. ISP Preparation Meeting for Individual #497 3. Grand Rounds addressing Individual #737 4. Fifteen-day preparation meeting for Individual #613 5. Location where active records are kept at Leon B, Trinity D, San Antonio A, and Pecos
	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: ▪ Settlement Agreement Cross-Referenced with ICF-MR Standards Section V (referred to in this report as Section V monitoring tool) ▪ Record audits using the Active Record Review ▪ Interview Tools for use of the record o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with most, but not all, requirements of the Settlement Agreement. 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 of information for

	assessing the status of compliance of records with requirements of this Section, However, the Self-Assessment did not report whether records were present and used in meetings at which decisions are made about care, treatment, and training. 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 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 and group data book information, 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: o Number of policies implemented and updated o Number of record audits and percent compliance o Number of records reviewed for inter-rater reliability and the level of agreement o Percent of corrections (identified as needed following record audits) completed on time o Number of records checked out and in, percent checked out that were not checked in, and number marked "not accessible" (per interview, meaning they were not present and not checked out) ▪ 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. The Facility may also want to use in its assessment the data provided by the audits on level of compliance on the Active Record Review tool; the Facility tracks this information through a database and included it in the Quality Assurance Monthly Report for Section V, June 2014. 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 clearly stated in the Self-Assessment data; for example, the Self-Assessment reported data from the Interview Tool and also gave examples of the types of answers given (a very positive finding that confirms the Facility carried out a thorough review of the responses) but did not indicate an

	assessment of the quality of those answers. Some items, such as clinical assessments, would be more appropriately measured by clinicians and are discussed in other sections of this report. o All data reported in the Self-Assessment for Section V were collected by the QA Department, including URC who work in the Medical Records Department and Program Monitors. ▪ The Facility rated itself as being in compliance with Provision V3. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Completed, In Process, or Not Started. For Provision V3, which had been found in substantial compliance at the last review, actions for maintenance were listed; all were stated as "Continue to…" ▪ The Self-Assessment identified areas of need/improvement. The Self-Assessment also identified which items in the Action Plan addressed the areas of need. The specific items did not all match the numbering of the Action Plan, but this identification was a useful way to cross-reference actions to areas of need and should be continued. ▪ The actions did provide a set of steps likely to lead to compliance with most requirements of this Section. Some actions involved single actions that needed to be taken. Some others involved a sequence of actions. In some cases, the sequence appropriately identified the next few actions needed, but additional actions will be needed when these are accomplished. For example, for Provision V4, actions a-c included two actions currently in place (URC attends meetings to observe and summarizes findings from observations) and were identified as In Process; the third action is to develop a tool to use while observing and was identified as Not Started. Once those three actions are completed, there will need to be processes to track the findings, to provide feedback to staff on the findings, and to take corrective or improvement actions as needed based on the findings from the observations.
	Summary of Monitor's Assessment: The Facility maintained a unified record for each individual. Prior improvements were maintained, including a comprehensive and robust random record audit process. Provision V1: Percentage of required documents found present remained similar to that found at the last compliance visit; improvement remains needed. Improvement found for the last compliance period in consistency with Appendix D requirements as reported on the Section V Monitoring tool were maintained, but not improved, during this compliance period. The Facility had established a more sensitive measure that rates compliance with Appendix D requirements on each required document; compliance rates were higher on this tool and approached an acceptable level of compliance. Provision V2: Processes for development, revision, and implementation of policies were in place. There remains a need for policies to address a few requirements of the Settlement Agreement (note, for example,

	the requirement reported in Section U for a policy or process to assess capacity for decision-making). The Facility needs to ensure all staff who are required to have training on new or revised policies receive consistent training. Provision V3: The audit system is robust, comprehensive, and sets high standards for finding compliance. Ten random audits are conducted each month (doubling the requirement in this provision), and these are supplemented with additional audits of specific items in the record. Reliability across auditors is adequate. 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. The improved level of compliance with Appendix D requirements and presence of documents has been maintained, although further improvement had not been demonstrated. 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. Although this must be addressed, the robust audit system and maintenance of improvement in compliance with Appendix D requirements merit a finding that the Facility is in substantial compliance with this provision. Provision V4: 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 identified by the Facility or Monitoring Team. Although staff were able to describe how they used the records for decision-making, actual use of the records in interdisciplinary meetings continued to improve but remained variable.

#	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.	<u>Policies Governing Recordkeeping</u> The Facility had a policy to maintain a unified record; this policy was consistent with statewide DADS policy. Recordkeeping was guided by RSSLC Policy A.6 Recordkeeping, which was revised 6/23/14. Significant revisions to this policy included requiring the staff member who completes documentation to include the individual's identifying information, requiring annual ISPs to be filed in the Active Record no more than 30 calendar days after the annual ISP meeting, and extensive revision to the chart checkout/check-in process. 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 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		the reviews for several Sections of this report. The Monitoring Team also audited the Active Record, Individual Notebook, and Master Record for Individual #350. In addition, the Monitoring Team reviewed the 30 Facility record audits from June, July, and August 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. 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 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. In part to address this, the Facility reported that it had begun a pilot trial that would include data sheets in the Individual Notebook and have that Notebook accompany individuals. 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.	

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		Based on audits conducted by the Facility, 30 of 30 (100%) audited records included an Active Record, Individual Notebook, and Master Record. In addition, the Monitoring Team audited the record for Individual #350, which 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" 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. Training and testing had not changed since the last compliance period. At the last compliance visit, the Facility reported the URCs did a follow-up assessment with a sample of 20% of new employees, in which URCs checked documentation and follow-up training as needed. The Facility reported during this visit that this process was discontinued and replaced with identification of direct support professionals (DSPs) who, based on audit findings, require refresher training. This focused on documentation on observation notes and was done individually. The Facility reported that repeat findings on multiple shifts for a unit led to provision of handouts/slides and tests to Residential Coordinators (RCs) so they could train all DSPs the RCs were responsible for sending completed training sheets and competency tests to the URCs. The Facility provided examples of emails to RCs that included description of errors being made by specific staff, the power point training slides, and competency tests. The Facility also provided examples of follow-up emails when the training verification was not returned to the URC timely or when the test indicated a need for retraining.	

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		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 Leon B, Trinity D, San Antonio A, and Pecos. In four of four homes (100%), Active Records were kept in an accessible area; records were secure. 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. 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 three of seven records (43% Individuals #86, #276, and #318), the Checkout Books were accurate. • For four individuals, at least one chart was not present. For two individuals (50% of those with a chart not present, Individuals #27 and #745), 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. Charts for Individuals #73 and #318 were appropriately checked out. For Individual #745, the Monitoring Team had just left the Individual's ISP at a conference room in the unit but not in the home, where the records were present. The Facility reported that any records taken away from the home needed to be checked out, even if they remained somewhere in the unit. • For two individuals (29%, Individuals #73 and #546), charts remained checked out but were present; while a lesser problem, it does indicate staff were not being careful in completing the checkout/checkin process. The Facility provided data on use of the tracking sheet from 1/2/14-7/31/14 by home. Because the number of records audited was not stated, the data were difficult to analyze. However, they reported many records not accessible (that is, not present when the audit was done) and up to 27% of the present records not checked back in after having been checked out. <u>Accuracy and Completeness of Records</u> To determine whether records were completed in compliance with Facility policy and	

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		Appendix D of the Settlement Agreement, the Monitoring Team: • Reviewed the documents V-Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 Trend Analysis data report for August 2013 through July 2014. • Reviewed the Quality Assurance Monthly Report for Section V, June 2014 • Reviewed record audits conducted June 2014 for Individuals 56, #70, #112, #174, #253, #300, #388, #603, #619, and #776, July 2014 for Individuals #29, #76, #91, #137, #324, #437, #530, #551, #568, and#723, and for August 2014 for Individuals #202, #322, #332, #384, #387, #463, #537, #626, #641, and #663 • Conducted, with a URC, an audit of the Active Record and Individual Notebook for Individual #350.; the Monitoring Team also audited the individual's Master Record using the Checklist for Minimum Documents Included in Master Record. Individual #350 was selected by computer randomization from among individuals who had been admitted between the end of the last compliance visit and the end of June 2014 (to permit time for assessments and ISP to be due). Completeness of Active Record and Individual Notebook: Of the 30 record audits the Facility audited for June, July, and August 2014, 16 (53%) were rated yes for Complete (for the Active Record) on the Section V Monitoring tool. The Monitoring Team audited the Active Record and Individual Notebook for Individual #350 alongside a URC. The Facility was continuing to use a database that allowed direct entry on the Active Record Review forms during a records audit, as reported in Provision V3, and that process was used for this audit. In addition, the Monitoring Team and the URC independently completed the Section V monitoring tool based on the information gathered in completing these audits. 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 #350, 56 documents were present in the Active Record, 17 were not present, and 105 were not applicable. The percent of applicable documents present was 77%; this percentage was slightly lower than found for two records at the last compliance visit. For the Individual Notebook, 13 documents were present, one was not present, and six were not applicable; the percent of applicable documents present was 93%; this was almost the same as found at the last visit.	

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		Consistency with Appendix D Requirements: The Facility provided graphs of audit data (see Provision V3 for a complete description of the audit process) from August 2013 through July 2014. The data were monthly percent of overall compliance as reported on the Section V monitoring tool. The last compliance report, with data beginning in February 2013, reported the data from audits showed an increase in compliance beginning in August 2013. That stabilized and has maintained, with a range in percent of compliance from 64% to 77% during the period from February 2014 through July 2014. Data from audits of August 2014 showed a decrease to 70% compliance, still within the range found for this period. Thus, although compliance had not improved since the last compliance visit, the Facility had maintained the earlier improvement. The Trends Report also provided compliance score averaged by month for the Active Record Review tool beginning in January 2014. Because this tool rates compliance for each criterion for each item rather than providing an overall rating as is done in the Section V monitoring tool, it may be a more sensitive measure of change. Compliance ranged from 84% in January and May 2014 to 88% in June 2014. In addition, the Trends report included data on the number of times some specific Appendix D requirements were scored "No" in 70 Active Records reviewed from 1/1/14-7/31/14. Because scoring was done for each applicable item, there were several hundred opportunities. However, not all criteria are likely to occur for some items; for example, gaps would be scored in IPNs and observation notes but would not be likely in consultation documents, as each consultation would be a separate document. The Facility did not specify the number of applicable items or the percent in compliance. • Legibility was scored "No" only two times. • Gaps were scored "No" between 12 and 18 times per month with a stable trend. • Number of times "Current" is scored "No" ranged from 89 times in a month to 150 times. Thus, on average, a range from nearly nine documents to 15 documents per record would be found not current. • Number of times "Filed Correctly" is scored "No" increased steadily to a peak in May 2014 of 52 times but decreased again to 21 times in July 2014. • Documents needing purging also increased until June but decreased again in July 2014. • Graphs were also present for "Signature," "Title," "Error Correct," "Time," and "Date." The detail provides excellent information for making decisions on what issues may need systemic improvement and for tracking the effectiveness of improvement actions. The data indicate a need for improvement in compliance with several Appendix D	

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		requirements. For the record for Individual #350, the compliance percentage found by the Monitoring Team on the Section V monitoring tool was 74% for applicable items (nearly the same as at the last compliance visit, and within the range of monthly averages reported in the Trends Report). Ratings by the Monitoring Team and the URC were in agreement on 81% of applicable items; this level of agreement indicates reviewers rate items consistently. For four of the five disagreements, the URC rated "No"; the URC found percent of compliance to be 63%. Thus, the URC rated these items on the Section V monitoring tool more strictly than did the Monitoring Team. The findings on the Active Record Review showed 32 (43% of all applicable items) met all Appendix D criteria; of the 56 items present, 32 (57%) met all Appendix D criteria. When considering all possible Appendix D criteria for each item, 80% of criteria were met (since several could be met even though the item was rated not in compliance), which is in the range of monthly averages presented in the Trends data report. The Monitoring Team reviewed many more records in review of other Sections of the Settlement Agreement. Findings included: • As reported in Provision M1, there was no difficulty with the availability of records and documents requested for onsite and offsite review. Furthermore, at the last compliance review, there was an issue identified with filing the Hospital Liaison Nurse's Integrated Progress Notes. A CAP was put in place to address this issue. Since the last compliance review, the actions taken for the CAP appeared to be effective and the issue was resolved. The nursing staff now have computer access campus-wide and have begun typing their Integrated Progress Notes, which has significantly improved the quality and legibility of the notes. • The Monitoring Team randomly reviewed the August 2014 Universal Signature Sheets for MARs at Trinity and Three Rivers Units, which found they were current for nurses who administer medications, with their printed names, signatures, and titles. • No difficulties were reported in finding records needed for review. <u>Use of Virtual Client Folder (VCF)/Share Drive</u> Although not considered by the Facility to be part of the Unified Record, the VCF/Share drive provided the potential for accessibility to assessments by all members of the IDT. To improve accessibility of information for use by IDT members, many documents are filed in both the VCF and the Active Record, including ISPs and assessments. The Facility had developed a structure or naming convention so that the location of documents was consistent. This should make access to documents easy.	

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		Conclusion The Facility had maintained a Unified Record that included all required components. Presence of documents and compliance with Appendix D requirements had maintained the improvements reported in prior compliance reports but had not improved since the last compliance review. The Facility tracks very detailed information from record audits and can identify requirements needing improvement. This should assist the Facility, including the departments and units responsible for completing and filing documentation, to determine what issues need to be prioritized for improvement.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Facility Process to Develop and Revise Policies A Facility process existed and was followed to develop and revise policies, protocols, and procedures; this process required periodic review and revision as needed. RSSLC Policy A.1 Developing/Revising/Reviewing Policy or Procedure was revised to simplify the approval process when revisions to a policy are minor (such as when a document title is changed but no procedures or responsibilities change). Other than that, the process for developing or revising policies remained the same. Development and Revision of Policies to Implement Part II of the Settlement Agreement There is evidence that many protocols and procedures required to implement Part II of the Settlement Agreement have been revised as needed. The Facility had established a process for review of policies to determine need for revision. The Facility reported that it had begun to include reports by Section Leads to the QA/QI Council of any revisions to policies needed or made. In addition, the list of policies not updated in over one year is provided quarterly to the QA/QI Council, which determines if there is a need to update any of those policies. The Facility provided a list of policies revised between 2/1/14 and 8/22/14, separated by those that required competency based training, inservice training, or notification. This list included 54 policies that had been implemented or revised. The Facility reported that most of these were revisions. Information on new and revised policies can be found in relevant Sections of this report. In addition, the Facility reported implementation or revision of two DADS policies—a new policy on use of restraint and a revised policy on use of protective devices. Numerous procedures were updated. For example, as reported in Section M, many DADS and RSSLC nursing procedures and protocols were revised. • The Infection Control Policy and Procedure Committee began reviewing and revising Infection Control Policies and Procedures for 2014, which were updated on the shared drive. The Pandemic Respiratory Infectious Disease Readiness Plan became	Noncompliance

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		part of the Infection Control Policies and Procedures on the shared drive. To date 44 Infection Control Policies and Procedures had been reviewed and revised. <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 7/10/14 email To All Users of reviews/revised training policies. Although it is acceptable to send out notices when revisions to a policy do not involve changes in procedures or responsibilities that require training, such notice should be timely. In this case, the email notification listed 13 policies. An example of a delay in notification is Policy E10 Participating in Unit Morning Meeting. The policy revision date was 6/9/14, so the notice was delayed by a month. The Monitoring Team requested, 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. The Facility provided two emails that informed staff of policies that had been revised and RSSLC Inservice Sign-In sheets for numerous policies. The Facility did not provide evidence of the substance of training or report any competency-based training. At the last compliance visit, the Facility did provide training slides for one policy, but no copies of content of training was provided for any of the policies revised during this compliance review period. The Facility did provide a list of revised policies sorted by whether training was competency-based or inservice; no definition of "inservice" was provided. Four policies (E.01, E.02, E.05, and I.56) were listed as requiring competency-based training. The Facility did not provide evidence of any communication or training/testing materials to substantiate that competency-based training was provided for these policies; Policies E.01, E.02, and E.05 were referenced in one of the emails that stated these policies had been revised, approved, and saved to the share drive. However, several sign-in sheets for Policy J.01 Use of Restraint stated "Competency Quiz." This policy was listed under "Inservice" rather than as requiring competency-based training. RSSLC Policy A.1 Developing/Revising/Reviewing Policy or Procedure assigns to the Contact Person (the individual responsible for reviewing and revising a specific policy) responsibility for determining what training is needed and for documenting that all applicable staff have been trained. The Contact Person may send inservice sign-up sheets to the QA department as documentation of who has been trained. During the last compliance visit, 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 training, but the revised policy did not include that detailed information.	

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		The Facility reported that it does not have a process to identify who has not yet been trained and who still requires training. It would be extraordinarily difficult to review all sign-in sheets to identify who continued to need training. Furthermore, it may be necessary to provide refresher training or training during new employee orientation, and to track completion of that training. In addition, the sign-in sheets did not have a place for a trainer to document whether each participant demonstrated competence. To achieve substantial compliance, the Monitoring Team recommends the Facility develop a process to track who requires training (when the Facility determines training is needed rather than notice) and who has, and has not, completed training. <u>Conclusion</u> Processes for development, revision, and implementation of policies were in place. There remains a need for policies to address a few requirements of the Settlement Agreement (note, for example, the requirement reported in Section U for a policy or process to assess capacity for decision-making). The Facility needs to ensure all staff who are required to have training on new or revised policies receive consistent 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. The Facility actually completed 10 audits per month, as verified by the audits provided for June, July, and August 2014. 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. For the Active Record Review, findings were entered on a database. The information on the database is based on the Active Record Order and Guidelines (AROG) and provides the ability to check whether a document is present, absent, or not applicable, to check and comment on any Appendix D requirement not met, and to make other comments as needed. The database permits 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 was taken directly from the database, which separates 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	Substantial Compliance

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		(Appendix D requirement not met), by living unit, by section (tab) of the Active Record, or by a combination of these. For example, a graph provided to the Monitoring Team showed the number of signatures errors in Observation Notes. 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 for the same sample of 10 records being audited by the URCs. 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. They also audited records of individuals who were moving between units at the Facility and in process of transitioning to more integrated settings or other SSLCs (including prior to Community Living Discharge Plan, or CLDP, meetings). For these audits, the URC was to send an email notice of corrections needed to responsible staff and discipline heads. The Facility provided copies of these emails and the corrections needed for several individuals, including Individuals #1, #130, #238, #306, #600, and #771. These additional audits, while not required by the Settlement Agreement, are a very positive action. 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 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. The Facility began a pilot at the Guadalupe and Pecos homes of replacing the Active Treatment Notebook and Group Data Notebook with an Individual Notebook that includes data sheets and accompanies the individual; this would minimize concerns about whether different notebooks had the same documents. 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. Nonetheless, as the Trends report	

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		indicated, the Overflow Checklist audits documented that a substantial number of documents that should have been purged and sent to Medical Records were not. <u>Interobserver Agreement/Interrater Reliability</u> At a prior 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 but instead audited those records together with the URC. However, the URC and Monitoring Team separately and independently completed the Section V monitoring tool, using information gathered from the audit of the Active Record and Individual Notebook. As reported in Provision V1, agreement on this tool was 81%, an acceptable finding. Program monitors selected five records each month from the 10 audited by URCs. These five records audited by the Program Monitors 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. The entries on the Section V monitoring tool from the URC and the Program Monitor audits are entered onto the 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 8/1/13 through 7/31/14, the levels of agreement on the Section V monitoring tool between audits conducted by URCs and by program monitors since the last compliance visit ranged 84% to 93%; these continued to be in an acceptable range. The Facility also tracked agreement for each individual item on the Section V monitoring tool. With only a few exceptions, agreement was consistently at least 80%; where agreement was only 60%, this occurred only for one or two of the five months reviewed. Furthermore, agreement between the Monitoring Team and the URC, as reported in Provision V1, was 81%. Therefore, reliability (agreement between auditors) on the Section V monitoring tool was sufficient to use the data for decision-making. <u>Audit Findings and Reviews of Trends</u> The Facility provided copies of the audits conducted in June, July, and August 2014. Ten audits were completed each month, for a total of 30 audits reviewed by the Monitoring Team. • For 30 out of 30 audits (100%), the Facility provided the Section V monitoring tool. • For 30 out of 30 audits (100%), the Facility provided the Active Record Review.	

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		• For 30 out of 30 audits (100%), the Facility provided the Individual Notebook Review. • For 30 out of 30 audits (100%), the Facility provided the Group Data Notebook Audit. • For 0 out of 30 audits (0%), the Overflow Checklists were provided. The Facility provided graphs of audit data from the Quality Assurance (QA/QI) Monthly Report of June 2014 covering the months of February through April 2014, a Trend Analysis Report covering 8/1/13-7/31/14, Active Record Review Tool Data covering 1/1/14-7/30/14, and Overflow Checklist Data 1/1/14-7/31/14. Both the QA/QI Monthly Report and Trend Analysis Report showed monthly percent of overall compliance as reported on the Section V monitoring tool (either for the quarter of 2/1/14-4/30/14, or for the year). The report from the last compliance period stated data from audits by the URCs showed an increase in compliance beginning in August 2013. This increase was maintained, with some months showing a slight trend upward. The range from March 2014 through July 2014 was from 64% to 77% compliance. Other findings from these reports since the last compliance visit included the following. Information is also presented in Provision V1. • All three components of the Unified Record were present each month. • All responses to the Interview Tool for V4 provided evidence the Facility routines uses the records to make decisions. • Percent of documents present, as identified on the Active Record Reviews, ranged from 85% to 88% per month. • Level of compliance from the Active Record Review Tool showed a slight decline from February 2014 through April 2014. The prior compliance rates were recovered in June and July 2014. August data provided on-site reported compliance continued to be maintained. A narrative provided in the QA/QI Monthly Report demonstrated a thorough analysis of the data presented. Although no corrective action plans (CAPs) were in place, the narrative reported that a process for tracking the filing of annual assessments was started with ISP preparation meetings in April for annual ISPs to be held in July. Data for August, September, and October is to be reviewed to determine the effect of the process. It was positive to find that a plan was in place to assess the effectiveness of the process, and that the assessment would be based on review of data that were routinely presented. In addition to the narrative, the review noted that one May audit identified an issue with filing Psychiatric & Behavior Management Clinic reports in the Active Record. Discussion had already been held to review the process from production to filing of these reports, and a meeting had been planned to address the issue. This indicates that the Facility	

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		assesses findings of individual audits, as well as aggregated data, and takes timely action when needed. The last compliance report recommended the Facility provide data not only on findings on the Section V monitoring tool, but also presence of current documents in the Active Record. The Facility went beyond that recommendation by reporting the number of errors made on several Appendix D requirements, a process that should assist the Facility in determining priorities for action. This was a significant improvement in the review and analysis process, and it demonstrated good use of the capacity of this Facility to provide information in useful ways. The Facility provided additional graphs of data on Appendix D compliance in Observation Notes from audits 3/1/14-8/25/14. This provided data for analysis on one section of the Active Record. Some data (asterisked below) were also provided in the Trends Data These covered number of errors found in the following requirements: • Gaps • Signature • Title • Error Correction • Time • Date These graphs showed significant reduction in errors on Date and variable but relatively stable numbers of errors on the remainder. Although they did not show significant improvement overall, they provide a baseline to determine whether new processes to improve documentation in the Observation Notes are effective. For example, these should show whether the recent change to individualized and home or unit-wide refresher training resulting from audit trends has any effect on documentation in Observation Notes. As reported in Provision V1, the Monitoring Team also used the Active Record Review database 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 #350, alongside the URC. Following collection of this information, the Monitoring Team and URC independently completed the Section V monitoring tool. Data from this review are reported in Provision V1. The audit process as conducted by the URC was extraordinarily thorough and comprehensive. The URC checked information in the Active Record against information in the VCF/Shared Drive to ensure consistency and accuracy. For example, she checked the Guardian list to confirm whether the individual should have had guardianship information in the Active Record.	

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		She also checked across sections of the Active Record. For example, she checked medications on the Medication Administration Records (MARs) and Annual Medical Summary to ensure consent had been received for all medications requiring consent. She discovered in an IPN a reference to an acute care plan (ACP); she checked to find out whether the ACP was documented in the Care Plans section, found it was not, and rated presence of ACPs "No"—an accurate finding that might have been missed with a less thorough review, which provides the Monitoring Team with confidence that the audits are accurate. The Monitoring Team commends the URC for the thoroughness of the review. The percent of compliant items found in this audit was 77%, somewhat lower than recent monthly averages. <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 the Active Record Review Corrections document that included database items that were marked "No" or had a check on an Appendix D requirement not met. The database report included a comment stating what was not correct. The Facility provided a copy of the email and the Active Record Review Corrections for each audited record. The Facility also sent a copy of the Individual Notebook Review form that included comments on any items needing correction. The email requests that corrections be made and gives a due date for them. In the past, emails stated that the URCs are to be notified when corrections are made; however, emails provided with recent audits did not have a standard format and did not consistently request notice. Emails did not identify who is responsible for making the corrections and notifying the URCs. As recommended in the last two compliance reports, 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. Two weeks after sending the email, the URC follows up by going to the record with the Active Record Review Corrections report. The URC then enters the corrected items in the	

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		database. If corrections remain to be done, the URC emails another notice listing items that have not been resolved. 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 the database stating what correction was made. The Facility provided emails and Corrections Needed sheets for all the audits done in June through August 2014, as well as follow up emails identifying corrections completed and still required. For 30 of 30 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. The Trends Report and an update provided by the Facility during the visit documented that form of corrections made on time ranged monthly from 39% to 55%. The audits identify information needed and actions that must be taken so the record meets requirements. Timeliness of corrections must improve. The audit provides useful information on this issue, and the Facility has taken initial action based on audit information. If the initial action is not effective, the Facility will need to take additional action. The information provided by the audits and follow ups provide a basis to evaluate effectiveness and whether there is a need for further action. The Monitoring Team randomly by computer selected one individual record from among those audited by a URC in June 2014, Individual #619. The Monitoring Team and URC audited the corrections that were to have been made in the Active Record. Of 10 items needing correction, five (50%) had been corrected (an improvement since the last compliance visit), one (10%) had been corrected initially but had not been updated as needed, and four (40%) had still not been corrected. For this one individual record, corrections had not been made consistently. The QA/QI Monthly Report stated that the database was revised in April 2014 to allow for entry of results of follow-ups to the record audits. URCs went back one month to enter data beginning in March 2014 in order to capture more information. Timely corrections were 53% in March 2014 and 38% in April 2014. The Report stated that this was a challenge needing to be addressed. An initial plan was to send reports to Unit Directors and discipline heads as applicable to show level of compliance for making corrections. <u>Review of Trends and Use of Audit Information for Systemic Improvement</u> It was clear that the Facility used information from the audits to make systemic improvements. Examples identified above or reported by the Facility included: • Identifying the need to make corrections as indicated in audits on a	

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		timely basis, and providing information to unit directors and disciplines heads as an initial step in addressing this need. • Establishing a process for Unit Clerks to track assessments required for annual ISP meetings and the date these are filed in the active record, in order to track timeliness of filing assessments. • Providing data to unit directors regarding accuracy of the check-out/check-in process • Establishing a process of in-service training for DSPs and notifying Residential Coordinators of inaccurate recordkeeping practices noted in Observation Notes <u>Conclusion</u> The audit system is robust, comprehensive, and sets high standards for finding compliance. Ten random audits are conducted each month (doubling the requirement in this provision), and these are supplemented with additional audits of specific items in the record. Reliability across auditors is adequate. 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. The improved level of compliance with Appendix D requirements and presence of documents has been maintained, although further improvement had not been demonstrated. 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. Although this must be addressed, the robust audit system and maintenance of improvement in compliance with Appendix D requirements merit a finding that the 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 generally, but not consistently, available and accessible. The Facility reported that audits of records found many records were not accessible (that is, not present when the audit was done). The Monitoring Team also audited records, as reported in Provision V1. The records storage area was readily accessible to staff. However, review of the checkout books for four individuals for whom at least one chart was not present found, for two (50% of those with a chart not present, Individuals #27 and #745), a chart was not present but was not checked out; therefore, the Checkout Book would not provide	Noncompliance

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		information as to where to find the chart. Charts for Individuals #73 and #318 were appropriately checked out. The Facility provided minutes of the 5/21/14 Recordkeeping PIT (process improvement team) meeting that discussed chart check-out/check-in and unavailability of active records. These minutes documented ongoing discussion about this process as well as a decision that active records are to be taken to Medical Records the next working day after an individual is admitted to a hospital, so that the records will be readily accessible. Accessibility not only involves the availability of the records but also whether the required documents are filed in the records. Several IPNs by Medical staff for Individual #429 were not found in the Active Record. When this was pointed out to the Facility, Medical staff provided the IPNs. To be available to all clinical staff and other IDT members who might need the information, IPNs must be filed in the Active Record and maintained there for the period established in maintenance guidelines. The Share Drive made assessments and other documents readily available to clinical staff, residential directors, QIDPs, 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. The Facility must also ensure that all staff who complete documents provide them for filing. <u>Documents are Filed in the Record Timely and Accurately</u> Information from Record Audits: 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 30 records (0%) was rated as Current. That was true also for the record audited by the Monitoring Team. The Facility database could produce reports by applicable document for individuals, Facility, or unit, among other possibilities. As reported in Provision V1, the Trend Report included a graph of compliance scores by month from January 2014 through July 2014 for the 10 monthly audits. This tool rates compliance for each criterion for each item. Compliance ranged from 84% in January and May 2014 to 88% in June 2014. Because an item must at a minimum be present in order to be in compliance (and must meet all relevant Appendix D requirements), that meant that a minimum of 84% to 88% of documents (and, indeed, more) were found to be present when audited. Along with the audits conducted in July and August 2014, the Facility also provided tables of items applicable (listed as "Total Quest") with the number yes or no for completion, and a completion percentage. For the individuals, completion percentage in	

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		July ranged from 75.71% to 91.67%, with an average of 86.86%; in August, completion percentage ranged from 81.08% to 93.48% with an average of 87.84%. The percentage found in the audit conducted during this visit by the Monitoring Team and URC was within this range, although somewhat lower than the averages. This very positive set of data allow the URCs to analyze whether lack of compliance with Appendix D relates to presence or absence of documents or, instead, to other requirements and provides much more sensitive information than the Complete item on the Section V monitoring tool. Even more, it allows for breakdown and tracking by living unit, so that needs for additional action can be targeted where most needed. The Facility audited also to ensure ISPs were filed in the record within 30 days following the annual planning meeting. The Facility provided an alphabetical list of individuals with dates ISP meetings were held, ISPs were completed, and ISPs were filed. The Monitoring Team did not attempt to calculate percentage of ISPs filed within 30 days since the last compliance visit. Timeliness of Assessments: The Facility provided information on assessments filed within 30 days after the ISP meeting, from 4/1/14-8/25/14. This included a graph of overall percentage and a table by assessment for each living unit. The overall percentage was 56%, indicating these were not consistently filed in the record timely. However, these were the final version of the assessment, and earlier versions should have been available no later than 10 business days prior to the ISP annual planning meetings, when they are most useful for making decisions on the selection of goals, treatments, and services. The Facility also provided a table of Required Annual Assessments Filed 10 Days Prior to ISP Meeting for meeting dates of 4/1/14-6/30/14. 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. The table reported that the percent of required assessments filed 10 (working) days prior to the ISP meeting for April, May, and June 2014 was 72%, 72%, and 69% respectively. In addition, the Facility had begun a process in which each IDT was to hold a "15-Day" meeting prior to each individual's annual ISP planning meeting to identify any discrepancies in assessments and review the IRRF. This was in place of the "3-Day" meeting held in the past, which would provide additional time to resolve any discrepancies or take any additional needed actions. The Facility reported this process	

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		was implemented in June 2014. This process has potential not only to improve timeliness of assessments but also to promote review of assessments by all members of the IDT. As reported in Provision F1c, the Monitoring Team reviewed assessments for a sample of seven completed ISPs, including the ISP Preparation documentation. Findings included: • In the sample of seven 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 88 required assessments, 63 were both present and completed according to the timeliness requirements. Overall for this sample, the rate of timeliness was 72%, just slightly below the timeliness rate of 74% found during the last monitoring period. This finding was consistent with the Facility's data reported above. • Some assessments were not simply late, but were not completed at all. For the nine individuals in this sample, there were 88 total required but only 81 (92%) present in the assessment packets provided to the Monitoring Team. Improved timeliness was found for one individual for whom assessments were due. The Facility identified Individual #181 as having an annual ISP planning meeting scheduled within the next ten working days. The Facility provided the list of required assessments, and the Monitoring Team viewed the assessments available on the shared drive. For 12 assessments that were required per the ISP preparation meeting, 12 (100%) current or updated assessments were posted, and 12 (100%) had been posted by 10 working days prior to the meeting. This was consistent with the findings from the last compliance visit. The Monitoring Team reviewed the assessments required for the annual ISP planning meeting for Individual #745. For 14 assessments that were required per the ISP preparation meeting, 14 (100%) current or updated assessments were posted, and 12 (86%) had been posted by 10 working days prior to the meeting (with the other two posted nine working days prior to the meeting). QIDPs interviewed reported that timeliness of assessments has improved. They reported the only times they generally have difficulty getting assessments is when there is a new clinician who is not yet experiences with the role of the QIDP in the interdisciplinary process. As a result, the Facility is starting a new process in October that will require newly hired clinicians to meet with the QIDP Educator during new employee orientation. Monthly QIDP Reviews: As reported in Provision F2d, problems were found in timely completion of monthly reviews by QIDPs. The Facility had identified this issue and had	

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		recently modified its procedures to address ongoing issues of timeliness of Monthly Reviews of the ISP by the QIDP. It provided a document for review entitled Monitoring the Timeliness of Monthlies. <u>Data Are Documented/Recorded Timely On Data And Tracking Sheets</u> For the most part, documentation and recording was timely. The Monitoring Team did not find significant lapses when reviewing documents during observations at living units and day program areas. However, gaps in documentation were found. For example: • As reported in Provision O7, zero of ten aspiration trigger sheets (0%) were completed correctly. The trigger sheets contained multiple gaps in data due to lack of completion. 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 20 of 25 (80%) of the group data notebook audits conducted in June, July, and August 2014, this item was checked "Yes". Of the checklists checked "No": • For Individuals #603 and #384, no data sheets were present. • For Individual #388, the training objective for use of an adaptive switch was not present. • For Individual #324, the handwashing data sheet was not present. • For Individual #551, data sheets for three training or activity plans were not present. In all these cases, the audit documented only presence of the data sheets or which sheets were missing. The Monitoring Team did not ask or determine whether this audit checked whether data were entered up to date as required. However, if data sheets are not present, data cannot be entered timely. <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 whether IPNs show communication between various disciplines. During joint review with a URC of the record of Individual #350, this comprehensive review was evident. Audits conducted by the Facility in June, July, and August 2014 rated that IPNs in 27 of 30 records audited (90%) indicated that staff routinely used the records to make decisions.	

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		Based on findings in the audit of the record for Individual #350, the Monitoring Team independently rated that the IPN indicated use of the record to make decisions. Staff Surveyed/Interviewed Indicate How The Unified Record Is Used 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. The Facility provided five interviews done as part of the random audits for June, July, and August 2014 for Individuals #322, #619, #776, #551, and #663. For each interview, two separate IDT members were interviewed. These included two QIDPs, two vocational staff, and one RN, residential coordinator, pharmacist, SLP, OT, and active treatment manager. For four of five (80%), the Section V monitoring tool item on whether the interview indicated use of the record was marked "yes" (the item was marked "no" for Individual #776). The Monitoring Team reviewed the summaries of responses on the survey tools and did not have concerns over the ratings. This indicated the interview process was implemented as planned, and that scoring was reliable. The Monitoring Team did not review reliability/agreement data between the URCs and program monitors. The interviews indicated staff use the records. Although only two IDT members were interviewed for each individual, the Facility ensured a broad representation of disciplines participated, as recommended in prior reports. The Self-Assessment reported that eight of 11 Interview Tools (73%) conducted from 1/1/14 through 6/30/14 indicated that staff routinely use the records to make decisions; the Self-Assessment also summarized and provided examples of responses given to questions. This was slightly lower than during the last compliance visit but may indicate a more thorough and critical analysis of the findings rather than a decrease in use of records. Observation At Meetings, Including ISP Meetings, Indicates The Unified Record Is Used And Data Are Reported Rather Than Only Clinical Impressions To assess this, the Monitoring Team observed the annual ISP planning meetings for Individuals #680 and #745, the ISP Preparation meeting for Individual #497, a 15-day	

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		ISP preparation meeting for Individual #613, and a Grand Rounds addressing Individual #737 to assess whether and how the unified record was used. Observation of the annual ISP planning meeting for Individual #745 found that the Active Record was present. Several IDT members brought information that, most likely, was also in the Active Record, such as assessment information. The IDT did review information from the record. For example, the medical provider (primary care provider, or PCP) provided information from the medical assessment regarding diagnoses and medications. The nurse case manager reported information from a diagnostic examination and checked that in the Active Record. The Integrated Risk Rating Form (IRRF) draft included clinical data, so that was available to the IDT; however, except for two comments by one IDT member, the IDT did not discuss any of this information. The IDT did look in the Active Record for some specific information during the meeting, such as when the individual had a modified barium swallow. Information from the record, rather than general impressions, was used in making decisions. At the meeting for Individual #680, the record was present. However, the record was not referenced during the meeting. At the 15-day meeting, a recently initiated meeting to review information in the IRRF and other preparation for the ISP annual planning meeting, the record was present; it was referred to one time. Most clinical information was provided on the IRRF, which included health information and detailed behavioral data. There was little discussion of the information. Of 22 risk areas, at least some discussion occurred for 12 (55%). At the ISP Preparation meeting for Individual #497, the record was not present. The QIDP later noted that the record had been provided for review by the Monitoring Team. The Monitoring Team has consistently reminded facilities that use for treatment, planning, and documentation purposes supersedes any request from the Monitoring Team. Nevertheless, the Monitoring Team understands that the QIDP might not have felt comfortable notifying the Monitoring Team of the need to have the record. Information from the record was available and reported during the meeting, such as recent data on progress on a skill acquisition program for toothbrushing, a list of injuries, date of discontinuation of a medication due to possible side effects, result of a diagnostic test, and data on target behaviors. The IDT also noted the need to "check the chart" for information on a couple of topics. Although information from the record was provided, this was not always the case. For example, regarding vocational programming, no data or specific information on progress was provided; instead, the report was that the individual had made "a lot of progress." Furthermore, for the toothbrushing program, review of the record showed the progress notes for this program included data only for	

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		July. The Facility reported that each URC attends one interdisciplinary meeting per month to assess utilization of records. They observe a variety of types of meetings, including ISP annual meetings, ISP preparation meetings, community living discharge plan (CLDP) and pre-CLDP meetings, medical meetings, and others. They do not use a specific monitoring tool. The Facility provided copies of emails and/or notes documenting the observations for Individuals #306 (CLDP meeting), #302 (CLDP meeting), #535 (annual ISP meeting), #569 (ISP Prep meeting), and #771 (pre-CLDP and CLDP meetings). • The Active Record was present at three of five meetings (60%). • Information from the Active Record was present at one of the other two meetings, but not all information that would have been useful was available. • The URC documented either review of the record or discussion of data and other information from the record at three of five meetings (60%). At the Grand Rounds, the record was present. Packets of clinical records were handed out to all participants. Clinical data, including some clinical indicators of the individual's health conditions, were reported. There was active discussion of the information from the record as well as of additional information that might be useful. <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 identified by the Facility or Monitoring Team. Although staff were able to describe how they used the records for decision-making, actual use of the records in interdisciplinary meetings continued to improve but remained variable.	

List of Acronyms

Richmond State Supported Living Center
August 25-29, 2014, Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADAMS	Anxiety Depression and Mood Scale
ADHD	Attention Deficit Hyperactivity Disorder
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
BHS	Behavioral Health Specialist
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BMD	Bone Mineral Density
BP	Blood Pressure
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BSPPS	Behavioral Support Program for Psychiatric Symptoms

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
CoS	Change of Status
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
DRA	Deficiencies Requiring Action
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
HPI	History of Present Illness
HRC	Human Rights Committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy
IBHA	Integrated Behavioral Health Assessment
IBW	Ideal Body Weight
IC	Infection Control/Informed Consent
ICF	Infection Control Form
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
IMM	Incident Management Meeting
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
NSI	Non-serious Injury Investigation
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
SPA	Speech Pathology Assistant
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