United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center

April 26-30, 2010

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Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the ICF/MR component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three (3) Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him/her every six (6) months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of Richmond State Supported Living Center (RSSLC).

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.

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 SA.

II. 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 April 26-30, 2010, the Monitoring Team visited Richmond 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. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

(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, PSP team 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.

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

III. 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 and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility, this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **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;

(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;

(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the facility undertook to assess compliance and the results thereof. The facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the facility self-assessments for reviews beginning in July 2010;

(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. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, 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 SA.

IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Richmond State Supported Living Center (RSSLC) for their welcoming and open approach to the first monitoring visit. It was clear that the State's leadership staff and attorneys as well as the management team at RSSLC had encouraged staff to be honest with the Monitoring Team. As is reflected throughout this report, staff throughout the Facility provided the Monitoring Team with information requested, and were forthright in their assessment of the Facility's status in complying with the Settlement Agreement. This was much appreciated, and set the groundwork for an ongoing collaborative relationship between RSSLC and the Monitor's Office.

The baseline tour provided an opportunity to become familiar with the policies, procedures, processes, and structure of RSSLC. Team members used this time to meet and discuss with a wide range of facility staff to provide an understanding of structure and services, and to develop a collaborative approach to the review and improvement process. The team examined a great deal of documentation and carried out many observations and interviews in order to evaluate the status of the facility practices. The report describes status of provisions but does not provide decisions about compliance with provisions; that will begin at the first compliance review.

Positive Practices

It is clear that RSSLC is making significant efforts to improve services and meet many of the provisions of the Settlement Agreement. The monitoring team would like to recognize some positive practices and improvements. This is not an exhaustive list. Reviewing the assessments of provisions will reveal additional positive practices, and there are certainly others not mentioned in this review.

- RSSLC has a well organized system for reporting and investigating allegations of abuse and neglect, investigating unusual incidents, and reviewing discovered injuries. This system includes the necessary incident management components to review reports, determine necessary follow-up, and track action plans through completion. The RSSLC policy E.17 is an exemplary process for the review of discovered injuries.
- RSSLC initiated a Campaign Against Abuse and Neglect (CAAN) in October, 2008 and again in September, 2009. Over 300 people attended each event which was described as a fun day of various activities and information booths to enable staff, individuals served, and LARs to become better informed and heighten awareness on the prevention of abuse and neglect. RSSLC should be commended for the proactive CAAN program.
- The Self-Advocacy meeting held during the site visit was an excellent example of staff encouraging and supporting self-direction. The meeting included training relevant to reporting abuse and neglect along with information on community living. Individuals at the meeting were encouraged to participate actively.
- The monitoring team saw tremendous skill and initiative on the part of a member of the Social Work staff in facilitating community placement for an individual. She knew the individual and the individual's mother well, understood what was important to them, and visited and researched homes in the community to find one that was a good fit.
- DADS was taking a series of actions to improve training for community providers.
- The Facility was taking aggressive steps to increase availability of psychiatrists. One psychiatrist has been hired, and recruiting for a second is actively occurring.
- The Chief Nurse Executive demonstrated excellent leadership skills in the manner in which she has organized the Nursing Department's management and organizational structure. The Nursing Management Team was comprised of experienced specialized nurses who worked well together, and were motivated to improve the quality of nursing services.
- The Chief Nurse Executive has organized numerous committees to address various areas in need of improvement, such as updating policies, procedures, reporting forms, and care plans.
- The Nursing Management Team was in the process of developing and implementing a variety of monitoring tools to address all aspects of nursing practice in order to improve the quality of care, and to meet compliance with the SA and HCG.
- The Nursing department has increased training for nurses regarding Health Assessments and care planning.
- The Chief Nurse Executive served as Chairperson of the Medication Error Committee that meets monthly. The committees thoroughly reviewed all medication errors and other medication administration practices and then made recommendations for corrective action when indicated, with follow-up at the next meeting.
- The Infection Control Nurse has recently developed and implemented Antibiogram for monitoring the appropriateness and effectiveness of antibiotic therapy. In addition to orientation and refresher Infection Control Training, staff receive specific training on infectious disease processes related to individuals as they were diagnosed. Environmental Surveillance has recently increased.
- The Wound Care Nurse has established a Skin Integrity Committee to review all incidences of reported skin integrity issues. When skin integrity issues were observed the Wound Care Nurse was consulted and directed the planning and management of care through to resolution.
- The Hospital Liaison Nurse routinely visits individuals hospitalized and consistently wrote comprehensive reports that were put on the share drive for all PST members to review as well as documented findings in the Integrated Progress Notes.
- The Virtual Client Folder could provide a basis for development of an electronic record.

- Fewer episodes of undesired behavior were generally observed in vocational workshops than other areas of the facility. Individuals employed at these workshops were noted to be happy and engaged in goal-oriented and productive activities.
- Staff members at all levels were routinely observed to be highly motivated in meeting the personal needs of the individuals living at the facility. The efforts of staff members included such goals as ensuring that an individual attending public school was able to participate in prom, arranging for tickets to highly desired sporting and entertainment events throughout the Texas, and organizing unique events to be held at the facility such as horse shows and a symphony concert.
- Skill acquisition programs, although areas of weakness were noted, possessed sufficient sophistication to provide a solid foundation for further development.
- The Forever Young retirement program was observed to provide multiple activities, good rotation of attention, and multiple opportunities for choice and personal preference.
- A good working relationship was consistently observed between psychology and psychiatry. The two disciplines were often observed collaborating on diagnostic and treatment issues. In addition, psychologists and psychiatrists were noted to display mutual respect for one another.
- PBSPs routinely included a variety of strategies to assist the individual in avoiding the need for undesired or dangerous behavior. These strategies included attempts to preemptively meet the needs of the individual or structure the individual's environment in a more stimulating and rewarding manner.
- The Pharmacy has introduced a new methodology for reporting Adverse Drug Reactions (ADRs), which is intended to increase the reporting of these events.

Status and Specific Findings

Use of Restraint

Overall use of restraint is trending down but still occurs frequently enough to merit thoughtful discussion by facility leadership.

RSSLC has many policies governing use of restraint. Many are not in alignment with various elements of the Settlement Agreement and/or DADS policy. Some policies are not being implemented or are not implemented consistently or correctly.

The RSSLC Trend Analysis Report does not provide data relative to the various types of restraints authorized by policy. Data are tracked by two variables: emergency and programmatic. Neither term is defined in RSSLC policy so it is impossible to use the tracking and trending data for analysis except in a very gross manner.

Staff training documentation indicates many staff have not received basic PMAB restraint training.

Abuse, Neglect, and Incident Management

RSSLC has a well organized system for reporting and investigating allegations of abuse and neglect, investigating unusual incidents, and reviewing discovered injuries. This system includes the necessary incident management components to review reports, determine necessary follow-up, and track action plans through completion.

RSSLC's policies are comprehensive although they could benefit from some updating to include better formatting, effective dates, and titling to include the name of the organization.

Some issues of potential significance were identified in the areas of timely reporting of incidents, timely investigations, protection of individuals, and policy compliance in injury categorization.

Quality Assurance

RSSLC does not have a written Quality Assurance Policy, a written Quality Assurance Plan, a written medical review system, a written nursing quality assurance plan, or a written medical quality improvement program. Current quality assurance activity is fragmented and only addresses a small number of specific issues within the facility operations. The facility engages in a great deal of QA monitoring resulting in voluminous data which does not seem to be regularly aggregated and analyzed for any useful management improvement functions. There is much work ahead to refine processes, integrate information, and determine how best to use all the information flowing from these current systems as well as those systems needing to be developed.

Integrated Services

RSSLC has eight policies that directly and indirectly describe expectations for PSP planning. There is little in these documents that establish expectations for integrated and collaborative program planning. These policies do place emphasis on person directed planning and personal outcomes which is commendable. The policies themselves could integrate information better to establish a framework for integrated planning across disciplines.

The monitoring team observed multiple PSP meetings and noted only a few instance of collaborative discussion. The monitoring team reviewed multiple PSPs and found little documentation of collaborative and integrated service planning.

Integrated Clinical Services

Although examples of integrated planning and review exist, there are many opportunities to improve integration. The PSP process needs to be revised; it consisted largely of the QMRP reading or summarizing reports. With some exceptions, such as collaboration on assessment by OTs and PTs with Speech Pathologist involvement, disciplines generally work in a parallel manner in development of PSPs.

Minimum Common Elements of Clinical Care

Provision of clinical services is variable across disciplines. Some aspects of clinical services meet current, generally accepted professional standards of care defined in the SA. Other aspects do not yet meet these standards. Improvements are needed in assessment, identification and use of indicators of efficacy, and monitoring of care.

Assessment of Risk

Individuals who are at a high risk are not being identified due to the criteria set forth by the DADS At Risk policy as well as inadequate follow through of said policy. RSSLC policy has some elements needed to identify and manage risk but needs improvement.

Psychiatric Services

The provision of psychiatric services at RSSLC has been undergoing a significant recent transition. The Facility has recently increased the number of consulting Psychiatrists, and is also moving toward the employment of two full-time Psychiatrists. There are on-going issues related to the degree to which the psychiatric diagnoses that are utilized for individuals at RSSLC correlate with the behavioral profile of the individual. There is relatively little documentation that supports the contention that the behaviors that are identified as the targets of the psychotropic medication are indeed primary symptoms of the identified psychiatric diagnoses. In the majority of the sample of individual records that was reviewed, there was no empirical evidence to support the clinical utility of the psychotropic medications being prescribed for a given

individual. Although many of the records contain "baseline" behavioral data, for which comparisons can be made to support the empirical justification of a psychotropic medication, these baselines are often very old, and there may have been multiple changes in psychotropic medications since that baseline was established.

Psychological Services

As indicated in the description of positive practices, there were several positive elements that should facilitate the efforts of RSSLC to comply with the Settlement Agreement. There are also a number of areas in which psychological services do not meet current standards.

A large percentage of the RSSLC staff were observed to lack the skills and training necessary to provide adequate services to the individuals living at the facility. The majority of staff members employed by RSSLC lack adequate knowledge regarding applied behavior analysis in relation to their personal responsibilities. Direct care staff was often unable to effectively use positive reinforcement to strengthen skills. Training programs and PBSPs frequently did not include structured procedures adequate for teaching or strengthening behavior. Staff members were observed to inadvertently elicit or intensify undesired behavior by use of inappropriate if well-meaning efforts to intervene.

A wide disparity was also noted in the knowledge and skills of psychology staff. A few psychologists are well-versed in applied behavior analysis and demonstrate reasonably sophisticated skills. The remainder of the psychology staff, based upon observations and a review of PBSPs, lack the knowledge and skills necessary to provide minimal services. Numerous Positive Behavior Support Plans (PBSPs) reflected inadequate or inappropriate applications of behavioral methods and technology, such as poorly defined behaviors, too little use of positive reinforcement, and a reliance upon data collected several months or years in the past. Very few of the records reviewed contained behavior assessments or functional assessments that would meet the minimum expectations of applied behavior analysis.

Substantial limitations were also noted in the data and documentation regarding PBSPs and definition and measurement of behavior. A single method of data collection is routinely used regardless of the characteristics of the behavior being measured, resulting in data that are often likely to be inaccurate. Seldom was it noted that a PBSP included specific instructions for collecting data or measuring behavior, and data collection was noted to vary across staff.

Psychological assessments also lacked adequate sophistication. The majority of psychological assessment reports included intellectual and adaptive assessment results that were conducted over 10 years prior to the date of the report. In addition, there was no routine use of formal assessments in formulating or supporting diagnoses of mental illness. There was minimal evidence that psychologists and other staff considered and attempted to integrate and differentiate undesired behavior and symptoms or behavioral indices of mental illness.

Nursing

RSSLC employs a significant number of nurses. The Facility does not use agency nurses. Nursing Department provides 24/7 nursing care in the Infirmary and all residential units, except for two that are not covered on the 10-6 Shift. The nursing staff has not fallen below the minimum staff ratios in the past six months.

RSSLC has a Quality Enhancement Nurse who worked closely with the Nursing Department. The Nursing Department did not have a formalized Peer Review System but were in the process of developing and implementing numerous monitoring tools to improve the quality of nursing services. The Facility monitoring process needs to be refined and developed into a process that identifies problematic systemic nursing practice issues that can be analyzed and trended. In addition, these data need to be integrated into the facility's Quality Enhancement and Risk Management System.

Many of the Nursing Department's Nursing Manual policies, procedures, and forms were outdated, as were the Infection Control Manual's policies and procedures.

Nursing notes were written in a narrative format as opposed to using the SOAP or DAP, therefore, they were difficult to read and quickly discern the actual nursing assessments data, nursing diagnoses, plans and interventions.

Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar and were revised when there were significant changes in health status. They provided comprehensive and detailed information regarding results of labs, diagnostics, consultations, hospitalizations, emergency room visits, medications, and treatments. The Annual and Quarterly Nursing Assessments failed to contain substantive information documented in their respective comment sections and nursing summaries describing clinical outcomes. Annual and Quarterly Nursing Assessments, comments and summaries completed within the past two month showed steady improvements.

Health Maintenance Plans (HMPs) were developed at the time of the Annual Nursing Assessment and Personal Support Plan (PSP) meeting to address each of the individual's health care needs, including needs associated with high-risk or at-risk health conditions, with review and necessary revision on a quarterly basis. New HMPs were not consistently developed when individuals had significant changes in health status throughout the PSP year. HMPs did not consistently include all relevant chronic health conditions. In reviewing the individuals' HMPs and cross-walking them with the Integrated Progress Notes it was not possible to clearly identify that interventions described in the HMP were carried out according to their plans nor how the plans were integrated into the PSP system.

Pharmacy

The Pharmacy Department at RSSLC recently employed a new Pharm.D. who has begun many new initiatives that address provisions of the Settlement Agreement related to Pharmacy Services. There is substantial documentation regarding clinical interventions by the Pharmacy staff, which involves feedback to the prescribing physicians. The documentation of Pharmacy consultations that appear in the individual medical records is in the form of the Quarterly Medication Reviews. These quarterly review forms are designed to require the signature of the reviewing Pharm.D., the primary care physician, and the psychiatrist for those reviews that relate to the use of psychotropic medication. There was only one example where a psychiatrist had signed a quarterly review document, which would suggest they are not routinely being reviewed by the psychiatrist.

Physical and Nutritional Management

RSSLC has a Nutritional Management Team that meets twice monthly to address many issues associated with physical and nutritional management. While the team had an Occupational Therapist, Speech Therapist, Dietitian, Physician, Nursing, and Case Manager, it did not contain a Physical Therapist or Behavior Analyst. The chairperson of the Nutritional Management Team is a well qualified Occupational Therapist as are members of the team; however, their knowledge of physical and nutritional supports is new and they are in need of support and additional education. The team focuses primarily on nutritional issues and did not cover the physical aspects of physical and nutritional supports. A Physical and Nutritional Management (PNM) team also exists and consists of the Physical Therapist, Speech Therapist, and Occupational Therapist. The PNM team focuses primarily on wheelchair and positioning assessments.

The current PNM system is highly informal and does not contain clear pathways or procedures to follow as it relates to providing supports related to physical and nutritional management.

The current system of risk assessment is a concern as it does not accurately identify those who are at risk. RSSLC has multiple risk forms and processes that are not coordinated and often contradict each other. Multiple occurrences were noted where one risk system classified someone as a "high risk" when the other classified them as not being "at risk."

Observations and reviews revealed implementation issues associated with the PNMP, lack of consistent competency based training and lack of a data system to help identify trends and shape future services.

Physical and Occupational Therapy

RSSLC had three and a half Physical Therapists, two Physical Therapy Assistants, Six Occupational Therapists and four Occupational Therapy Assistants. The Occupational Therapists and Physical Therapists were the primary stakeholders of the PNMPs. Though staff received new employee training as well as annual refreshers, implementation of the PNMPs related to positioning was an issue identified by the monitoring team. Individuals were poorly positioned in bed while they received medication and enteral feedings and when seated for meals in the dining room. Individuals were also observed being provided with unsafe mealtime techniques.

Dental

RSSLC had an onsite dental clinic. Annual dental examinations were completed within their anniversary month of admission and/or the last annual dental examination. There was evidence that individuals received dental services timely and according to their recommended follow-up care or when emergency dental care was indicated.

RSSLC's Dental Program did not have a formalized tooth brushing program but was in the process of starting one. The facility does not use suction toothbrushes for individuals at risk for aspiration because of concern that they may not be safe.

RSSLC's Dental Clinic staff worked with the Behavior Analyst to develop desensitization plans for individuals who were identified as uncooperative and/or resistant to dental services. Of the total facility population, it was reported that approximately 125 individuals could not manage with only oral sedation and required Total Intravenous Anesthesia. Reportedly, the use dental sedation was decreasing. The dental data related to the use of dental sedation were not formally analyzed or trended in a manner to discern whether a decrease in use of sedation was occurring. The facility's dental staff needs to collaborate with the behavioral analyst to continue to track and trend data related to the utilization of dental sedation, by type, and desensitization plans.

RSSLC's Dental Clinic Policy and Procedure Manual has not been reviewed and/or revised since 02/09/01. Reportedly, the State Office was in the process of developing new dental policies and procedures. When these are finalized they will be incorporated into the facility's Dental Policy and Procedure Manual.

Communication

RSSLC's approach to augmentative communication and assistive technology is fragmented and not team-oriented. RSSLC lacks sufficient coordination and collaboration between and among the various disciplines, especially with regard to the need for proper communication devices on wheelchairs and to address aspects of communication associated with behaviors.

In addition, the center fails to provide sufficient assistive communication systems to all individuals who would benefit from such supports. Although it is positive that communication plaques were placed in many common areas, and all individuals have at least a communication dictionary, these were not observed to be used nor was the staff knowledgeable of the dictionaries.

Currently, RSSLC does not have enough clinicians to provide adequate speech therapy to meet the needs of individuals who require these services.

Habilitation, Training, and Skill Acquisition

There were many positive elements to the habilitation program, some of which are noted in the list of positive practices. There were also many areas needing improvement.

In numerous settings, staff of all levels was observed to be poorly prepared for providing services. In dining rooms, staff were frequently observed to be unaware of teaching opportunities. In many circumstances, For example, staff often were observed to interact with individuals in ways that have been shown to maintain or strengthen problematic behaviors (such as unintentionally providing possible reinforcers following the behavior where the contingencies were obvious) and did not recognize their actions could be a reason that a behavior occurred or was maintained nor were these actions corrected based on functional assessment. In other situations, the minimal interaction between staff and individuals inhibited the opportunities for teaching and intervention. The majority of skill acquisition programs involved good organization, the basic elements of sound data collection, and a logical approach to teaching a skill. Despite these strengths, there was no indication that attempts were being made to identify and use effective and individualized skill acquisition training techniques. Staff had not been provided sufficient training on specific formal programs. Staff typically could locate individual programs and data sheets, but often demonstrated that they were uncomfortable or unsure about implementing the programs.

Planning for Movement, Transition, and Discharge

The leadership at RSSLC expressed a belief in and commitment to facilitating services in the most integrated setting possible. The Facility has a relatively high rate of referral for community living and of successful moves to the community. The monitoring team saw a number of good practices in the area of serving institutionalized persons in the most integrated setting appropriate to their needs, but these were often the practices of certain individuals rather than systemic approaches. The system should build on the positive practices that are in place. The Self-Advocacy meeting held during the site visit was an excellent example of such a practice, with staff encouraging and supporting self-direction, thus enhancing the ability of individuals to make choices about community living.

Other practices required further attention. There was an emphasis on promoting community awareness through the Community Living Options Discussion (CLOIP) tours, but the Facility needed to ensure individuals from all residences had equal opportunity to have these experiences. It also needed to provide additional experiential opportunities that are individualized to meet the learning needs of each individual. The post-move monitoring process was generally thorough, if not always timely.

Each PSP reviewed began with the section "what's most important to the person." As a general rule, this information did not serve as the starting point for the identification of the supports and services required in the community. PSTs did not seem to be prepared to connect the dots of what's important to the person with what supports and services would be needed and desired in the community. This is the essence of person-directed planning. The monitoring team also reviewed four Personal Focus Worksheets: Individualized Assessment Screening Tool (PFW.) This review also appeared to reflect a lack of understanding of Person-Directed Planning on the part of the PSTs. The PFW asks, among other things, the following questions:

- Are there things you are proud of?
- Are there things you would like to learn to do yourself?
- Do you have any goals that we can help you achieve?

- What does the person want to accomplish or achieve?

In the four PFWs reviewed, the PSTs failed to identify a single personal goal and only rarely were able to identify something an individual was proud of, whether the individual had anything s/he would like to learn to do, or whether the individual had anything s/he wanted to accomplish or achieve. Without this information, it is difficult to ensure that supports needed to ensure successful transition to community living are identified.

There were also several issues identified that will require additional guidance and decision-making on the part of DADS. These included the need to assess and increase the availability of high-quality services and supports to ensure families of young people with extensive support needs do not find institutional services necessary; the need to continue to evaluate and enhance the current training and orientation for community providers; the need to examine the status of individuals who live in the SSLCs, but are not citizens and therefore do not have access to funding for community services; and the need to provide additional guidance to the facilities on a number of policy issues.

Guardianship and Consents

RSSLC appeared to be taking a well-modulated approach to obtaining guardianship for individuals who lack functional capacity to render a decision regarding health or safety, as the Facility awaited further guidance that is reported to be forthcoming from DADS. The Facility was using what appeared to be a consistent, although informal, process for referring an individual for guardianship and prioritizing the needs of those individuals through the PSP. The Facility was actively seeking guardianship only for those who are determined through this process to be at the highest need. Policies and procedures had been drafted in some areas, such as Determining Need for Guardianship and Monitoring Guardianship, but the process for prioritization being used had not been committed to writing as of yet.

The discussion and referral process being used during the PSP did not appear to be an adequate guide for assessment of an individual's functional capacity to render a decision regarding the individual's health or welfare.

Recordkeeping

DADS is in process of revising the policy for recordkeeping. RSSLC follows the current DADS policy and has established a Facility policy that adds local procedures.

All records had sections and documents in the same order, were typed or written with non-erasable pen. They were in chronological order, but the order (new to old or vice versa) varied among sections. Some items were filed in wrong sections. Some signatures and legends were missing.

RSSLC has not begun quality assurance reviews of random records but is waiting to begin after the statewide records policy is implemented. Two Medical Records staff spot check records and work with clerks to identify and make corrections and to use consistent filing practices.

Use of records in decision-making is variable. Records were not referred to during PSP meetings, but a record was used to resolve a question during an HRC meeting.

RSSLC also had a system called a virtual client folder (VCF). This electronic system had a great deal of information which could be available at any linked computer in the Facility. Clinical staff have access to the VCF. This system could be an entry into developing an electronic client record.

In Summary

The above comments summarize the details presented in the full report. Although the challenges presented may seem overwhelming, the monitoring team encourages RSSLC to meet those challenges. RSSLC is making significant efforts, with the support of the state of Texas, to improve services. Making these improvements is a long-term process. The monitoring team is optimistic that this process can go forward effectively.

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. DADS Policy #001: Use of Restraint, dated 8/31/09 2. DADS Policy #006: At Risk Individuals 3. RSSLC Policy J.1: Use of Restraint (9/1/09) 4. RSSLC Policy J.2: Using Restraint in a Behavioral Emergency (9/1/09) 5. RSSLC Policy J.3.01: Using Restraint in a Safety Plan – Contingent Restraint (8/1/08) 6. RSSLC Policy J.3.02: Using Restraint in a Safety Plan – Protective Restraint (8/1/08) 7. RSSLC Policy J.4.01: Using Restraint during Medical/Dental Procedures (8/1/08) 8. RSSLC Policy J.4.02: Using Restraint to Promote Healing/Recovery (8/1/08) 9. RSSLC Policy J.5: Using Restraint to Prevent Involuntary Self-Injury (11/15/04) 10. RSSLC Policy J.6: Using Restraint to Provide Postural Support (11/15/04) 11. RSSLC Policy J.7: Completing/Routing Restraint Checklist 12. RSSLC Policy J.8: Documenting Significant Behavior Incidents (4/19/05) 13. RSSLC Policy J.9: Conducting Interim for Repeat Incidents of Aggression (undated) 14. RSSLC Policy J.11: Using Sedation for Medical/Dental Appointments (3/10/10) 15. RSSLC Policy J.12: Intervention and Documentation for Suicidal Behavior (2/27/08) 16. RSSLC Policy J.13: Implementing Dental Treatment Support Plan (2/4/08) 17. RSSLC Policy C.6: Ensuring Individual Rights (2/8/08) 18. RSSLC Policy C.7: Reviewing Restrictive Levels of Supervision (7/1/05) 19. RSSLC Policy C.16: Review of Rights Restrictions by the HRC 20. RSSLC Plan of Improvement Section C. Protection from Harm – Restraints (2/11/10) 21. PMAB Training Curriculum 22. Restraint Reduction Team Meeting minutes for 1/29/10, 3/19/10 and 4/22/10 23. Restraint Checklist and Debriefing Form for Individual's #25 (1/19/10, 3/1/10, 3/2/10, & 3/4/10), #113(3/10/10), #160 (2/11/10 and 2/15/10), #267 (9/23/09, 9/27/09, 10/1/09, 10/2/09 & 11/9/09), #448 (2/11/10 & 3/4/10), #523 (2/4/10), & #630 (2/14/10 & 2/28/10). 24. Multiple Restraint Analysis for Individuals #315 & #630 25. Facility restraint log July, 2009 to date 26. List of individuals injured during restraint (July, 2009 to February, 2010). 27. Facility Restraint Analysis report for period ending 3/31/10 28. PSPs for Individual's #9, #25, #159, #267, #315, #332, #429, #448, #579, #630, and #663. 29. PSP Addendum's for Individuals #50, #174, #374, and #624. 30. Behavior Incident Report for Individual #695 31. HRC minutes from 4/1/10 32. FY10 Trend Analysis 3/31/10 33. Incident Management Notes (minutes) for meetings on 4/5/10, 4/12/10, 4/19/10, and 4/26/10. 34. Dental Support Plan documentation for Individuals #36, #39, #44, #73, #76, #227, #308, #315, #321,

	#349, #429, #456, #465, #643, and #719. 35. Direct Care Professional Training Records (15) **People Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Judy Miller, Settlement Agreement Coordinator 3. Reuben Muhammad, Incident Management Coordinator 4. Dr. David Partridge, Medical Director 5. William Eckenroth, PhD, Director of Behavioral Services 6. Billie Jean, Behavior Analyst 7. Shelly Evans, Behavior Analyst 8. Jim North, Program Auditor 9. Pam Turner, Rights Officer 10. Donald Paviska, Competency Training & Development Coordinator 11. Carol Agu, QMRP Consultant 12. QMRP's Sherri Zirbes, Jolly Onwukee, Netta Bridgewater, Tom Virripan, Casandra Uzomah, and Lenin Mathews 13. Sixteen Direct Care Professionals 14. Thirteen individuals served: #25, #241, #267, #315, #344, #363, #399, #429, #448, #557, #630, #680, and #738 **Meetings Attended/Observations:** 1. Incident Management Team 4/26/10 2. Annual PSP for Individual #57 3. HRC meeting 4/29/10 4. Living Area Observations: 4/26/10 at San Jacinto, Lavaca, Leon A & C, Sabine: 4/28/10 at Angelia; and, 4/29/10 at Rio Grande and Leon 5. 4/29/10 Unit Morning Meetings at Rio Grande and Leon 6. Restraint application demonstration by DCPs
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Overall use of restraint is trending down. There were an average of 22 restraint episodes per month in the quarter ending November, 2009, 15 per month in the quarter ending February, 2010, and 12 in March, 2010. There were only a total of six instances of programmatic (non-emergency) restraints listed during this seven month reporting period. The RSSLC has many policies governing use of restraint. Many are not in alignment with various elements of the Settlement Agreement and/or DADS policy. Some policies are not being implemented or are not implemented consistently or correctly. The RSSLC Trend Analysis Report does not provide data relative to the various types of restraints authorized by policy. Data are tracked by two variables: emergency and programmatic. Neither term is defined in RSSLC policy so it is impossible to use the tracking and trending data for analysis except in a very gross manner.

	The restraint log from July 1, 2009 through March, 2010 indicates 32 different individuals were restrained a total of 160 times. Twenty-three (72%) of these individuals were restrained at least once for being aggressive toward staff. This could be indicative of a number of things (staff conduct, staff training, meaningful activities for individuals, schedule flexibility, among many others) and merits thoughtful discussion by facility leadership. Staff training documentation indicates many staff have not received basic PMAB restraint training and the RSSLC does not have a curriculum for training staff in the use of mechanical restraints.

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C1	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.	DADS Policy 001 – Use of Restraints prohibits the use of prone restraint. This policy also addresses the other elements required by the Settlement Agreement (SA). RSSLC Policy J.1 Use of Restraint in the Definitions section states a prohibition of the use of prone restraint. This prohibition is stated clearly in the Procedures section of the policy at 4.d. The monitors did not discover any evidence of the use of prone restraint. Staff interviews also confirmed understanding of this prohibition. RSSLC has a comprehensive set of policies defining and governing use of restraints. These include, in addition to J.1, J.2 Using Restraint in a Behavioral Emergency, J.3.01 Using Restraint in a Safety Plan – Contingent Restraint, J.3.02 Using Restraint in a Safety Plan – Protective Restraint, J.4.01 Using Restraint during Medical/Dental Procedures, J.4.02 Using Restraint to Promote Healing/Recovery, J.5 Using Restraint to Prevent Involuntary Self-Injury, and, J.6 Using Restraint to Provide Postural Support. RSSLC restraint policies do not explicitly limit the use of restraint other than medical restraints to situations where an individual poses an immediate and serious risk of harm to him/herself or others. RSSLC Policy J.4.02 authorizes the use of restraint to promote healing/recovery, J.5 authorizes use of restraint with mechanical devices to prevent involuntary self-injury, and J.6 authorizes use of restraint to provide postural support. State policy would seem to exclude much of this from the definition of restraint by defining mechanical restraint as "any device attached or adjacent to an individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. The term does not include any device used to achieve functional body position or proper balance or to prevent injury due to involuntary movement (e.g., falls due to seizures)". Nevertheless, RSSLC policy defines these interventions as restraint and in doing so should keep tracking and trend data. The RSSLC Trend Analysis Report does not provide data relative to the various types of restraints authorized by policy. Data are tracked by two variables: emergency and	

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		programmatic. Neither term is defined in RSSLC policy so it is impossible to use the tracking and trending data for analysis except in a very gross manner. Data shows that overall use of restraint is trending down. There were an average of 22 restraint episodes per month in the quarter ending November, 2009, 15 per month in the quarter ending February 2010, and 12 in March 2010. There were only a total of six instances of programmatic restraints listed during this seven month reporting period. It is not clear if Policy J.1 Use of Restraint is intended to be the primary RSSLC policy on restraint and the other restraint policies in the J series are meant to provide supplementary requirements and instructions. Much of the language in J.1 suggests to the monitors that J.1 is intended to be the primary policy that establishes overall restraint policy at the RSSLC. If J.1 is intended to be the overall restraint policy then it should at least reference the other documents that apply in specific situations and be clear that the requirements of these various policies are intended to complement one another. Alternatively, the RSSLC may want to consider consolidating these policies into one comprehensive policy on restraint use. If each policy in the J series that addresses restraint is intended to be a standalone document then each should be reviewed to ensure they contain specific language addressing each required element of the SA. For example, two policies, J.5 and J.6, were last revised in 2004 and do not contain language that prohibits use of restraint for punishment, convenience of staff, or in the absence of or as an alternative to treatment. RSSLC should reexamine its restraint policies to ensure alignment with the State policy and the requirements of the Settlement Agreement (SA). All policies could be improved by using a standardized format for organizing sections and subsections. For example, J.1 does not have a logical numbering/lettering system to denote sections and subsections. In some areas headings are just named (e.g. definitions, procedures) and within these sometimes hash marks are used to denote subsections, sometimes bullet points, sometimes nothing. This makes policy references difficult which could impact negatively on staff training. Another example is J.2 which uses bullet points extensively making policy reference very difficult. Because of this, policy references cited in this section of the report may reference only the page number of the policy under discussion. Policies could also be improved by removing from the definitions sections statements that are policy or procedure related. These are most often found in the definitions sections as a note. For example, in Policy J.1 after the definition of Mechanical Restraint there is a note stating "only commercially available devices or devices specifically designed for the safe restraint of an individual will be used as mechanical restraints and include…" (followed by	

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		a long list). This is a statement of policy rather than a definition of mechanical restraint. It is unclear whether options are always considered that might result in reduced use of restraint. For example, Individual #25 was in restraint for 30 minutes on 3/1/10 beginning at 3:55 pm. According to the Restraint Checklist and Debriefing form the individual wanted to keep working (at the workshop) but it was time to go home for the day. This created an outburst that resulted in the restraint. This individual is often in restraint and it would appear the response to her desire to want to continue working could have been handled differently and in a manner that would not have resulted in two staff holding the individual horizontally for 30 minutes and the individual being injured. Individual #765 had been admitted on 4/7/10 with a diagnosis of dehydration. He received enteral feeding and was also treated with intravenous therapy for hydration. The individual was wearing a mitten on the right hand, both to protect from self-inflicted bites, as well to prevent the individual from removing his g-tube; a physician's order entered 4/27/10 at 9:30 a.m. stated "continue Mitten R hand to promote wound healing R thumb X 7 days." The monitoring team did not check records to determine whether this was recorded as a medical restraint or whether other approaches for protection were considered. Additionally, it was noted that the monthly restraint log from July 1, 2009 through March, 2010 indicates 32 different individuals were restrained a total of 160 times. The logs identify twenty-three (72%) of these individuals as being restrained at least once for being aggressive toward staff (that is, "aggression toward staff" is listed in the column for "Cause.") This could be indicative of a number of things (staff conduct, staff training, meaningful activities for individuals, schedule flexibility, among many others) and merits thoughtful discussion by facility leadership.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	DADS policy SectionII.I.1 states" the individual must be released from restraint as soon as he or she no longer poses an immediate and serious risk of harm to him/herself or others. If there is a Safety Plan, the individual will be released according to the instructions that are stated in the Safety Plan (indicators when the individual no longer poses an immediate and serious risk of harm.)" RSSLC Policy J.1 Procedures 4.n requires that "individuals must be released from restraint when the individual is no longer dangerous to self or others." Policy J.2 Using Restraint in a Behavioral Emergency Step 5 (page 2) describes release criterion as being when the person is calm without regard to any specific behavior which the restraint was intended to abate. An individual may not be calm but is also not exhibiting dangerous behavior. For example, yelling, cursing, crying, and/or screaming but not being aggressive to self or	

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		others. Being calm should not be a sole criterion for restraint release. Without behaviorally related release criterion it is possible an individual is kept in restraint longer than necessary. In order to adequately protect the individual, the Facility should explicitly define release criteria based upon the characteristics of each unique individual. A limited review of Restraint Checklists found that the release from restraint code used most often was number eight which is the code for calm. For example code eight was used for Individual #25 for a restraint episode on 1/19/10 and 3/1/10, Individual #113 for a restraint episode on 3/10/10, and Individual #160 for a restraint episode on 2/11/10.	
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.	Refer to C1 for additional discussion of RSSLC restraint policies. The collection of restraint policies in the J series establish detailed descriptions of the type of restraint techniques and devices that have been approved for use at the RSSLC. Policy J.1 Use of Restraint (page 6) establishes a clear set of graduated levels of intervention to be attempted prior to restraint. J.1 (page 8) also establishes clear training requirements "staff may not initiate restraint if they have not received training and demonstrated competence in initial/annual refresher training using the specific restraint procedure/mechanical device to be used." Policy J.2 (Using Restraint in a Behavioral Emergency) requires that "staff should first attempt verbal or other de-escalative interventions in which they have been trained." J.2 goes on to state "if the individuals' behavior escalates into a behavior emergency, one or more staff may initiate crisis intervention procedures." This policy does not explicitly require that staff have been competently trained although in practice all Direct Care Professionals (DCP) are required to be successfully trained in new employee orientation and annually thereafter. Policy J.3 Using Restraint in a Safety Plan – Contingent Restraint requires that prior to the approval of a Safety Plan for an individual the Personal Support Team (PST) must review the Positive Behavior Supports (PBS) plan to ensure interventions less restrictive than restraint are addressed. J.3 also states "staff trained in the application of restraint" followed by a series of bullet points describing how trained staff would go about applying restraint. The monitoring team had two recent restraint episodes reenacted by the same DCP staff who actually applied the restraint, using a staff trainer from the Staff Development Department role playing as the individual. One demonstration was a bear hug followed by taking the individual to the floor in a side lying position. This restraint (actual) lasted 30 minutes. As staff talked through what they were doing, and why, it was apparent they	

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		were well trained. The other demonstration was a four point mechanical restraint that lasted (actual) 22 minutes. As staff (a different set of staff than the first demonstration) talked through what they were doing, and why, for the most part they followed correct procedures. A notable exception was the placement of the individuals' arms above his head when wrist restraints were applied to him and the bed. This is an unsafe method as it can affect breathing and potentially result in injury, for example, shoulder dislocation. In a limited review of Restraint Checklists and Debriefing forms problems were identified that indicate a need for further training and quality assurance activity in either documentation or practice or both. For example, Individual #630 was restrained on 2/14/10. The Restraint Checklist indicates the restraint occurred at 1:40 am when in fact it was at 1:40 pm. Policy requires a Restraint Monitor to be present within 15 minutes. The checklist indicates the restraint lasted 22 minutes and staff reported the monitor did not arrive until after the restraint episode was over. The Debriefing form, which is to be completed by the Restraint Monitor, indicated the debriefing occurred at 1:54 pm which would have been eight minutes before the restraint ended. Individual #25 was restrained on 3/1/10. The restraint began at 3:55 pm and ended at 4:25 pm. Staff reported that no Restraint Monitor was ever present. The Debriefing form, to be completed by a Restraint Monitor, indicates the debriefing occurred at 4:00 pm which is 25 minutes before the restraint ended. These two examples are particularly alarming as they suggest a serious breakdown in restraint monitoring required by policy and call into question the efficacy of restraint documentation. Restraint is not always used as the least restrictive intervention necessary to manage behaviors. Refer to the example in C1 regarding Individual #25. The RSSLC has not properly trained staff in the use of PMAB approved techniques and in restraint application. Training records were reviewed for 15 Direct Care Professional selected by the RSSLC Training Director. Nine of the 15 records failed to document completion of Restraint PMAB training. Additionally, there is not standardized training for the use of mechanical restraints. In response to a document request for training curriculum used in initial and refresher training on the use of mechanical restraint the monitors were provided with a Restraint Checklist and a Restraint Refresher Checklist. Staff indicated there is no formal curriculum. When asked for a list of staff who provide training in the use of mechanical restraint the monitors were provided with a list of all staff in the psychology department. In discussing this with staff in the training department, and with a Unit Director, it was apparent there was not a uniform method used throughout the RSSLC in training staff on the proper use of mechanical restraint.	
C4	Commencing within six months of the Effective Date hereof and with	RSSLC Policy J.1 lists six circumstances under which restraint will be used. Two are described as crisis intervention, two as related to medical/dental procedures or recovery,	

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	full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	one related to self-injurious behavior, and one related to postural support. Under the right circumstances each use may be appropriate although the policy clarifications described in C1 and language changes related to clearer delineation of what constitutes a medical restraint are needed. On Page 7 of J.1 a description of an Individual Risk Assessment is presented that would address the SA requirement that no restraint be used that is prohibited by medical orders or the individuals PSP. RSSLC Policy J.11 using Sedation for Medical/Dental Appointments looks to include treatment as it states "in order for an individual to receive dental or medical treatment…." The Policy requires the Personal Support Team (PST) to consider five general questions that address considerations other than restraint. These include: what are the frequency and possible causes of behaviors that interfere with the individual's ability to receive routine medical/dental treatment, what does staff do to prepare the individual for medical or dental examinations in order to reduce the need for sedation, and similar questions. This policy refers to Policy J.13 Implementing Dental Support Treatment Support Plan. In a review of implementation of J.13 the monitoring team determined that the Dental Treatment Support Plan Checklist called for in the policy was, for the most part, not being used by PSTs. This checklist is characterized in the policy as "the form that is used to develop an individualized approach to increase toleration for dental procedures by selecting applicable methods from the following" followed by descriptions of ten possible strategies. In response to a document request the monitors were provided with materials that were presented as representing dental treatment support plans All but one did not meet the requirements of policy J.13. Most were limited to tooth brush tolerance programs. The behavior analyst for Individual #456 created his own version of a support plan that was related to one of the 26 items in the Plan required by policy ("sits in dental chair with it tilted back and exam light on without attempting to leave the chair for 3 minutes"). The accompanying data showed nine successful trials over a one month period. This was the closest any of the provided documents came to meeting RSSLC policy requirements.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from	RSSLC Policy J.1 Use of Restraints requires a face to face assessment by a restraint monitor no later than 15 minutes after the restraint is implemented and an assessment by a licensed health care professional at least every thirty minutes from the start of the restraint. The policy does not specifically address restraint episodes that occur away from the facility. There is reference to "coordination" but lacks specificity that places specific requirements for away from facility episodes of restraint. Policy J.2 Using Restraint in a Behavioral Emergency contains the same requirement.	

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	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.	Policy J.3 Using Restraint in a Safety Plan – Contingent Restraint does not contain these explicit requirements. J.3 does not explicitly require a face to face assessment. Instead the language reads "monitor the individual to the extent necessary to ensure the individuals safety." It does not specify who is to monitor and the policy makes no reference to a restraint monitor. J.3 requires that a nurse check the person for injuries within 30 minutes of release but does not require a licensed health care professional documentation of vital signs and mental status at least every 30 minutes. Policy J.4.01 Using Restraint during Medical/Dental Procedures does not call for the physician to specify the schedule and type of monitoring required. There is a requirement that the physician order must include "special instructions for the individual's care, if any, while in restraint and following restraint." This is overly vague in light of the specificity called for in the SA. These policies need to be revised to ensure they include all requirements of the SA. The issue presented in C1 regarding Policy J.1 being an over-riding restraint policy should be addressed. If it is to be an over-riding restraint policy the review of the series of RSSLC policies to be done by RSSLC staff should ensure there are no contradictory statements among and between the various restraint policies. The RSSLC does not always conduct and properly document face-to-face assessments as required by the SA. Refer to C3 for examples. None of the restraints reviewed were longer than 30 minutes in duration.	
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	RSSLC Policy J.1 Monitoring section does not explicitly require that an individual be checked for restraint related injury. Policy J.1 does not require the completion of a Restraint Checklist which is required by the State and is where an injury check is documented. Policy J.2 (Behavioral Restraint) and J.3 (Contingent Restraint) do require use of the Restraint Checklist. In practice RSSLC does use the Restraint Checklist as required by the State. Policy J.1 monitoring section does not explicitly require opportunities for exercise, fluids, or use of the toilet except for instances of protective restraint. Policy J.2 does not address this at all. Policy J3 does include this provision. Policy J.4.01 (Medical/Dental) does not explicitly reference enhanced supervision, only a reference to "staff must evaluate the individual periodically." This is too vague to guide staff conduct.	

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	individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	Policy J.1 (page 8) requires 1:1 staff supervision when an individual is in emergency or contingent restraint. The Restraint Checklist includes Action Codes related to motion/exercise, toileting, meal offered, and fluid offered, Most of the restraints reviewed were of short duration where one would not expect to see these codes used. Three of the restraint episodes reviewed were of longer duration (Individual #25 15 minutes horizontal on 3/2/10 and Individual #630 22 minutes 4pt mechanical on 2/14/10 and again on 2/28/10). In no case did the Restraint Checklist indicate use of the above codes.	
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:	RSSLC Policy J.1 (page 12) contains the following provision: "The Unit Team Meeting will include tracking of restraint use by individual to notify the QMRP of the need to conduct a PST review for any person who had more than 2 emergency or contingent restraints within any rolling 30 day period. The PST review must consider the accuracy of treatment plan implementation; environmental factors including scheduling issues; personal factors including diagnostic characteristics, medical problems, psychosocial issues; skill deficits and need for additional skill training (e.g. additional SPOs or a PBS); and risk management including need for a Safety Plan" Using the SA criteria of 3+ restraints used in a rolling30 day period, the monitoring team identified five individuals who met the criteria for team review as called for in the SA. They are individuals #25, #267, #315, #429, and #448. Individual #448's PSP and related documents was selected to test a-g below. Individual #448 had been in restraint 18 times from 7/27/09 to 3/4/10 including three 30 day periods with four or more episodes. Based on this the treatment team should have met the last week in September, 2009, the third week in February, 2010, and the second week in March 2010 to assess Individual #448's treatment plan in the context of a-g below.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	There was no documentation in PSP addendums that a review of this nature occurred.	
	(b) review possibly contributing environmental conditions;	There was no documentation in PSP addendums that a review of this nature occurred	
	(c) review or perform structural assessments of the behavior provoking restraints;	There was no documentation in PSP addendums that a review of this nature occurred	
	(d) review or perform functional assessments of the behavior provoking restraints;	There was no documentation in PSP addendums that a review of this nature occurred	
	(e) develop (if one does not exist)	Individual #448 had a PBSP developed in April 2009. There were PSP Addendums to	

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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;	indicate any changes from the original plan.	
	(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	Fifteen of 19 episodes of restraint resulted from aggression towards staff. This suggests relevant treatments and supports are not effective or being modified as needed.	
	(g) as necessary, assess and revise the PBSP.	Individual #448 had a PBSP developed in April 2009. There were not any PSP Addendums to indicate any changes from the original plan.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of	RSSLC Policy J.1 (page 12) in what is labeled 10.d requires a review of each episode of restraint within 3 working days by the Unit Team and the Incident Management Team. Section 10.e requires that Behavioral Services conduct a review of each instance of restraint and write up recommendations for the PST to complete a PSP Addendum to address all restraint follow-up recommendations. This seems to be part of the 3 day review process but because of the way the paragraphs are organized in Section 10 it is not	

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	restraint, other than medical restraint. ISPs shall be revised, as appropriate.	explicit. As referenced in C1, C3, C4, C5, and C6 RSSLC would be well served to engage in a significant review of its restraint related policies to ensure they are instructive to staff who must carry them out and are clear, consistent, and unambiguous. Through interview and observation it was apparent restraint review is a topic in each unit morning meeting and in the facility-wide Incident Management daily meeting. From the various restraint documentation reviewed, including several PSPs and related Addendums it was not apparent that the review called for in Section 10.e referenced in the previous paragraph occurs.	

Recommendations:

1. Review all restraint related policies – establish a standardized format, update and/or consolidate various policies, and align each policy with DADS policy and the elements of the Settlement Agreement.
2. Audit training records to identify staff that have not received PMAB training and get them trained.
3. Develop a standardized curriculum and defined strategy for training in the use of mechanical restraints.
4. In order to adequately protect the individual, the Facility should explicitly define release criteria based upon the characteristics of each unique individual.
5. Develop a quality assurance process for restraint documentation.

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. DADS Policy #002.1 Protection From Harm – Abuse, Neglect, and Incident Management, dated 11/06/09 2. DADS Policy #001 Use of Restraint dated 8/31/09 3. Healthcare Guidelines, dated May, 2009 4. RSSLC Policy A.17: Managing Unusual Incidents (3/16/10) 5. RSSLC Policy A.24: Enhanced Campus Supervision & Professional Oversight (3/25/09) 6. RSSLC Policy A.25: Securing Evidence (7/17/09) 7. RSSLC Policy B.15: Taking Disciplinary Action Following Confirmed Abuse, Neglect, or Exploitation (8/1/07) 8. RSSLC Policy B.23: Processing Employee Not Passing Training and Competency Evaluation 9. RSSLC Policy C.1: Reporting Abuse, Neglect, Exploitation (6/3/09) 10. RSSLC Policy C.2: Actions Following Report of Abuse, Neglect, Exploitation (1/14/10) 11. RSSLC Policy C.3: Action Following Investigation of Abuse, Neglect, Exploitation (3/25/09) 12. RSSLC Policy C.5: Initial Actions Regarding Sexual Abuse, Neglect and Exploitation, and Other Sexual Incidents (12/30/02) 13. RSSLC Policy C.8: Determining Appropriateness of Home Visits (Alleged Offenders) – (8/24/04) 14. RSSLC Policy C.12: Reporting Incidents to DADS Regulatory (1/23/03) 15. RSSLC Policy D.9: Reviewing Injuries to Individuals Served and Employees: The Workplace Injury Review Team (8/26/99) 16. RSSLC Policy D.8: Completing/Routing Client Injury Report (3/16/09) 17. RSSLC Policy D.12: Monitoring the Effectiveness of Safety, Health and Risk Programs: Risk Management/Safety Committee (6/16/05) 18. RSSLC Policy D.13: Conducting an Addendum Meeting for Repeated Injuries (5/1/09) 19. RSSLC Policy D.20 Conducting an Interim Meeting for a Serious Injury (7/14/03) 20. RSSLC Policy E.17 Completing Incident Information Reports (2/28/08) 21. RSSLC Policy J.9: Conducting Interim for Repeat Incidents of Aggression (undated) 22. RSSLC Plan of Improvement Section D. Protection from Harm (2/11/10) 23. PMAB Training Curriculum 24. HRC minutes from 4/1/10 25. Incident Management Notes (minutes) for meetings on 4/5/10, 4/12/10, 4/19/10 and 4/26/10 26. Campus Administrator Logs March 2010 27. Sample Home Shift Logs and related Monitoring Form 28. Individual Training Records and personnel documentation for Facility Investigators 29. Sample documentation of volunteer background checks 30. Sample documentation of employee background checks 31. New Employee Training curriculum

	32. Acknowledgement of Reporting signed forms for randomly selected employees 33. Abuse and Neglect Allegations log 7/1/09 to 3/26/10 34. DFPS Investigation Reports 35267149, 35656931, 35558689, 35372879, 34763149, 34952609, 35567871, 35585669, 35284735 and 35481690 35. Peer Caused Injury log 7/1/09 to 3/19/10 36. Incident and Injury Summary Log (by individual) 7/1/09 to 2/28/10 37. Incident Information Report (E.17) for Individual #174 (3/25/10), #338 (3/20/10), #462 (3/23/10), #618 (3/21/10), #645 (3/24/10), and #708 (3/21/10) 38. Top 10 Aggressors (Individuals who caused injuries to other individuals) 7/1/09 to 3/19/10 and detailed data on each 39. UIR's 09-130, 10-035, 10-043, 10-0477, 10-048, 10-049, 10-050, 10-052, 10-054, 10-057, 10-058, 10-062, 10-068, and 10-069. 40. Top 10 Injured Individuals 7/1/09 to 2/28/10 and detailed data on each 41. Direct Care Professionals Training Records (15) 42. Minutes of 3/18/10 meeting between RSSLC, local law enforcement, DFPS, & OIG **People interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Judy Miller, Settlement Agreement Coordinator 3. Reuben Muhammad, Incident Management Coordinator 4. Dr. David Partridge, Medical Director 5. Jim North, Program Auditor 6. Delphine Baldon, DFPS/APS Program Administrator 7. Benny Sauceda, DFPS/APS Supervisor 8. Vanessa Brown, DFPS/APS Investigator 9. Deatrice Potlow, DFPS/APS Investigator 10. John Kimble, OIG Investigator 11. Pam Turner, Rights Officer 12. Cedric Gardner, DADS Attorney for RSSLC 13. Donald Paviska, Competency Training & Development Coordinator 14. Carol Agu, QMRP Consultant 15. QMRP's Sherri Zirbes, Jolly Onwukee, Netta Bridgewater, Tom Virripan, Casandra Uzomah, and Lenin Mathews 16. Robin Eversole, Volunteer Services Coordinator 17. Sixteen Direct Care Professionals 18. Thirteen individuals served: #25, #241, #267, #315, #344, #363, #399, #429, #448, #557, #630, #680, and #738 **Meetings attended/Observations:** 1. Incident Management Team 4/26/10 2. Annual PSP for Individual #57 3. HRC meeting 4/29/10 4. Living Area Observations: 4/26/10 at San Jacinto, Lavaca, Leon A & C, Sabine: 4/28/10 at Angelia; and, 4/29/10 at Rio Grande and Leon

	5. 4/29/10 Unit Morning Meetings at Rio Grande and Leon 6. 3+ injury special meeting for individual # 267 **7.** Restraint application demonstration by DCP's **8.** Self-Advocacy Council Meeting of 4/28/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC has a well organized system for reporting and investigating allegations of abuse and neglect, investigating unusual incidents, and reviewing discovered injuries. This system includes the necessary incident management components to review reports, determine necessary follow-up, and track action plans through completion. RSSLC's policies are comprehensive although they could benefit from some updating to include better formatting, effective dates, and titling to include the name of the organization. There are some SA areas not addressed in RSSLC policy. This will need to be corrected. The RSSLC policy E.17 is an exemplary process for the review of discovered injuries. RSSLC should be commended for the proactive CAAN program, an event intended to enable staff, individuals served, and LARs to become better informed and heighten awareness on the prevention of abuse and neglect. Some issues of potential significance were identified in the areas of timely reporting of incidents, timely investigations, protection of individuals, and policy compliance in injury categorization, including the following: • Review of documentation of reporting identified several incidents of late reporting. • Policy does not require removal of alleged perpetrators from direct contact. • Some DFPS investigations are not completed within policy timelines. • Physicians at the RSSLC have discretionary authority to decide whether an injury is labeled serious, even if the injury has required medical intervention. This appears to be contrary to State and RSSLC policy

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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 DADS policy on abuse, neglect, and incident management was completed on November 6, 2009. The monitoring team reviewed the policy and it was found to correspond in most respects to what is required under the Settlement Agreement. Any variations from the SA are noted under the corresponding sections below. The DADS abuse, neglect, and exploitation rules and incident management policy state that abuse, neglect, and exploitation are prohibited. SSLC's are required to comply with these State policies and rules.	

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		RSSLC Policy C.1 Reporting Abuse, Neglect, Exploitation includes the following statement in bold print on page 1: "THE FACILITY IS COMMITTED TO ZERO TOLERANCE FOR ABUSE, NEGLECT, AND EXPLOITATION OF ANY INDIVIDUAL SERVED." This policy provides a comprehensive set of definitions for abuse, neglect, and exploitation and describes the reporting obligations and process that every employee, agent, and contractor is to follow if they suspect or have knowledge that an individual is being abused, neglected, or exploited. Staff interviewed were knowledgeable of the abuse and neglect policy and knew the phone number to call to report. The phone number was also displayed on the back of each employees ID badge.	
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:	RSSLC has the following policies in place to address this section of the SA: A.17 Managing Unusual Incidents A.25 Securing Evidence C.1 Reporting Abuse, Neglect, Exploitation C.2 Actions Following Report of Abuse, Neglect, Exploitation C.3 Actions Following Investigation of Abuse, Neglect, Exploitation C.5 Initial Actions Regarding Sexual Abuse, Neglect, and Exploitation, and Other Sexual Incidents C. 6 Ensuring Individual Rights C.12 Reporting Incidents to DADS Regulatory D.8 Completing/Routing Client Injury Report E.17 Completing Incident Information Reports I.5 Medical Attention Following Suspected Sexual Contact	
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with	RSSLC Policy A.17 Managing Unusual Incidents establishes the reporting process. Policy requires unusual incidents to be reported to the unit director or designee. Policy also requires allegations of abuse, neglect, or exploitation to be called in to the Department of Family Protective Services (DFPS) immediately but in no case more than one hour after suspicion or after learning of the incident. The designee in off hours is the Campus Coordinator. The Unit Director or designee is to report the incident to the Facility Director's Secretary who is to notify the Facility Director as well as several other administrators. Policy requires this to occur within one hour of the initial report. Unusual incidents are defined in the policy and include serious injury and death. The facility uses a standardized form for reporting, the Unusual Incident Report (UIR). This policy is not always followed. In a limited review of DFPS case files several instances of late reporting	

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	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.	were noted. Case #35481690 indicates an allegation of abuse at 5:00 pm which was not called in to DFPS until 11:43 pm. Case #35372879 indicates an allegation of abuse and neglect at 3:50 pm which was not called in to DFPS until 5:58 pm. Case #35485909 indicates an allegation of abuse at 10:55 pm which was not called in to DFPS until 9:01 am the next day. RSSLC needs to address this through additional training and administrative oversight. RSSLC uses a standardized reporting system for reporting all unusual incidents. This process includes notification of the Facility Director (or designee). From observation and document review it was apparent the Facility Director is a regular participant in the daily facility Incident Management meetings. The RSSLC also has a defined process for the administrative review of all non-serious injuries (discovered and witnessed). This review looks at levels of supervision, suspicion of abuse or neglect, nursing treatments, behavior variables, environmental considerations, and protective actions needed and/or taken. This process is guided by Policy E.17 and staff generally refers to it as "E-17's" in unit level morning meetings and at the daily incident management team meetings. The monitoring team believes this is an excellent process worthy of replication at other SSLCs. Discovered injuries, even though not serious from a medical assessment, can result from mistreatment of individuals by staff or other individuals. The E-17 process can provide an early warning that interventions may be called for. At the first compliance visit, the monitoring team will review whether issues identified through this process lead to effective actions to reduce future risk.	
	(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	RSSLC Policy C.2 Actions Following Report of Abuse, Neglect, Exploitation establishes requirements and procedures to protect individuals who are the alleged victims. Step 2 in the policy delineates a number of possible actions that can be taken to ensure the safety of the alleged victim(s). These include assessing and treating any injuries, placing the alleged perpetrator (AP) on emergency leave or reassigning the AP to a non-direct care area, reassignment of the alleged victim to another group, temporary transfer of the alleged victim to another home/location, increased monitoring of the home or area by administrative staff, and, if the AP is not an employee imposing a restriction on the AP's access to the alleged victim pending investigation. The monitoring team has several issues with this policy. The policy does not require an AP be removed from direct contact with individuals. While it was reported through interview that removal is standard practice the policy provides for administrative discretion. If it is the intent of RSSLC to always remove an AP from client contact (as was explained is the practice) the policy should be clarified to	

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	the investigation.	remove any ambiguity in this regard. The monitoring team is concerned about the provisions that suggest reassignment or relocation of the alleged victim may be an appropriate client protection measure. The policy provides this option in instances where an AP is unknown at the time the investigation is initiated. There may be circumstances where this is a necessary and appropriate client protection measure but clinical considerations should be taken into account in reaching this decision. Care should be taken to ensure the alleged victim of abuse is not unintentionally made to feel as if he/she is being punished (i.e. made to move to a different home separated from friends and preferred staff) for having been victimized. The late reporting noted in D2.a resulted in unnecessary exposure of individuals to alleged perpetrators of abuse and/or neglect. For example, DFPS Case #35485909 indicates an allegation of abuse at 10:55 pm which was not reported until 9:01 the following morning. The alleged perpetrator worked the rest of the shift and was not reassigned until the start of her shift the next day. DFPS confirmed the abuse. Individuals were exposed to other potentially abusive acts by this staff person from 10:55 pm until 6:00 am, the end of the shift. A similar scenario presents itself in DFPS Case #35481690.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	RSSLC Policy C.1 Reporting Abuse, Neglect, Exploitation establishes training requirements in Step 4. Policy requires that DCPs receive training on "signs of possible abuse, neglect, and exploitation" and that physicians are to receive "additional training on how to identify signs and symptoms of abuse, neglect, and exploitation." This policy does not require that DCPs receive training on symptoms although the person who does the training indicated symptoms were part of what was taught. In interviewing DCPs, responses to this question were generally weak. This is an area needing improvement. Limited review of training records indicated adequate documentation that training had occurred was in place.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All	RSSLC Policy C.1 addresses each element required in this section of the SA. Limited review of personnel documentation found signed statements acknowledging reporting requirements were evident. The monitoring team did not discover any instances of a mandatory reporter failing to	

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	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.	report. From interviews with staff they were very clear there were consequences for failure to report – almost all responded "you'll get fired."	
	(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 monitoring team did not identify any RSSLC policy that was directed towards this topic. The members of the RSSLC Self Advocacy Council were knowledgeable of issues related to abuse and neglect. They could articulate examples and had initiated their own campaign by creating wristbands for them to wear that displayed the DFPS 800 number to call. They were also well aware that the RSSLC had a Rights Officer who was there to assist them with any complaints on any topic. The Rights Officer routinely provided training at the Self Advocacy meetings, including during the meeting on 4/28/10. One effort identified by the monitoring team to reach out to LARs was provision of a pamphlet conveying information on how to report. The pamphlet also included detailed information on signs and symptoms to look for in assessing possible abusive or neglectful actions. It was reported this pamphlet is in the process of being translated to Spanish to be of greater utility to Spanish speaking guardians and LARs. The RSSLC initiated a Campaign Against Abuse and Neglect (CAAN) in October, 2008 and again in September, 2009. Over 300 people attended each event which was described as a fun day of various activities and information booths to enable staff, individuals served, and LARs to become better informed and heighten awareness on the prevention of abuse and neglect. RSSLC should be commended for the proactive CAAN program.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The monitoring team did not identify any RSSLC policy that was directed towards this topic. Policy C.1 does contain a requirement for a more limited posting of the 1-800 number to call to report abuse and neglect. The RSSLC has a very attractive color "You Have The Right" poster to display throughout the facility. It highlights, using pictures and words, 24 rights and includes pictures and	

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		phone numbers of the Rights Officer and Assistant Rights Officer as well as 1-800 numbers to report to the DADS Consumer Rights office and the DFPS Abuse hotline. Through observation of multiple living areas the prominent display of this poster was mixed. In some areas it was not displayed or displayed in a location not likely to be viewed such as behind a door.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The monitoring team did not identify any RSSLC policy that was directed towards this topic. Despite the lack of policy direction it was apparent law enforcement was appropriately involved in incidents at the RSSLC. It was reported that all allegations of abuse, neglect, and serious injury are reported to the Office of Inspector General (OIG). Some incidents are also reported to the local Sheriff's office. OIG reported a high degree of cooperation between their office, local law enforcement, DFPS, and RSSLC administrative staff. This cooperation was demonstrated in a high level meeting in March, 2010 between RSSLC administrative staff, four staff from OIG, three staff from DFPS, and three staff from the Fort Bend Sheriff's Department. The purpose of this meeting was for each party to be aware of everyone else's role and responsibility with respect to reporting, investigation, and follow-up. Minutes of this minute also indicate the DOJ SA was discussed.	
	(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.	RSSLC Policy C.1 Step 3 provides a process for anyone who believes they are being subjected to retaliatory action to report it to multiple entities. The training elements provided in Step 4 of this policy address the definition of retaliatory action, explanation that such action is prohibited, and the consequences of such action. The Incident Manager reported this topic is covered in the class he teaches to all new employees and most DCP staff interviewed were aware that retaliation was prohibited and were aware there were ways to report it should it occur. None of the staff interviewed acknowledged any awareness of retaliatory acts directed at reporters of abuse or neglect. Interviews with DFPS staff suggested they feel there is some suspicion of retaliation that presents itself in subtle ways. Examples cited included staff ignoring or isolating another staff person, a supervisor enforcing rules with a particular staff person differently than with others, and staff creating a tense work environment for another staff person. They also are suspicious of what is sometimes referred to as a "code of silence" where peer pressure exists that requires new employees to "go along to get along." DFPS indicated these kinds of concerns do not show up in a direct way in their reports as they are usually not supported with any direct evidence. The monitoring team suggested that when DFPS has these suspicions they initiate discussion with the Facility Director to ensure he is aware of them and can contemplate appropriate administrative follow-up.	

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The monitoring team did not identify any RSSLC policy that was directed towards this topic. The monitoring team did not identify any administrative activity that directly targeted this element of the SA. There were several types of review activities that could identify unreported injuries but none that represent an organized audit system. An example of this is Campus Supervisor checks of daily home logs to see that incident reports were initiated for anything described on the log which would require a report. Another example would be the daily discussion of a variety of things at unit morning meetings.	
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:	DADS Policy 2.1 Protection From Harm – Abuse, Neglect, and Incident Management establishes policy direction to SSLC's in nearly all elements of this section of the SA. One exception is the absence in State policy of requiring investigators to have training in working with people with developmental disabilities. The RSSLC has several policies (A.17, C.1, C.2, C.12, and D.8) that address some elements of these SA requirements. For the most part the RSSLC relies on the State policy to guide its investigatory process. The RSSLC appears to have a well organized system for the investigatory process. It would be well served to have this process and all its components described in one place, such as an Investigations Manual.	
	(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.	DADS Policy 2.1 establishes training requirements for investigators and anyone else that would be expected to complete a UIR. Staff must complete the Comprehensive Investigator Training (CIT0100) course within one month of employment or assignment as an investigator and prior to completing a UIR. Policy also requires that the Incident Management Coordinator and primary investigator (s) complete the Labor Relations Alternatives (LRA) Fundamentals of Investigations training (INV0100) within six months of employment. A review of personnel information confirms that investigators have completed this training. The facility investigators have all had experience working with people with developmental disabilities. For example, the Incident Manager/Lead Investigator has worked at the RSSLC for nine years as Director of Recreation, QMRP, and Unit Director. Through interview it was also apparent that DFPS and OIG investigators had appropriate qualifications and experience with investigations involving people with developmental	

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		disabilities. The DFPS supervising investigator had worked at the RSSLC.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	DADS Policy 2.1 establishes the principle and required expectation of cooperation with outside entities. Through interview with RSSLC staff, DFPS staff, and the Office of Inspector General (OIG) staff it is apparent such cooperation is occurring in the conduct of investigations. The Incident Management Coordinator was clear in his understanding of his responsibility to fully cooperate with outside entities. RSSLC Policy C.2 Step 7 establishes a requirement that employees cooperate with DFPS investigators in all matters related to an investigation. Through interview, DFPS investigators reported occasional instances where cooperation from staff being interviewed was a problem. When this occurred, and it was brought to the attention of RSSLC administrative staff, appropriate follow-up occurred. DFPS was clear that the RSSLC administrative staff was committed to thorough and complete investigations and did everything DFPS would expect to ensure cooperation from employees.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	Most law enforcement investigations at the RSSLC are conducted by OIG. OIG reported a high degree of coordination with RSSLC staff. There are instances where local law enforcement is involved in an investigation. In the sample of Investigation Reports reviewed there was nothing that would indicate lack of coordination with local law enforcement.	
	(d) Provide for the safeguarding of evidence.	DADS Policy 2.1 Section V.2 describes procedures for safeguarding evidence in the event of a serious incident. RSSLC Policy A.25 Securing Evidence contains specific RSSLC specific procedures for securing and safeguarding evidence.	
	(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,	DADS Policy 2.1 Section VIII establishes timelines for investigations. This policy requires that investigations begin within 24 hours of the incident being reported. Current policy requires investigations to be completed within 14 days (10 days after June 1, 2010). From the investigation files reviewed DFPS investigations of serious incidents began within 24 hours of notification. Not all investigations are completed within 14 days as currently required by policy. For example, Case #35485909 is a confirmed case of abuse. The incident was reported on 3/8/10 and the investigation was completed on 4/2/10. Case #35372879 is a confirmed case of abuse and neglect. The incident was reported on 2/25/10 and the investigation was completed on 3/16/10. In this case the case file indicates DFPS was delayed in beginning its investigation because OIG was first deciding if it would be investigating. All investigation reports reviewed included a summary of the investigation, findings, and	

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	findings and, as appropriate, recommendations for corrective action.	recommendations for corrective action. Documentation in investigation files was in place to validate corrective action had occurred as planned.	
	(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.	DADS Policy 2.1 Section VIII.H establishes investigation and record keeping requirements for investigation reports that include the elements required in this section of the SA. All investigation reports reviewed contained these essential elements. Investigation reports and related files were organized in a manner that was logical and easy to follow. The sample of DFPS reports reviewed contained the data elements required in this section of the SA.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to	DADS Policy 2.1 requires that a summary of each investigation be sent to DADS Regulatory within 5 working days of the incident and that a final DFPS report be completed within 14 working days for review by DADS Regulatory. From interview and document review it is apparent that the Incident Manager (the	

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	ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	person supervising investigations) reviews each investigation report and initiates dialogue with necessary parties if there is any ambiguity or incomplete information that would reflect on the investigation conclusions. Reports are also subject to an independent review by the RSSLC Assistant Ombudsman, the Director of Residential Services, and a Unit Director from a unit that is not the subject of the investigation. The concerns and conclusions of each party are reviewed as needed in an Incident Management meeting.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	RSSLC reports reviewed were written in a clear and understandable manner. They included detailed discussion of investigative procedures, relevant history and personal information about the individual, a description of immediate actions that have been, and need to be, taken, and an analysis of findings and further recommendations. Reports are reviewed and approved by the Incident Manager and Facility Director.	
	(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.	Recommendations that result from an investigation report and the attendant review activity are entered into a log for tracking and subsequent documentation. The Quality Assurance Department is responsible for following up and documenting resultant activity. A limited review of documentation provided by the QA Department validates that this process is in place. The document used to achieve this could be improved. It is not titled and is not structured so as to allow a yes/no/comment entry for each item that is supposed to be checked for inclusion in a UIR review.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The RSSLC maintains a log and report system that is staff specific and includes the following data items: name of individual involved, date of incident, time of incident, allegation code, allegation descriptor, DFPS case number, disposition, and, disciplinary action taken. This system permits access to every investigation involving a particular staff member or individual.	
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	RSSLC has a tracking and trending system that includes the data elements required by the SA and was able to produce reports specific to any variable sought by the monitoring team in its pre-visit document request or in document requests during the site visit. A review of these documents disclosed one particularly perplexing issue. From 7/1/09 through 2/28/10 there were 2,718 injuries reported. None were classified as serious. Serious injuries are defined in policy as "any injury requiring medical intervention or an	

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	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.	injury determined to be serious by a physician or advanced practice nurse. Medical intervention is defined as treatment by a licensed medical doctor, osteopath, podiatrist, dentist, physicians' assistant, or advanced practice nurse. The term does not include first aid, an examination, diagnostics (e.g. x-ray, blood test), or the prescribing of oral or topical medication." The monitoring team finds it difficult to believe that throughout the course of nine months, and over 2,700 injuries not one required intervention by a physician. In discussing this issue with RSSLC it was discovered that physicians at the RSSLC have discretionary authority to decide whether an injury is labeled serious, even if the injury has required medical intervention. This appears to be contrary to State and RSSLC policy. This also would produce inaccurate data for tracking, trending, and quality improvement activities.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	Section 3200.3 of the DADS regulations on Volunteer Programs requires criminal background checks on volunteers. The DADS Operational Handbook, Revision 09-21 effective 10/29/09 (Section 19000 Part E) requires criminal background checks on employees. The DADS criminal history rule also contains prerequisites for allowing staff or volunteers to work directly with individuals. In a limited review of employee and volunteer records required background checks were completed and properly documented.	

Recommendations:

1. Policies should be reviewed to be sure to include topics identified in the report that are not currently in policy.
2. RSSLC Policy C.2 Actions Following Report of Abuse, Neglect, Exploitation should be revised to support the current practice of removing an AP from direct contact.
3. RSSLC should provide additional training and administrative supervision and oversight to incident reporting requirements and timeframes.

4. RSSLC should continue efforts with DFPS to coordinate investigations and ensure their timelines are met.
5. DFPS should initiate discussion with the Facility Director if they have suspicions of concern about possible retaliation to ensure he is aware of them and can contemplate appropriate administrative follow-up.
6. Provide DCPs additional training in recognizing signs and symptoms of abuse and neglect.
7. Establish an audit process to ensure significant injuries are reported.
8. Conduct a specific policy review regarding injury classification.

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. DADS Policy 003-Quality Enhancement 2. Restraint Trend Report 3/31/10 3. Injury Trend Report 3/31/10 4. Allegations Trend Report 3/31/10 5. Unusual Incidents Trend Report 3/31/10 6. QA Monitoring tools and summary reports for person directed planning, integrated protections & services, PSP monitoring, psychology assessment, Positive Behavior Support Plan Analysis, various elements of nursing services, PSP attendance, PSP Addendum attendance, active treatment notebook review, various element of the Plan of Improvement, active treatment reviews, 7. Performance Improvement Council minutes from meetings on 1/26/10, 2/23/10, and 3/30/10 8. Plan of Improvement compliance tracking log 9. Facility Restraint Analysis report for period ending 3/31/10 10. FY10 Trend Analysis 3/31/10 11. RSSLC Policy J.1: Use of Restraint (9/1/09) 12. RSSLC Policy J.7: Completing/Routing Restraint Checklist 13. RSSLC Plan of Improvement Section C. Protection from Harm – Restraints (2/11/10) 14. Restraint Reduction Team Meeting minutes for 1/29/10, 3/19/10 and 4/22/10 15. Multiple Restraint Analysis for Individuals #315 & #630 16. HRC minutes from 4/1/10 17. RSSLC Policy D.9: Reviewing Injuries to Individuals Served and Employees: The Workplace Injury Review Team (8/26/99) 18. RSSLC Policy D.12: Monitoring the Effectiveness of Safety, Health and Risk Programs: Risk Management/Safety Committee (6/16/05) 19. RSSLC Plan of Improvement Section D. Protection from Harm (2/11/10) 20. RSSLC Plan of Improvement Section E. Quality Assurance 21. CMS 2567 from survey completed 2/19/10. 22. Corrective Action Plan dated 1/22/10 23. Survey/monitoring assignment/schedule document provided by QA 24. Incident Management Plan Logs **People interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Judy Miller, Settlement Agreement Coordinator 3. Reuben Muhammad, Incident Management Coordinator 4. Dr. David Partridge, Medical Director 5. William Eckenroth, PhD, Director of Behavioral Services 6. Jim North, Program Auditor 7. Pam Turner, Rights Officer 8. Donald Paviska, Competency Training & Development Coordinator

	9. Carol Agu, QMRP Consultant 10. QMRP's Sherri Zirbes, Jolly Onwukee, Netta Bridgewater, Tom Virripan, Casandra Uzomah, and Lenin Mathews 11. Sixteen Direct Care Professionals 12. Thirteen individuals served: #25, #241, #267, #315, #344, #363, #399, #429, #448, #557, #630, #680, and #738 **Meetings attended/Observations:** 1. Incident Management Team 4/26/10 2. Annual PSP for Individual #57 3. HRC meeting 4/29/10 4. Living Area Observations: 4/26/10 at San Jacinto, Lavaca, Leon A & C, Sabine: 4/28/10 at Angelia; and, 4/29/10 at Rio Grande and Leon 5. 4/29/10 Unit Morning Meetings at Rio Grande and Leon 6. 3+ injury special meeting for individual # 267 7. Restraint application demonstration by DCP's
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC does not have a written Quality Assurance Policy, a written Quality Assurance Plan, a written medical review system, a written nursing quality assurance plan, or a written medical quality improvement program. Current quality assurance activity is fragmented and only addresses a small number of specific issues within the facility operations. For example, the facility gathers data on injuries and incidents and has a system for trending these data but there is not any indication this is used to address facility systems issues that might have a broad impact on reducing injuries and incidents. The facility engages in a great deal of QA monitoring resulting in voluminous data which does not seem to be regularly aggregated and analyzed for any useful management improvement functions. There is some question as to if the staff using the monitoring tools are sufficiently trained in knowing what to look for and how to assess a given data item. Some QA reports show a high degree of compliance that was not evident to the monitoring team during observation in the course of the review (e.g., certain elements in the meal monitoring tool). RSSLC has taken important initial steps that can progress into a good QA system. There is much work ahead to refine processes, integrate information, and determine how best to use all the information flowing from these current systems as well as those systems needing to be developed.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living	RSSLC collects the data required by this section of the SA and generates a monthly tracking and trend report. Four separate reports are generated: (1) Unusual Incidents, (2) Abuse/Neglect/Exploitation, (3) Restraints, and (4) Injuries. Each report concludes with a narrative overview and any recommendations. Recommendations from the most	

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	units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	recent report (3/31/10) do not reflect a level of analysis necessary to address systemic issues. For example, the recommendation from the Unusual Incidents Trend Analysis Report is "continue increased rounds by professional staff to minimize the risk of emerging behaviors." This is an overly simplistic response to what is likely a much larger and more systemic problem related to variables such as staff interaction with individuals, staff sophistication in implementing behavior programs correctly, environmental conditions that create maladaptive behavior, and undiagnosed or untreated medical conditions. RSSLC does not have a written Quality Assurance Plan. A QA Plan should address subjects such as what is going to be monitored, by whom, at what frequency, what other data are to be collected, how data are to be organized for analyses, who analyzes data, what analysis is to be used for, and similar activity that allows the organization to understand how things are working, what and where things seem to be working well, what and where improvement is needed, and other elements designed to initiate organizational improvements, particularly systemic improvements. Despite the lack of a written QA Plan the RSSLC engages in a great deal of QA activity and should be commended for this. RSSLC produced a document for the monitoring team labeled "Monitoring Survey" that is a work schedule for each of the program monitors. It defines what they monitor, the tools to use, the sample size, the frequency of that specific monitoring, and what happens to the completed monitoring tool. There are a total of 101 monitoring activities noted in this document although some are duplicated because multiple program monitors monitor the same thing (e.g. engagement in active treatment) in different locations. Through the use of these monitoring tools much data is gathered in key subject matters. Some of these data are summarized and submitted to State Office as part of a Plan of Improvement process. It does not appear most of these data are used for anything beyond identifying a specific problem in a specific location needing correction. Nevertheless, this is a good starting point for development of a more refined and organized QA system.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each	Data summaries other than what was described in E1 are not routinely prepared. Without this, data analysis is not possible. As referenced in E1 the depth of analysis currently occurring is not sufficient to identify systemic issues that need to change to create sustainable improvement. The Performance Improvement Council appears to be one vehicle that RSSLC could use to begin a conversation on data compilation, analysis, and review. This Council includes in its membership many key program and clinical management staff of the facility. The meeting minutes reviewed did not give any indication of substantive discussion with respect to performance improvement. State policy defines this group as one that should	

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	action step; the person(s) responsible; and the time frame in which each action step must occur.	initiate performance improvement. It would seem that because of the membership of this group it could become an important forum for assessing QA information and determining appropriate organizational responses to the analysis of QA data. Some evidence of corrective action plans responding to specific findings from specific monitoring was evident although that was not a focus of this review. Future reviews will need to assess this in more detail. The limited number of corrective action plans reviewed by the monitoring team identified the noncompliant area (e.g. medication error), the corrective action to be taken, documentation to be submitted to verify the corrective action, the responsible person, and the due date for correction. To make this process complete the template should have a final column that records the actual date verification of completion occurred as well as a way to document if there is revision of the planned corrective action.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Refer to E2	
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.	Refer to E2	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Refer to E2	

Recommendations:
1. RSSLC needs to develop a formal Quality Assurance plan that incorporates all current activity that is QA related and is compliant with the DADS policy on Quality Assurance..
2. Once developed, the leadership of the Facility should determine if there is any additional QA activity that is needed to ensure the plan is comprehensive and when fully implemented will ensure sustained compliance with the SA and continued improvement in quality of services, safety, and other aspects of facility operation.
3. RSSLC needs to identify a more formalized process than what was evident to the monitoring team for the review of QA data and planned corrective actions, including the QA related activity associated with the Plan of Improvement process and the work of the Performance Improvement Council and any other groups or committees that exist to assess performance and recommend improvement plans to facility leadership.

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. RSSLC Policy F.1 Scheduling Annual Personal Support Plan Meetings (12/12/08) 2. RSSLC Policy F.3 Participating in Annual Personal Support Plan Meeting (6/1/07) 3. RSSLC Policy F.4 Participating in Initial Personal Support Plan Meeting(1/28/09) 4. RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation (8/10/09) 5. RSSLC Policy F.6 Participating In/Documenting Addendum Meetings (6/1/07) 6. RSSLC Policy F.8 Participating in PSP Quarterly Reviews (6/1/08) 7. RSSLC Policy F.17 Participating in PSP Monthly Reviews (7/15/09) 8. RSSLC Policy F.18 Participating in Personal Focus Worksheet Meetings 9. RSSLC Policy I.8 Health Status Team Guidelines (10/12/09) 10. RSSC Plan of Improvement Section F 11. PSP Training Materials Power Point Slides (3/16/10), Steps to Take for Program Development (undated), and Person Directed Plans (PER0200) 12. PSPs for Individuals #2, #9, #16, #25, #30, #52, #57, #91, #99, #267, #402, #426, #437, #455, #525, #579, #598, #640, #681, #755, and #786 13. PSP Tracking Worksheet/Compliance Rates (3/24/10) 14. PSP Discipline's Assessments Tracking Worksheet (7/17/09) 15. Section F Compliance Review Checklist (10/15/09) 16. Person Directed Planning Process Compliance Review Checklist (undated) 17. Personal Support Plan Meeting Monitoring Checklist (11/6/07) **Persons Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Judy Miller, Settlement Agreement Coordinator 3. Pam Turner, Rights Officer 4. Donald Paviska, Competency Training & Development Coordinator 5. Carol Agu, QMRP Consultant 6. QMRP's Sherri Zirbes, Jolly Onwukee, Netta Bridgewater, Tom Virripan, Casandra Uzomah, and Lenin Mathews 7. Sixteen Direct Care Professionals 8. Thirteen individuals served: #25, #241, #267, #315, #344, #363, #399, #429, #448, #557, #630, #680, and #738 **Meetings Attended/Observations:** 1. Annual PSP for Individuals #57, #402, and #681 2. HRC meeting 4/29/10 3. Living Area Observations: 4/26/10 at San Jacinto, Lavaca, Leon A & C, Sabine: 4/28/10 at Angelia; and, 4/29/10 at Rio Grande and Leon 4. 3+ injury special meeting for individual # 267

	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC has eight policies that directly and indirectly describe expectations for PSP planning. There is little in these documents that establish expectations for integrated and collaborative program planning. These policies do place emphasis on person directed planning and personal outcomes which is commendable. The policies themselves could integrate information better to establish a framework for integrated planning across disciplines. The monitoring team observed multiple PSP meetings and noted only a few instances of collaborative discussion. The monitoring team reviewed multiple PSPs and found little documentation of collaborative and integrated service planning. The current PSP process meets many of the technical requirements of the Settlement Agreement (SA); however, some of the elements required in Section F were either not developed or not thoughtfully implemented. The monitoring team is aware the PSP format, and accompanying instructions, are subject to a significant modification and that a statewide workgroup is working to develop a PSP policy that will refine the PSP process in a manner intended to facilitate compliance with the SA. Comments in this section are limited because of this. Overall, through document review, interview, and meeting observation there was little evidence of departments and disciplines coming together throughout the year, and in anticipation of the annual PSP planning process, to assess individual needs and develop service strategies in an integrated manner.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	THE RSSLC has the following policies which are in place and intended to guide the PST process: 1. RSSLC Policy F.1 Scheduling Annual Personal Support Plan Meetings (12/12/08) 2. RSSLC Policy F.3 Participating in Annual Personal Support Plan Meeting (6/1/07) 3. RSSLC Policy F.4 Participating in Initial Personal Support Plan Meeting(1/28/09) 4. RSSLC Policy F.5 Completing Personal Support Plan Meeting Documentation (8/10/09) 5. RSSLC Policy F.6 Participating In/Documenting Addendum Meetings (6/1/07) 6. RSSLC Policy F.8 Participating in PSP Quarterly Reviews (6/1/08) 7. RSSLC Policy F.17 Participating in PSP Monthly Reviews (7/15/09) 8. RSSLC Policy F.18 Participating in Personal Focus Worksheet Meetings All of these policies include a "definitions" section. Often, the definition of a term includes a policy or procedural statement. This is typically displayed by a note following a definition. For example, following the definition of a Personal Support Team a note	

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		follows which establishes mandatory and optional members of the team. This is a common practice in many RSSLC policies and can lead to incorrect policy implementation. A person who is looking for policy direction on a given subject may not necessarily refer back to the definitions section of a policy.	
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 policies referenced in F1 establish the QMRP as the person from the team who is responsible for facilitating each Personal Support Plan meeting and ensuring assessments are completed by relevant disciplines, and that necessary treatments, services, and supports are developed by the team for each individual. Through observation, interview, and document review it was apparent that the QMRP was the facilitator of each PST meeting.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	RSSLC Policy F.3 and F.6 define team membership that is generally consistent with this section of the SA. These policies require that an individual's Personal Support Team (PST) always includes the individual, the LAR, and the individual's QMRP, social worker, nurse, and behavior analyst. These policies do not directly reference a requirement that Direct Care Professionals (DCPs) are mandatory members of the PST. The RSSLC QA Department tracks attendance for PSP meetings and PSP Addendum meetings. Forty- three PSP meetings were held in March, 2010. 100% attendance was reported for the QMRP, nurse, and psychologist/behavior analyst; 93% attendance was reported for the social worker and DCPs; the individual was present 89% of the meetings; and LARs were present 48% of the meetings. These data for LARs may be misleading as not every individual has an LAR. This report also indicated considerable attendance by OT/PT (74%), vocational/day programs (78%), and the community Mental Retardation Authority (81%). The lack of attendance by certain disciplines was of concern. None of the 43 PSP meetings included a physician or dietician and only 4% included a speech pathologist. Twenty-three PSP Addendum meetings were held in March, 2010. One hundred percent attendance was reported for the QMRP; 96% attendance was reported for the nurse, psychologist/behavior analyst, and social worker; DCP's were present at 52% of the meetings; the individual was present at 9% of the meetings; and LARs were never present. DCPs interviewed during the tour provided a variety of responses as to their input into PSP processes, their participation in planning meetings, and any regular communication they had with non-unit based staff (primarily clinical) about the needs, services, and supports of the people they worked with. Some responses from DCPs generally reflected	

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		a lack of regular and substantive dialogue with QMRPs and clinical staff. Most typically they reported their source of providing input, and receiving direction, was through their supervisor.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	RSSLC does not have a policy that clearly identifies assessments that are required in anticipation of an initial or annual PSP meeting. RSSLC Policy F.5 establishes some assessment requirements (Personal Focus Worksheet, Risk Screening Tools described in Policy I.8, and Water Activity Safety Assessment) but this is obviously incomplete; for example, nursing and PT/OT assessments are not included. In a review of the Table of Contents of the RSSLC Policy and Procedure Manual the monitoring team could not identify any policy that specifically addressed assessments. Despite the absence of policy, PSP's reviewed contained assessments that seemed reasonable for the individuals needs. Assessment information was presented at the PSP meetings attended by the monitoring team but these presentations usually did not generate cross-discipline discussion. Assessments are not always completed accurately. For example, the Water Safety Assessment for Individual #579 indicates he participates in facility sponsored aquatic activities. Checking this box on the assessment form requires that Section II be completed. There were no entries in Section II.	
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.	Refer to F1c. Document review and meeting observations indicate assessment results were used to develop planned supports. These plans are sometimes incomplete or inaccurate. Refer to F.2.a.2.	
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).	No reference to ADA or the Olmstead decision could be identified in the policies referenced in F1. Policy F.3 Steps 8 and 9 contain considerable detail regarding living options including a requirement that a discussion of living options occur at each annual plan meeting. Mental Retardation Authorities (MRAs) attend most PSP meetings. They were reported to have attended 81% in March, 2010, 83% in February, 2010, and 73% in January, 2010. Through interview and meeting observation, exploration of living options away from the RSSLC is a regular part of PSP discussions. PSTs at the Facility had not yet demonstrated an understanding of how to fully implement the fundamentals of person-directed planning, beginning with the Personal Futures Worksheets (PFW) and extending through the Community Living Discharge Plan (CLDP). This lack of understanding limits the	

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		discussion of supports needed for successful community living.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:	The policies referenced in F.1 contain many elements that suggest the intent of the individual planning process is to develop a plan which integrates services and supports. Policy F.3 and F.4 provide a description of the purpose of the Annual PSP meeting and the Initial PSP meeting. Neither statement of purpose speaks to the issue of service integration. None of the referenced policies offer a definition or discussion of integrated planning and services. Through interview and meeting observation the monitoring team found very few examples of cross-discipline discussion and decision making that would lead to an integrated PSP. The DADS policy on integrated PSPs will be undergoing review and revision. It is anticipated the new state policy will clearly establish expectations for integrated program planning and establish training for SSLC staff to ensure the operational aspects of implementation meet the intended outcomes. The monitoring team looks forward to reviewing the DADS policy once it is completed and in reviewing the RSSLC implementation	
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:	The PSPs reviewed and the meetings attended had little discussion or activity in most of the seven areas. Clearly, more definitive policy direction and competency based training is needed to ensure progress in this area of the SA. The PSP document did contain some required elements as noted in subsections 1-6.	
	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;	The PSP document includes sections on "What's Most Important to the Person?", "How Is This Supported?", and "Achievements and Abilities." This information is a good start but it was difficult to find information in PSPs that used this information to prioritize needs, increase meaningful community participation, and develop supports needed to eliminate barriers.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the	The specification of observable and measurable objectives is variable, whereas the specification of treatments or strategies to be employed and necessary supports to attain identified outcomes needs significant improvement. For example, fourteen PSPs were reviewed to assess communication programs; 14 of 14 PSPs contained reference or a brief statement of an individual's communication skills; such as, "communicates with	

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	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;	facial expressions" or in other cases simply stated "the individual uses a communication board" but did not provide detail regarding skills. Actions Plans do not consistently integrate information from the communication assessments nor was there a process in place that ensures action plans are developed that correspond and include the training of the communication device. Review of 24 skill acquisition programs found that all included behavioral objectives. Most reflected reliance on some sort of task analysis. The treatments or strategies were not well defined. Cues, prompts and other elements of effective training are often not offered or are presented in an informal and inconsistent manner. No staff members were observed to be collecting data during the implementation of a skill acquisition program. There was little connection between an individual's personal goals and the identified outcomes to which supports and training were aimed. In the four PFWs reviewed, the PSTs failed to identify a single personal goal. In only one PFW did the PST answer yes to whether the individual had anything s/he would like to learn to do and that was documented only as "clothing."	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Through record review, interview, and observations there was little evidence of integrated planning, with some examples of integrated planning reported. For example: • At the PSP meeting for Individual #681, there was little reference to data found in the Active Record; the monitoring team could not make a conclusion as to whether the staff reporting assessments used information from the Record in developing those assessments. Much of the meeting involved reading reports with little discussion about how information from one discipline affected information from another. • In reviewing the individuals' HMPs and cross-walking them with the Integrated Progress Notes it was not possible to clearly identify that interventions described in the HMP were carried out according to their plans nor how the plans were integrated into the PSP system. • Each of the PSPs reviewed for PNMP integration reflected integration of the PNMP by referring to it as a support; however, the PNMP was not fully integrated as it did not contain plans for how the interventions are provided across settings or information on how the interventions improved the individual's life by mitigating his/her risk. • Review of the PSPs revealed limited integration of the OT/PT assessment into the document other than being referenced if there was an indirect service or a restatement of the objective if direct services were provided by therapy. • Notwithstanding the limited integration of OT/PT assessments into the PSP, OT/PT assessments are jointly conducted by both therapies. The Speech Therapist was observed as well during this baseline review to be actively	

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		participating in the joint assessment. • Details regarding communication were not integrated into the PSP. Action Plans do not consistently integrate information from the communication assessments nor was there a process in place that ensures action plans are developed that correspond and include the training of the communication device. • The dental clinic works with the behavior analysts to develop desensitization plans for individuals who were identified as uncooperative and/or resistant to dental services.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Information contained in the PSPs reviewed provided minimal information that would contribute to integrated planning and the degree of specificity called for in the SA. Refer to F.2.a.3.	
	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	Information contained in the PSPs reviewed provided minimal information that would contribute to integrated planning and the degree of specificity called for in the SA. Refer to F.2.a.3.	
	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.	Information contained in the PSPs reviewed provided minimal information that addresses the degree of specificity called for in the SA. For example, in the PSP for Individual #579 the standard form used to document action plan #2 contains a column for "responsible person" (QMRP), "when" (monthly)," "where to record" (progress notes), and "comments" (refer to the service plan located in the group data notebook). This suggests the QMRP will take data monthly and record these data in the progress notes. This action plan contains insufficient detail to meet this element of the SA.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the	From documentation review, interviews, and observations during this review it did not appear that coordination of goals, objectives, anticipated outcomes, services, supports, and treatments flowed from the PSP document and the PSP meeting. Individuals, for the most part, are receiving services; however, they do not appear to be coordinated. For example, the PSP is the central mechanism at the Facility for assessing the supports and services an individual would need to ensure safety and the provision of adequate	

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	ISP.	habilitation in the most integrated appropriate setting. Each PSP reviewed began with the section "what's most important to the person." As a general rule, this information did not serve as the starting point for the identification of the supports and services required in the community.	
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.	From limited interviews it appears DCPs and other staff have access to PSPs. PSPs reviewed were written in comprehensible language but were not complete enough to provide adequate guidance for daily supports and services.	
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.	From the limited record review it was evident monthly and quarterly reviews took place. The lack of qualitative substance in some PSPs and of data available for clinical indicator of efficacy described elsewhere in this document made this monthly review, for many individuals, perfunctory. For example, behavior data were graphed for monthly progress review. Because of the manner in which these data were graphed, such as multiple graphs for one PBSP, no indication on the graphs of treatment or environmental changes, and the lack of labels for axes and other components of the graphs, it was not typically possible to effectively use the graphs for determination of treatment efficacy. In some areas, there was no evidence of monthly review. For example, there was no evidence in the records submitted of monthly reviews by the PST or member of the Nutritional Management Committee that focus on the individual's progress or response to interventions provided by therapy or direct support staff related to nutritional management plans.	
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-	At this point the monitoring team does not believe additional training in the overall requirements for PSP planning should occur until the planned development of statewide policy and procedure intended to ensure compliance with this section of the SA is completed. There are some areas that merit immediate attention. Refer to provision O-5 for additional information relevant to Physical and Nutritional Management. The new policy should include specific training requirements consistent with the SA.	

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	based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.		
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.	The monitoring team did not review any new admissions during this visit.	
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 RSSLC uses several tools in their quality assurance activities which are directed at the PSP process. These include a PSP Tracking Worksheet (3/24/10), a PSP Discipline's Assessments Tracking Worksheet (7/17/09), a Section F: Integrated Protections, Service, Treatments and Support compliance review checklist (10/15/09), a Person Directed Planning Process compliance review checklist (undated), and, a Personal Support Plan Meeting Monitoring Checklist (11/6/07). All these tools produce useful information in ensuring the technical aspects of compliance with policy and procedure. Through continued use and refinement, and a deeper understanding of this section of the SA, these tools are a good start to a workable quality assurance process.	

Recommendations:

1. Once DADS State Policy is established the RSSLC will need to use it to create its own policy that can describe in detail, and in operational terms, the elements that will be necessary to lead to compliance with this section of the SA.
2. The new DADS policy should include specific training requirements consistent with the SA.
3. RSSLC needs to take steps to define its assessment processes and to begin a process where there is cross disciplinary discussion of assessment results and meaning.
4. RSSLC needs to establish a mechanism where Direct Support Professionals can develop a working understanding of the PSP process, the interdisciplinary nature of it, the benefits of integrated planning, and the relationship to all this to their daily work.

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement, including but not limited to the items below. **Documents Reviewed:** 1. Active Record for Individuals #342, #452, #538, and #614 **Meetings Attended/Observations:** 1. Annual PSP Meeting for Individual #681
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Although examples of integrated planning and review exist, there are many opportunities to improve integration. The PSP process needs to be revised; it consisted largely of the QMRP reading or summarizing reports. With some exceptions, such as collaboration on assessment by OTs and PTs with Speech Pathologist involvement, disciplines generally work in a parallel manner in development of PSPs. The PST reviews recommendations and agrees or disagrees, but there is little substantive interdisciplinary discussion demonstrated in the planning meetings or documented in records.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The annual PSP meeting for Individual #681 did not involve a great deal of integrated discussion. Assessments were read by the QMRP in summary but not discussed to identify how one discipline assessment would relate to another; team members did not participate in assessment in an interdisciplinary manner. No data were provided. Treatments, supports, and services were identified by the individual discipline clinicians or QMRP and approved by the PST. Toward the end of the meeting, the Community Living Options Discussion began; at that point, everyone participated. A move had already been determined, the LAR approved, and there was integrated discussion of supports needed for the move. This seemed like two different meetings. RSSLC has developed some examples of integrated planning and review. For example: • OT/PT assessments (i.e., Individual #478) are jointly conducted by both therapies. The Speech Therapist was observed as well during this baseline review to be actively participating in the joint assessment • OT/PT assessments and updates contained a list of medical diagnoses and health issues identified over the past year and relevant issues related to PNM and OT/PT (e.g., falls, skin breakdown). Medical issues and risk indicators were noted and rationale for many interventions and recommendations were	

#	Provision	Assessment of Status	Compliance
		provided. • A good working relationship was consistently observed between psychology and psychiatry. The two disciplines were often observed collaborating on diagnostic and treatment issues. • The dental clinic works with the behavior analysts to develop desensitization plans for individuals who were identified as uncooperative and/or resistant to dental services. • There is substantial documentation regarding clinical interventions by the Pharmacy staff, which involves feedback to the prescribing physicians with regard to problematic medication orders, as well as the need for additional laboratory monitoring or in some cases, identifying a laboratory value that warrants attention and then referring it to the primary care physician. There are also many areas in which integration of clinical services could be improved to ensure individuals receive the clinical services they need. For example: • There was not a Behavior Analyst or Physical Therapist representing the skills and knowledge of those disciplines on the Nutritional Management Team. • Risk assessment and assignment of risk levels is done in multiple areas, and the risk levels assigned are not consistent across those areas. • Skill acquisition training programs do not reflect development by people with training and experience in development of effective programs. • The Nursing Department needs to collaborate with the Physical and Nutritional Management team to evaluate the need for more nursing participation in the dining room by the nurses.	
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.	This will be reviewed at the first compliance visit.	

Recommendations:

1. Development of integrated planning is a long and difficult process. The Facility should begin to identify opportunities for integrated planning and

engage staff in identifying means to make the PSP/PST process an interdisciplinary planning process rather than a reporting process.

2. Continue to identify opportunities for integrated planning, assessment, and intervention.

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement, including but not limited to the items below. **Documents Reviewed:** 1. Active Record for Individuals #342, #452, #538, and #614 2. Additional PSPs, CLDPs, and other records reviewed by members of the monitoring team, as identified in sections below. **People Interviewed:** Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report. **Meeting Attended/Observations:** PSP, HST, and other meetings attended by members of the monitoring team, as identified in other sections of this report.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Provision of clinical services is variable across disciplines. Some aspects of clinical services meet current, generally accepted professional standards of care defined in the SA. Other aspects do not yet meet these standards. Improvements are needed in assessment, identification and use of indicators of efficacy, and monitoring of care.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The status of assessments is variable across disciplines. In general, assessments are done according to schedule, but there are disciplines for which assessments are out of date. The following are examples of assessments that are performed on a regular basis or in response to changes in an individual's status and of assessments that do not meet this requirement: • The majority of psychological assessment reports included intellectual and adaptive assessment results that were conducted over 10 years prior to the date of the report. • Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar and were revised when there were significant changes in health status. • Annual updates or assessments are conducted by OT/PT. SLPs provide updates annually if the individual is receiving direct services and a full assessment every	

#	Provision	Assessment of Status	Compliance
		three years if not receiving direct service. • There was not a clear process in place in which the PNM team is notified should a sign or symptom associated with aspiration occur. Therefore, re-assessments may not be done although a change in status occurs. The comprehensiveness and quality of assessments also vary, as shown in the following examples: • The Annual Medical Assessment and Plan (AMAP) are comprehensive and provide a detailed review of both the individuals' past history, recent history, and their current status. The documents provide in one place a source of comprehensive, up-to-date overview of the individual's medical status. • Psychiatric assessments cover the major sections of a standard psychiatric assessment and meet the requirements of the SA. • Very few of the records reviewed contained behavior assessments or functional assessments that would meet the minimum expectations of applied behavior analysis. Although a template for functional assessment was used by most psychologists at RSSLC, this template was a revision of an obsolete format for such assessment and lacked essential elements such as the identification of functional replacement behaviors and the development of a function-driven intervention. • Although all records reviewed contained some form of a psychological assessment report from the previous 12 months, none of these records, contained current information in all required areas. The inclusion of a current intellectual assessment was found in 25% of records reviewed, and only 8.3% of the records contained a current assessment of adaptive behavior. • OT/PT assessments and updates contained a list of medical diagnoses and health issues identified over the past year and relevant issues related to PNM and OT/PT (e.g., falls, skin breakdown). Medical issues and risk indicators were noted and rationale for many interventions and recommendations were provided. • Rationales for the interventions listed in the assessments were often incomplete or insufficient. For example, the majority of assessments fail to incorporate medical, personal, mental health or emotional assessments into the standard psychological assessment report. As a result, the assessments lack sufficient depth and rigor to allow for the development of beneficial interventions. However, as noted in the bullet above, OT/PT assessments and updates provided rationales for many interventions and recommendations were provided. • Speech-Language assessments contained terminology which was difficult to measure, was vague or was incomplete as identified in the findings for Provision R.2.	

#	Provision	Assessment of Status	Compliance
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Annual and Quarterly Nursing Assessments and accompanying Health Maintenance Plans and Acute Care Plans validated the use of North American Nursing Diagnoses Association (NANDA) nursing diagnoses for health issues identified requiring nursing interventions. This was a positive finding because the use of NANDA, a standardized nursing language for documentation of care, is vital both to the nursing profession and the direct care nurse. The benefits to using this classification for nursing diagnoses include: better communication among nurses and other health care providers, increased visibility of nursing interventions, improved nursing care, enhanced data collection to evaluate nursing care outcomes, greater adherence to standards of care, and facilitated assessment of nursing competency. A format of psychiatric assessments had a "Summary of Findings" that included the psychiatric diagnosis in the DSMIV-TR multiaxial format. Review was not conducted to determine whether all diagnoses were consistent with the International Statistical Classification of Diseases and Related Health Problems (ICD) but will be done during compliance visits.	
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.	Provision of treatments and intervention based on assessments and diagnoses is variable across disciplines. Identification of risk is not consistent with clinical need and does not adequately trigger a risk-based frequency of assessments. As a result, intervention may not be timely if an individual's health or behavioral risk changes. For development of PBSPs, functional assessment is used; however, many functional assessments are not adequate for use in planning interventions, and replacement behaviors often do not chosen based on the identified functions of behavior.	
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.	Use of clinical indicators of efficacy is variable across services and disciplines. In some cases (such as physical and nutritional management), monitoring is done by people who do not have the clinical knowledge needed to identify subtle changes. In others (such as nursing), comprehensive information is provided. Review of efficacy of psychiatric services is carried out by qualified psychiatrists. Behavioral data related to psychiatric and behavioral services, however, consisted largely of the individual's performance on targets for overall behavioral treatments. There was little use of generally accepted observer rating tools for signs and symptoms of disorders like anxiety and depression. Furthermore, because reliability of the behavioral data was not checked, even the behavioral data do not provide adequate indication of efficacy of treatment.	

#	Provision	Assessment of Status	Compliance
		Monitoring of physical and nutritional management plans focuses primarily on whether or not equipment is available and staff are implementing the strategies as listed in the PNMP and dining plan. The effectiveness of the plans was not clearly monitored. While it is positive that therapists are participating in the monitoring, the frequency of the monitors as well as what is monitored is informal and does not provide a clear process to follow. Nursing assessments include comprehensive information. The nursing case managers need to continue to strengthen comment section and summaries to include whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working	
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.	HST meetings provided a means for monitoring of health status. In addition, nursing quarterly and annual reviews were done timely. Refer to provisions O.7 and P.4 for additional information regarding the PNM and OT/PT monitoring process. Although monitoring occurred, it did not provide adequate information about health status.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	There are numerous opportunities for review and modification of interventions. There are regular HSTs, for example. It is sometimes unclear whether modifications are based on clinical indicators reported at those reviews. For example, PBSPs were continued in the absence of demonstrated effectiveness. Monitoring of frequency, timeliness, and appropriateness of interventions will be done at compliance reviews.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility needs to establish policies and procedures to ensure assessments are timely and include minimum required components. For example, the process in place in which the PNMP team is notified should a sign or symptom associated with aspiration occur relies on DCPs determining an issue is severe enough to contact nursing then nursing determining an issue is severe enough to contact the physician and make a referral. This results in clinical judgments regarding PNM being made by individuals who are not clinicians and too many opportunities of signs and symptoms that are not overt to be missed therefore resulting in a more reactive than proactive approach. During several meals on Trinity, Leon, Pecos, and San Antonio, potential signs associated with aspiration were observed but no interventions were provided and no referrals were made in response to these issues. Policy should ensure assessments should provide clear identification of criteria for notification of clinicians, and reassessment frequency should relate to risk level.	

Recommendations:

1. Policy should ensure assessments provide clear identification of criteria for notification of clinicians, and reassessment frequency should relate to risk level.
2. Review the status of adaptive behavior and intellectual functioning assessments to ensure they are within required timelines that meet current, generally accepted professional standards defined in the SA.
3. Develop processes to monitor timeliness of modifications in treatments and interventions.

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 Policy I.8 Health Status Team Guidelines 2. RSSLC Policy I.15 Actions Following Choking Incident 3. RSSLC Policy I.19 Responding to Weight Loss/Gain 4. RSSLC Policy D.23 Using Bed Rails 5. RSSLC Policy D.25 Completing/Routing Fall Evaluation Form 6. RSSLC Policy E.2 Crisis Intervention 7. RSSLC Plan of Improvement Section I 8. PSP Addendum – Medical High Risk for Individual # 103 and #207 9. Fall Evaluation Form for Individual #578 10. High Risk Assessment Rating Tool for Individuals #7, #70, #84, #114, #145, #281, #500, #508, #535, #621, and #651 11. DADS At Risk Policy 006 dated 8/31/09 **People Interviewed:** 1. Joan Poenitzsch, Director of Quality Assurance 2. Dr. David Partridge, Medical Director 3. William Eckenroth, PhD, Director of Behavioral Services 4. Pam Turner, Rights Officer 5. Carol Agu, QMRP Consultant 6. Sixteen Direct Care Professionals **7.** Thirteen individuals served: #25, #241, #267, #315, #344, #363, #399, #429, #448, #557, #630, #680, and #738 **Meetings Attended/Observations:** 1. Annual PSP for Individual #57, Individual #402, and Individual #601 2. HRC meeting 4/29/10 3. Living Area Observations: 4/26/10 at San Jacinto, Lavaca, Leon A & C, Sabine: 4/28/10 at Angelia; and, 4/29/10 at Rio Grande and Leon 4. 4/29/10 Unit Morning Meetings at Rio Grande and Leon 5. Restraint application demonstration by DCPs
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC Policy I.8 Health Status Team Guidelines is the facility policy governing high risk individuals. It references DADS Policy 006 At Risk Individuals. As with other RSSLC policies the definitions section contains many statements of policy and procedure. This policy should be reorganized to distinguish definitions of terms from policies and procedures. The policies and procedures for a risk management system should draw together the various assessment instruments, other relevant information, and procedures into one process that can reliably identify individuals whose health or well-

	being place them at risk and need special planning to mitigate risk. A process to bring this all together should include a review of each assessment tool to ensure they measure what is intended to be measured and criteria to assign risk levels is as objective as possible. Existing RSSLC policy has some elements of this but needs improvement. Individuals who are at a high risk are not being identified due to the criteria set forth by the DADS At Risk policy as well as inadequate follow through of said policy. RSSLC in coordination with other state centers and the state of Texas should revisit the policy and redesign it so that the policy identifies those who are at risk. Additionally, the level of risk should be openly shared with staff and used to help drive and shape future services.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The risk assessment screening, assessment, and management system does not appear to functioning in a manner that identifies risk correctly and causes appropriate follow-up actions to occur. For example, many RSSLC individuals have medical conditions that seriously complicate the swallowing and digestion of their food and beverages as well as increase their difficulty in being able to safely manage their oral secretions. Determination of risk level for physical and nutritional management is done through both the Nutritional Management Team (NMT) process and the Health Status Teams (HST) process. Levels of risk assigned to individuals are not always consistent across these processes. For example: • Individual #640 was identified by the NMT as being a Level 1 aspiration risk while the HST identifies the individual as a level 3 aspiration risk. • Individual #99 was identified by the NMT as being a Level 1 weight loss risk while the HST identifies the individual as not being at risk. • Individuals #91 and #437 were identified by the NMT as being a Level 1 choking risk while the HST identifies both of them as not being at risk. RSSLC was using a standardized Fall Risk Assessment Tool (name of tool not identified) different from or in addition to the Health Risk Assessment Tool. This tool grades fall risk high if the score was greater than 10. Individual #7 was scored 17 on three consecutive quarterly assessments, respectively on 09/25/09, 12/07/09, and 03/29/10. This individual also has a diagnosis of osteoporosis, and according to his PSP has movement precautions. The Health Risk Assessment Tool did not have a specific rating tool for falls. The Health Risk Assessment Tool did include a specific rating section for injuries. This individual's Health Risk Assessment Tool on 11/09/09 was marked "NA" for injuries. It is of concern that individual #418 has had nine incidents of pressure sores during the	

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		reporting period, yet this individual's Health Risk Score was listed as only a 3 (low). Currently, the levels of risk assigned by the HST are utilized primarily as a method to determine meetings or review and do not consistently represent an individual's potential of risk. Based upon observation, there were a significant number of individuals who were observed to be at "high risk" but were listed as being at "low risk" according to their screening forms. For example: • Individual #418-Skin breakdown occurring 9/8/09 and 10/21/09. Identified as level 3 (low risk) on 11/17/09. • Individual #73-Aspiration Pneumonia occurring 6/2004, 3/2007, and 2/2010. Identified as level 3(low risk) of aspiration. Refer to Provision O.2 Assessment of Status for additional examples and information. Thorough review of the RSSLC implementation of DADS Policy 006 At Risk Individuals revealed multiple issues. One was that the center was incorrectly following the policy as RSSLC was placing the majority of their individuals as being at low risk when they should have been placed as at medium risk. Second, the policy as written is flawed in its ability to identify those who are at a high risk of physical and nutritional decline. In its current state, the policy identifies individuals as being at high risk if they are having an acute issue ,medium risk if they require ongoing supports (i.e., a PNMP), and low risk if they do not require supports. Following the policy as written would result in RSSLC having the majority of its population listed as medium risk since most of the individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at RSSLC. Examples that the current system was not accurately identifying those who are at risk include: • The Facility carries out Health Risk Assessments, which utilize a rating system to monitor multiple factors which contribute to an individual's overall health risk status. The Health Risk Assessment Instrument provides a numerical rating of risk, but in actuality the process relies heavily on the subjective impressions of the RSSLC professionals who complete them. The individual ratings are from 1 (High) to 3 (Low) risk. Although these ratings are in fact somewhat subjective, the quantification of risk gives the appearance of objectivity. The process is administered through the "Health Service Teams". The internal quality assurance process for medical services track two items related to this process. The first of these is "The records reveal the Health Services Team has met and assigned a risk score", and the second is "The records reveal the Health Services Team meets at an interval according to the risk assessment (minimum of every	

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		six months)". • RSSLC was using the Health Risk Assessment Tool-Nursing Section as the tool for the identification of clinical risk indicators for individuals. The Health Risk Assessment procedure was of concern due to the fact there were no specific and/or clear criteria for determining risk levels. The tools asked "yes" or "no" questions for items relating to Cardiac, Constipation, Dehydration, Diabetes, GI Concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. This Health Risk Assessment Tool was not adequate to provide a comprehensive health risk assessments for any of the areas listed above, nor did it result in an appropriate identification of clinical risk indicators. • RSSLC was using a standardized Fall Risk Assessment Tool (name of tool not identified) different from or in addition to the Health Risk Assessment Tool. This tool grades fall risk high if the score was greater than 10. Individual #7 was scored 17 on three consecutive quarterly assessments, respectively on 09/25/09, 12/07/09, and 03/29/10. This individual also has a diagnosis of osteoporosis, and according to his PSP has movement precautions. The Health Risk Assessment Tool did not have a specific rating tool for falls. The Health Risk Assessment Tool did include a specific rating section for injuries. Falls risk should be included in the tool because of the risk for injuries. This individual's Health Risk Assessment Tool on 11/09/09 was marked "NA" for injuries. Individual #7 also has a history of aspiration pneumonia, a diagnosis of GERD, and a G-tube, yet was marked low for aspiration. Individual #7's overall score was marked low. Further, the Health Risk Assessment Tool rating section for aspiration does not include a question regarding the use of G-tubes. This question is included in High Risk Medical rating sections. Therefore, it misses an adequate assessment of risk related to aspiration. • Ratings assigned by the HST do not correlate with the Nutritional Management Screening Tool. For example: o Individual #640 was identified by the NMT as being a Level 1 aspiration risk while the HST identifies the individual as a level 3 aspiration risk. o Individual #99 was identified by the NMT as being a Level 1 weight loss risk while the HST identifies the individual as not being at risk. o Individuals #91 and #437 were identified by the NMT as being a Level 1 choking risk while the HST identifies both of them as not being at risk. o Individuals #525 and # were identified by the NMT as being a Level 1 aspiration risk while the HST identifies them as not being at risk. o Individual #2 was identified by the NMT as being a Level 1 choking risk while the HST identifies the individual as being a Level 3 choking risk. o Individual #598 was identified by the NMT as being a Level 1 weight	

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		loss risk while the HST identifies the individual as being a Level 3 weight risk. • Further examples include: o Individual #418-Skin breakdown occurring 9/8/09 and 10/21/09. Identified as level 3 (low risk) on 11/17/09. o Individual #73-Aspiration Pneumonia occurring 6/2004, 3/2007, and 2/2010. Identified as level 3(low risk) of aspiration. o Individual #7-Aspiration Pneumonia occurring 3/8/10. Identified as level 3(low risk) of aspiration o Individual #538-Aspiration Pneumonia occurring 1/4/2010. Identified as level 3(low risk) of aspiration o Individual #597-Falls occurring 1/15/10, 1/16/10, and 1/27/10. Identified as level 3(low risk) of injury • Per sections J4 and J7, The RSSLC used the Reiss Screen for possible psychopathology across the campus, but the use of the screen was new. There was no information on whether information from this screen was used to identify 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.	Policy I.8 Health Status Team Guidelines identifies roles and responsibilities for members of the Health Status Team, including the primary care provider, the RN Case manager, the behavior analyst, the health status coordinator, the pharmacist, and the QMRP. These responsibilities include risk rating tools that are to be used. This policy requires that a PST meet within five working days to formulate a plan once an individual is determined to present a high risk condition. The monitoring team did not have an opportunity to observe any meetings of the Health Status Team as no meetings were scheduled the week of the review. PSP Addendums reviewed in response to high risk conditions contained sparse information and did not indicate interdisciplinary activity. For example, A PSP Addendum for Individual #103 was to review high risk of aspiration/choking. In the discussion record there was no indication that seating and positioning or pace of eating was part of a discussion.	
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	Refer to I1 and I2	

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	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.		

Recommendations:

1. There is a variety of clinical information available at RSSLC from which to identify individuals who are potentially at risk. The policies and procedures for a risk management system should draw together the various assessment instruments, other relevant information and procedures into one process that can reliably identify individuals whose health or well-being place them at risk and need special planning to mitigate risk. A process to bring this all together should include a review of each assessment tool to ensure they measure what is intended to be measured and criteria to assign risk levels is as objective as possible.
2. RSSLC Policy I.8 Health Status Team should be reorganized to distinguish definitions of terms from policies and procedures.
3. Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy as well as inadequate follow through of said policy. Therefore, RSSLC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that is identifies those who are at risk. Additionally, the level of risk should be openly shared with staff and used to help drive and shape future services.

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:** The following activities occurred to assess compliance: **Documents Reviewed**: 1. Protocol for Oral Sedation (for Dental Procedures), not dated. 2. Lists of Individuals who Received Sedation for Dental Procedures for the Months of August 2007 and April 2010. 3. TIVA (Total Intravenous Anesthesia) Procedures, not dated 4. The Documentation related to TIVA for Individual #320, for the procedures performed on (packet includes Behavior Incident Report dated 4/27/10; Consultation Report dated 1/21/10; Dental TIVA Appointment Protocol, dated 1/25/10; Post-Op. Orders Form, revised 3/15/10, Anesthesia record, dated 2/12/10; Procedure flow sheet, dated 7/15/09; and Oral Sedation Protocol, Form Revised 8/25/05) 5. Policies related to "Behavior Intervention – Using Sedation for Medical/Dental Appointments Behavioral Symptoms – Revised 3/10/10 6. Copy of e-mail from William Eckenroth, Ph.D., to RSSLC Behavioral Services Members related to Medical Support Plans, dated 1/8/10 7. Policy labeled "Program Plan" and also "Purpose: To Participate in Routine Medical Procedures Methodology" 8. Lists of Individuals who received "sedation for dental appointments" from 9/1/09 through 2/28/10 9. Lists of Individuals who received "sedation for medical appointments" from September, 2009 through March, 2010 10. "Drug Order Report" forms for Individuals receiving benzodiazepines with a "run date" of 3/24/10 11. "Drug Order Report" forms for Individuals receiving diphenhydramine and benztropine with a "run date" of 3/18/10 12. List of Individuals diagnosed with Tardive Dyskinesia, which identifies the following individuals: Individual #315, Individual #31, and Individual #140 13. Response to request for "Description of Efforts to Reduce the use of Psychoactive Medication", with the RSSLC response being "No Written Process. To be discussed during baseline visit", dated 3/31/10 14. Response to Request for Description of System for Identifying and Attending to Individuals with Urgent Psychiatric Needs. RSSLC response dated 3/31/10, "No written procedure. To be discussed during baseline visit" 15. Response to Request for Description of System for Identifying and Attending to Individuals with Urgent Psychiatric Needs, RSSLC response dated 3/31/10. "No written procedure. To be discussed during baseline visit" 16. Response to Request for Description of Conduct of Psychiatry Services with regard to where and how they are conducted and who attends the meetings: RSSLC response dated 3/31/10. "No written response. To be discussed during baseline visit" 17. Response to Request for Description of Relationship between Psychiatrists and Psychologists including whether data presented by Psychologists are used by Psychiatrists to make recommendations to the Psychologists about target symptoms or target behaviors: RSSLC response dated 3/31/10. "No

	written procedure. To be discussed during baseline visit" 18. Response to Request for Description of Opportunities for Interaction between Psychiatrists and Medical Doctors, Neurologists, and other Medical Specialists: RSSLC response "No written procedure. To be discussed during baseline visit" dated 3/31/10 19. Response to Request for Description of Relationship between Pharmacy Staff and Psychiatry Physicians: RSSLC response "No written procedure. To be discussed during baseline visit" dated 3/31/10 20. Response to Request for Documentation related to how Pharmacists communicate information about drug interactions and medication side effects, and how Psychiatrists/Physicians respondto those recommendations: RSSLC response "No written procedure. To be discussed during baseline visit" dated 3/31/10 21. Response to Request for Description of Frequency and Type of Family Member participation in Psychiatric activities and decision making: RSSLC response "No written procedure. To be discussed during baseline visit" dated 3/31/10 22. Description of Availability of Genetic Screening for Individuals, RSSLC response "No written procedure. To be discussed during baseline visit" dated 3/31/10 23. Lists of Meetings and Rounds attended by Psychiatrists, not dated 24. Outline for Preparation of Psychiatric Assessment Notes, not dated 25. Blank forms for the "Monitoring of Side Effects Scale (MOSES)", and the "Dyskinesia Identification System: Condensed Users Scale (DISCUS)" 26. Policy entitled "Providing Health Care Services – Prescribing Psychoactive Medications" 27. Job Description for a Psychiatrist 3 for the State of Texas Health and Human Services Job Center 28. Undated List of all Psychiatrists at RSSLC and their contract status, hours worked, and Board Certification Status 29. Copy of Contractual Agreement with Hermant S. Patel, M.D. for the time period 9/1/09 through 8/31/10 30. Curriculum Vitae and Texas Medical Board Search Results for Hermant Patel, Ashok Jain, and Raphael Darrio Guerrero 31. Overview of Psychiatrists Weekly Schedule, dated 3/31/10 32. Response to Request for Description of Administrative Support offered to Psychiatrists with regard to secretarial and scheduling services: RSSLC response, "No written procedures" 33. Undated document indicated that there had been no complaints about Psychiatric and Medical Care made by "any party to the Facility," document not dated 34. Policies related to Behavioral Intervention – Use of Restraint, revised 9/1/09, as well as the use of restraint in the following sub-categories: 1. a) Use of Restraint in a Behavioral Emergency, Revised 9-1-09, b) Use of Restraint in a Safety Plan – Contingent Restraint, revised 8/1/08; c) Using Restraint in a Safety Plan – Protective Restraint, revised 8-1-08, d) Using Restraint during Medical/Dental Procedures, revised 8/1/08; e) Using Restraint to Promote Health/Re-covery, revised 8/1/08; f) Using Restraint to Prevent Involuntary Self-Injury, revised 11/15/04; g) Using Restraint to Provide Postural Support, revised 11/15/04; h) Policy Related to Completing/Routing Restraint Checklist, and i) Using Sedation for Medical/Dental Appointments/ Behavior Symptoms, Revised 3/10/10

	35. List of New Admissions since 7/1/09 and whether REISS Scale was used 36. List of Individuals identified as having Challenging Behavior, dated 3/17/10 37. List of all Restraints that have been utilized since 7/1/09, which provides the Individual's name, the date of the Restraint, the beginning time and the end time, the type of restraint, the method used, the reason, the duration, and whether or not any medication was also administered 38. List of Individuals where there have been allegations of abuse/neglect/exploitation from 7/1/09 to 3/19/10 39. Trend Analysis Report for the use of Restraint from 12/1/09 through 2/28/10 40. List of Emergency Personal Restraints from 7/1/09 to 2/28/10, giving the Individual's name and the total personal restraints, dated 3-15-10 41. List of Individuals receiving Emergency Mechanical Restraints from 7/1/09 through 2/28/10, dated 3/15/10 42. List Individuals receiving Emergency Chemical Restraints from 7/1/09 through 2/28/10, dated 3/15/10 43. Critical Incident Data Summary Report for 7/1/09 through 2/28/10, dated 3/15/10 44. List of the Individuals who are "The 10 Individuals who have had the highest number of injuries", from 7/1/09 through 2/28/10, dated 3/18/10 45. Organizational Chart for the RSSLC Administration, dated March 2010 46. The Psychiatric Consultation by Ashok Jain, M.D., dated 11/2/09, related to Individual #96 47. The Psychiatric Consultation by Ashok Jain, M.D., dated 11/2/09, for Individual #770 48. Psychiatric Assessments performed by Hermant Patel, M.D., for the following Individuals: (date of the consult will be in parentheses after the individual number), Individual #174 (4/3/10); #613 (2/23/10); #51 (11/28/09); #70 (2/15/10); #8 (2/27/10) 49. Psychiatric Assessment performed by Ashok Jain, M.D., dated 11/2/09, Individual #770 50. Consultation Reports from the "Psychiatric and Behavioral Management Clinic" for the following individuals (date of consultation report will be in parentheses following the Individual number). Individual #613 (2/26/10), (11/21/09), and (9/11/09); Individual #51 (2/23/10), (10/23/09), and (9/26/09); Individual #770 (3/12/10), (2/13/10), and (12/12/09); Individual #70 (3/12/10), (2/13/10), (1/15/10). All of these Psychiatric Consultations were signed off by a member of the Nursing Staff, the QMRP, Raphael Guerrero, M.D., Psychiatric Consultant and the Associate Psychologist/Behavioral Analyst 51. A listing of all Individuals Receiving Psychotropic Medication by Residence, including medications for other conditions, as well as their Medical and Psychiatric Diagnoses 52. Internal Quality Assurance Review of Positive Behavior Support Plan Analysis, from January 2010 and April 2010, completed by Andrea Faniel 53. Internal Quality Assurance Reviews related to Multiple Restraint Analysis, completed by Andrea Faniel, dated January 2010 and April 2010 54. Internal Quality Assurance Assessments related to Psychology Assessments, prepared by Andrea Faniel, dated January 2010 55. Documents related to the Human Rights Committee, which was attended on Thursday, 4/29/10

	56. Review of the medical records for Individuals: #467, #726, #760, #8, #755, #714, #542, #641, #455, #630, #615, #525, #16, #644, #723, #585, #450, #320, #51, #800, #60, #181, #100, #264, #547, #146, #778, #328, and #144. **People Interviewed**: 1. William Eckenroth, Ph.D, Director of Behavioral Services Date of Interview: 4/26/10 2. Ashok Jain, M.D. Date of Interview: 4/28/10 3. Hermant Patel, M.D., Consulting Psychiatrist Date of Interview: 4/28/10 (with Dr. Eckenroth) 4. Dominic Joseph, M.D., Consulting Psychiatrist Date of Interview: 4/28/10 (with Dr. Eckenroth) 5. Rafael Guerrero, M.D. , Consulting Psychiatrist Telephone Interview Dated: 4/28/10 **Meetings Attended/Observations**: Individuals: #623, #465, #212, and #649, (Trinity C Residential Unit); #179, (Trinity A Residential Unit); #99, (Trinity B Residential Unit); #146, (Trinity D Residential Unit); #219, #429, and #644, (Leone Residential Unit); #144, (San Antonio Residential Unit); #322, #665, #668, and #137, (569 Tejas); #273 and #379, (Guadalupe Residential Unit); #180, (Nueces Residential Unit); #142, #225, #736, #302, #29, #473, #627, #750, #44, #39, and #798, (Colorado Satellite Vocational Program); #76, #447, and #555, (PICA Workshop); #437and #92, (Main Vocational Workshop); #41, (Angelina Pre-vocational Program); #760, (Forever Young Day Program); #723, and #644, (Neurology Clinic); #450 and #585, (Infirmary Unit); and #152, (Neches Residential Unit).
	Facility Self-Assessment A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The provision of psychiatric services at RSSLC has been undergoing a significant recent transition. For the majority of the prior decade the provision of psychiatric services was carried out through quarterly psychiatric clinics, which were performed by Rafael Guerrero, M.D. These twice monthly clinics were also attended by members of the Psychology staff, Nursing staff, Direct Care staff, the individual whose care was being reviewed and other members of the Interdisciplinary Team, including the QRMP. The overall process was coordinated by Dr. William Eckenroth, The Director of Behavioral Services. During these twice monthly, day-long clinics every individual receiving psychotropic medication would be reviewed at least quarterly, and more frequently as needed. Psychiatric consultation that was required in between the occurrence of these clinics would be facilitated by telephone discussion with Dr. Guerrero. The Facility has recently increased the number of consulting Psychiatrists, and is also moving toward the employment of two full-time Psychiatrists. In this regard, Ashok Jain, M.D. is currently providing two days (16 hours) of psychiatric services at RSSLC with a view toward moving to being full-time at RSSLC by July 2010. Dr. Jain's involvement has been primarily in the form of providing psychiatric assessments and STAT or urgent

	psychiatric consultations that may need to occur in between the quarterly psychiatric clinics. The Facility is also actively recruiting a second full-time Psychiatrist. Hermant Patel, M.D., has been added as a consultant for eight hours a week to provide detailed psychiatric assessments. Dr. Eckenroth has allocated approximately four of Dr. Patel's weekly visits to prepare a thorough psychiatric assessment based on a comprehensive review of the records, meeting with staff and other collateral sources of information, and then preparing a comprehensive psychiatric assessment. The most recent addition to the Psychiatric staff has been Dominic Joseph, M.D., who is also contracted for a part-time position. His role has not yet been clearly identified. The Director of the Behavioral Services Department is in charge of coordinating the schedules of the consulting psychiatrists and their duties. The documentation that is in the records that were analyzed for this monitoring review primarily reflects the services that are administered through Dr. Guerrero's quarterly psychiatric clinics. The narrative sections below, and the recommendations that follow, discuss on-going issues related to the degree to which the psychiatric diagnoses that are utilized for individuals at RSSLC correlate with the behavioral profile of the individual. There is relatively little documentation that supports the contention that the behaviors that are identified as the targets of the psychotropic medication are indeed primary symptoms of the identified psychiatric diagnoses. A related problem is the degree to which behaviors that are addressed as being targets of the psychotropic medication are also alluded to as being maintained on an environmental or operant basis. In the majority of the sample of individual records that was reviewed, there was no empirical evidence to support the clinical utility of the psychotropic medications being prescribed for a given individual. Although many of the records contain "baseline" behavioral data, for which comparisons can be made to support the empirical justification of a psychotropic medication, these baselines are often very old, and there may have been multiple changes in psychotropic medications since that baseline was established. The quarterly reviews performed by the Pharm.D. are not routinely signed off on by the Psychiatrist, although they are signed by the Pharm.D. and the Primary Care Physician. This would suggest that those documents are not being reviewed by the Psychiatrist; this practice should be corrected. The only current documentation with regard to polypharmacy occurs in the quarterly reviews by the Pharm.D. and a brief Yes/No column in the quarterly psychiatric reviews. There was no indication of monthly reviews. There was also no cohesive data base, which would illustrate trends and the rates and types of polypharmacy. Future monitoring reviews will focus on the degree to which the significant increase in psychiatric resources has impacted these issues.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The Psychiatrists employed by RSSLC are Board Certified. Psychiatric services are only provided by these individuals who have passed the examinations in Adult Psychiatry provided by the American Board of Psychiatry and Neurology.	

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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.	The prescription of psychotropic medication at RSSLC is based on an evaluation and diagnosis by a Board Certified Psychiatrist. The Department of Psychiatry Staff currently includes Ashok Jain, M.D., who is Board Certified in Adult Psychiatry. He is currently working at the Facility 16 hours per week with a goal of transitioning to full time by July 2010. The Facility is also recruiting another full time psychiatrist. Hermant Patel, M.D., is employed by RSSLC on a part-time consultant basis. He works approximately eight hours per week. His primary focus is detailed extensive psychiatric assessments and evaluations, which he then distills into a lengthy report. Dr. Patel is Board Certified in both Adult and Forensic Psychiatry. Raphael Guerrero, M.D., has provided the psychiatric services at RSSLC over the last decade. He continues to do two clinics per month, in which the quarterly reviews are performed, as well as any STAT assessments that need to be done. He is Board Certified in Adult Psychiatry. The newest addition to the Team is Dominic Joseph, M.D., who will be working approximately 8 hours per week. Dr. Joseph is also Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	The individuals at RSSLC, who are prescribed psychotropic medication, also have Behavioral Support Plans. There is a working psychiatric diagnosis for each individual who is prescribed psychotropic medication. There is no indication that the medications are prescribed simply for the convenience of the staff; however, as will be discussed in section J-13, there is the appearance in many of the records that the psychotropic medications are prescribed primarily to control aggressive and self-injurious behavior and not for the symptoms of a psychiatric disorder. Thus, although there is a working psychiatric diagnosis in the record of each individual who is prescribed psychotropic medication, it is not clear how valid this diagnosis is based on analysis of the individual's behavior profile. This finding is discussed in more detail in section J-13. There are no indications that psychotropic medications are used as a punishment.	
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	Carol Heath, D.D.S., is the full-time Dentist for RSSLC. The Facility is also hiring another full time dentist. During the 4/27/10 interview with Dr. Heath she described the desensitization procedures from her perspective. Approximately one half day a week of her time is devoted to working with the desensitization plans. The plan is developed by members of the Psychology Staff, but she is involved in the implementation of the plan. In general, the plan involves the individuals, first of all, becoming comfortable with coming to the Dental Office, and then eventually being able to sit in the dental chair. The next step involves having the dental bib being placed around their neck. The central part of the plan involves the individual becoming comfortable with having their teeth brushed in the dental office, as this makes them familiar with the process of having a device in their mouth. The Dental Clinic also allocates one day a week to implementing teeth brushing plans for new clients. The individuals come to the dental office which increases	

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	medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	their familiarity with the surroundings. Dr. Heath noted that much of the brushing program is constructed to contribute to the desensitization process, but is not officially identified as such. Her subjective impression is that the amount of dental pre-treatment sedation that they have had to utilize has declined significantly. During the interview she estimated that greater than half of the individuals no longer required any dental pre-treatment sedation. The usual medication that is used when sedation is required prior to a dental appointment is Ativan in a range of 1 to 4 mg. However, only a few individuals required 4 mg, and most of them would receive 2 to 3 mg. She also estimated that approximately 125 individuals require IV conscious sedation (TIVA: Total Intravenous Anesthesia) to accomplish the procedures. This process was discussed at length in the 4/27/10 interview, as there are medical risks related with this procedure. In order to be a candidate for TIVA, the individual must be approved by both the Anesthesiologist and the Primary Care Physician. If either of these professionals feels that the individual is not a candidate due to their medical status, then the procedure would not be performed at RSSLC and they would be referred to another Facility, such as an operating room at the University of Texas, Galveston Hospital. The protocol on the day of the procedure involves the individual being admitted to the Infirmary at 6 a.m. The rationale for this is the observation that when the individuals were left on their living units prior to the procedure breakfast would arrive, and it was difficult to maintain the NPO status, as they would often eat something off of another individual's tray. Admission to the Infirmary early in the morning makes it possible to maintain the NPO status. The Dental Anesthetists bring all of the necessary medication with them. A few individuals may require a pre-procedure IM injection of Ketamine. The agent that is administered via the intravenous line is usually Propofol, although occasionally Ketamine is added. During the procedures the individual is monitored with a 3-lead EKG, as well as ongoing monitoring of oxygen saturation, blood pressure, and pulse via an automated process. The Dental Anesthetist also brings with him his own assistant, so Dr. Heath is completely free to attend to the dental work. Suctioning takes place throughout the procedure and there is gauze packing that is put in the oral pharynx to prevent any aspiration. Dr. Heath could only recall two episodes during which the procedure was aborted. In one of these individuals the EKG was suggesting that there might be ischemic cardiac changes. A 12-lead EKG was brought in, which continued to indicate this concern, and the individual was sent to the Emergency Room where a diagnosis of an old myocardial infarction was determined. There were no acute ischemic changes. The other individual, for whom the procedure was aborted, had severe kyphoscoliosis and the procedure could not be done because proper positioning could not be established. These examples illustrated the careful medical monitoring that is carried out during these procedures and also indicate that the team will abort the procedure if there are concerns about safety. The individual remains in the Dental Office for 15 to 45 minutes or longer, if necessary, until deemed to be physiologically stable, at which point they are released and returned	

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		to their Unit. If there are concerns about a slow recovery, the individual can be sent to the Infirmary for further observation. Dr. Heath estimated that approximately 5% of individuals will be admitted to the Infirmary after the procedure. For the individuals that do return to their Units, the staff is instructed to observe them closely for the next four hours. Dr. Heath could recall only one individual who subsequently died after the procedure in a short enough amount of time that the case was reviewed by both the State Board of Dental Examiners and the Medical Examiner. The outcome of this extensive evaluation, which included an autopsy, indicated that the death was unrelated to the procedure. The review of the individual records identified above indicated that there was a reference to utilization of Ativan for dental procedures in the records of the following individuals: #467, #755, #542, #615, #16, #181, and #585. The dosage range was from 1 to 4 mg. The record of individual #181 indicated that it had not been administered in the last year. Individuals identified as requiring the TIVA procedure included individuals #8, #723, #800, #320, #328, and #644. For the latter individual, #644, there was a notation that TIVA had been required in the past, but now the Team was able to use Ativan 2 mg as a pre-treatment sedation for dental procedures with success. The documentation, with regard to the desensitization programs, could not be located in either the Behavioral, Medical or Psychiatric sections of the records reviewed. Dr. Heath had indicated in the interview that this documentation might be kept on the individual units in log books. Going forward, it would be useful to have documentation related to both the construction and implementation of these programs in the Psychological/Behavioral section of the record, and referred to in the Psychiatric section as well. Pre-treatment sedation for routine medical procedures was not reviewed as part of this baseline review. This will be reviewed at the first compliance visit.	
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 provision of psychiatric services at the RSSLC is undergoing a significant transition. Over the past decade the primary provider of psychiatric services to the individuals who reside at RSSLC, was Raphael Guerrero, M.D. Dr. Guerrero would deliver these services through two extended Psychiatric Clinics per month, with an interval of two weeks in between clinics. During these clinics every individual would be seen at least quarterly, and more frequently if needed. Individuals who developed acute psychiatric changes in between the scheduled clinics would be addressed via telephone consultation with Dr. Guerrero. Dr. William Eckenroth, the Director of Psychological Services, coordinated these clinics, and continues to coordinate them. The clinics are also attended by the Psychological Assistants and the QRMPs, who are responsible for the individuals, as well as a representative from Nursing. Recently, Dr. Ashok Jain has been hired to become a full-time Staff Psychiatrist at RSSLC. He is in the process of transitioning from his private	

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		practice. He currently comes to RSSLC two days per month, Wednesdays and Sundays, and is able to provide a variety of services, including psychiatric assessments, meeting with families, and STAT consults. The current plan is for him to be fully transitioned into the full-time block by July 1, 2010. The Facility has also authorized the addition of another full-time Psychiatrist, and is in the process of recruiting an individual who appears to be a good candidate for the position. In addition, the Facility has contracted with Dr. Hermant Patel for approximately 8 hours a week. Dr. Patel's time is primarily devoted to doing extensive psychiatric assessments and evaluations, and then preparing detailed lengthy reports based on those assessments. The most recent addition to the Psychiatric Staff is Dr. Dominic Joseph, who has also been hired on a consultant part-time basis. Dr. Joseph's job description is still being defined. Dr. Eckenroth coordinates the Psychiatric Services and the schedules of the Psychiatrists. Future monitoring visits will assess the degree to which the full-time Psychiatrists and Consultants are working in a cohesive manner to provide Psychiatric Services to the individuals who reside at RSSLC. Two full-time Psychiatrists, in addition to the part-time consultants, should be adequate given the number of individuals at RSSLC who receive psychotropic medication.	
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.	The RSSLC is currently employing four Psychiatrists, each of whom has somewhat different roles. The most recent addition to the Psychiatry staff, Dr. Dominic Joseph, has only just begun and a product of his work was not available for review. As noted above, Dr. Guerrero has provided the primary psychiatric serves to the Facility for the last decade through the mechanism of twice monthly day-long Quarterly Reviews during which an individual's on-going psychiatric status is assessed and treatment recommendations are made. The reports from these clinic assessments were reviewed for the cohort of individuals contained in the random sample that is discussed throughout this report. These reports contain the Psychology Behavioral Data, as well as the frequency of the monitored behaviors that the psychotropic medication is meant to address. Thus, the Psychology Department has significant input into the preparation of these documents. Dr. Guerrero's contribution to the document consists of a brief section at the end of the report which summarizes the individual's status, and discusses any changes in the treatment plan. He also reviews the psychiatric diagnosis. These paragraphs often contain similar terminology with regard to the individual's mental status, unless there has been a change in their mental status. Thus, these notes are utilitarian in nature and are primarily directed to the immediate treatment of the individual. The review of the random sample of 29 individual medical records, related to the use of psychotropic medication, revealed only one record that had a complete psychiatric assessment. That was individual #714. The assessment was prepared by Dr. James McManus, and was dated 11/5/09. Dr. Ashok Jain is currently at RSSLC for 16 hours a week and is transitioning into a full-	

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		time position. His psychiatric assessment of individual #96, dated 11/2/09, is three pages in length, and his psychiatric assessment of individual #770 is six pages in length. These assessments cover the major sections of a standard psychiatric assessment. On 4/28/10, the psychiatric consultation that Dr. Jain performed with regard to individual #152 was observed. Dr. Jain subsequently made available a copy of his two-page progress note from that consultation. This report addressed the circumstances leading up to the consultation, reviewed the mental status in detail, and provided a clear assessment and plan section, which addressed the environmental, interpersonal, and pharmacological issues related to individual's #152 recent increase in self-injurious behavior. The current contract for Dr. Hermant Patel involves his working at the Facility for approximately 8 hours per week. His time is allocated solely to doing thorough psychiatric assessments. Dr. Eckenroth indicated that he has allocated Dr. Patel three to four weekly visits to complete a historical review of the individual and their records, prepare a detailed report, and meet with the Interdisciplinary Treatment Team with regard to his findings, as well as the individual's family if they are available. The Psychiatric Assessments of Dr. Hermant Patel related to individuals #174, #70, #8, #627, #51, #25, #530, #325, #92, and #521 were reviewed. These reports were produced by Dr. Eckenroth due to a request made during the on-site tour. It is not clear if they reside in the individual's record. Dr. Patel has now done several individual assessments; none of his assessments were located in the records reviewed in the sample of 29 individuals described above. Dr. Patel's reports range in length from six to ten pages, with an average of eight. He begins by identifying the individual in terms of their demographics, including their age, place of birth, marital status, whether or not they are a registered voter, any Court imposed restrictions, source of income, Social Security Number, Medicaid number, Medicare number, UTMB number, primary language, race, nationality, religion, legal status, competency status, whether or not an interpreter is needed, resuscitative status, burial arrangements, routine notifications required, primary correspondent and emergency contact, any restrictions, as well as approved visitors. The next section addresses the reasons for the evaluation. There is also a section on the reliability of the individual's self reporting. The sources of information are described, as well as the location where the psychiatric interview and examination took place. This is followed by a description of the chief complaint, the history of present illness, and current medications. Any specific allergies to psychotropic medications are identified. There is a lengthy past psychiatric and medical history section. A section devoted to prior medications lists the medications that the individual has been exposed to.	

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		However, these sections in the sample reviewed do not identify the maximum dosage of the medication, duration of the medication trial, and whether or not it was discontinued due to lack of efficacy or side effects. The family history is reviewed in detail, as is the individual's personal history, including data related to any school history, military history or legal history. The results of the most recent physical examination and laboratory tests are summarized. There is a comprehensive mental status examination. A section is also devoted to "Patient's and Family Strength", which is followed by a "Summary of Findings" that includes the psychiatric diagnosis in the DSMIV-TR multiaxial format, as well as a brief comment about prognosis. The final section is entitled "Comprehensive Treatment Plan and Recommendations"; this section includes not only a detailed discussion of the current psychopharmacological treatment, but also additional medical workup and laboratory testing that might be useful, including whether or not a Neurology Consultation would be helpful. There is also a request for collateral information that would help to clarify unresolved issues. The reports of Dr. Patel clearly meet the standards set forth in the Settlement Agreement.	
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.	The purpose of the Reiss Screen for Maladaptive Behavior is to detect individuals who may require subsequent psychiatric assessment and evaluation as based on the results of the Screening Tool. Thus, it is not meant to be utilized for those individuals who already have had a psychiatric assessment and are being treated with psychotropic medication. The initial request for documentations from RSSLC included a request for data with regard to the utilization of the Reiss Screen at the Facility. In response to this, the Facility produced a document entitled, "List of New Admissions Since July 1, 2009, and whether a Reiss Scale was utilized". This document lists 13 individuals admitted between 7/13/09 and 3/15/10. The document indicates that the use of the Reiss Screen would have been "N/A" for individuals #315 and #267, as they had a formal psychiatric assessment. However, it indicates that the Reiss Screen was carried out for individual #25 and individual #92, even though they also had a psychiatric assessment. The review of the record of the random sample of individuals receiving psychotropic medication found notation of a Reiss Screen being performed for individual #146; however, this was done on July 3, 1996. There was a more recent Reiss performed for individual #778 on 2/18/10. There was also a notation that individual #100 had been administered the Reiss Screen. Future monitoring visits will assess for progress with regard to meeting the requirements of this Provision.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three	There is a close working relationship between the Psychology and Psychiatric Professionals at the RSSLC. Dr. Eckenroth has played a significant role in integrating the Behavioral/Psychological Services with regard to the Psychiatric Services. He currently	

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	years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	coordinates the schedules of Dr. Guerrero and the new part-time Consulting Psychiatrists. Over the last decade, when the Facility has primarily relied on Dr. Guerrero's quarterly psychiatric clinics to provide psychiatric services, Psychology has played a significant role in that process. The primary sections of the documentation contained in those quarterly reviews are prepared by the Psychology Department, and includes the current behavioral data, as well as a historical review of that data. There is also a discussion by the Associate Psychologist with regard to their interpretation of the individual's current status. The section prepared by Dr. Guerrero primarily relates to a brief summary of the psychiatric diagnosis, any changes in the individual's status, as well as any recommendations for further changes in the psychotropic medication. Thus, there is considerable involvement of the Psychology Team with the processes related to the administration and prescription of psychotropic medication. The documentation clearly indicates that the psychiatrist reviews and considers the frequency of the monitored behaviors that the psychotropic medications are prescribed to address. The Psychology section will also address environmental and behavioral factors that may be contributing to the maintenance of the monitored behaviors, as well as any change in frequency. The degree to which there is an attempt to discern or make a distinction between the contribution of environmental/operant factors to the maintenance of the monitored behaviors, as opposed to the degree to which they are related to an underlying psychiatric diagnosis is less apparent. In many cases the behaviors that are identified as symptoms of the psychiatric disorder are also identified as behaviors that are a result of, or are maintained by environmental and operant factors. (See further discussion below). On 4/28/10 it was possible to directly observe Dr. Jain's psychiatric consultation on individual #152. The evaluation took place on the Neches Residential Unit. The reason for the consult was an increase in self-injurious behavior (SIB). In addition to Dr. Jain, the interview was also attended by Dr. Eckenroth. The case was presented by Associate Psychologist, Josephine Harper, who has completed her Ph.D. work and is doing her clinical internship at RSSLC. Also, contributing to the assessment was India Gardner, B.A., who is the Psychological Assistant for individual #152. There was an extensive discussion of both the environmental and psychological factors that were related to the increase in self-injurious behavior, as well as a discussion of possible medical contributions to the increase in self-injurious behavior. Individual #152 was also interviewed during the assessment. The consultation report that Dr. Jain prepared related to this consultation indicates that he did take into account environmental, interpersonal, and behavioral factors that were contributing to this individual's dramatic increase in self-injurious behavior. The consultation report presents a reasoned comprehensive discussion of these factors. Thus, the consultation report mirrors the interdisciplinary interaction that took place during the actual consult.	
J9	Commencing within six months of the Effective Date hereof and with	The Record Reviews of the individuals who reside at RSSLC, and who are receiving psychotropic medication, indicates that there is a discussion of the least intrusive and	

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	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.	most positive interventions prior to the introduction of psychotropic medication. There is also an indication that positive behavioral supports are continued after psychotropic medication has begun. However, there is considerable overlap in the individual records reviewed with regard to specific behaviors that are identified as both targets of the psychotropic medication, and for whom there is also an explanation for their occurrence on a learned or environmental basis. This primarily occurs in individuals who have Autism Spectrum Disorders and/or who have more profound intellectual disabilities. It is, of course, conceivable that a monitored behavior could represent both a symptom of an underlying psychiatric disorder, and also be maintained due environmental or operant factors. To the extent that this occurs, an attempt should be made to discuss the co-existence of the contributing factors and to differentiate to the extent possible, how these contributory factors interact. An example of an individual whose record contained a good differentiation of these factors is individual #146. This individual has Down Syndrome, and is also identified as having Alzheimer's Dementia. The individual is being treated with two pharmacological agents, Namenda and Aricept, to ameliorate the cognitive effects of the Alzheimer's Disease and also receives a low dose of Seroquel, specifically to address agitation related to the cognitive decline. Another example of differentiation is individual #181, for whom the antidepressant Lexapro is used to address depressive symptoms related to the diagnosis of a depressive disorder, whereas, behavioral strategies are utilized to address verbal aggression that is thought to be behavioral in nature.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	This provision addresses the analysis of risk versus benefit with regard to the use of psychotropic medication, as well as the input of the Psychiatrist, Primary Care Physician, and Nursing Staff into this determination. The records reviewed do indicate that there are discussions of the risk versus benefit of the use of psychotropic medication in the record. However, in many of these sections of the records the language is very general, and they are not specific to the individual's behavioral profile and the potential side effects of the medication. There were no examples of what could be considered an empirical discussion of the risks and benefits of psychotropic medication, which reviewed in detail the morbidity of the on-going symptoms of the psychiatric disorder, the potential side effects of the medication, and the likelihood of the amelioration of the symptoms with implementation of the medication. An example picked at random is the following section from the 5/5/09 "HRC Review of BSP" for individual #630. ***Program Summary (to include restrictive/intrusive components):*** *This plan attempts to eliminate the triggers of aggression as much as possible, alter the methods of presentation of offending stimuli, and introduce the use of antecedent stimuli that trigger incompatible, alternative, and appropriate behavior. Development of appropriate alternative responses requires training and positive reinforcement. Relaxation training was selected to provide an alternative response to agitation and aggression.*	

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		[Individual #630] receives [four medications] to treat aggression. He takes [a medication] for side effects of medication. ***Justification:*** *The only rights restrictions are the medications he takes.* *Less intrusive approaches previously attempted: We have tried reinforcing appropriate behavior and the use of psychotropic medication. The only rights restrictions are the medications he takes. Reductions in medications will be attempted as he remains behaviorally stable.* ***Risks vs. Risk Analysis****: The support plan is designed to reduce or eliminate aggression to others and consequent potential injuries. PMAB protective skills are included to prevent injury.* *The 5/11/09 DISCUS assessment noted no abnormal movements.* *Plan to remove restriction/intrusive component: Reductions in medications will be attempted as he remains behaviorally stable.* A similar example is contained in the HRC Review of the BSP dated 6/25/09 for individual #714. ***Program Summary (to include restrictive/intrusive components):*** ***Risks vs. Risk Analysis****: The support plan is designed to reduce or eliminate aggression to others and consequent potential injuries. PMAB protective skills are included to prevent injury.* *The 5/11/09 DISCUS assessment noted no abnormal movements.* *Plan to remove restriction/intrusive component: Reductions in medications will be attempted as he remains behaviorally stable.* A similar example is contained in the HRC Review of the BSP dated 6/25/09 for individual #714. ***Program Summary (to include restrictive/intrusive components):*** *[Individual #714] uses the psychoactive medications [four medications listed] and has positive behavior supports. [Individual #714] is also on a weight reduction diet.* ***Justification:*** *This program's strategy is to reinforce [Individual #714's] compliance with daily routine tasks and with a variety of activities designed to ensure that aggressive or destructive behaviors to not occur. This plan was developed to reduce/prevent injuries resulting from his target behavior.* *Less intrusive approaches previously attempted:*	

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		Verbal redirection. ***Risk vs. Risk Analysis**: This individual exhibits overt physically aggressive and self-injurious behaviors, thus, creating a potential for danger to self and others.* ***Plan to remove restriction/intrusive component:*** *As [Individual #714's] behavior becomes more stable without use of psychotropic medications, reduction of medications will be attempted.* ***HRC Comments:*** *His only restriction is psychoactive medications. He is on a weight reduction diet as he is over weight. There were increased rates probably due to medication changes. They are trying to reduce one medication, but had problems so went back up.* An example of a risk benefit analysis that provides more specific information, as well as a more comprehensive discussion of the risk and benefits, is contained in the following example from the HRC Review of New Medication for Individual #542 dated 12/2/09. ***Program Summary (to include restrictive/intrusive components):*** *[Individual #542] resides on Neches A Home. [Individual #542] is currently on routine level of supervision and contains a PBS targeting self-injurious behaviors and pica. Ambien was ordered during last psych clinic on 11/13/09 to address night time sleep. Trazodone was discontinued and appeared to be ineffective for [Individual #542].* ***Justification:** Trazodone had been ordered to address sleep back in May 2009. After several adjustments were made, it appeared the Trazodone did not have any effect. Ambien was ordered to replace the Trazodone to address sleep.* ***Less intrusive approaches previously attempted:** Within the past year,[individual #542's] sleep has been averaging less than 2.5 hours per night. Less intrusive approaches previously attempted have been medication and keeping [individual #542] more physically active during the day. [Individual #542] does not sleep during the day so this did not work.* ***Risk vs. Risk Analysis:** The risk of [individual #542] not taking the medication as a sleep aid could lead to chronic fatigue, difficulty in ambulation, more susceptible to injury and illness. The risk of [individual #542] taking the medication for sleep includes all of the adverse side effects, with the most frequent being hiccups. The benefits of taking Ambien 10 mg outweigh the benefits of Trazodone or no sleep at all.* ***Plan to remove restriction/intrusive component:** Procedures will be faded as the frequency of sleep increases to an average of at least 5 hours per night and maintained for 12 consecutive months. Please refer to program.*	

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		HRC Comments: *[Individual #542] moved from [one home] to [a different home] in July. A new medication, Ambien, was added. The reason for the new medication is he was not getting enough sleep. He does not sleep during the day. Trazodone was tried and it did not work so it was discontinued. Ambien was ordered to try for sleep.* The other section of the record that routinely prompts a discussion of the potential benefits and risks of the psychotropic medication are the documents entitled "IDT Review of Psychotropic Medication as Part of an Active Treatment Program Monthly Review Progress Note." These notes invariably have a section at the bottom before the signature lines, which is preceded by the following header "IDT Consensus and Active Treatment Plan." This list begins with an item that states "The harmful effects of the behavior outweigh the harmful side effects of the medication", and is followed by the items, "The harmful side effects of the medication outweigh the harmful effects of the behavior."; "The individual is stable. The medication is appropriate at the present dosage"; "The individual is stable. Continue the medication reduction"; "The individual is unstable. Refer to the Psychiatric and Behavior Management Clinic for possible medication adjustment", and "the individual is unstable, revisions in the positive support plan and/or environmental changes will be considered". There is also an entry at the bottom of the check list for "Other". In virtually all of the records reviewed there was a check mark next to "the harmful effects of the behavior outweigh the harmful side effects of the medication", which is meant to serve as the risk management analysis with regard to the use of psychotropic medication. Check list documentation does not meet the provisions of the Settlement Agreement. The input of the Psychiatrist, Primary Care Physician, and Nurse is not clearly identified in this documentation. The increase in the number of psychiatrists by the facility in the coming months should facilitate more direct collaboration between disciplines in this regard.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is	This provision addresses the degree to which individuals receiving two or more psychotropic medications from the same class, or three or more psychotropic medications regardless of class, are monitored on a monthly basis. The review of the records identified above indicates that this process is not occurring on a monthly basis. The discussion of polypharmacy regarding psychotropic medication occurs in two places on a quarterly basis. The first of those is the reports that are produced as a result of Dr. Guerrero's quarterly psychiatric clinics. As noted above, these may be performed more frequently than quarterly if the individual is unstable, but in general, they are performed on a quarterly basis. The discussion of polypharmacy is simply a yes or no line item. There is no discussion of the potential interactions related to the polypharmacy. The second section of the medical records that addresses this provision are the quarterly reviews performed by the Pharmacy. This is also accomplished by a check-list format; however, Dr. Shatz, the new Pharm.D., will also discuss potential interactions if they are relevant. Of interest is the observation that there are three signatures at the bottom of these forms, one is for the Pharm.D., the second for the Primary Care Physician, and third	

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	clinically justified, and that medications that are not clinically justified are eliminated.	for the Psychiatrist. There were no signatures by the Psychiatrist in any of the 29 records that comprised the random sample, with the sole exception of individual #615, for whom the Psychiatrist had signed one of the three quarterly reviews that were in this individual's record. The lack of the Psychiatrist's signature would suggest that the Psychiatrist is not reviewing this documentation. In addition, no information on tracking or trending of polypharmacy was provided to the Monitoring Team.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The record reviews, as well as the reports relating to the utilization of the MOSES and DISCUS indicate that they are being carried out on a routine basis. Specifically, the review of the individual records identified above documents that the MOSES is completed by a member of the Nursing staff every six months and after a medication change. The DISCUS is completely quarterly by a member of the Nursing staff.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as	An analysis of the prescribing patterns related to the use of psychotropic medication at RSSLC was performed. This analysis was based on the Patient Profiles that were prepared by the Pharmacy Department, in response to the request for a list of all individuals receiving psychotropic medication, including the specific medication and the diagnoses. These one page reports list the individual's medical and psychiatric diagnoses across the top, and then to the right of the listing of the medications appears the diagnosis that is used to justify the prescription of that medication. The lists are grouped by residential unit. This database indicates that at the time the information was printed (3/26/10) there were 168 individuals receiving psychotropic medication. The list of individuals residing at RSSLC, which was produced by the Facility and dated April 23, 2010, indicates there were 416 individuals residing at the Facility on that day. Thus, 40 percent of the total population is receiving one or more psychotropic medications. Within the group of 168 individuals who are receiving psychotropic medication, 131 individuals (80 percent) are receiving one or more antipsychotic agents. The primary antipsychotic agents utilized are within the class of antipsychotic medications referred to as the second generation antipsychotic agents. The antipsychotic medications that are used most frequently are: Risperidone (33; 24 percent), Olanzapine (32; 23 percent), Quetiapine (22; 16 percent), Invega (15; 11 percent). The other two second generation medications that are utilized are Ziprasidone (11; 8 percent), and Aripiprazole (10; 7 percent). Eight individuals are receiving first generation antipsychotic agents in the form of Haloperidol (7; 5 percent), and Perphenazine (1; 1 percent). Eleven individuals were receiving two antipsychotic agents.	

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	necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	The second most utilized class of psychotropic medications are the antidepressant agents. Eighty-four (50 percent) of those individuals receiving psychotropic medication are prescribed one or more antidepressant agents. Within this group the largest class of antidepressants utilized is the selective serotonin reuptake inhibitors (SSRIs), with a total of 66 individuals (79 percent of those receiving an antidepressant). Within the SSRI class the most frequently prescribed medications were Escitalopram (20 individuals; 39 percent); Paroxetine (17 individuals) and Citazopram (11 individuals, 17 percent). The first generation antidepressant Trazodone was prescribed for nine individuals (11 percent). Trazodone is primarily utilized for the treatment of insomnia. Three individuals are receiving Clomipramine for treatment of obsessive-compulsive symptoms. Seventy-one individuals (42 percent of individuals who are prescribed psychotropic medication) are receiving one or more anticonvulsants or Lithium for mood stabilization. This frequency was arrived at by analysis of the Individual Profile Reports and editing out those individuals for whom the anticonvulsant was listed as being utilized to treat a seizure disorder. The most utilized agent within this subgroup of psychotropic medications was Valproic Acid with 39 (55 percent of individuals) receiving that agent. This was followed by lithium carbonate (10 individuals; 14 percent). Eight individuals were receiving Carbamazepine (11 percent) with a further 7 (10 percent) receiving Oxcarbazepine, which is a derivative of Carbamazepine. Finally 7 individuals (10 percent) were receiving Lamotrigine. A total of seven individuals (10 percent) were receiving two mood stabilizers. Subclasses of psychotropic medications that were used in much less frequency included Concerta (3), and Guafacine (1) for treatment of a diagnosis of Attention Deficit/Hyperactivity Disorder. Six individuals were receiving Donepezil for treatment of Alzheimer's Dementia symptoms. With regard to anti-anxiety agents, five individuals were receiving the non-benzodiazepine anti-anxiety medication Buspirone, and 20 were receiving Benzodiazepines: Clonazepam (12), and Lorazepam (8). Ten individuals were receiving Propranolol, and one individual was receiving Clonidine to address an Impulse Control Disorder. In addition to Trazodone being utilized for sleep, there is some use of other hypnotic agents in the form of Temazepam (4), Zolpidem (3), and Melatonin (2). Twenty-nine individuals are receiving the anti-cholinergic agent Benztropine for treatment of extrapyramidal motor side effects related to the use of antipsychotic medication, or in some cases to address drooling. The patient profiles also listed the medical and psychiatric diagnoses. This listing appeared in two places, the first being across the top of each of the profile sheets. The second list occurred to the right of the medications that was entered to justify the	

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		medication. The most frequently utilized psychiatric diagnosis is either an Impulse Control Disorder or an Intermittent Explosive Disorder, both of which refer to the same phenomenon. There were 34 individuals who were diagnosed with an Impulse Control Disorder, either alone or in conjunction with other psychiatric disorders, and a further 12 were diagnosed with an Intermittent Explosive Disorder, either alone or in conjunction with other diagnoses for a total of 46 (27 percent). Intermittent Explosive Disorder is a valid psychiatric diagnosis; however it is somewhat non-specific. In addition, individuals whose aggressive and/or self-injurious behavior is secondary to environmental or behavioral factors may appear to meet the criteria for this psychiatric disorder. This requires care in diagnosis and identification of appropriate approach (medication, behavioral services, or both), and identification of useful clinical indicators of progress. The second most utilized psychiatric diagnosis is some form of the diagnosis of a Psychotic Disorder, either alone or in conjunction with another diagnosis and/or Schizophrenia. There were 25 individuals with a diagnosis of some for of psychotic disorder, and a further 18 with a diagnosis of Schizophrenia for a total of 43 (26 percent). Of interest, is the utilization of the diagnosis "Observation for other Suspected Mental Condition", or a phrase similar to that, which was utilized for 17 (10 percent) of individuals who were receiving psychotropic medication. In future reviews there will be a rigorous analysis of the documentation of the symptoms that justify and support diagnoses. This provision also addresses three interrelated, extremely important factors related to the rational use of psychotropic medication in individuals with intellectual and developmental disabilities. The first of these is the degree to which the psychiatric diagnosis correlates with the symptoms for which the psychoactive medication is being prescribed. The second important factor is the degree to which the psychotropic medication regimen can be justified for the psychiatric diagnosis of record based on either the available published literature or a reasonable specific behavioral-pharmacological hypothesis. The third factor relates to the degree to which the psychotropic medication can be empirically proven to have been of use in ameliorating the symptoms of the identified psychiatric disorder. The methodology for the assessment of these factors included a detailed analysis of a random sample of individual records that was generated by selecting the record for every seventh individual who is receiving psychotropic medication at RSSLC. The database from which these names were selected was the individual patient pharmacological profiles, which were produced by the Facility, in response to the request for a list of individuals receiving psychotropic medication. The lists were sorted by living unit, thus, the sample selected from the lists was not in alphabetical order. This process identified 25 individuals. These individuals represent the first 25 identified in the Listing	

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		of the Records Reviewed in the introduction above. The four individuals identified at the end of that list were those who were selected for reviews related to the medical aspects of their care at RSSLC. They were included in this sample as they were also receiving psychotropic medication, and could be considered to have been selected on a random basis. Thus, the total sample size was 29 (17 percent of individuals receiving psychotropic medication). The construction of the individual reviews was purposely designed to be as accommodating as possible for this initial review of psychiatric services. For example, for the analysis related to the degree to which the psychiatric diagnosis of record correlates with the behavioral profile, strict DSMIV-TR criteria or the criteria set forth in the Psychiatric Manual – Intellectual Disability (DM-ID) developed by the National Association of Dual Diagnosis in conjunction with the American Psychiatric Association, were not required. Instead, the focus of the reviews related to assessing the degree of thought that had been put into the Psychiatrist's consideration of the individual's profile in establishing the psychiatric diagnosis. Future reviews will look for more detailed criteria that document and clinically support the working psychiatric diagnosis. This methodology found that there was a plausible correlation between the psychiatric diagnosis and the behavioral profile of the individual in 55 percent of the random sample. The individuals for whom a plausible correlation between the psychiatric diagnosis and the behavioral profile could not be established, included individuals #450, #585, #723, #644, #525, #615, #455, #542, #467, #100, #320, #800, and #778. The second analysis related to the aspects of this provision regarding the appropriateness of the psychotropic medication for the individual's diagnosis, or the existence of a plausible neuro-pharmacological hypothesis for the use of the medication. The results were the same as those of the first analysis, both with regard to the percentage of individuals for whom a rational basis for the psychopharmacological profile could not be determined, and the specific individuals that were identified. A primary issue in both of these analysis related to repeated terminology and references in the medical record, which would suggest that the psychotropic medications were being primarily used to control aggressive and/or self-injurious behavior, rather than to address the symptoms of a psychiatric disorder. Documentation of empirical evidence that would support the efficacy and continued utility of psychotropic medication for a given individual could only be found in eight percent of the records reviewed. The individuals whose records did contain this documentation were individuals #641, #44, #760, #726, #264, #181, #51, and #146. The RSSLC Psychology staff does provide detailed documentation with regard to the behaviors that are identified as those that the psychotropic medication is prescribed to address. For many individuals there is also a section in the tabular representations of the	

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		frequencies of the monitored behaviors for "baseline data". The dates related to this "baseline period" are frequently not carried forward in the current documentation, although it can usually be located at some point in the earlier record. For example, for individual #547 a documentation of the time frame for the baseline period could not be found. This was also true for individual #264, as well as individual #44. With regard to individual #181, there were four different baselines. For the categories of Aggression toward Others and Verbal Aggression the baseline period was simply identified as "6/1/1994. " The corresponding baseline time period for non-compliance (NC) was "1/1/03-11/30/03," and for Aggression to the Environment (ATE) the baseline period was "4/1/03-10/03." The baseline timeframe that is used to monitor her progress with regard to "Incontinence" was from 6/01/07 through 8/31/07, and for the category of "Participation", the baseline period was 12/10/07 through 1/10/08. The baseline data collection, to which current frequencies are compared for individual #800, was collected between 7/1/00 and 6/30/01. Multiple changes in psychotropic medication have been made for this individual since that time. These are only meant to be examples of what is a pervasive problem. In virtually all of the contemporary tabular charts and graphs the time frame from which the baseline data were drawn is not identified, and it is only by further investigation into the record that it can be found, if it can be found at all. The existence of multiple pharmacological changes, since the baseline data was obtained, makes these frequencies an unreliable comparator. There also may well have been programmatic and environmental changes in the months and years since the baseline data was collected. A simpler and more useful system would be to simply indicate with phase lines on the on-going graphs changes in the psychotropic medication dosages and/or the addition of new medications as well as the discontinuation of medications. For tabular presentations of data, an average of the three months of frequency data with regard to the monitored behavior listed prior to the addition or change in the medication would accomplish a similar function. This provision also alludes to the requirement that the psychiatric assessment of the individual's status occur "no less often than quarterly". The review of this sample of individual records indicated that Dr. Guerrero, in conjunction with the Psychology Team, and other members of the interdisciplinary Team have been carrying out at least quarterly reviews of all individuals receiving psychotropic medication and that individuals who have required more frequent assessment have been accommodated by their addition to the list of individuals reviewed at the quarterly clinics.	
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	The randomly selected sample of individual records that was utilized for the record reviews for provision J13, and other sections of this report, was also analyzed with regard to the requirements of this provision, related to Informed Consent. Of the 29 individuals in this sample, 14 had been appointed a legal guardian, and 14 were Court committed. The 29th individual #467, did not have a guardian and there was a reference to her being "legally competent"; however, in fact a review of the informed consent	

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	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.	documents indicates that the Facility Director signs the consent forms for this individual, which is the practice that is employed for those individuals who are Court committed and do not have a legal guardian. The consents for psychotropic medications and behavioral interventions are relatively detailed, with the exception of an empirical assessment of risk versus benefit as it relates to the use of psychotropic medication. There is also documentation in the record of contacts with the legal guardians who are involved with the individuals, as well as documentation that the Social Work staff will discuss with involved family members, who are not guardians, the possibility of them becoming a guardian in the future. It is this ongoing interaction that likely has resulted in almost 50 percent of this sample having a legal guardian. The majority of the legal guardians are family members and only a few are agency guardianships. There is documentation of the review by the Facility Director of the consent forms when there is no legal guardian available.	
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.	The Neurology Clinic that was carried out by Dr. Croft on 4/27/10 was attended by the Primary Care Physician, but was not attended by the Psychiatrist. At the present time the Psychiatrist and the Neurologist would communicate primarily through their written consultation notes and other documentation. As the Facility moves toward hiring two full time Psychiatrists, it should be possible for the Psychiatrist to also attend the Neurology Clinic for those individuals who are prescribed anticonvulsant medications for both seizure control and for a diagnosed mental disorder.	

Recommendations:

1. The validity of the psychiatric diagnosis should be supported by identifying the specific symptoms that the individual exhibits, which support that diagnosis.
2. To the extent that a behavior that is addressed by psychotropic medication is identified as being both a symptom of the underlying psychiatric disorder, as well as being maintained by operant indoor environmental factors, there should be a discussion which further delineates this distinction.
3. The utilization of graphs with phase lines to represent changes in psychotropic medication and other significant events would greatly facilitate the empirical assessment of the utility of those medications that are prescribed to address the behaviors that are identified as symptoms of the psychiatric disorder.
4. The working psychiatric diagnosis is not consistent throughout many of the records. Once the psychiatric diagnosis has been firmly established, the utilization of that diagnosis should be consistent throughout the record.
5. The MOSES and DISCUS side effect rating instruments are being routinely administered by Nursing staff and appear in the record at the specified intervals. This practice should be continued.
6. A cohesive data base that illustrates the rates and types of polypharmacy should be developed.
7. The Psychiatrist is not currently reviewing and signing the quarterly medication reviews by the Pharm.D.; this should be corrected.

8. It would be useful to have documentation related to both the construction and implementation of desensitization programs related to pre-treatment sedation in the Psychological/Behavioral section of the record, and referred to in the Psychiatric section as well.
9. The Facility's internal Quality Assurance Team will be crucial to establishing and maintaining compliance with the provisions of the Settlement Agreement as they relate to Psychiatry. Periodic monitoring of the issues identified above by the RSSLC Internal Quality Assurance Department will both enhance and document this process.

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:** Documents that were reviewed included the annual PSP, PSP updates, SPOs, PBSPs, 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, and behavioral and functional assessments. These documents were reviewed for the following individuals: #8, #16, #25, #44, #51, #70, #96, #107, #120, #149, #162, #193, #267, #315, #320, #429, #448, #450, #525, #531, #613, #630, #643, and #676 **People Interviewed:** 1. Heather Blackwell - Director Vocational Services 2. Bill Eckenroth - Director of Behavioral Services 3. Cynthia Fannin - Director of Education and Training 4. Ashok Jain, M.D. - Psychiatrist 5. David Partridge, M.D. - Director of Medical Services 6. Jane Purcell - Assistant Director of Programs 7. Frank Rainer - Director of Recreation 8. Gary Sandler - Director of Habilitation Therapies 9. All Behavior Services staff 10. Six QMRPs 11. 17 Direct Care staff 12. Two night shift DCPs at Nueces 13. Two night shift DCPs at Three Rivers **Meeting Attended/Observations:** 1. Peer Review Committee 2. Human Rights Committee 3. Psychiatric Assessment (Neches) 4. PSP 5. Observations of all workshops 6. Observations of meals, program implementation and leisure activities in the following residences: Angelina, Colorado, Leon, Neches, Rio, San Antonio, and Trinity
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: The initial site visit to RSSLC provided an opportunity to obtain a benchmark or baseline measure of where the facility currently stands in relation to the delivery of services. Among what was observed and reviewed

were several positive elements that should facilitate the efforts of RSSLC to comply with the Settlement Agreement. These positive elements included the following.

- A good working relationship was consistently observed between psychology and psychiatry. The two disciplines were often observed collaborating on diagnostic and treatment issues. In addition, psychologists and psychiatrists were noted to display mutual respect for one another.
- PBSPs routinely included a variety of strategies to assist the individual in avoiding the need for undesired or dangerous behavior. These strategies included attempts to preemptively meet the needs of the individual or structure the individual's environment in a more stimulating and rewarding manner.
- Vocational workshops routinely were observed experiencing fewer displays of undesired behavior than other areas of the facility. Individuals employed at these workshops were noted to be happy and engaged in goal-oriented and productive activities.
- A computer resource room was observed in the final stages of preparation. This area, which will include multiple computers, as well as leisure activities and access to refreshments, is intended to be used for personal enjoyment and as a teaching resource for people who live at RSSLC.
- Staff members at all levels were routinely observed to be highly motivated in meeting the personal needs of the individuals living at the facility. The efforts of staff members included such goals as ensuring that an individual attending public school was able to participate in prom, arranging for tickets to highly desired sporting and entertainment events throughout the Texas, and organizing unique events to be held at the facility such as horse shows and a symphony concert.

All of these positive factors contribute to the overall quality of life for individuals living at RSSLC. Unfortunately, multiple other circumstances observed at RSSLC indicate that the facility in general is poorly prepared to provide the minimum necessary level of services required by the Settlement Agreement.

Throughout the facility there was noted to be a lack of coherence and consistency in the provision of services. Several examples of sophistication and success regarding service delivery were observed, such as the positives noted above and one residence where treatment integrity assessments were sometimes conducted. These pockets of success were driven by the efforts of individual staff members rather than policies or standards. Furthermore, when such successes were recognized, there was typically little effort by the facility to reinforce these successes or incorporate the successes into the policies and practices of the facility. As a result, all individuals at the facility were not provided the same level of access to effective and beneficial services.

A large percentage of the RSSLC staff were observed to lack the skills and training necessary to perform their assigned duties and provide adequate services to the individuals living at the facility. The majority of staff members employed by RSSLC lack adequate knowledge regarding applied behavior analysis in relation to their personal responsibilities. Direct care staff was often unable to effectively use positive reinforcement to strengthen skills. Training programs and PBSPs frequently did not include structured procedures adequate for teaching or strengthening behavior. Staff members were observed to inadvertently elicit or intensify undesired behavior by use of inappropriate or poorly conceived efforts to

	intervene. Without adequately trained staff, RSSLC will not be able to effectively teach and prepare the individuals living at the facility, and will be unable to comply with the requirements of the Settlement Agreement. A wide disparity was also noted in the knowledge and skills of psychology staff. A few psychologists are well-versed in applied behavior analysis and demonstrate reasonably sophisticated skills. The remainder of the psychology staff, based upon observations and a review of PBSPs, lack the knowledge and skills necessary to provide minimal services. Numerous PBSPs reflected inadequate or inappropriate applications of behavioral methods and technology, such as poorly defined behaviors, too little use of positive reinforcement, and a reliance upon data collected several months or years in the past. Very few of the records reviewed contained behavior assessments or functional assessments that would meet the minimum expectations of applied behavior analysis. Although a template for functional assessment was used by most psychologists at RSSLC, this template was a revision of an obsolete format for such assessment and lacked essential elements such as the identification of functional replacement behaviors and the development of a function-driven intervention. Frequently, there was minimal if any effort of incorporating the symptoms of mental illness, if present, into the functional assessment or behavior intervention. Due to the multiple limitations noted during reviews and observations, RSSLC lacks the ability to effectively address the behavioral needs of the individuals living at the facility. Substantial limitations were also noted in the data and documentation regarding PBSPs and behavior. A single method of data collection is routinely used regardless of the characteristics of the behavior being measured, resulting in data that are often likely to be inaccurate. Seldom was it noted that a PBSP included specific instructions for collecting data or measuring behavior, and data collection was noted to vary across staff. Despite these practices, the facility was not noted to commonly assess the validity or reliability of behavioral data. As these data are used to determine the benefit from and need for behavioral interventions and psychotropic medications, the facility currently lacks the ability to unequivocally justify the use of such interventions. Psychological assessments also lacked adequate sophistication. The majority of psychological assessment reports included intellectual and adaptive assessment results that were conducted over 10 years prior to the date of the report. In addition, there was no routine use of formal assessments in formulating or supporting diagnoses of mental illness. There was minimal evidence that psychologists and other staff considered and attempted to integrate and differentiate undesired behavior and symptoms or behavioral indices of mental illness. One additional result of the limitations summarized above is a lack of adequate protections for the individuals living at RSSLC. Behavioral and diagnostic assessments lack sophistication and do not typically lead to adequate interventions. Data at best are of questionable accuracy and provide minimal support for intervention efficacy. The treatment review process by the interdisciplinary team often results in prolonged use of questionable interventions, while the peer review process lacks sophistication. The Human Rights Committee, although more thorough than the peer review process, can often add weeks of delay. The product of these conditions is an unfocused and unempirical approach to treatment that has the

	potential to jeopardize the well-being of the individuals living at RSSLC. Based upon the information summarized above and presented in greater detail in the following sections, RSSLC does not meet minimum expectations in many areas of psychological and behavioral services. Despite the enthusiasm and motivation of many staff members, observations and reviews suggest that the efforts of the facility are at best diligent but do not comply with the provisions of the Settlement Agreement. Explanation of scores: During a site visit, a group of people is chosen to be reviewed. This group is called a sample. Each person in the sample group is rated on several items. These ratings can show how successful the center has been complying with the Settlement Agreement. The ratings can be a 0 (Not Successful), 1 (Partially Successful) or 2 (Fully Successful). Each table below has a column called Average Score. The Average Score is the average of every person's score on that item. The average can be from 0 to 2. A higher average score can show progress has been made meeting that item. Each table also has a column for Percentage FS. The Percentage FS is the percentage of the people in the sample group who was rated as 2 (Fully Successful). A higher percentage shows that more people in the sample scored a 2 for that item. An item with a higher Average Score can still have a low Percentage FS. This is because the two numbers show things in different ways. By comparing both numbers from site visit to site visit, progress can be measured in two different ways.

#	Provision	Assessment of Status	Compliance
K1	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	At the time of the site visit, RSSLC did not employ any psychologists who were board certified as a behavior analyst. A small number of the psychology staff is in various stages of preparation for the required coursework. As a result, none of the 24 reviewed PBSPs were prepared by a BCBA. This lack of training and sophistication is a substantial contributing factor regarding the inadequate quality of the PBSPs. There is a plan for reimbursing psychologists for the expense of taking classes required for board certification, as well as the possibility for the State to pay for courses in advance rather than requiring psychologists to wait for reimbursement. At the time of the site visit, however, there were no clear plans or goals to encourage psychology staff to attain the BCBA.	

	Qualified professionals for PBSP	Average Score	Percent FS

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>
<table>
<tr><td>1</td><td colspan="2">PBSP developed by a BCBA (If less than FS, complete items below)</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><td>Completed by BCABA with BCBA supervision (Y or N)</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>b.</td><td>Completed by professional enrolled in BCBA certification program (Y or N)</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>Completed by professional with demonstrated competence (Y or N)</td><td>0.00</td><td>0.0%</td></tr>
<tr><td>2</td><td colspan="2">A plan/policy exists with a goal to increase the number of professionals who possess board certification in applied behavior analysis through training, recruitment or other means.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td>3</td><td colspan="2">The plan/policy above is being actively implemented.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td>4</td><td colspan="2">A process exists for auditing credentials of those staff members who possess board certification in applied behavior analysis.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td>5</td><td colspan="2">The PBSP promotes growth, development, and independence; and minimizes regression and loss of skills; and ensures safety, security and freedom from undue restraints</td><td>0.17</td><td>0.0%</td></tr>
</table>
</td><td></td></tr>
<tr><td>K2</td><td>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</td><td>At the time of the site visit, RSSLC employed Dr. Bill Eckenroth, a licensed Psychologist, as the Director of Behavior Services. Dr. Eckenroth meets all criteria for this section.</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>consistent level of psychological care throughout the Facility.</td><td></td><td></td></tr>
<tr><td>K3</td><td>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.</td><td>
An internal peer review process was in place at RSSLC at the time of the site visit. Peer review occurs on a weekly basis and is documented by meeting minutes. The Peer Review Committee consists of various senior members of the psychology staff, not all of whom attend meetings on a regular basis. The Peer Review Committee meetings consist of case presentations of the PBSP and related documentation for individuals whose plans are being revised or who are scheduled for an annual PSP.

During an observation of the Peer Review Committee, the review process consisted of activities not typically associated with peer review. The PBSPs for individuals #101 and #166 were presented. A substantial portion of the review consisted of clerical aspects of the documents, such as typographical errors, misspellings and formatting. Time allocated to the review of clinical aspects of the interventions was diligent, but comments and discussions often reflected limited knowledge of applied behavior analysis and evidence-based intervention. For example, it was not clear from discussions that the committee members recognized the significance of an undesired behavior that was displayed in one setting but not another. In addition, comments made by the committee members during the meeting about the characteristics of an individual's behavior were not in agreement with the data being presented. This difference in data was not discussed.

Based upon observations and review, it cannot be stated that the Peer Review Committee at RSSLC functions with a true peer review process. Rather, the meeting activities more closely resemble a general discussion.
<table>
<tr><th></th><th colspan="2">Peer review system of PBSPs</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td colspan="2">Internal Peer Review</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><td>A policy for internal peer review exists.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>b.</td><td>Membership of internal peer review meetings consists of PBSP authors and those that supervise implementation of plans.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>Minutes demonstrate occurrence of weekly peer review meetings.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>d.</td><td>Observations of meetings reflect active member participation and data-based decisions.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>e.</td><td>Individuals with PBSPs are reviewed at least annually.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>f.</td><td>Individuals with Safety Plans are reviewed at least annually.</td><td>1.00</td><td>0.0%</td></tr>
</table>
RSSLC does not currently have an external peer review process.
<table>
<tr><th></th><th>Peer review system of PBSPs</th><th>Average Score</th><th>Percent FS</th></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

2	External Peer Review			0.00	0.0%
	a.	A policy for external peer review exists.		0.00	0.0%
	b.	Membership of external peer review meetings consists of other Texas State BCBAs/supervisors.		0.00	0.0%
	c.	Minutes demonstrate occurrence of monthly peer review meetings.		0.00	0.0%

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

Data collection for PBSPs at RSSLC is inadequate to the task of measuring behavior and determining the need for or benefit from behavioral or psychopharmacological interventions. In 24 out of 24 records reviewed, data collection consisted of narrative documentation of circumstances surrounding the display of an undesired behavior. In situations where the undesired behavior occurs at a low frequency and is easily observable, this approach might be adequate. With other behaviors, this method will not produce an accurate measure of the behavior in question. Despite concerns about the quality of behavior data, the facility does not conduct assessments to determine the reliability or validity of those data.

Many PBSPs (23 of the 24 reviewed) include multiple target behaviors. It is not clear from the assessment information that any of these behaviors in any PBSP are functionally related to the others in that plan. Yet, programmatic progress is determined by looking at all the included behaviors. By forcing relationships between potentially unrelated behaviors, it is unlikely that a program will be identified as successful even if benefit is produced in one or more of the collection of target behaviors.

In 24 of 24 records, behavior data were graphed for monthly progress review. Because of the manner in which these data were graphed, such as multiple graphs for one PBSP, no indication on the graphs of treatment or environmental changes, and the lack of labels for axes and other components of the graphs, it was not typically possible to effectively use the graphs for determination of treatment efficacy.

	Data and monitoring progress of PBSPs		Average Score	Percent FS
1	A standard methodology exists for data collection that conforms to ABA generally accepted professional standards (All items below must be FS for this to be scored FS)		1.00	0.0%
	a.	Targeted behavior data collection sufficient to assess progress.	0.00	0.0%
	b.	Replacement behavior data collection sufficient to assess progress.	0.00	0.0%
	c.	Data reliability is assessed.	0.00	0.0%
	d.	Target behaviors analyzed individually.	0.17	8.3%
	e.	Targeted behaviors graphed sufficient for decision-making.	0.13	0.0%
	f.	Replacement behaviors graphed sufficient for decision-making.	0.13	0.0%

Graphed data are reviewed monthly according to procedures for the interdisciplinary teams. As no BCBAs are employed by the facility, there is no BCBA participation in the review. Input is encouraged from all team

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.</td><td>members, including direct care staff. It is not always possible to have a direct care staff member present during the review process or ensure that the direct care staff member that is present is familiar with the individual whose data are being reviewed.

In many cases, PBSPs were not revised when data suggested a need for revision. In only 2 of 24 reviewed cases (Individuals #315 and #320) was there an indication that data were used to determine treatment efficacy. In 22 of 24 cases, either data did not support the changes made or no changes were made when data reflected a lack of response or worsening of behavior following the introduction of treatment.

In only 2 of 24 cases (Individuals #162 and #531) were treatment expectations with specific time frames included in the PBSP. In the remainder of the cases, treatment expectations were too vague to be measurable or extended for durations far in excess of what is appropriate according to applied behavior analysis.

<table>
<tr><th></th><th colspan="2">Data and monitoring progress of PBSPs</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>2</td><td colspan="2">A standard methodology exists for monitoring and review of progress of PBSP (All items below must be FS for this to be scored FS)</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><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>1.75</td><td>75.0%</td></tr>
<tr><td></td><td>b.</td><td>Review is conducted by a BCBA.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>Input from direct care staff is solicited and documented.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>d.</td><td>Modifications to the PBSP reflect data-based decisions.</td><td>0.17</td><td>8.3%</td></tr>
<tr><td></td><td>e.</td><td>Criteria for revision are included in the PBSP.</td><td>0.17</td><td>0.0%</td></tr>
<tr><td></td><td>f.</td><td>Progress evident, or program modified in timely manner (3 Months).</td><td>0.17</td><td>0.0%</td></tr>
</table>
</td><td></td></tr>
<tr><td>K5</td><td>Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that</td><td>Standard psychological assessment practices at RSSLC are often inadequate and/or contain data far too old to be useful. All records reviewed contained some form of a psychological assessment report from the previous 12 months. None of these records, however, contained current information in all required areas. The inclusion of a current intellectual assessment was found in 25% of records reviewed, a percentage of success likely due to the greater length of time in which an intellectual assessment is considered to be current. Only 8.3% of the records contained a current assessment of adaptive behavior, potentially due to the expectation that adaptive behavior is more volatile and should be assessed annually.

None of the records reviewed contained an adequate assessment of psychopathology. Although diagnosis of mental illness typically is the responsibility of the psychiatrist, it is essential that psychologists conduct assessments of mental illness in order to determine what aspects of behavior may be due to the illness rather than from the environment or learning. The majority of assessments fail to incorporate medical, personal, mental health or emotional assessments into the standard psychological assessment report. As a result, the assessments lack sufficient depth and rigor to allow for the development of beneficial interventions.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.		

	Standard psychological assessment procedures		Average Score	Percent FS
1	Individual's record includes a psychological assessment that at a minimum contains the following. (All items below must be FS for this to be scored FS)		0.96	0.0%
	a.	Standardized assessment or review of intellectual and cognitive ability.	1.21	25.0%
	b.	Standardized assessment of adaptive ability.	0.71	8.3%
	c.	Screening for psychopathology, emotional and behavioral issues.	0.00	0.0%
	d.	Assessment or review of biological, physical and medical status.	0.00	0.0%
	e.	Review of personal history.	0.17	8.3%

An additional aspect of the psychological assessment is the functional assessment of behavior. All but one of the reviewed records included a functional assessment. A review of these documents indicated substantial weaknesses in the document and the assessment process.

The functional assessment template found in the records is a local revision of the Functional Assessment Interview (FAI), a widely used and respected guided interview. The revision used at RSSLC is based upon the first edition of the FAI, which lacked features and was replaced by a more comprehensive second edition. In addition, the FAI revision used by the Facility is lacking key components, such as the section that guides the user through selecting a functional replacement behavior and the development of an intervention framework. With these limitations, the revision of the FAI used at RSSLC does not produce an acceptable assessment of behavior functions and is not capable of serving as a foundation for behavior interventions.

Apart from the limitations of the revised FAI, substantial limitations were noted in how the functional assessment was conducted. In most cases, the revised FAI forms were completed in a manner that included only subjective opinions and anecdotal reports without an effort to support this information with direct observation. The sections of the revised FAI that require the psychologist to identify contingencies for the target behavior often had "none" or "unknown" as the response.

A review of the 23 revised FAI protocols also revealed that, regardless of the number of undesired behaviors, only one FAI was completed; All behaviors were included in this single FAI. Including multiple and potentially unrelated behaviors in one FAI violates the intent of the assessment and reflects poor conceptualization of the functional assessment process by the psychologist.

All of these limitations indicate that the psychological assessment process at RSSLC is inadequate and prevents the effective delivery of psychological services.

	Standard psychological assessment procedures	Average Score	Percent FS
2	If the individual's record or assessments reflect behavioral disturbance or	0.83	0.0%

#	Provision	Assessment of Status					Compliance
				psychopathology, a functional assessment that includes the following is incorporated into the standard psychological assessment. (All items below must be FS for this to be scored FS)			
			a.	A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis.	0.54	8.3%	
			b.	Differentiation between learned and biologically based behaviors.	0.00	0.0%	
			c.	Identification of setting events and motivating operations relevant to the undesired behavior.	0.08	0.0%	
			d.	Identification of antecedents relevant to the undesired behavior.	0.17	0.0%	
			e.	Identification of consequences relevant to the undesired behavior.	0.25	0.0%	
			f.	Identification of functions relevant to the undesired behavior.	0.29	0.0%	
			g.	Identification of functionally equivalent replacement behaviors relevant to the undesired behavior.	0.00	0.0%	
			h.	Identification of preferences and reinforcers.	0.63	0.0%	
		3		The functional assessment is reviewed when the Individual does not meet treatment expectations and is revised as needed with a maximum of one year between reviews.	0.33	16.7%	
		4		If the individual's record or assessments reflect behavioral disturbance or psychopathology, assessment of possible psychopathology that includes the following is incorporated into the standard psychological assessment. (All items below must be FS for this to be scored FS)	0.17	8.3%	
			a.	Identification of behavioral indices of psychopathology	0.17	8.3%	
			b.	Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0.17	8.3%	
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	As indicated in Section K5, very few of the reviewed records contain psychological assessment data that are current, accurate or comprehensive.					
				Psychological assessments based on clinical data	**Average Score**	**Percent FS**	
		1		Individual's records demonstrate that the assessment is based on	0.17	0.0%	
				• Current,	0.25	8.3%	
				• Accurate, and	0.33	8.3%	
				• Complete clinical and behavioral data.	0.08	0.0%	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>and behavioral data.</td><td></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>A review of 24 records reflected that each record contained a report from within the previous 12 months. The fact that a report was available does not indicate that all elements of that report were in compliance with other sections of the Settlement Agreement. This finding only indicates that a report was completed within the required time frame. As noted above, the content of those reports was substantially lacking.

<table><tr><th></th><th>Psychological assessments completed for every individual</th><th>Average Score</th><th>Percent FS</th></tr><tr><td>1</td><td>Individual records demonstrate that these psychological assessments are conducted as often as needed, and at least annually, for each individual.</td><td>2.00</td><td>100.0%</td></tr><tr><td>2</td><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>2.00</td><td>100.0%</td></tr></table></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</td><td>Only 5 of the 24 records reviewed included psychological services other than a PBSP. For each of these 5 individuals, the psychological services being provided lacked empirical support, did not include measurable objectives and were not evidence-based. Documentation of the intervention was included, but most often in the form of general therapy notes. Per discussion with psychologists, the therapy process was separate from other interventions. Meetings are held either monthly or quarterly depending on the individual. Therapy notes indicated no clear goal other than to discuss problems or develop a therapeutic relationship. There were no data reported.

Non-behavioral interventions can be a vital part of an individual's treatment regimen. These interventions must include adequate evidence to support their use or continuation, and must be based upon an empirical model of treatment. RSSLC has not met this provision.</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>progress can be measured to determine the efficacy of treatment.</td><td></td><td></td></tr>
<tr><td>K9</td><td>By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary 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</td><td>As documented earlier in this section of the site visit report, numerous and substantial limitations exist in the psychological and behavioral assessment process at RSSLC. Such weaknesses in assessment profoundly limit the development of effective, rational and empirical interventions.

The majority of PBSPs reviewed included steps to address all aspects of the contingencies of the undesired target behaviors. Without rigorous and comprehensive assessment, however, these proposed steps rely primarily upon subjective opinion and educated guesses. Such interventions possess a low probability for success and can precipitate the eventual use of more intrusive procedures.

At the time of the site visit, RSSLC was not utilizing adequate behavioral assessment procedures. For example, functional assessments did not include all expected components, did not clearly identify behavior functions, did not identify functional replacement behaviors, and were not directly integrated into the PBSP development process. Furthermore, measurement of targeted behavior was limited by vague operational definitions, inadequate staff training, and data collection methods that produced data of questionable validity. Because these essential elements of the treatment development process were lacking, the behavioral interventions produced by this process were at best unlikely to produce substantial changes in undesired behavior. In situations where undesired behavior could result in risk of harm to the individual or their peers, there existed the potential for an inadequate behavioral intervention to allow a possibly harmful behavior to continue.

In all cases that were reviewed, consents and approvals were obtained prior to the implementation of the PBSP. Because of the limitations presented above, these consents and approvals were obtained for PBSPs that were not likely to be successful and had the potential to expose the individual to unnecessary risks.

<table>
<tr><th></th><th>PBSP consent and initial implementation</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td>Necessary consents and approvals are obtained for each PBSP and safety plan prior to implementation.</td><td>1.54</td><td>54.2%</td></tr>
<tr><td>2</td><td>Within 14 days of obtaining consents the PBSP or safety plan will be implemented.</td><td>0.75</td><td>37.5%</td></tr>
</table>

<table>
<tr><th></th><th>PBSP consent and initial implementation</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>4</td><td>The PBSP for which consent was obtained conforms to current best practices in applied behavior analysis. (All items below must be FS for this to be scored FS)</td><td>1.00</td><td>0.0%</td></tr>
</table>
</td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th colspan="5">Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.</td><td colspan="5"><table>
<tr><td></td><td>a.</td><td>Rationale for selection of the proposed intervention.</td><td>0.17</td><td>0.0%</td></tr>
<tr><td></td><td>b.</td><td>History of prior intervention strategies and outcomes.</td><td>0.08</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>Consideration of medical, psychiatric and healthcare issues.</td><td>0.17</td><td>0.0%</td></tr>
<tr><td></td><td>d.</td><td>Operational definitions of target behaviors.</td><td>0.58</td><td>20.8%</td></tr>
<tr><td></td><td>e.</td><td>Operational definitions of replacement behaviors.</td><td>0.25</td><td>0.0%</td></tr>
<tr><td></td><td>f.</td><td>Description of potential function(s) of behavior.</td><td>0.17</td><td>0.0%</td></tr>
<tr><td></td><td>g.</td><td>Use of positive reinforcement sufficient for the strengthening of desired behavior.</td><td>0.08</td><td>0.0%</td></tr>
<tr><td></td><td>h.</td><td>Strategies addressing setting event and motivating operation issues.</td><td>0.25</td><td>8.3%</td></tr>
<tr><td></td><td>i.</td><td>Strategies addressing antecedent issues.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>j.</td><td>Strategies that include the teaching of desired replacement behaviors.</td><td>0.08</td><td>0.0%</td></tr>
<tr><td></td><td>k.</td><td>Strategies to weaken undesired behavior.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>l.</td><td>Description of data collection procedures.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>m.</td><td>Baseline or comparison data.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>n.</td><td>Treatment expectations and timeframes written in objective, observable, and measureable terms.</td><td>0.17</td><td>0.0%</td></tr>
<tr><td></td><td>o.</td><td>Clear, simple, precise interventions for responding to the behavior when it occurs.</td><td>0.46</td><td>0.0%</td></tr>
<tr><td></td><td>p.</td><td>Signature of individual responsible for developing the PBSP.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td>5</td><td colspan="2">Evidence that the intervention is based on functional assessment results, individual preferences, and on-going individual behavior.</td><td>0.17</td><td>0.0%</td></tr>
</table></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</td><td colspan="5">As noted previously in this report, at the time of the site visit RSSLC did not routinely assess the validity and reliability of behavioral data. Without such assessments, any data collected are of questionable value and may lead to unnecessary or detrimental changes in interventions. See section K4 for additional discussion.<table>
<tr><th></th><th colspan="2">PBSP implementation and documentation</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td colspan="2">Inter-observer agreement (IOA) exists for PBSP data (All items below must be FS for this to be scored FS).</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><td>IOA for target behavior data.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>b.</td><td>IOA for replacement behavior data.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>IOA meets minimum expectations.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td>2</td><td colspan="2">PBSP data are graphed at least monthly</td><td>1.92</td><td>91.7%</td></tr>
<tr><td>3</td><td colspan="2">Data graphs are adequate for interpretation (All items below must be FS for this to be scored FS).</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><td>The graph is appropriate to the nature of the data.</td><td>0.08</td><td>0.0%</td></tr>
</table></td><td></td></tr>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>
<table>
<tr><td></td><td>b.</td><td>Horizontal axis and label.</td><td>1.08</td><td>8.3%</td></tr>
<tr><td></td><td>c.</td><td>Vertical axis and label.</td><td>1.08</td><td>8.3%</td></tr>
<tr><td></td><td>d.</td><td>Condition change lines.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>e.</td><td>Condition labels.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>f.</td><td>Data points and path.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>g.</td><td>IOA and data integrity.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>h.</td><td>Demarcation of changes in medication, health status or other relevant events.</td><td>0.00</td><td>0.0%</td></tr>
</table>
</td><td></td></tr>
<tr><td>K11</td><td>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.</td><td>
A review of 24 records reflects that many behavior interventions are written using complex language and technical terms. In some sections of a PBSP, such writing may be unavoidable. The specific intervention methods that direct care staff will be expected to implement should be written in a manner that is user friendly, easy to read and allows for quick and effective implementation. This was not the case with the majority of PBSPs and substantially limits the ability of staff to implement interventions correctly and efficiently.

In a wide variety of homes and other settings, staff were unable to describe specifically how an intervention plan was to be implemented. Furthermore, staff often did not implement the appropriate intervention when it was needed, and did not recognize that they had made an error.

• In the Leon dining room, individual #162, who has a PBSP for pica, was observed engaging in pica without staff intervention.
• In the Trinity dining room, Individual #134 has a program that includes verbal prompts for posture and the pace of eating. Staff provided interaction with #134 only when the individual became loud and intrusive.

Although these weaknesses in PBSP implementation were readily observable, RSSLC at the time of the site visit did not routinely assess the ability of staff to implement PBSPs as written.
<table>
<tr><th></th><th>PBSPs can be understood and implemented by staff</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td>Staff are able to explain how they implement the individual’s PBSP.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td>2</td><td>The facility implements a system to monitor and ensure treatment integrity.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td>3</td><td>Observations of staff and individuals demonstrate at least 80% treatment integrity.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td>3</td><td>Written style and length of plan allows for staff understanding.</td><td>0.29</td><td>8.3%</td></tr>
</table>
</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></td><td></td><td></td></tr>
<tr><td>K12</td><td>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.</td><td>RSSLC did not at the time of the site visit use a competence-based approach to staff training. In regard to PBSPs, it was both observed and reported that training on PBSPs consisted of being read or asked to read the intervention plan followed by signing a form stating that training had been conducted on the particular PBSP in question. This process did result in the majority of staff receiving training prior to the implementation of a PBSP but clearly did not produce competence in many of those staff. There were some instances in which competency-based training might have occurred. Night shift DCPs at Nueces and Three Rivers did report that someone comes in to provide inservice training. When asked about this training, the DCPs uniformly reported that the trainer first demonstrates the program and then asks the DCPs to demonstrate. Staff at Nueces reported that a Behavior Analyst retrains one program each month, sometimes to several staff and may retrain if there is a program change.

Furthermore, other than training conducted to capture those staff that had been absent previously or otherwise unable to participate in the original training, very little ongoing training was provided following PBSP implementation. As is abundantly clear in the published literature, such training practices generally lead to drift in program implementation. Despite the lack of competence-based or ongoing training, RSSLC did not routinely assessment of staff knowledge or the ability to implement behavioral interventions was variable.

<table><tr><th></th><th>Staff training on specific PBSPs</th><th>Average Score</th><th>Percent FS</th></tr><tr><td>1</td><td>Training logs reflect that all staff have received training on individual PBSPs':</td><td>1.00</td><td>0.0%</td></tr><tr><td></td><td>Overall purpose</td><td>1.00</td><td>0.0%</td></tr><tr><td></td><td>Specific objectives</td><td>1.00</td><td>0.0%</td></tr><tr><td>2</td><td>Staff training includes a combination of didactic, modeled and in vivo strategies.</td><td>0.00</td><td>0.0%</td></tr><tr><td>3</td><td>Staff training is conducted prior to PBSP implementation.</td><td>2.00</td><td>100.0%</td></tr><tr><td>4</td><td>Staff training is conducted throughout the duration of the PBSP.</td><td>0.00</td><td>0.0%</td></tr><tr><td>5</td><td>The facility has implemented a system to ensure that pulled and relief staff, receive competency based training on PBSPs they will be responsible to implement.</td><td>0.00</td><td>0.0%</td></tr><tr><td>6</td><td>Staff training is provided in part by the professional responsible for the development of the PBSP.</td><td>2.00</td><td>100.0%</td></tr></table></td><td></td></tr>
<tr><td>K13</td><td>Commencing within six months of the Effective</td><td>As RSSLC did not employ any BCBAs at the time of the site visit, all ratios fell below minimum expectations.

<table><tr><th></th><th>Ratio of psychology professionals and assistants to individuals</th><th>Average</th><th>Percent</th></tr></table></td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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.		

		Score	FS
1	Program maintains an average of 1 BCBA to every 30 individuals.	0.00	0.0%
2	Program maintains one psychology assistant for every 2 BCBAs.	0.00	0.0%

Recommendations:

1. RSSLC should develop a specific plan for ensuring competence in applied behavior analysis across all psychology staff. This plan should include incentives and encourage as many psychologists as possible to obtain board certification as a behavior analyst. A curriculum should also be developed for additional training in applied behavior analysis on-site and through external sources.

2. RSSLC should expand upon the existing Peer Review Committee to ensure that the committee makes use of a true peer review model and produces improvement in the quality of behavior assessment and intervention at RSSLC.

3. RSSLC should develop and implement an external peer review process.

4. RSSLC should establish minimum standards for data collection and presentation. In addition, RSSLC should act to ensure that all staff are competent in relation to their responsibilities in data collection, presentation and interpretation.

5. RSSLC should establish minimum standards for psychological and behavioral assessment that reflect current accepted practices within applied behavior analysis. Staff should then be provided with the training and support necessary to meet the established standards.

6. All members of the interdisciplinary teams should be able to demonstrate competence in the basics of applied behavior analysis and evidence-based practices. RSSLC should develop a training curriculum to ensure that these staff develop competence in these areas.

7. RSSLC should establish minimum standards for non-PBSP psychological services and train staff to competence on these standards. Such standards should require that there is a process to ensure PBSPs and other psychological services are complementary, that goals and measures of efficacy are established, and therapy plans are established and followed.

8. RSSLC should establish minimum standards for data quality, including validity, reliability and inter-observer agreement. Procedures should be developed for ensuring adherence to these standards and staff should be trained to competence on these standards.

9. RSSLC should develop competence-based training for staff responsible for implementing PBSPs. In addition, procedures should be developed and implemented to assess treatment integrity for PBSP implementation and guidelines for follow-up training.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: **Review of Following Documents Reviewed**: 1. RSSLC Enteral Formula Roster – Medical Nutrition Therapy, Updated 4/19/10 2. Diagnosis of Pneumonia, Reporting Period 3/1/09 through 4/27/10 . 3. Richmond State School Clients' Hospital Admission Log 2009 4. Richmond State School Individual Record Index (not dated) 5. Richmond State Supported Living Center Filing and Retention Schedule, revised 3/24/10 6. Documentation of the CME activities and licensure for the Primary Care Physicians 7. Undated document indicated that there had been no complaints about Psychiatric and Medical Care made by "any party to the Facility", document not dated 8. Mock CPR Drill Report from July 2009 through February 2010 9. External Medical Hospital Admission Log for RSSLC for the year 2009 10. Policy Related to Providing Health Care Services – Health Status Team Guidelines, revised 10/1/09 11. Blank copies for forms to be completed after an Individual's Death, including additional reviews of the death, not dated 12. Sign-in Sheet for Human Rights Committee Meeting attended on 4/29/10 13. Schedules for the Psychiatric and Behavioral Management Clinics, scheduled for 4/23/10 and 4/10/10 14. Lists of Individuals prescribed drugs for behavior management by residence, dated 4/3/10 15. List of the 39 Individuals that Dr. Hermant Patel has performed Psychiatric Consultations on, as well as the Status Assessment, for the calendar year 2009 through 2010 16. Copies of 2009 and 2010 Neurology Consultation Reports prepared by Steven Croft, M.D. related to the following Individuals: #113, #483, #450, #500, and #778 17. List of Individuals with Enteral Feeding, updated 4/19/10 18. List of Individuals with a Diagnosis of Pneumonia, 3/1/09 through 4/27/10 19. Organizational Chart for the RSSLC Administration, dated March 2010 20. Organizational Chart for the Medical Department, dated March 2010 21. Policy Related to Seizure Management produced in request for documentation of policies on Seizure Management, which is not dated, and which appears to be 5 pages copied from an unidentified text 22. Policy Related to Seizure Management, revised 6-30-08, which identifies origin as Nursing Procedure Manual 23. Internal Quality Assurance Reviews related to Medical Services, dated February 2010 24. Medical Record from Memorial Hermann Hospital concerning medical hospitalization of RSSLC Individual #225 in March 2010

25. Discharge Summary and sections of the in-patient medical record from medical hospitalization at Oak Bend Medical Center for Individual #144, in January 2010
26. Discharge Summary and related sections of the record for medical hospitalization at Oak Bend Medical Center for Individual #201, from November 2009
27. Discharge Summary and sections of the medical record for medical hospitalization at Oak Bend Medical Center, Individual #202, February 2010
28. Discharge Summary and in-patient medical record from Oak Bend Medical Center for Individual #408, from January 2010
29. Review of the medical records for Individuals: #467, #726, #760, #8, #755, #714, #542, #641, #455, #630, #615, #525, #16, #644, #723, #585, #450, #320, #51, #800, #60, #181, #100, #264, #547, #146, #778, #328, #144, #32, #500, #2, #651. #476, #575, #342, #202, #173, #7, #765, and #169

People Interviewed:

1. Julie Graves Moy, M.D., MPH
   Date of Interview: 4/26/10
2. David Partridge, M.D., Medical Director
   Date of Interview: 4/26/10
3. Carol Heath, DDS, Director of Dental Services
   Date of Interview: 4/27/10
4. Steven Croft, M.D., Consulting Neurologist
   Date of Interview: 4/27/10
5. Charlene McCurry, R.N., Chief Nurse Executive
   Date of Interview: 4/27/10
6. Wilma Parker, R.N., Quality Assurance Nurse
   Date of Interview: 4/27/10
7. Kimberly Randel, R.N., Infectious Disease Nurse
   Date of Interview: 4/27/10 (All three of these nurses were seen in the same meeting)
8. Pauline Ike, R.N., B.S., J.D.
   (Tour of infirmary) 4/27/10

Meetings Attended/Observations:

Individuals: #751, #675, #106, #403, #635, #169, #159, #286, #724, #227, #184, #418, #173, #384, #402, #553, and #209, (Trinity C Residential Unit); #666, #386, #661, #215, #500, #477, #413, #470, #765, #360, #632, #324, #454, #284, #593, and #283, (Trinity A Residential Unit); #491, #463, #84, #482, #107, #6, #30, #351, #385, #330, #348, #233, #268, #551, #251, and #57, (Trinity B Residential Unit); #436, #621, #7, #40, #564, #125, #512, #535, and #571, (Trinity D Residential Unit); #301, #12, #729, #745, #265, and #603, (Trinity Program Room); #601, #164, #375, #719, #308, #428, #71, #157, #434, #377 #344, and #503, (Leone Residential Unit); #114, #202, #101, #200, and #328, (San Antonio Residential Unit); #550, (569 Tejas), #161, #98, and #220, (Guadalupe Residential Unit); #508 (Nueces); #767, #410, #213, #342, #781, #758, #396, #540, and #253, (Colorado Satellite Workshop Vocational Program); #796, #577, #138, and #791, (Main Vocational Workshop); #300 and #793, (Angelina Pre-vocational Program); #693, #716, #493, and #2 (Forever Young Day Program); #7, #678, #173, #169, and

	#500, (Neurology Clinic); #515, #476, #651, and #765, (Infirmary Unit).
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Dr. David Partridge is the Chairman of the Medical Department at RSSLC. His staff includes four physicians, all of whom are Board Certified in a specialty related to direct care. The Medical Team also employs one Nurse Practitioner, who is certified in Adult Medical Care. The Medical Services are primarily administered through a "sick call" format, which involves direct care staff bringing an individual to the attention of the nursing staff who then make the appropriate referral to the sick call. There is a "sick call" clinic room on each of the living unit clusters. The sick call is usually carried out in the morning hours and is facilitated by Nursing. In addition to direct care instigating the process for referral to sick call, this can also be done by members of the nursing staff who may notice a change in an individual's clinical status. The physicians do have a presence on the unit, but this is variable. During a tour of the residential units staff on all of the units were asked about the frequency with which the physicians were on the units and the responses varied. A log book that would document when the physicians are on the units could not be identified, so these subjective impressions cannot be verified. It is clear that there is a much greater physician presence on the Trinity Units, where the most physically compromised individuals reside. On each unit staff members were asked if they knew who the attending physician was for their living unit and the responses were uniformly accurate. As discussed in Section L1, the Facility has an extensive roster of sub-specialty consultants, many of whom come to RSSLC to perform clinics or are available to see RSSLC individuals in their community offices. The Neurological clinic of Dr. Daniel Croft was observed on 4/27/10, and is described in the narrative section below. The record review, as well as the observation of Dr. Croft's clinic, would indicate that individuals whose seizure disorder was stable had not been receiving routine annual neurological reviews on a regular basis; however, those individuals who had an active seizure disorder were being followed closely by Dr. Croft. The RSSLC primary care physicians are increasing their referrals to the Neurology Clinic, and this would appear to be to maintain an annual review for all of the individuals who have a diagnosis of a seizure disorder and are receiving anticonvulsant medication. A current Annual Medical Assessment and Plan (AMAP) could be located in all but a few individual medical records. The AMAPs provide a comprehensive overview of the individual's current medical status and past history. The Health Risk Assessment Instrument provides a numerical rating of risk, but in actuality the process relies heavily on the subjective impressions of the RSSLC professionals who complete them. The Facility relies on external community hospitals for acute emergency room assessments and for hospitalizations. There are also two long-term care facilities that are utilized for individuals who cannot return to RSSLC following a medical admission. The Facility also maintains an infirmary. The tour of the Infirmary, and the description of the individuals who were residing there at the time, is described in the

	narrative section below. Utilization of the Infirmary is appropriate in terms of the acuity of individuals who are referred there, either as a step down from an external hospitalization or for treatment of a condition that does not require external hospitalization. The RSSLC has not developed the monitoring processes addressed in provisions L2, L3, and L4 of the Settlement Agreement. The Central Office Administration of DADS will be assisting RSSLC in developing the resources to address these provisions.

#	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.	The purpose of this initial review of the Medical Services at RSSLC is to provide an overview of those services and the baseline statistics related to issues that are relevant to the quality of medical care at the Facility. On 4/26/10, David Partridge, M.D., Medical Director for the RSSLC, provided an overview of the Medical Staff for the Facility. Dr. Partridge is Board Certified in Family Medicine. He oversees the work of the following Primary Care Physicians: Juanita Arcilla, M.D., Board Certified Physiatrist; Karin Parikh, M.D., Board Certified Pediatrician; Wena Chirinand, M.D., Board Certified Pediatrician; Nan Chirinand, M.D., Board Certified in Family Medicine; and Leelamma Francis, Adult Nurse Practitioner, with her area of practice defined as Adult Medicine. The Facility Psychiatrists also report administratively to Dr. Partridge. The Psychiatric Staff consists of Ashok Jain, M.D., who is Board Certified in Adult Psychiatry. Dr. Jain is currently working at the Facility for 16 hours a week but is decreasing his private practice as he moves to a full-time position at RSSLC. Dr. Partridge also indicated that he and the Facility Administration are optimistic that they will be able to recruit another full-time psychiatrist. The part-time Consulting Psychiatrists consists of Hermant Patel, M.D., who is Board Certified in Adult and Forensic Psychiatry; Raphael Guerrero, M.D., who is Board Certified in Adult Psychiatry; and Dominic Joseph, M.D., who is also Board Certified in Adult Psychiatry. Dr. Patel and Dr. Joseph currently work 8 hours per week, and Dr. Guerrero does Quarterly Medication Review Clinics two times a month for a total of 16 hours per month. Dr. Partridge also indicated that the current caseload for each Primary Care Physician is approximately 72 individuals. The Facility does have a Radiology Department, which has recently been donated a CT scanner. They are also able to do digitized x-rays, ultrasounds, and have a DEXA scan machine to check bone density. In addition, the Facility has the capability to perform echocardiograms. Lucky Chopra, M.D. is the Consulting Radiologist, and he also does the modified barium swallows to assess for dysphagia and swallowing problems. Dr. Chopra's modified barium swallow clinic was observed on 4/29/10.	

#	Provision	Assessment of Status	Compliance
		The Neurology Consultation is provided by Dr. Steven Croft, who has an appointment at the Baylor College of Medicine. He performs a clinic at RSSLC the fourth Tuesday of each month. Direct observation of this clinic on 4/27/10 indicated that the cases are presented to Dr. Croft by the Primary Care Physician. Dr. Croft will then do a Neurological Examination and review the record. In two of the individuals he reviewed there was feedback from the primary care physician that Dr. Michael Shatz, the Clinical Pharmacist for the Facility, had made recommendation for consideration of the Neurologist. Dr. Croft then dictates his notes. The observations during this clinic indicated that for many individuals there had not been a recent Annual Neurological Review. Specifically, individual #723 had last been seen in the Neurology Clinic in 2005. Individual #678 had most recently been evaluated by the Neurologist in 2003. Individual #169 had not been seen since 2002. This pattern was also documented by the review of the individual records as noted above. For example, for individual #651 there was a gap in Neurology Clinic consultations from 2005 until 2010. In general, the observations at the Neurology Clinic, as well as the review of records, would indicate that individuals who had an active seizure disorder were being seen as frequently as quarterly or monthly, if needed; however, for those individuals who were relatively stable on their anticonvulsant medication, the Neurology consultations were not being routinely done on an annual basis. During the 4/27/10 Clinic Dr. Croft also noted a subjective impression that there had been an increase in the number of individuals referred to the Neurology Clinic. This is likely due to the Facility's efforts to obtain an annual neurological review for everyone receiving anticonvulsant medications and then continue that practice going forward. Additional Sub-specialty Consultation, which is available at the Facility, includes Ophthalmology, which is provided by Dr. Steven White, who performs a monthly clinic that lasts from 3 to 4 hours. Nelson Reber, O.D., provides an Optometry Clinic two times a week on Tuesday and Wednesday mornings. There is a monthly Podiatry Clinic with Dr. Anderson. Sharon Raimer, M.D., from the University of Galveston, also does a Dermatology Clinic, and usually will bring Dermatology Residents from the Medical School at Galveston with her. Off-grounds consultation is available for Cardiology and Pulmonary consultation. The Facility has a full-time dentist, Dr. Heath and is also recruiting a second full-time dentist. TIVA, (Total Intravenous Anesthesia) for complex dental procedures, is carried out by Dr. Chancellor, D.D.D., when indicated. Dr. Partridge estimated that 90% of the external medical hospitalizations of RSSLC	

#	Provision	Assessment of Status	Compliance
		individuals take place at Memorial Hermann South West Medical Center. The other external hospital that is utilized is the Oak Bend Medical Center. He also estimated that there were usually between 4 and 10 individuals hospitalized externally at any given time. Emergency Room visits usually take place at the Memorial Hermann South West Medical Center, unless the ambulance diverts the individual to the Oak Bend Medical Center. Long term rehabilitation hospitalizations take place at the Triumph Hospital or the Cornerstone Hospital. RSSLC also has an arrangement with the Contra Vitas Hospice Center, and Dr. Partridge estimated perhaps 3 to 4 hospice admissions per year for RSSLC residents. Dr. Partridge indicated that the medical services are primarily provided through a "sick call" system. There are "sick call" examination rooms on each of the living units. Individuals can also be seen at the Clinic building during the day. He noted that the identification of individuals to be seen at the "sick call" usually begins with observations by the Direct Care Staff. Discussions with Nursing and Direct Care Staff, during the physical tour of the RSSLC living units, confirmed that the sick call method is the primary method of identifying individuals who need to be seen by the physician, unless there is an acute emergency such as a laceration that has to be sutured or an individual needs to be evaluated after a seizure. The descriptions of the degree to which the individual physicians are physically present on the living units, other than for sick call, vary from unit to unit. However, it is clear that the primary care physicians do have a perceived presence on the unit. The Trinity Living Units, where the most physically challenged individuals reside, naturally has the greatest daily physical presence of the primary care physician. During the physical tour of the units, staff members were routinely asked if they could identify the attending physician for their unit. Their responses were uniformly accurate. A review of the document entitled "Diagnosis of Pneumonia" for the "Reporting period: 3/1/09-4/27/10" identified a total of 36 individuals who had been diagnosed with pneumonia during that time. Ten individuals were specifically identified as having the type of pneumonia as "aspiration." Within the group whose designation was aspiration pneumonia there were five who were identified as being fed by "tube." Overall, 17 of the individuals who had been diagnosed with pneumonia during this time period were also identified as "tube" fed. Individuals are often placed on enteral feeding because of swallowing problems, which makes them at risk for pneumonia. The initiation of enteral feeding should reduce the risk of pneumonia that is directly related to dysphagia. Future monitoring reports will analyze corresponding data for trends in frequency. The documented entitled "Richmond State Supported Living Center Admission Log 2010 for the time period from January 1, 2010 through March 30, 2010" identifies 36 hospital	

#	Provision	Assessment of Status	Compliance
		admissions during that time period, or an average of 12 per month. This list also includes what would appear to be emergency room visits that were not hospital admissions; however, the emergency room visits account for only two of the individuals identified on the list. Of interest is the observation that 11 of these individuals were transferred from the medical hospital (Memorial Hermann South West Medical Center), to either the Triumph Healthcare Southwest Long-Term Care Center or the Cornerstone Hospital Long-Term Care Center. During the tour, the hospital admission records for four individuals was requested and received. The hospital record for individual #144 related to admission to the Oak Bend Medical Center from 11/28/09 through 12/1/09 indicated that during the hospitalization the attending physician was Pankaj K. Shah, M.D. The hospital course and discharged diagnoses are contained in the following excerpt from the medical record. *DATE OF DISCHARGE: 12/01/2009* *HOSPITAL COURSE: The patient is a [age and gender deleted] with a history of cerebral palsy, mental retardation, having moderate respiratory distress. Came to the emergency room with acute respiratory failure, hypoxemia and decompensation. The patient was found having a right lower lobe infiltration and bilateral pleural effusion. Cardiac enzymes were elevated. Cardiology consult obtained. Physician felt that patient might have decompensated CHF. MI was ruled out. Stress test was performed by Dr. Parikh. Echocardiogram was performed which showed ejection fraction of 55. CPK was 1447, suggestive of mild rhabdomyolysis. Function pulmonary embolism. CT of the chest was performed which did not reveal any pulmonary embolism but large right pneumonia noted. After discussing, it was felt that the patient had a pneumonia, respiratory failure, atrial tachycardia, diastolic dysfunction and mild rhabdomyolysis requiring long-term care/acute care. Patient planned to transfer to a long-term care hospital.* *DISCHARGE DIAGNOSES:* *1. Respiratory failure.* *2. Right-sided pneumonia.* *3. Congestive heart failure, decompensated, acute coronary syndrome, diastolic dysfunction.* *4. Mental retardation.* *5. Rhabdomyolysis.* *6. Seizure disorder.* Dr. Partridge indicated that Dr. P.K. Shah will frequently follow their individuals in the hospital. The available record for the March, 2010 hospital admission for individual #225 does not contain the discharge summary. The consultation note prepared by Mauricio A. Reinoso indicates that the attending physician is Dr. Amir Kahn. The history of present illness and past medical history section of that report are as follows:	

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		<u>REASON FOR CONSULTATION</u>: *Right lower lobe cavitary mass and a large right pleural effusion.* *<u>HISTORY OF PRESENT ILLNESS</u>:* *Patient is a [age deleted] mentally retarded man from Richmond State School who was transferred to the ER with cough and desaturation. The patient has had a history of right pleural effusion thought to be part pneumonic documented in 8/2006. At that time, he was evaluated by OTMS pulmonary service. He had a thoracentesis, a CT of the chest that only shows a tiny pulmonary nodule, and a small residual pleural fluid. The patient did not describe any significant abscess at that time. He is not fully cooperating and unable to expectorate phlegm, but he does not have any obvious respiratory distress. He is afebrile and his white blood cell count is mildly elevated at 13,000. He is calm at this point with a respiratory rate of 16 per minute.* *<u>PAST MEDICAL HISTORY</u>:* *Mental retardation, autism, prior pneumonia in 2006, there is no known dysphagia. Apparently, the patient is eating by mouth. Sitter is not able to tell me more details about him.* The observation that the past medical history makes reference to "sitter is not able to tell me more details about him" would suggest that there had not been adequate communication by the primary care physician at RSSLC to the hospital personnel at Memorial Hermann Southwest Hospital. The Discharge Summary for individual #408, prepared by Pankaj K. Shah, for the admission from 1/4/10 to 1/8/10, describes the following hospital course: (note: The blank spaces are reproduced from the original). *<u>HOSPITAL COURSE</u>: The patient is a [age deleted] Richmond State School patient with a history of mental retardation and diabetes mellitus, status post PEG placement. Was admitted from the emergency room with acute shortness of breath and dyspnea. Found having a bilateral aspiration pneumonia. Patient was seen with metabolic acidosis with possible sepsis with continued_____. _____and also included D-dimer. Possible pulmonary embolism was considered but unable to do respiratory due to_____protocol secondary to high BUN and creatinine are from an abnormal renal function. Patient was not standing still. Considering that, perfusion scan was performed which was showing the low probability of pulmonary embolism.* *Patient was transferred into intensive care unit. Cardiac enzymes were obtained with Dr. Mayan Parikh, and the patient was treated with symptomatic therapy. Echocardiogram*	

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		was also obtained for a left ventricular dysfunction. *Clinical condition continued to deteriorate, and patient required monitor. Had _____ respiratory distress with significant agitation with tachypnea and tachycardia and alluding impending respiratory failure. Patient was intubated, and patient was place on the mechanical ventilator support with an ASA-assisted control mode. Patient was kept on the ventilator, and patient was sedated for protection of the airways.* *ID consult obtained with Dr. Butler, as recent as January 6, and it was felt that patient had healthcare-associated pneumonia, and the patient was treated with Maxipime and Vancomycin was added later on in view of the gram-positive possible MRSA in the _____study. Patient _____ leukocytosis, but blood cultures were negative so far until January 7.* *In view of requiring mechanical ventilation support for long period time, returned to intensive care. Possibility of long-term acute care_____was obtained. Patient was evaluated by the Cornerstone Hospital and was accepted, and it was planned to transfer the patient to Cornerstone. History for further workup and management and critical care.* This individual eventually died from this illness on 1/21/10 at the Cornerstone Hospital and did not return to RSSLC. It is not clear if earlier detection of the decline in his physical status would have led to earlier intervention, which might have altered this outcome. The Discharge Summary for Individual #202, covering admission to Oak Bend Medical Center from 2/2/10 through 2/6/10, indicates that the individual was also followed by Pankaj K. Shah during the medical hospitalization. The hospital course indicates that he was "admitted with altered mental status and dehydration" and was subsequently found to have a urinary tract infection which was then treated. Data with regard to the mock cardiopulmonary resuscitation (CPR) drills was reviewed for the time period from July, 2009 through February, 2010. These data indicate that the mock CPR drills are held frequently, (approximately 30 per month), and that deficiencies are noted and corrective action is taken when a deficiency is noted. Nurses only participated in three of the 26 drilled conducted. No physicians or other professional staff participated in the drills. Results of a drill conducted during the review and the limited number of failed drills reported in the CTD's tracking and trending report indicated the accuracy of the drill reports and staff competency were questionable. The review of the individual records identified above indicates that the Annual Medical Summaries are up-to-date and present with the exception of the following individuals:	

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		#51 and #641. AMAPs could not be located in the records of individual #500 and individual #2; however, this assessment is based on documentation that was reviewed off-site, and it is possible that the AMAP was simply not included in the documentation that was provided by RSSLC. The AMAPs are comprehensive and provide a detailed review of both the individuals' past history, recent history, and their current status. The documents provide in one place a source of comprehensive, up-to-date overview of the individual's medical status. Each individual's record also contains a "Preventive Care Flow Sheet", which provides information on the following screening tests and examinations: • Annual history and physical examination, • Annual assessment for hypertension • Height, weight, and body mass index (BMI) annually • Annual vision, hearing check, and dental examinations • Colorectal cancer screening (for individuals over the age of 50) • Annual fecal occult blood test • Colonoscopy every 10 years • Prostatic specific antigen and digital rectal examination annually for males, as well as annual testicular examination • Mammograms every 1 to 2 years for woman age 40 and over • Annual breast exams for females over the age of 18 • Osteoporosis screening every 2 years or every 5 years for women age 65 or older • Lipid screening every 5 years or at physician's discretion • Annual diabetes check • There is also a section covering immunizations, laboratory work, and EKGs. The Preventive Care Flow Sheets were uniformly present in the records review. The Facility carries out Health Risk Assessments, which utilize a rating system to monitor multiple factors which contribute to an individual's overall health risk status. The individual ratings are from 1 (High) to 3 (Low) risk. Although these ratings are in fact somewhat subjective, the quantification of risk gives the appearance of objectivity. The process is administered through the "Health Service Teams". The internal quality assurance process for medical services track two items related to this process. The first of these is "The records reveal the Health Services Team has met and assigned a risk score", and the second is "The records reveal the Health Services Team meets at an interval according to the risk assessment (minimum of every six months)". The Quality Assurance Review for March, 2010 reviewed the records of ten individuals and found that the compliance for the item related to the assignment of a risk score achieved a	

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		compliance rate of 83 percent, whereas, the requirement that the Health Services Team meets at an interval according to the risk assignment was met in only 50 percent of the records reviewed. The corresponding data for another monthly review (the specific month was omitted from the form) identified a compliance of 75 percent for the first item and 33 percent for the second item. The corresponding QA review involving 12 individuals that was carried out in December, 2009, indicated a compliance rate of 67 percent for item number one and 25 percent for item number two; thus, the Facility's internal quality assurance reviews would indicate that this process is not routinely being carried out according to the schedules that the Facility has developed. RSSLC maintains a separate Infirmary Unit. The tour of this unit took place on 4/27/10, and was facilitated by Pauline Ike, R.N., B.S., J.D. The Infirmary has a capacity for 12 to 14 beds depending on the number of occupants per room. The census usually ranges from seven to ten individuals. The following individuals were residing in the Infirmary at the time of the tour: Individual #515 had been admitted to recover from cataract surgery. The individual was wearing a helmet for protective purposes. A staff member was also present with the individual at the time of the tour. Individual #450 had been admitted the prior day for monitoring of symptoms related to an upper respiratory tract infection and pneumonia. He did have a 1 to 1 staff person with him. It was also noted that the individual has a vagal nerve stimulator (VNS) for seizure disorder. Individual #585 was identified as living in the Infirmary at his mother's request. He has been living in the Infirmary since 2008. He also had with him a direct care staff person, who is referred to as a "sitter." Individual #476 had been admitted on 4/22/10 to monitor status during recovery from pneumonia. The individual did not have a sitter. Individual #651 had been admitted to the Infirmary in November, 2009. The individual has enteral feeding, and had been admitted for observation of status post pneumonia. The individual also had a sitter. Individual #765 had been admitted on 4/7/10 with a diagnosis of dehydration. He received enteral feeding and was also treated with intravenous therapy for hydration. The individual was wearing a mitten on the right hand, both to protect from self-inflicted bites, as well to prevent the individual from removing his g-tube; a physician's order entered 4/27/10 at 9:30 a.m. stated "continue Mitten R hand to promote wound healing R thumb X 7 days." The monitoring team did not check records to determine whether this was recorded as a medical restraint. The tour of the Infirmary also indicated that there is a Dining Room. It was estimated that approximately 30 percent of the individuals are able to eat in the dining room. There is also a conference room for staff, a director's office, and a nursing station. The Unit is spacious and clean. Communication between the medical staff is facilitated by an 8:30 a.m. daily medical meeting. This meeting was observed on 4/28/10. The meeting is chaired by Dr.	

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		Partridge. Dr. Ashok Jain represented the psychiatry staff at the meeting. The review discusses any significant events that occurred overnight with specific reference to hospitalizations or emergency room visits. Dr. Partridge noted that he had been on-call the prior night, and early that morning had sent Individual #382 to the emergency room after having been contacted at 6:20 a.m. by Nursing staff, who noted the individual had a facial asymmetry. The rationale for the transfer to the emergency room was for assessment of a differential diagnosis of transient ischemic episode versus an evolving stroke. During the meeting Dr. Jain also indicated to the other physicians that he would be available for telephone consultation during the overnight on-call periods and on weekends if a matter arose that required discussion with him. The review of the Resident Mortality information that is contained in the document entitled "Deaths 5/1/2009 to 4/29/2010," indicates an average age of death of 51 years, with a range of 38 to 65 years of age at the time of death. Twelve individuals died during this time frame. All but two of these deaths occurred at an external facility. Two occurred at Memorial Hermann South West Medical Center, and one at the Oak Bend Medical Center. Three of the individuals had been referred to an inpatient hospice facility and died there. Four of the deaths occurred in an external long-term care facility: Cornerstone Hospital (2) and Triumph Hospital (2). Additional longitudinal data was not available to substantiate whether or not this is the typical age and frequency for the death of individuals who reside at RSSLC. Future reviews will assess for trends in this data.	
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.	During the 4/26/10 interview with Julie Graves Moy, M.D., M.P.H., Medical Director, Texas State Supported Living Centers, she indicated that the DADS Central Office will be assisting the individual facilities in developing and maintaining this system of external medical review. She noted that in the past, facilities have sometimes relied on retired physicians from the Facility or the community to conduct these external reviews. She is hoping to be able to develop alliances with teaching hospitals that may make it possible to use physician resources from those academic centers to perform these reviews. Thus, this Provision is not currently being met, but plans are being developed to address it. Future monitoring reviews will follow-up on the progress in this regard. The subsequent interviews with Dr. David Partridge, Medical Director for RSSLC, also confirmed that these external reviews are not currently taking place.	
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	During the 4/26/10 interview with Julie Graves Moy, M.D., M.P.H., Director for the Texas State Supported Living Centers, she indicated that the Central Office of DADS will be helping the facilities to develop and maintain the quality improvement process that is referred to in this Provision. Thus, this Provision is not currently being addressed, but there are plans to develop a system for complying with this Provision. David Partridge, M.D., Medical Director, also indicated that this Provision is not currently being met.	

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	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.		
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.	Julie Graves Moy, M.D., M.P.H., Medical Director for the Texas State Supported Living Centers, has indicated that the Central Office of DADS will be working with the facilities to develop the necessary clinical monitoring tools to bring the Facility into compliance with this Provision, which is not currently being met. Interviews with David Partridge, M.D., Medical Director, confirmed that this Provision is not currently being addressed.	

Recommendations:

1. The Health Status Assessment Process should be reviewed from the prospective of making the process more objective and reliable.
2. Internal quality assurance monitoring has indicated that the timelines for convening the Health Status Team are not being met on a regular basis. This monitoring should continue.
3. The primary mechanism for the delivery of medical services is accomplished via a sick call format, which relies heavily on the observational abilities of direct care staff to detect changes in an individual's status. The Facility should determine if more frequent direct clinical rounds by the Primary Care Physicians would increase the timely detection of evolving medical problems.
4. The data reviewed would suggest that annual neurological reviews were not taking place for individuals whose seizure disorder is stable. There is an attempt to obtain an annual neurological review for all individuals receiving anticonvulsant medication and this should continue.
5. The Facility currently does not have a mechanism in place to fulfill the requirements of Provisions L2, L3, and L4. A plan to meet those requirements is being developed and should be implemented. Future monitoring will address the progress of the efforts to fulfill these requirements.
6. An in depth clinical review of the individuals who have developed pneumonia, and also receive enteral feeding, could provide insight into common factors that may be preventable.
7. The RSSLC Quality Assurance Department will have an important role in bringing the Facility into compliance with the provisions of the Settlement Agreement. The Facility should ensure that the Department has sufficient resources to carry out its functions.

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 Campus Map 2. RSSLC Organizational Chart 3. RSSLC Nursing Organization structure, Staffing Positions, Staffing Patterns 4. RSSLC Nursing Orientation and Refresher Training Curriculum and Competency-based Test 5. RSSLC Nursing Administration Job Descriptions 6. RSSLC Nursing Shift Change Worksheets, October, 2004 through March, 2010 7. RSSLC Job Specific Orientation – RN, LVN, and CMA 8. RSSLC Nursing Procedure Manual • A.0 (a) Medication Error Committee, Date: 01/09/09 • A.01 Administration of Oral Medications, Date: 02/12/10 • A.02 Medication Administration Via Nasogastric Tube or Gastrostomy Tube, Date: 06/10/08 • A.03 Injections, No Date • A.04 Administration of Topical Medication, No Date • A.05 Medication Administration of Nose Drops/Nasal Spray, No Date • A.06 Medication Administration/Instillation of Eyes Drops/Ointments, No Date • A.07 Medication Administration/Instillation of Ear Drops, No Date • A.08 Medication Administration of Vaginal Suppositories, No Date • A.09Medication Administration of Rectal Suppositories, No Date • A.10 Medication Administration for Off Campus Activities, Date: September, 2004 • A.11 Facility Medication Times, Date: September, 2004 • A.12 Administration of Oropharyngeal Inhalers, Date: September, 2004 • A.13 Medication Administration for Therapeutic Home Visits, No date • A.13a Medication Furlough Instruction Sheet, Date: October, 2004 • B.01 Hemocult, No Date • B.04 Specimen Collection – Stool, Date: September, 2004 • B.05 Colostomy Care, Date: September, 2004 • B.06 Procedure for use of Colon Tube, Date: September, 2004 • B.07 Gastrostomy Stoma Care, Date: October, 2004 • B.08 Jejunostomy Care, Date: October, 2004 • C.02 Small Volume Nebulizer (SVN) Therapy, Date: October, 2004 • C.04 Chest Percussion, Date: October, 2004 • C.06 Administration of Cool Bland Aerosol with Large Volume Nebulizer, Date: October, 2004 • C.08 Sputum Specimen Collection, Date: October, 2004 • C.11 Tracheostomy Tube Change, Date: October, 2004 • C.12 Care of Respiratory Equipment, Date: October, 2004 • C.13 Administrating Cool Mist, Date: October, 2004

	• C.14 CPAP Procedure, Date: October, 2004 • C.15 Resuscitation with Ambu Bag, Date: October, 2004 • C.16 Oxygen Tank use and Maintenance with Form, No Date • C.16A PSI Oxygen Tank Check Form, No Date • C.17 Humidifier Sanitizing, Date: October, 2004 • C.18 Pulse Oximetry, Date: October, 2004 • C.o1 Specimen Collection – Voided Urine, No Date • D.03A Menstrual Cycle Monitoring, Date: October, 2004 • D.04 Vaginal Douche, No Date • E.04 Vital Signs - Pulse, Date: October, 2004 • E.05 Vital Signs – Respiration, Date: October, 2004 • E.06 Hold Breakfast, Date: October, 2004 • E.08 Diabetic Management Treatment and Care, Date: October, 2004 • E.09A Glucometer Form, No Date • E.09 Glucometer Testing, Date: October, 2004 • E.11A Release of Body Form, No Date • E.11C Telephone Consent for Autopsy Form, Date: October, 2004 • E.D Consent for Autopsy in Person, Date: October, 2004 • E.11E Death Procedure Checklist, Date: October, 2004 • E.12 Pressure Ulcer Management, Date: October, 2004 • E.16 Post Infirmary Nursing Assessment and Diagnosis, Date: 10/04 • E.20 Measuring the Individual, Date: October, 2004 • E.22A Seizure Management Record, No Date • E.22B Seizure Graph, No Date • E.22C Protocol for Vagal Nerve Stimulators, Date: October, 2004 • E. 23A FLACC Behavioral Scale, Date: October, 2004 • F.01A Quarterly Case Conference Example, Date: October, 2004 • F.02B Vital Sign Information Sheet, Date: October, 2004 • F.03 Breast Examination, Revised: 06/10/08 • F.03A Breast Examination Template, No Date • F-03A Breast Examination Calendar, Date: 06/10/08 • F.04 Annual/Quarterly Physician's Orders, Date: 02/10/10 • F.05 Tardive Dyskinesia (Abnormal Involuntary Movement Scale), Date: October, 2004 • F.05B Abnormal Involuntary Movement Scale (AIMS) Form, Date: October, 2004 • F.08A 24 Hour Nursing Report Instructions, Date: October, 2004 • F.08B 24 Hour Nursing Report Form, Date: October, 2004 • F.08D Acute Care Follow-up Form, Date: October, 2004 • IA.01 Admission to Infirmary, Reviewed: October, 2004 • IA.03A Exhibit Medical Care Plan, Revised: October, 2004 • IA.06 Infirmary Integrity Management, Date October, 2004

	• IA.08A Pre-discharge Information Form, Date: October, 2004 • IA.09 Shift to Shift Communication, Date: October, 2004 • IA.10 Injury/Health Changes in Infirmary, Date: October, 2004 • IA 10A Daily Living Area Summary Form, Date October, 2004 • IA.13 IV Therapy Training Certification, Date: October, 2004 • IP.01 Automatic Blood Pressure Monitoring, Reviewed: October, 2004 • IP. 09 Endotracheal Aspirate, Date: October, 2004 • IP. 10 Gastric Washing, Date: October, 2004 • IP.11 Hypothermia Care? Infirmary, Date: October, 2004 • IP.13 Iced Saline/water Lavage, Date: October, 2004 • IP.15 IV Therapy, Date: October, 2004 • IP.18 Nasogastric Suction, Date: October, 2004 • IP.19 Nasopharyngeal/Airway Placement, Date: October, 2004 • IP.22 Intravenous Lock, Date: October, 2004 • IP.23 Skin Traction, Date: October, 2004 • IP.26 24 Hour Specimen Collection, Date: 10/04 • IT.02A Hepatitis B Vaccine Declination Statement, Date: October, 2004 • IT.03 Immunizations, Date: October, 2004 • IT.06 Scheduling of Specialty Clinics, Date: 01/6/09 • IT.08A Consent Form for TB Results, Date: October, 2004 • P.01 Preface, Date: September, 2004 • P.02 Medication Procedures, Date: September, 2004 • P.05 On-Call Personnel, Date: September, 2004 • P.06 Poison Control Information, September, 2004 • P.08 Definition of Levels of Self Administration of Medication, Date: September, 2004 • P.09 Pre-Post Evaluation for Self Administration of Medication, Date: September, 2004 • P.10 Emergency Procedures and First Aid, Date: September, 2004 • P.11 Nursing Assessment and Care Screening (NACS), No Date • P.12 Development of Medical Care Plan, Date: September, 2004 • P.12A Example Medical Care Plan, Date: September, 2004 • P.13 Quarterly Nursing Physical Assessment, Date: September, 2004 • P.13C Quarterly Nursing Physical Deferral, Date: September, 20044 • P.16A AED Incident Form, Date: September, 2004 • P.16B AED Check Off Sheet, Date: October, 2004 • P.16C AED In-service Sheet, Date: October, 2004 • P.16E AED Forms – AED Incident Report, Date: September, 2004 • P.16F AED Powerheart AED Annual Maintenance, Date: September, 2004 • P.17 Nursing Objective Data Sheet, Date: September, 2004 • P.17B Development of Health Care Procedures, Date: September, 2004 • P.17C Risk Assessment for Impair Skin Integrity Tool,

	• P.19 Accepting Verbal or Telephone Orders from Physician, Date: September, 2004 • P.20 Exhibit B Notification of Reportable Conduct Allegation at Facility, No Date • P.20 Exhibit C Confidentiality Guidelines for Participants in Nursing Peer Review, No Date • P.20 Exhibit D Notice of Receipt of Report, No Date • P.20 Exhibit E Nursing Peer Review Committee – Case Activity, No Date • P.20 Exhibit F Detailed Summary Investigative Nursing Peer Review Committee, No Date • P.20 Exhibit G Rebuttal Statement, No Date • P.20 Exhibit H Nursing Peer Review Committee's Final Report, No Date • P.20 Exhibit I Peer Review Committee's Final Report to Sponsoring Facility, No Date • P.20 Exhibit J Report Form-Licensing/Review Agency's Report to BNE, No Date • P.23 Durable Medical Equipment Policy, Date: September, 2004 • P.29 Initial Emergency Response Procedure - Code Blue Drill, Date: October, 2004 9. RSSLC Policy and Procedure Manual H Communication with Family/Guardians • H.01 Updating Contact Information, Implementation/Revision/Date: 07/07/09 • H.02 Notifying Social Worker of Sick Call, Implementation/Revision/Date: 02/02/10 • H.03 Notifying the Primary Respondent, Implementation/Revision/Date: 02/02/10 • I Providing Health Care Services • I.01 Conducting Mock Medical Emergency Drills, Implementation/Revision Date: 07/24/08 • I.02 End of Life Care/Hospice Services, Implementation/Revision Date: 06/01/09 • I.03 Testing for Tuberculosis (Individuals Served), Implementation/Revision Date: 08/23/05 • I.04 testing for Tuberculosis (Employees), Implementation/Revision Date: 12/10/99 • I.05 Medical Attention Following Suspected Sexual Contact, Implementation/Revision Date: 12/30/02 • I.06 Providing Acute Health Care, Implementation/Revision Date: 05/22/09 • Designing Out of Hospital DNR, Implementation/Revision Date: 03/09/10 • I.08 Health Status Team Guidelines, Implementation/Revision Date: 10/12/09 • I.09 Obtaining After Hour Respiratory Therapy, Implementation/Revision Date: 08/23/05 • I.10 Admitting to Infirmary for Acute Care, Implementation/Revision Date: 02/02/10 • I.11 Transporting Persons Served to Infirmary Following Discharge From Hospital, Implementation/Revision Date: 12/17/08 • I.12 Routing Off Campus Consultations, Implementation/Revision Date: 02/02/10 • I.13 Routing On Campus Consultations, Implementation/Revision Date: 02/02/10 • I.14 Requesting Non-Traditional Supplements, Implementation/Revision Date: 02/05/08 • I.15 Actions Following Choking Incident, Implementation/Revision Date: 04/29/03 • I.6 Monitoring Episode of Acute Illness/Use of Sedation, Implementation/Revision Date: 06/20/06 • I.17 Routing Physician's Orders to Habilitation Therapies, Implementation/Revision Date: 07/15/99 • I.18 Actions During and Following Medical Emergency (4444), Implementation/Revision Date: 03/16/10

	• I.19 Responding to Weight Loss/Gain, Implementation/Revision Date: 02/11/10 • I.20 Changing Diet, Implementation/Revision Date: 07/27/09 • 1.21 Physician's Orders – Programming Limitations, Implementation/Revision Date: 03/01/02 • I.22 Ensuring Nursing Staff Coverage, Implementation/Revision Date: 01/11/06 • I.23 Documenting Nursing Staff Coverage, Implementation/Revision Date: 01/11/06 • I.24 Using Enteral Feeding Pumps, Implementation/Revision Date: 02/15/08 • I.25 Providing Eyeglasses, Implementation/Revision Date: 05/01/06 • I.26 Prescribing Psychoactive Medication, Implementation/Revision Date: 03/24/10 10. RSSLC Infection Control Policy and Procedure Manual • A.000 Infection Control Committee, No date • B.4 Oral Hygiene Procedure, Date: 07/28/02 • B.7 Gowns in Infection Control, Date: 07/28/02 • B.7 Use of Gowns in Infection Control, Date: 02/02/10 • B.11 Visitation Procedure, Review/Revised: 02/22/10 • B.13 Artificial/Native Nails, Reviewed/Revised: 02/02/10 • B.14 Rabies, Date: 03/30/10 • D.3 Isolation and Individual's Rights, Date: 02/16/10 • D.6 Administrating Medication in Isolation, Date: 02/16/10 • D.8 Transporting the Isolated Individual, Date: 02/16/10 • D.10 Care of the Body in Isolation after Death, Revised: 06/04/09 • E.3 Parenteral (Needlestick or Cut) or Mucous Membrane Exposure to Blood or Other Body Substance, Revised: 02/23/10 • E.5 Cleaning Thermometers Aster Use, Date: 07/29/02 • E.7 Care of Sterile Equipment and Supplies, Reviewed/Revised: 03/09/10 • F.2 Care of Training Materials, Date: 08/05/02 • F.5 Cleaning the Dining Room Table Between Each individual Use, Date 07/29/02 • G.0C Tuberculosis Skin Test (Mantoux), Date: 07/02/02 • G.1A Consent for Initiation/Refusal of Post-Exposure Prophylaxis (PEP) – Exhibit A, No Date • G.1B Texas Department of Mental Health and Mental Retardation – Release from Liability for HIV, Exhibit B, No Date • G.1C Texas Department of Mental Health and Mental Retardation– Release from Liability for Anti-HCV, Exhibit C, No Date • G.1D Texas Department of Mental Health and Mental Retardation– Consent Form, Exhibit D, No Date • G.1E Hepatitis B Vaccine Declination Statement, Exhibit E, No Date • G.1F Texas Department of Mental Health and Mental Retardation– Release from Liability for Hepatitis B, Exhibit F, No Date • G.4 Hepatitis B Vaccine Information, Date: 08/05/02 (in process of updating) • G.5 Hepatitis C Surveillance Issues and Answers, Date: 08/05/02 (in process of updating) • G.6 Hepatitis A Fact Sheet, Date: 08/05/02 (in process of updating)

	• I.2 Support Services – Dental Services, Reviewed/Revised: 03/09/10 • I.4 Support Services – Housekeeping, Reviewed/ Revised: 03/05/10 • I.9 Support Services – Habilitation Therapy, Reviewed/Revised: 03/09/10 • I.11 Support Services – Recreation, Reviewed/Revised: 03/09/10 • Steps to Take When A Center Has A Suspected Case of H1N1, No Date • Screening Questionnaire for H1N1 – Instructions for Supervisors 11. RSSLC Infection Control In-services/Staff Training Regarding H1N1, 09/14/09 12. RSSLC Infection Control In-services/Staff Training Regarding Individual Specific Infectious Disease and infection Control Measures to take in controlling/Preventing the Spread of Infections, July. 2009through April, 2010 13. RSSLC Client Tracking Data Sheet for H1N1, 10/06/09 through 10/11/09 14. RSSLC Seasonal Flu and H1N1 Vaccine Schedule, 10/02/09 15. RSSLC Seasonal Influenza and H1N1 Vaccine Rate, No Date 16. RSSLC Infection Control Memo to All RSSLC Personnel Regarding H1N1, 03/09/10 17. RSSLC Infection Control Curriculum and Testing Competency-based Materials 18. RSSLC's DADTX Course Delinquency List for Infection Control, Printed: 04/26/10 19. RSSLC Infection Control Committee Minutes, 09/15/09, 12/08/09, and 03/09/10 20. RSSLC Infection Control's Monthly Infectious Disease and Antibiotic Therapy Tracking Reports, September, 2009 through March, 2010 21. RSSLC Infection Control Surveillance Report – Facility/Hospital Acquired Infections Tracking Reports, July. 2009 through February, 2010 22. RSSLC Infection Control's AVATAR Pneumonia Tracking Report for individuals #281 and #142 23. RSSLC Infection Control Facility Environmental Checklists, Finding and Corrective Action, December, 2009 through April, 2010 24. RSSLC Infection Control Handwashing and Infection Control Internal Monitoring Form, Revised: 02/01/10 25. RSSLC Hospital Admission Log, January, 2009 through February, 2010 26. RSSLC Infirmary Admission log, July. 2009 through March, 2010 27. RSSLC Diagnosis of Pneumonia Tracking Report, 04/12/09 through 03/19/10 28. RSSLC Unstageable and/or Stage Pressure Sores Tracking Report, 06/05/09 through 04/07/10 29. RSSLC Administrative Policy, A.7 Actions Following Death of Individual Served, Revised: 03/30/06 30. RSSLC Records Reviewed for individuals with Skin Integrity Issues, #405 and #175 31. RSSLC's DADTX Course Delinquency List for CPR Training, Printed: 03/30/10 32. RSSLC Mock Medical Emergency Drill Sheets (Sample), 10-6 shift conducted on 02/20/10 33. RSSLC Mock CPR Drill Reports prepared by Competency Training and Development (CTD), July. 2009 through February, 2010 34. RSSLC Trinity Emergency Equipment Check Off Lists, 04/01/10 through 04/26/10 35. RSSLC Quality Enhancement Nursing Services Monitoring Reports, November, 2009 through April, 2010 36. RSSLC Nurse Manager's Monthly Chart Audit, March, 2010 through April, 2010 37. RSSLC Plan of Improvement, Updated: 02/11/10 38. RSSLC Corrective Action Plan, 01/2210

	39. RSSLC Corrective Action Plan for AED, No Date 40. RSSLC 24 Hour Nursing Report, 04/26/10 41. RSSLC Medication Error Committee Minutes, 01/10, 02/10, and 03/10 42. Reviewed Medication Error Report on Individual #651 43. RSSLC Pharmacy and Therapeutics Minutes, 10/20/09, 01/12/10, and 03/30/10 44. Texas Department of Aging and Disability Services, SSLC, Policy: Self Administration of Medication (SAMS), Date: 08/09 45. Records Reviewed: Individuals #84, #145, #281, #500, #174, #7, #614, #621, #114, #70, #651, and #535 46. Unusual Incident Investigation-Incident Tracking Number:09-130 (Individual #558) 47. Reviewed Hospital Liaison's Hospitalization Integrated Progress Notes for Individuals #607,#145, #586, #303, #150, and#364 48. Records Reviewed for Individuals #175 and #405 Relating to Skin Integrity Issues 49. RSSLC Decubitus Report, September, 2009 through April, 2010 50. RSSLC Medication Error Reports, 12/09/09 through 02/15/10 51. Record Reviewed: Individuals #84, #145, #281, 500,, #174, #7, #614, #621, #114, #70, #651, and #535 **People Interviewed:** 1. Valerie Kipfer, RN, BSN, MSN, State Office Nursing Services Coordinator 2. Charlene McCurry, RN, BSN, Chief Nurse Executive 3. Constance Bowie, RN, Nursing Operations Officer 4. Wilma Parker, RN, BC, Quality Enhancement Nurse 5. Kimberly Randel, RN, Infection Control Nurse 6. Ugo Nweke, RN, Nurse Educator 7. Kay Galloway, RN, Nurse Recruiter 8. Wickliff Fawibe, RN, Skin Integrity Coordinator 9. Adriano (Jun) Soria, RN, Hospital Liaison 10. Unit Nurse Managers and Case Manager Nurses **Meeting Attended/Observations:** 1. Tour Trinity, 04/26/10 2. Nursing Shift to Shift Report, 6-2 and 2-10, 04/26/10 3. Medication Observation Pass in Trinity, 04/26/10 4. Infection Control Policy and Procedure Committee Meeting, 04/27/10 5. PSP Meeting, 04/27/10 6. Chief Nursing Executive and Infection Control Nurse, 04/27/10 7. Nursing Wound Care/Skin Integrity Committee Meeting, 04/28/10 8. Medication Error Committee Meeting, 04/29/10 9. Nursing Administration and Nurse Manager Staff Meeting, 04/29/10 10. Nurse Educator, 04/29/10 11. Chief Nurse Executive and State Office Nursing Services c Regarding SOAP Documentation, 04/29/10

	Coordinator, 04/29/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC's Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing data at the time of the review indicated the following information for Full Time Equivalency (FTE) filled and unfilled positions: 11 Nurse IV, 45 Nurse III, 51 Nurse II, 67 LVN with two RNII and two LVN unfilled positions for a total of 178 nursing positions. Five RN positions were in the process of being downgraded to LVNs to increase nursing coverage on the 10-6 shift. The Facility does not use agency nurses. Nursing Department provides 24/7 nursing care in the Infirmary and all residential units, except for two that are not covered on the 10-6 Shift. The nursing staff has not fallen below the minimum staff ratios in the past six months. RSSLC's Nursing Department's administrative and management structure consisted of a Chief Nurse Executive, Nursing Operation Officer, Infection Control Nurse, Wound Care Nurse, Nurse Educator, Nurse Recruiter, Hospital Liaison Nurse, Five Nurse Managers, Infirmary/Campus Director, 23 Nurse Case Managers, Campus Nurses (who function like a supervisor), Clinic Nurses, and Staff Nurses (RNs and LVNs). RSSLC has a Quality Enhancement Nurse who worked closely with the Nursing Department. The Nursing Department did not have a formalized Peer Review System but were in the process of developing and implementing numerous monitoring tools to improve the quality of nursing services. As the monitoring system evolves it needs to be in alignment with the Settlement Agreement (SA) and Health Care Guidelines (HGC). Their monitoring process needs to be refined and developed into a process that identifies problematic systemic nursing practice issues that can be analyzed and trended. In addition, these data need to be integrated into the facility's Quality Enhancement and Risk Management System. Many of the Nursing Department's Nursing Manual policies, procedures, and forms were outdated, as were the Infection Control Manual's policies and procedures. Through the leadership of the Chief Nurse Executive numerous committees were formed and these are in the process of being updated. Conversely, many of the nursing orientation and training materials were outdated. As the policies, procedures and forms are updated the Nurse Educator needs to update the training material. In addition to the policy, procedure, and forms committees, there were committees working to update the Infection Control policies and procedures. Another committee was tasked with working on care plans. Nursing notes were written in a narrative format as opposed to using the SOAP or DAP, therefore, they were difficult to read and quickly discern the actual nursing assessments data, nursing diagnoses, plans and interventions. The Nursing Department needs to use a standardized format, such as SOAP or DAP. These are the two methods of charting required in the HCG. These methods of charting improve the quality of the documentation and are an efficient way to summarize pertinent data. Acute Care Plans were found specific to most, but not all, of the incidents of reported acute illnesses and/or injuries. It was difficult to determine from the documentation whether the Acute Care Plans were fully implemented as described. Therapeutic response related to side-effects, adverse reactions, and

	effectiveness of medications, particularly antibiotics, were not consistently monitored or documented in the Integrated Progress Notes. When individuals were transferred to and returned from the emergency room or hospital, full body assessments were not consistently completed, particularly skin assessments. Documentation provided by the Hospital Liaison Nurse who visits individuals in the hospital was consistently thorough and properly reported. Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar and were revised when there were significant changes in health status. Sections listing lab values, diagnostic tests, consults, and system reviews provided comprehensive and detailed information regarding results of labs, diagnostics, consultations, hospitalizations, emergency room visits, medications, and treatments. The Annual and Quarterly Nursing Assessments failed to contain substantive information documented in their respective comment sections and nursing summaries describing clinical outcomes. Annual and Quarterly Nursing Assessments, comments and summaries completed within the past two month showed steady improvements. Health Maintenance Plans (HMPs) were developed at the time of the Annual Nursing Assessment and Personal Support Plan (PSP) meeting to address each of the individual's health care needs, including needs associated with high-risk or at-risk health conditions, with review and necessary revision on a quarterly basis. New HMPs were not consistently developed when individuals had significant changes in health status throughout the PSP year. HMPs did not consistently include all relevant chronic health conditions. In reviewing the individuals' HMPs and cross-walking them with the Integrated Progress Notes it was not possible to clearly identify that interventions described in the HMP were carried out according to their plans nor how the plans were integrated into the PSP system. The nursing staff had limited involvement with the Physical and Nutritional Management Team (PNMP). Nurses only completed dining observations once per quarter. Nurses need additional training in PNMP since they are responsible for assessing individuals for swallowing difficulties during mealtime when reported by the Direct Care Professional (DCP) staff. In addition, they need to ensure that individuals are in proper position and good bodily alignment when administering medications, as well as follow PNMP procedures for administering medications.

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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	RSSLC's Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing data at the time of the review indicated the following information for Full Time Equivalency (FTE) filled and unfilled positions: 11 Nurse IV, 45 Nurse III, 51 Nurse II, 67 LVN with two RNII and two LVN unfilled positions for a total of 178 nursing positions. Five RN positions were being held for 5 LVNs who graduated from school but had not yet taken the RN board exam to increase nursing coverage on the 10-6 shift. The Facility does not use agency nurses. RSSLC's Nursing Department's administrative and management structure consisted of a	

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	individuals' health care status sufficient to readily identify changes in status.	Chief Nurse Executive, Nursing Operation Officer, Infection Control Nurse, Wound Care Nurse, Nurse Educator, Nurse Recruiter, Hospital Liaison Nurse, Six Nurse Managers, Infirmary/Campus Director, 23 Nurse Case Managers, Campus Nurses (who function like a supervisor), Clinic Nurses, and Staff Nurses (RNs and LVNs). RSSLC's Nursing Department provides 24/7 nursing care in the Infirmary and all residential units, except for two who are not covered on the 10-6 Shift. The campus nurses covers those units giving medication and treatment as needed. The Nursing Department has a policy and procedure to ensure nursing coverage, e.g., I.22 Ensuring Nursing Staff Coverage, absolute minimum staffing patterns established for each residential unit and the Infirmary. Review of Daily Nursing Shift Change Worksheets, 10/01/09 through 03/29/10, demonstrated that a shift count for coverage was made daily for each shift, and each residential unit and the Infirmary, ensuring that the required minimum staffing ratios were met. The nursing staff has not fallen below the minimum staff ratios in the past six months. It is of concern that two units are not staffed with nurses 24/7; The Facility should evaluate the need for 24/7 coverage in those units to identify whether the individuals who live there need or do not need such coverage. The Facility's Nursing Department needs to continue to make every effort to fill vacant positions to ensure nursing 24/7 coverage on residential units not currently covered. Interview and discussion with the Quality Enhancement (QE) Nurse revealed that the QE Department did not have a written QE Plan. The QE Monitoring Tool for auditing Medical, Nursing, and Pharmacy Settlement Agreement (SA) issues included: Sections G 1 and 2, H 3, L1, and M1, 2, 3,4 ,5, and 6, and N 2, 3, and 5. Twelve charts, two from each unit were audited monthly. Audit findings were summarized in tabular form from each unit, by each specific question, and then weighted by percentage of compliance, e.g., questions marked "Yes" = 100%, "No" 0 =0%, "No" 1 = 25%, "No" 2 =50% compliance, and "No" 3 = 75%. The methodology for calculating the percentages or what the percentages could not be discerned. The monthly percentages were represented on a year-to-date graph. February, 2010 monitoring data were reviewed which were too limited to draw any sound conclusions as to how well the Facility was meeting compliance with their recently revised monitoring tool. The QE Nurse stated that results of the monthly audits along with recommendations for corrective action were given to the QE Director who then included this information in the POI Report that was used internally as well as sent to the State Office. The audit findings and recommendations for corrective action were also provided to the respective disciplines. The following month, the QE Nurse follows up on the recommended corrective actions for compliance.. The Facility's QE Department needs to continue to refine and organize their QE system. The QE Department has one QE Nurse who in addition to completing audits related to Medical, Nursing, and Pharmacy audits, attends many committee meetings, e.g., Incident	

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		Management Meeting – daily, Medication Error Committee – monthly, Wound Care Committee – weekly, Infection Control Committee –quarterly, Skin Integrity Committee – weekly, POI Nursing Committee – weekly, Clinical Death Review Committee – as needed, Administrative Death Review Committee – as needed, and special projects when requested by the Facility Director. Most State Supported Living Centers QE Departments' the size of RSSLC were staffed with two QE Nurses. It was a concern given the level of responsibility the QE Nurses have, particularly as related to providing internal monitoring SA items, that one QE Nurse may not be adequate to meet the Facility's needs. The Facility's QE Department needs to evaluate the need for an additional QE Nurse. The Nursing Department did not have formal procedures for monitoring nursing services, such as a Peer Review system. Nurse Manager's Monthly Chart Audit tools were developed and implemented. Each nurse Case Manager had an average of four of their charts audited monthly. This was evident through review of completed Nurse Manager's Monthly Chart Audit tools, 03/08/10 through 04/07/10. Information monitored on the audit tools included, among others, the following categories: • Breast Exam; • Weight Loss/Gain/Enteral Feeding; • Acute Illness/Injuries/Infection Control; • Health Management Plans; • Quarterly Nursing Assessments; • MOSES/DISCUS; • Diagnostics/Lab/X-ray/Dental Consent; • Medication Administration Record; and • Physician's Quarterly Orders and Daily Orders. The Nursing Department has taken first steps in developing a monitoring system. The items on the monitoring tool were mostly "yes" or "no" type question with blanks to fill in when the answers were "no. " If the answer was "no" to any question, it required corrective action with documentation. The tool did not capture the quality of nursing services rendered. There was no tracking, trending and analysis of data derived from the audit tools. The Facility's Nursing Department needs to develop a policy and procedure for monitoring all aspects of nursing services that relates to the SA. Data derived from nursing audits needs to be tracked, trended, and analyzed to in order to measure compliance toward the SA. The SA Monitoring Tools were shared with both the CNE and QE Nurse. They should review the tools and cross-walk with the SA and Health Care Guidelines (HCG) to gain a more in-depth understanding of the compliance requirements for the SA. The Facility's Nursing Department and QE Nurse need to strengthen their monitoring tools in order to ensure that the quality of nursing care and all nursing related SA compliance issues are	

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		routinely monitored. Review of the following individuals' (#84, #145, #281, #500, #174, #7, #614, #621, #114, #70, #651, and #535) Integrated Progress Notes for the last six months indicated the following general trends: • There was documentation indicating that individuals who were reported to the nurses by direct care professional (DCPs) or those who were observed by the nurses as having acute illnesses and/or injuries were then assessed by the nurses. There was documentation that the respective physicians were notified timely of the acute illnesses and/or injuries. When indicated, new orders for treatment were prescribed, implemented, and documented. Unless the individual's health status warranted urgent or emergency transfer to the emergency room, the individuals were placed on "sick call" for the following day. In the meantime, the nurses placed the individuals on Medical Monitoring (nursing assessment every shift or more frequently when indicated) until seen in "sick call." When individuals were transferred to and returned from the emergency room or hospital, full body assessments were not consistently completed, particularly skin assessments. Because many of the incidents of hospital acquired skin breakdowns were reported on the Facility's Decubitus Report Log, September, 2009 through April, 2010, it is imperative that full body skin assessments are completed before transfer to the hospital and upon return as a preventative measure. The Nursing Department needs to ensure that full body assessments be completed on individuals prior to transfer to the hospital and upon return as a preventative measure. This item needs to be included on Nursing Monitoring tools and monitored routinely to ensure compliance. • When individuals were placed on 24 or 72 Hour Medical Monitoring it was not consistently documented when the monitoring was terminated. Therapeutic response related to side-effects, adverse reactions, and effectiveness of new orders for medications, particularly antibiotics, were not consistently monitored or documented in the Integrated Progress Notes. It is important that these indications are documented in the Integrated Progress Notes in order to monitor the individuals' therapeutic response to newly prescribed medications, and to provide written communication to other relevant PST members. The Nursing Department needs to ensure that therapeutic responses to newly prescribed medications are consistently monitored and documented in the individuals' Integrated Progress Notes. • When incidences of acute illness and/or injuries were identified in the documentation of the individuals' Integrated Progress Notes; examples of findings were too numerous to list because they were found in all of the individuals notes reviewed. A cross-check was conducted for significant incidents of acute illness and	

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		injuries for evidence that Acute Care Plans were established. Acute Care Plans were found specific to most, but not all, of the incidents of reported acute illnesses and/or injuries. Acute Care Plans did not consistently have the signatures and dates signed at the bottom of the plans by DCP Supervisors attesting to fact that direct care staff had been trained in the Acute Care Plans. Some of the Acute Care Plans failed to contain the signed names and titles over the typed signatures and titles. It was difficult to determine from the documentation whether the Acute Care Plans' were fully implemented as described. Completion dates of Acute Care Plans were not consistently documented. The Nursing Department needs to ensure that: o DCP staff have been trained in all aspects of care for which they are responsible by way of the DCP Supervisors' signature on the Acute Care Plans; o Nurses consistently document interventions carried out according to the Acute Care Plans, and when plans are completed; and o Ensure that nurses' who author the Acute Care Plans sign their signatures above their typed signatures. • When individuals were documented to have sustained head injuries, there was evidence that neurological checks were completed, followed up according to protocol, and documented on the Neurological Check Sheet and in the Integrated Progress Notes. The notes also contained physicians' assessments, orders for skull x-rays, CT scan, and medical follow-up. This was demonstrated best through record review of individual #145, who sustained multiple head injuries secondary to falls from seizure activity and balance problems. • There was evidence that when individuals' were identified with skin integrity issues the Wound Care Nurse was consulted and then assessed the individuals, recommended treatments, and followed through to resolution. Examples of the Wound Care Nurse's assessment and intervention were best demonstrated upon review of individuals' #7 and #145 documentation. • The nursing staff did not document in the Subjective, Objective, Assessment, and Plan (SOAP) charting format. Nursing notes were written in a narrative format as opposed to using the SOAP or Data, Assessment, and Plan (DAP); therefore, they were difficult to read and quickly discern the actual nursing assessments data, nursing diagnoses, plans and interventions. The Nursing Department needs to use a standardized format, such as SOAP or DAP. These are the two methods of charting required in the HCG. This method of charting improves the quality of the documentation and is an efficient way to summarize pertinent data. Discussion with the Chief Nurse Executive and State Office Nursing Coordinator regarding the failure of RSSLC nurses to document in the SOAP charting format. It was explained the state	

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		office will be finalizing which method of the charting the nurses will use state wide since there are many different accepted formats for charting. The Nursing Department needs to adopt a standardized format for charting such as SOAP or DAP. The monitoring team will follow up on state-wide method of choice on the next tour. Interview with the Hospital Liaison Nurse and review of the recent hospitalization-related Integrated Progress Notes for individuals #364, #150, #303, #586, and #145 indicated that the Hospital Liaison Nurse consistently provided comprehensive nursing assessments detailing the individuals' health status, diagnostic and laboratory results, treatments, medications and general care received, their therapeutic response to treatment, and plans for discharge. The Hospital Liaison Nurses identified follow-up care and training needs and communicated to the appropriate discipline. All reports were scanned into the Facility's computer shared drive, in each individual's record, for all relevant PST members to review and act upon as indicated. In addition to placing the hospitalization documentation in the shared drive, Hospital Liaison Nurses placed hard copies chronologically in the integrated progress notes to ensure continuity of care. The emergency equipment in the dining room was checked while touring the Trinity Unit. The emergency equipment was located just inside the door against the right side of the wall. There were three portable oxygen tanks, a suction machine on a stand, two small portable containers with an assortment of cluttered/disorganized medical supplies, and an Automated External Defibrillator (AED). Located front and below the AED were two portable laundry hampers, one labeled clean and the other one dirty; both contained clothing. Dirty and clean laundry hampers should never be set side by side as it would be easy for staff mix up the two. Dirty laundry should not be kept in the dining room because it is an infection control violation. In addition, the laundry hampers obstructed access to the AED. The AED was mounted so high on the wall that the nurse who was asked to demonstrate the use of the AED could scarcely reach the key located near the top of the AED. The nurse was also asked to demonstrate the use of the oxygen tank and suction machine, which she did successfully. The checklists for all emergency equipment present in the dining room were checked and were found consistently signed to date for April. The observations and concerns noted above were discussed with the Nurse Manager who agreed to correct the issues identified. While the basic equipment to support CPR was present and operational, the equipment in Trinity homes and Infirmary were not stored on emergency carts for ready and rapid access for transport. Emergency medications were stored in a locked box in the medication rooms. The Facility's emergency equipment needs to be placed on an emergency cart or contained in a backpack for ready and rapid transport. At the request of the monitoring team member an impromptu Mock Medical Emergency Drill was called in the Infirmary Conference Room at the 6-2 to 2-10 shift change. The	

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		staff from CTD brought the resuscitation manikin and AED to the site, put it down on the floor and announced "man down." Two RNs responded within 30 seconds and began resuscitation efforts; another nurse activated a 911 or 4444 call. The remaining nurses (approximately six) stood by and observed. The remaining RNs failed to obtain the suction machine until prompted by the CNE. No oxygen was brought to the scene until the monitoring team member prompted the RNs. Finally, an RN brought in a portable oxygen tank. The drill was stopped at that point. The monitoring team member asked the RN to demonstrate the use of the suction machine, which was done successfully. Next the RN was asked to demonstrate the use of the oxygen tank and was able to turn it on but the tank failed to have tubing and a nasal cannula with it. No one brought an Ambu bag or one-way mask to the scene. Needless to say this was a grossly failed drill. This was of great concern because these were RNs and the drill was called in the Infirmary, the most likely place in the Facility where there was the most potential for individuals to experience a medical emergency and require CPR. The Facility's CTD staff needs to re-in-service all Infirmary staff in CPR, equipments' function and proper use, as well as drill procedures. CTD needs to call Mock Medical Emergency Drills in the Infirmary frequently enough to ensure that all RNs competently pass the drills. The Facility had three Medical Emergency policies and procedures, e.g., Health Services: Conducting Mock Medical Emergency Drills, Revised: 07/24/08, I.18 actions During and Following a Medical Emergency (4444), Revised: 03/16/10, and Nursing: P.29 Emergency Response Procedure – Code Blue Drill, Dated: October, 2004. Two of the policies and procedures had not been reviewed and/or updated since October, 2004 and July, 2008, respectively. The Facility's responsible staff for Emergency Response Policies and Procedures needs to review and update the following policies and procedures to ensure continuity: Health Services: Conducting Mock Medical Emergency Drills, Revised: 07/24/08, I.18 actions During and Following a Medical Emergency (4444), Revised: 03/16/10, and Nursing: P.29 Emergency Response Procedure – Code Blue Drill, Date: October, 2004. Review of CTD's Mock CPR Drill Reports, July, 2009 through February, 2010, and actual Mock Medical Emergency Drill Sheets for 10-6 shift on 02/20/10, indicated that drills were conducted according to facility policy. Review of the completed drill sheets indicated that two of 26 drills failed. Nurses only participated in three of the 26 drilled conducted. No physicians or other professional staff participated in the drills, probably because the drills were conducted on the 10-6 shift. According to policy nurses were always expected to participate in drills, and the physicians 8:00 a.m. to 5:00 p.m., Monday through Friday. Items always marked "not applicable" related to the presence of emergency equipment and whether in good working order, e.g., AED, backboard, Ambu bag, oxygen, suction machine, and one-way mask. It was of concern that the nursing and medical staff did not participate routinely in the Mock Emergency Drills. The purpose for	

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		conducting Emergency Medical Drills was to ensure that all staff responsible for responding to medical emergencies maintained their skills, and tests the Facility's emergency preparedness; required by state policy. Because of the complete failure of the impromptu Mock Medical Drill performed by the nurses in the Infirmary and the limited number of failed drills reported in the CTD's tracking and trending report, the accuracy of the drill reports and staff competency were questionable. This issue will be further reviewed on the next tour. Review of RSSLC's DADTX Course Delinquency List for Basic CPR Training, printed 04/48/10 indicated 12 employees were delinquent, three have not received training for three years, and the remaining nine for two years. According to facility policies and procedures, and discussion with the CNE and QE Nurse, the completed drill checklists were routed to the Director of CTD within 24 hours of the drill. Drill checklists were evaluated by the Director of CTD and serious concerns shared with respective department heads within 48 hours of the drill. It is the responsibility of the department heads to take corrective action and ensure that staff were re-in-serviced. A trend analysis was performed monthly by the Director of CTD and documentation on systemic corrections of identified issues was maintained in the CTD Department. The QE Department does not monitor Code Blues or Mock Medical Emergency Drills. The Facility does not have a formal committee that addresses code blues or drills other than a discussion of such events at the next day's Incident Management Team Meeting. The Facility needs to evaluate the Emergency Management Response system to ensure: • Emergency Medical Response Policies and Procedures are revised and/or update to ensure continuity and meet acceptable standards of professional practice; • Nurses, Physicians, and other ancillary personnel responsible for responding to medical emergencies participate in Mock Medical Drills; • All personnel required to maintain CPR certification are up-to-date; • Mock Emergency Medical Drills are reviewed by a designated committee that analyzes tracks, and trends facility-wide data to identify systemic issues that may require corrective action; and • The QA department monitors all aspects of emergency management response.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a	Review of records for individuals # #84, #145, #281, 500, #174, #7, #614, #621, #114, #70, #651, and #535, showed Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar and were revised when there were significant changes in health status. Sections listing lab values and diagnostic tests, consults, and system reviews provided comprehensive and detailed information regarding results of labs, diagnostics, consults, hospitalizations, emergency room visits,	

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	quarterly basis and more often as indicated by the individual's health status.	medications, and treatments. The Annual and Quarterly Nursing Assessments failed to contain substantive information documented in their respective comment sections and nursing summaries describing clinical outcomes. However, Annual and Quarterly Nursing Assessments, comments and summaries completed within the past two month showed steady improvements. Annual and Quarterly Nursing Assessments enable the nurse to make comparisons of individuals' health status from quarter to quarter, culminating in a comprehensive annual assessment containing relevant information that contributes to developing Health Maintenance Plans (HMPs) and provides the personal support team (PST) information from which to develop personal support plans (PSPs). The Nursing Department need to ensure that Nursing Case Managers continue to strengthen comment sections and summaries of Annual and Quarterly Nursing Assessments to include whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working, and to recommend changes, if indicated, in strategies, support and/or services. Noticeably missing in the Annual and Quarterly Nursing Assessments, summaries and HMPs were Self Administration of Medication (SAM) Program assessments and plans. According to facility policy, nursing was responsible for implementing SAM programs and collecting data. Review of the Annual and Quarterly Nursing Assessment form indicated there was no printed space for this information. The Nursing department needs to review their Annual and Quarterly Nursing Assessment Policy and Procedures and report forms to ensure the inclusion of SAM information. Annual and Quarterly Nursing Assessments and accompanying Health Maintenance Plans and Acute Care Plans validated the use of North American Nursing Diagnoses Association (NANDA) nursing diagnoses for health issues identified requiring nursing interventions. This was a positive finding because the use of NANDA, a standardized nursing language for documentation of care, is vital both to the nursing profession and the direct care nurse. The benefits to using this classification for nursing diagnoses include: better communication among nurses and other health care providers, increased visibility of nursing interventions, improved nursing care, enhanced data collection to evaluate nursing care outcomes, greater adherence to standards of care, and facilitated assessment of nursing competency. HMPs were developed at the time of the Annual Nursing Assessment and PSP to address each of the individual's health care needs, including needs associated with high-risk or at-risk health conditions, with review and necessary revision on a quarterly basis. New HMPs were not consistently developed when individuals had significant changes in health status throughout the PSP year. HMPs did not consistently include all relevant chronic health conditions, which the monitoring team member identified through review of individuals' records and cross-walking them with their respective Nursing Diagnoses	

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		and HMPs. The Nursing Department's Nursing Case Managers need to ensure that all chronic health conditions have a HMP, even it those conditions were stable, to ensure they remain stable. The HMP procedure and form did not require a signature validating that the nurse reviewed/revised the HMP quarterly. The Nursing Department needs to include signature and date lines on the HMPs that ensures that they are reviewed and/or revised at the time Quarterly Nursing Assessment are completed. In reviewing the individuals' HMPs and cross-walking with the Integrated Progress Notes it was not possible to clearly identify that interventions described in the HMP were carried out according to their plans or how the plans were integrated into the PSP system. The Nursing Department needs to ensure that interventions described in individuals' HMP are clearly documented in the Integrated Progress Notes when implemented.	
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.	Refer to Section M 2.	
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.	Review of the Nursing Policy and Procedure Manual indicated that many policies and procedures were outdated. There was a Nursing Policy and Procedure Committee and an Infection Control Policy and Procedure Committee, each made up of different Nurse Case Managers from each Unit. These committees were in the process of going through the manuals in order to review and revise them. As these policies and procedures were revised, the completed policies and procedures were then taken to the Nurse Managers Meeting for review and discussion. When finalized, the Nurse Managers were responsible for training their unit nurses on the revised policies, procedures, and forms. In addition, the CNE was working with state-wide nursing work groups who were developing new policies and procedures. The CNE reported that a Forms Committee was being established to review all the forms used by nurses. Old forms no longer in use will be	

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		purged. The Care Plan Committee was developing and implementing generic care plans, which when completed the Nurse Managers were responsible for training their unit nurses in the use of the newly developed care plans. Currently, this committee was placed on hold, pending the State Nursing Coordinator's evaluation of generic care plans, specifically designed to meet the needs of individuals with intellectual and developmental disabilities. The Lippincott Manual of Nursing Practice, fourth edition and Mosby's Clinical Nursing were used as references. As these policies, procedures, and protocols mature and are followed it is expected that nursing care will continue to demonstrate improvement. Newly employed nurses received two weeks of orientation. Competency Training and Development Department (CTD) only allowed three days for orientation training, and then required the nurses to go their respective units where they were shadowed for the remainder of their orientation. Nurses are given a packet of competency-based material to complete within 60 days of employment. Competency check-offs must be completed with another nurse. Review of the training indicated curriculum, policies and procedures, and forms used to train and the competency-based materials were out of date. The Facility's Nurse Educator needs to ensure that as information is updated the orientation and ongoing training materials are updated as well. The Nursing Department needs to increase the available time made through CTD for orientation as opposed to sending the nurses back to their units in order to continue their orientation. It was of concern that newly employed nurses were allowed 60 days to complete their competency-based packet. The best practice would be for nurses to complete competency-based testing within two weeks of orientation and be evaluated by the Nurse Educator. The Nursing Department needs to evaluate the practice of allowing 60 days to complete the competency-based packet as well as having it completed with another nurse who is not the Nurse Educator. All nurses received refresher training annually and were competency-based tested annually. The CNE has established a working relationship with the University of Victoria's Sugarland Campus and Wharton County Junior College Schools of Nursing. Nursing students from these schools served six months rotations at the Facility. The CNE served on the University of Victoria's Sugarland Campus, School of Nursing's Advisory Council. Because of this relationship the Facility's Nursing Department was able to use the Simulation Lab for training facility nurses. This was a positive asset and should serve to enhance competency-based skill training. The Nurse Educator has paired with Vitas Hospice to provide training in end of life issues and pain management, as well as with the University of Houston Victoria's Sugarland Campus for multiple nursing training issues. The Nurse Educator stated efforts were being made to obtain Continuing Education Units (CEUs) for the courses taught at the Facility. There was evidence from review of nursing training records and discussion with the CNE and Nurse Educator that increased training	

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		has been provided to all nurses on care planning and the nursing process. Health Assessment Training DVDs have been viewed and discussed by all Nurse Managers, and distributed to each unit for training with all nurses, in order to improve their nursing skills. The Nursing Educator needs to continue to develop and present educational topics relevant to high risks and topics unique to individuals with intellectual and developmental disabilities. Due to the high risk for aspiration/aspiration pneumonia in the intellectual and developmentally disabled population these topics need to be routinely covered in nursing orientations and in refresher courses. The Facility's Nurse Educator needs to ensure that nurses receive comprehensive Physical and Nutritional Management training from qualified professionals such a Speech and Language Therapist. RSSLC's Nursing Department did not have any policies, procedures, and/or other documents describing the role of nursing in the management of issues related to positioning and eating. Nurses did not routinely participate in mealtime observations. The nurse case managers did perform dining monitoring observations, at least quarterly, and participated in NMT, PSP, and HST Committees. Nurses were responsible for assessing individuals who experience difficulty swallowing during mealtimes. It is of concern that the lesser trained direct care professionals (DCPs) were responsible for determining whether or not the severity of the individual's difficulty rose to the level necessary for assessments by nurses. The DCP staff may not readily recognize subtle signs and symptoms of aspiration and refer individuals to the nurses for assessments. Therefore, it is critical that nurses are competent in assessing and managing dysphagia for individuals at high risk for choking and aspiration, which has the potential to lead to aspiration pneumonia. The Nursing Department needs to collaborate with the Physical and Nutritional Management team to evaluate the need for more nursing participation in the dining room by the nurses.	
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.	RSSLC was using the Health Risk Assessment Tool-Nursing Section as the tool for the identification of clinical risk indicators for individuals. The Health Risk Assessment procedure was of concern due to the fact there were no specific and/or clear criteria for determining risk levels The tools asked "yes" or "no" questions for items relating to Cardiac, Constipation, Dehydration, Diabetes, GI Concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. This Health Risk Assessment Tool was not adequate to provide a comprehensive health risk assessments for any of the areas listed above, nor did it result in an appropriate identification of clinical risk indicators, as was demonstrated below.	

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		RSSLC was using a standardized Fall Risk Assessment Tool (name of tool not identified) different from or in addition to the Health Risk Assessment Tool. This tool grades fall risk high if the score was greater than 10. Individual #7 was scored 17 on three consecutive quarterly assessments, respectively on 09/25/09, 12/07/09, and 03/29/10. This individual also has a diagnosis of osteoporosis, and according to his PSP has movement precautions. The Health Risk Assessment Tool did not have a specific rating tool for falls. The Health Risk Assessment Tool did include a specific rating section for injuries. Falls risk should be included in the tool because of the risk for injuries. This individual's Health Risk Assessment Tool on 11/09/09 was marked "NA" for injuries. Individual #7 also has a history of aspiration pneumonia, a diagnosis of GERD, and a G-tube, yet was marked low for aspiration. Individual #7's overall score was marked low. Further, the Health Risk Assessment Tool rating section for aspiration does not include a question regarding the use of G-tubes. This question is included in High Risk Medical rating sections. Therefore, it misses an adequate assessment of risk related to aspiration. The Facility did use the standardized BRADEN Scale for assessing skin integrity issues. Professionally recognized standardized health risk assessment tools should be used statewide in all facilities to ensure that accepted professional standards of practice were followed. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria for determining risk to eliminate subjectivity, and to ensure that the Tool meets accepted professional standards of care. Infection Control Policies and Procedures were reviewed. Many of the Infection Control Policies and Procedures were recently revised. The Infection Control Committee continued to review and revise outdated policies and procedures, as was demonstrated at the Committee's meeting attended by the monitoring team member on 04/27/10. Hepatitis A, B, and C Policies and Procedures were revised using current Communicable Disease Control (CDC) reference material to ensure that professional standards of practice were met. Some polices and procedures reviewed were not dated. It is important to include dates when policies and procedures are developed, reviewed and or revised. It is also important to review and/or revise policies and procedures annually to ensure that they currently meet professional standards of practice. The Facility's Infection Control Committee needs to continue to review and/or revise all outdated Infection Control Policies and Procedures to ensure that they are current and meet professional standards of practice. Discussion with the Infection Control Nurse and review of the Facility's Infection Control reporting and tracking documents, e.g., Infections (all types of infections reported) and Use of Antibiotic Therapy (Antibiogram) Reports, Surveillance of Facility and Hospital Acquired Infections Reports, Client Tracking of H1N1 Report, Seasonal Influenza and H1N1 Vaccinations Report, and Avatar Pneumonia Tracking Report, demonstrated that the Facility actively collects data with regard to infections and communicable disease.	

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		This data were maintained for tracking infections, identifying outbreaks, and other problematic trends. Review of the Infections (all types of infections reported) and Use of Antibiotic Therapy (Antibiogram) Reports and Surveillance of Facility and Hospital Acquired Infections Reports indicated when individuals were treated with antibiotics that the dates of resolution were consistently documented. There was no formalized written procedure in place describing how data were collected, communicated, and reported. The Infection Control Nurse stated that case managers fill out a form for individual-specific infection information that was then sent to the Infection Control Office. This information was entered into the respective Infection Control spreadsheet. The Infection Control Nurse reviews the spreadsheet weekly for undesirable trends. When undesirable trends were noted in particular homes, she talked with the respective Physicians, Case Managers, PSTs as well as other relevant facility program staff, e.g., Housekeeping, Food Services, Building Maintenance, etc. When undesirable trends were identified Case Managers were responsible for completing risk assessment tools, initiating care plans, and following through until issues were resolved. When issues were resolved reports were completed and sent to the Infection Control Office. The Infection Control nurse related that much of the information, described above, was communicated verbally/telephone calls and through e-mails. Such information was not routinely documented in the integrated progress notes. The Facility's Infection Control Nurse needs to develop and implement written procedures for how communication flows to and from the Physicians, Case Managers, PST and other relevant facility program staff. The Facility's Infection Control Nurse needs to ensure that relevant individual-specific information relating to Infection Control communication is documented in the integrated progress notes. There was no annualized or long-term tracking, trending, and analyzes performed. It is important to track, trend, and analyze data over time for data to be meaningful and to identify systemic trends. The Facility's Infection Control Program needs to track, trend, and analyze data annually or over time to identify systemic trends, and use such data for making systemic improvement when indicated. Review of Diagnosis of Pneumonia reported, 04/12/09 through 03/19/10, there were a total of 30 diagnoses with three individuals (#572, #16, and #30) having two episodes each. The remaining 27 individuals had one episode each. The report further revealed: • 16 or 53% of the of the 30 pneumonia diagnoses were to individuals orally fed • 14 or 47% of the 30 pneumonia diagnoses were to individuals tube fed ▪ 9 or 30% of the all diagnoses were for aspiration o 5 or 56% diagnosed with aspiration pneumonia were tube fed o 4 or 44% diagnosed with aspiration pneumonia were orally fed ▪ 6 or 20% of all diagnoses were for bacterial pneumonia	

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		o 5 or 83% diagnosed with bacterial pneumonia were orally fed o 1 or 17% diagnosed with bacterial pneumonia was tube fed ▪ 3 or 10% of all diagnoses were for viral pneumonia o 3 or 10% diagnosed with viral pneumonia were orally fed ▪ 12 or 40% of all diagnoses were for "other" hospital care acquired pneumonias (HCAP) o 8 or 73% of the 11 (HCAP) diagnosed with "other" types of pneumonia were tube fed o 3 or 27% of the 11 (HCAP) diagnosed with "other" types of pneumonia were orally fed Review and analysis of the nine diagnosed cases of aspiration pneumonia involved eight individuals. One individual was diagnosed with aspiration pneumonia twice, and another diagnosed case of pneumonia listed as other (HCAP). Since this case of pneumonia was diagnosed as HCAP it was plausible to wonder if this case could have also been aspiration pneumonia. Of the eight individuals diagnosed with aspiration pneumonia, their Health Risk Screening Levels (supplied through the document request) were listed as follows: • Two individuals' risk levels were scored as "two" (medium risk). • Three individuals' risk levels were scored as "three" (low risk). • Three individual had no risk level scored for aspiration. Further review and analysis of the three individuals (#16, #572, and #30) diagnosed with repeated episodes of all types of pneumonia indicated that the repeated episodes of pneumonia occurred three times for individual #16 within two months, individual #572 had two episodes occurring within seven months, and #30 had two episodes occurring within eight months. The Facility's Infection Control Nurse needs to collaborate with the NMT and HST to track, trend, and analyze pneumonia data to ensure that individuals' Health Risk Screening scores accurately represent their risk level for pneumonia, particularly aspiration pneumonia, and develop and implement aggressive preventative heath care plans to closely monitor individuals at risk to prevent further episodes. It is of great concern that 12 or 40% all types of pneumonia diagnoses, involving 11 separate individuals, were listed as "other" (HCAP). Of those cases, eight or 73% were tube fed. This points out the need for the Facility's Physicians, Infection Control Nurse, and Hospital Liaison Nurse, NMT, HST, and/or other related disciplines to evaluate probable causes for the high percentage of individuals diagnosed with HCAP. Efforts need to be made to work with the local hospitals to specifically and correctly diagnose the types of pneumonia acquired. It is important to know whether those pneumonias were related to aspiration, particularly since 73% of the individuals were tube fed. Further efforts need to be made by the Hospital Liaison Nurse and NMT to closely monitor hospitalized individuals to ensure that hospital staff are trained and follow	

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		individuals' PNMP. It was positive that the Facility has a Skin Integrity Committee that meets weekly to review skin integrity issues. The committee is chaired by the Certified Wound Care Nurse. Membership includes the CNE QE Nurse, infection Control Nurse, Unit Nurse Managers, Unit Nurse Case Managers, Nutritionist, Habitation, and Rehabilitation Staff. The monitoring team member attended the committee meeting on 04/28/10. Individuals having skin integrity issues of any kind had their Acute Care Plans and status of skin integrity issues thoroughly reviewed and discussed. Lists of pressure sores and non-pressure sore wounds, reported 04/12/10 through 04/28/10, included one individual who had an unstageable pressure sore that was reported healed on 04/27/10, and four individuals who had non-pressure sore wounds of which three of the four were reported as healed with one individual continuing to be followed. Policy and Procedures governing the Skin Committee were not available for review; therefore, it could not be discerned whether such a policy exist. This will be followed up on the next tour. Review of the Pressure Sore Report, 06/05/09 through 04/27/10, prepared by the infection Control Nurse, indicated that there were seven facility incidences of various staged/unstaged pressure ulcers and nine hospital acquired incidences of staged and unstaged pressure ulcers. These incidents of pressure sores represented six separate individuals, with individual #418 having nine incidents of staged or unstaged pressure sores, #571 and 785 had two incidents of staged or unstaged pressure sores, and #535, #84, and #436 had one incident each. When cross-checking these individuals' Health Risk Status, individual #418 had nine incidents of pressure sores with a risk score of 3 (low), individuals #571 and #785 had two incidents each of pressure sores with a risk score of 2 (medium), individual #84 had one incident of a pressure sore with a risk score of 2 (medium), and individual #436 had one incident of a pressure sore with no risk score listed. It is of concern that individual #418 has had nine incidents of pressure sores during the reporting period, yet this individual's Health Risk Score was listed as only a 3 (low). The Facility's Wound Care Nurse, Infection Control Nurse, NMT, HST, and other relevant disciples need to re-evaluate individuals risk level for pressure sores against reported incidents of reoccurring pressure sores. The numbers reported in the Infection Control Report regarding the incident of pressure sores conflicts with the Decubitus Report prepared by the Wound Care Nurse and the Infection Control Report prepared by the Infection Control Nurse. It is important to have consistent and reliable data to complete root cause analysis and/or other trending information in order to draw conclusions and develop care plans to improve care. The Facility's Wound Care Nurse and Infection Control Nurse need to collaborate to ensure that information regarding pressure sores both stageable and unstageable were consistent across both reports.	

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		Review of the Decubitus Report, reported by the Wound Care Nurse, indicated that data are reported monthly and summarized quarterly. Data reported September, 2009 through March, 2010 revealed that of the reported incidents of pressuring ulcer, six were facility acquired and 15 were acquired outside the Facility, e.g., hospital or long term acute care facilities. Of all pressure sores reported, five were stage 1, six were stage 2, none were stage 3 or 4, and ten were unstageable. To date there were no data trended or analyzed beyond raw numbers. The Facility's Wound Care Nurse needs to work collaboratively with the Infection Control Nurse, Hospital Liaison Nurse, NMT, HST, and other relevant disciplines to conduct a root cause analysis to determine the causes for both facility and hospital (outside facility) acquired pressure sores and then, based on findings, develop and implement a plan of corrective action to eliminate or reduce the occurrence of pressure sores. Review of the Influenza and H1N1 Report submitted to the State Office (no date included on the report) indicated that 98% of the individuals were vaccinated for influenza and 96% were vaccinated for H1N1, which is commendable. Only 25% of the employees were vaccinated for influenza and 10% were vaccinated for H1N1. It was apparent from review of the Facility's Pandemic Plan for H1N1 that much effort was in place to prevent or control the spread of H1N1 as well as influenza. The Facility's Infection Control Program needs to continue to increase the percentage of employees receiving influenza and H1N1 Vaccines. During the tour the monitoring team member observed staff wearing the blue jacket that identified staff as RSSL employees. The jackets did not always appear clean, and direct care staff were observed working with and come in contact with numerous individuals throughout the Facility. RSSLC staff were also observed by the monitoring team member wearing jackets when they left work and while in the community shopping and/or dining. There were several concerns with the requirement that staff wear such jackets, e.g., potential for the jackets to serve as a vector for infections, particularly if they contain splashes of respiratory secretions from themselves or other as well as other infectious organisms. Jackets were not always clean, and wearing such identifiable jackets could stigmatize the individuals when staff accompanies them into the community. The state and Facility needs to evaluate the risk and benefits associated with staff wearing the blue identification jacket. Review of Infection Control's Environmental Surveillance Reports, December, 2009 through April, 2010, indicated that such inspections were completed in all areas of the Facility. When violations were identified the Infection Control Nurse ensured that violations requiring immediate attention were corrected on the spot, others not requiring immediate attention but needing corrected were given recommendations to	

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		resolve the problems identified. There was evidence that the Infection Nurse conducted follow-up inspections to ensure that corrections were made. During the environmental surveillance inspections staff were monitored for handwashing and standard precautions. It was noted in the reports that the Facility areas were notified of their scheduled visit for inspection. Providing the Facility areas with an advance schedule precludes the ability for the Infection Nurse to conduct an objective environmental assessment of the status of compliance with Infection Control standards. The Facility's Infection Control Nurse needs to conduct unannounced environmental inspections to ensure an objective inspection. Review of the Infection Control Training curriculum and competency-based testing for new employee orientation and refresher training indicates these meet professional standards of practice, particularly as relates to Handwashing and Standard Precautions. In addition, there was evidence by review of signed in-service sheets that the Infection Control Nurse provided relevant staff on all shifts with training on specific topics related to the individuals' unique needs when infectious processes were diagnosed and/or identified, e.g., urinary tract infections, MRSA, pneumonia, Hepatitis B and C, and other infectious disease processes. Review of the Facility's DADTX Course Delinquency List, indicated that 11 employees were delinquent in their Infection Control refresher courses. The Facility needs to ensure that all required staff are current in infection Control training. Review of Infection Control Committee Minutes, 09/15/09, 12/08/09, and 03/09/10, indicated that the Infection Control Nurse reported the number of infections and whether or not there was any clustering of infection in the homes. No clustering of infections was report in the three quarters reviewed. There were no discussions or recommendations for further investigation or preventative measures of the infections identified in these reports. The Infection Control Committee needs to consistently examine causative factors for all infections regardless of whether they are clustered in order to take every means necessary to prevent infections. The Infection Control Committee was to be commended on their environmental efforts to reduce the spread of infection. Examples of these efforts include: installation of touch-less hand sanitizers and paper towel dispensers in all the buildings; piloting a UV kit designed to fit each individual air unit in an effort to improve air quality in Trinity home; and upgrading air filters to Minimum Efficiency Reporting Value (MERV) of 8. A problem with the current bath mats was discussed because the current mats hold water causing overflow and damage to the walls, the mats are hard to clean, and they have the potential for causing infection control and safety issues.	

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M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Medication Pass Observations were made in Trinity at 4:00 p.m., 04/26/10. During the observation of the two staff nurses checking the Control Drug Sheet at the change of 6-2 to 2-10 shifts, review of the Control Drug Signature Sheet indicated only one signature was signed by another nurse who had left earlier in the day. This is a violation because procedure for checking control drugs requires that two nurses always check and sign together. The Unit Nurse Manager was notified of the violation on the spot and requested to investigate and to take corrective action. Medication Pass Observations were made for both orally and enterally administered medication. Medication carts were taken to the bedside to administer medications to individuals who were in bed. The first individual received medications orally. The individual resided in the bedroom with another individual. A privacy screen partially separated the two individuals. The nurse failed to observe or move the screen to ensure complete privacy during medication administration. The individual receiving medication was poorly positioned in bed as the nurse attempted to administer medication. The nurse attempted to administer the medication without repositioning the individual into an upright position with good bodily alignment. The individual resisted taking medication by turning to the right side while the nurse presented the medication, prepared in pudding, from the left side. The nurse was prompted to reposition before continuing to administer the medications. The individual continue to resist taking medication after being repositioned. Two pills were mixed in the pudding for administration. The individual took one bit of the pudding containing one of the pills and refused to take more. The nurse said she would return later to see if the individual would take the remaining medication. Then nurse placed the cup containing the other pill back in the individuals' medication drawer, thus contaminating the medication drawer. This was against professional standards of practice. The medication should have been disposed of and recorded as wasted. In addition, it was discovered during checking and setting up medication for administration in the room that one liquid medication was not on the cart. A prudent nurse would have checked to see that the needed medications were on the medication cart prior to taking the cart to the bedside. The second Medication Pass Observation was made for another nurse to an individual receiving medication enterally. During this observation the medication cart was taken to the bedside. This individual was poorly positioned in bed, and the nurse failed to properly reposition prior to administering medications. The nurse was prompted to reposition the individual before attempting to administer, and then the individual was repositioned. The nurse correctly checked the placement of the tube by checking for residual stomach contents and auscultation. After the nurse checked and prepared the medications for administration, the tray containing the medications was placed on the head of the bed beside the individual; when prompted to remove the tray, the nurse	

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		replaced the tray lower on the bed. After the second prompting to put the tray on the cart, it was placed on the cart. Placing the medication tray on the individual's bed was an improper and unsafe practice. Upon completing administration of medications, the nurse failed to pull down the individual's shirt over the abdomen. This demonstrated a lack of respect for the individual's dignity. The Medication Pass Observations of the two individual demonstrated a need for the Nursing Department and Nurses Managers to increase monitoring of medication administration practices of the staff nurses to ensure the following: • Control drugs are always checked and signed by two nurses, even if a nurse should leave the shift early. • Individuals are always positioned in an upright position with good bodily alignment for safe medication administration, whether in or out of bed while receiving medications. • For individuals who have positioning plans for time out of bed, nursing needed to coordinate medication times to correspond with time out of bed. When necessary, the respective physician needs to be notified to determine if there is a need to adjust medication times to coincide with out of bed plans. • Contaminated medications are not placed back into individuals' medication cart drawers and medication policy and procedures are followed for proper disposing/wasting medications. • Individuals' privacy and dignity are respected at all times. The Medication Error Committee membership includes, but was not limited to the: Medical Director; Chief Nurse Executive; Pharmacy Director; Unit Nurse manager, and at least one LVN. The purpose of the Medication Error Committee was to monitor the occurrence of medication errors on campus, identify and correct trends, and prevents the re-occurrence. The Medication Error Committee meets monthly, quarterly, biannual, and annually, to analyze medication errors, identify issues and trends, and determine and utilized teaching/training opportunities, and implement corrective actions to prevent re-occurrence. The Medication Error Committee Meeting, 04/29/10, was attended by Nursing Administrative staff, Unit Nurse Managers Nurse and Unit Nurse Case Managers, Medical and Pharmacy Directors as well as other related disciplines. The Committee was chaired by the Chief Nurse Executive. There was a thorough discussion of medication errors that had occurred during the prior month and contributing factors. This discussion also included specific reference to the problems related to distraction of the nurse who is administering the medications due to the increased agitation of the individuals who are receiving medication during this time frame. Suggestions were offered by members of	

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		the Nursing staff for refining the process so that this confusion and distraction does not take place. Review of the Medication Error Committee Minutes and Attachments, 10/19/09 through 03/18/10, indicated that the Medication Error Committee Policy and Procedure, Dated: 01/10/09, was carried out consistently as described. A review of the Medication Error Committee Meetings Minutes for the six months were uniform in the degree of details presented, both with regard to the frequency and type of errors, as well as the detailed description of specific individual events. This was validated not only through review of the minutes but also the attachments. At least four monthly Medication Observations were made by the Nurse Case Managers in addition to approximately 12 observations made by the QE Nurse. When deficiencies were found corrective actions were taken. Review of monthly Medication Error Reports indicated that corrective action was taken for each medication error. Medication errors were represented in monthly, year-to-date tabular form then tracked, trended, and analyzed on graphs. An overall Plan of Improvement (POI) was developed and implemented and updated monthly to address systemic trends identified. Review of the Facility's last ten Medication Error Reports are described below: • Two errors were classified as category A (Neither error or harm occurred. The circumstances or events only had the *potential* to cause an error). According to the explanation found upon investigation: Both errors were due to omission. One was caused by distraction and the other because procedure/protocol was not followed for sending the request for newly prescribed medication to the pharmacy. • One was classified as category B (An error occurred but the medication did not reach the individual). According to the explanation found upon investigation: The omission error was caused by failure to transcribe the order. • Four errors were classified as category C (An actual error occurred. The error *reached* the individual. The individual was *not* harmed by the error). According to the explanation found upon investigation: One wrong dosage error was caused because the physician had written an incomplete order and the individual's medication was given with water as opposed with food as required by the medication. The wrong other dosage error was caused by the pharmacy who did not calculate the medication correctly, the dispensing device was involved, and labeling was incorrect. One wrong time error was caused because the medication was given early. One wrong administration technique was caused by failure of the physician to order the medication to be given with food. • One omission error classified as category D (An error occurred that reached the consumer and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm). According to the explanation found upon	

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		investigation: The omission was cause by failure to give the prescribe antibiotic. • Two errors of omission failed to have the Severity Index (classification category) marked. The Facility's Medication Error Report forms were comprehensive, and when all components are marked, it provides valuable information for completing a root cause analysis for medication errors. The Facility needs to ensure that nursing, pharmacy, physician, and other professional staff responsible for medication administration completely fill out the Medication Error Form and use the information to conduct a root cause analysis in tracking and trending medication errors in order to eliminate or reduce the occurrence of medication errors. The Nursing's Medication Error Policy and Procedure and the Pharmacy's Medication Error Policy and Procedure vary significantly in instruction as to how medication errors were reported. The Medication Error Reporting Forms were different. The Pharmacy's Medication Error Forms were used for the errors reviewed above. It could not be discerned if both Policies and Procedures were operational or if the Pharmacy's policy and procedures supersedes Nursing's policy and procedure. If that was the case, then Nursing's policy and procedure need to be removed from operation. The Facility's Chief Nurse Executive and Pharmacy Director need to collaborate to establish one Medication Error Policy and Procedure that nursing, pharmacist, physicians, and other professional staff responsible for medication administration use. If Nursing's Medication Error Policy and Procedure has been superseded by the pharmacy's, it needs to be removed from the Facility's operational manual.	

Recommendations:

1. The Facility's Nursing Department needs to continue to make every effort to fill vacant positions to ensure nursing coverage on residential units not covered 24/7.
2. The Facility's QE Department needs to continue refinement and organization of their QE system.
3. The QE Department needs to evaluate the need for an additional QE Nurse.
4. The Nursing Department and QE Nurse need to strengthen their monitoring tools in order to ensure that the quality of nursing care and all nursing related SA compliance issues are routinely monitored.
5. The Nursing Department needs to develop a policy and procedure for monitoring all aspects of nursing services that relates to the SA. Data derived from nursing audits needs to be tracked, trended, and analyzed to in order to improve the quality of nursing services and measure compliance toward the SA. As the policies, procedures and forms are updated the Nurse Educator needs to update the training material.
6. The Nursing Department needs to adopt a standardized format for charting such as SOAP or DAP.
7. The Nurse Educator needs to ensure that nurses receive comprehensive Physical and Nutritional Management training from qualified professionals such a Speech and Language Therapist.

8. The Nursing Department needs to collaborate with the Physical and Nutritional Management team to evaluate the need for more nursing participation in the dining room by the nurses.
9. The Nursing Department needs to ensure that full body assessments are routinely completed on individuals prior to transfer to the hospital and upon return as a preventative measure (for example, to ensure information on origin of skin breakdown is available and plans to minimize hospital-acquired skin breakdown are implemented). This item needs to be included on Nursing Monitoring tools and monitored routinely to ensure compliance.
10. The Nursing Department needs to ensure that therapeutic responses to newly prescribed medications are consistently monitored and documented in the individuals' Integrated Progress Notes.
11. The Nursing Department needs to ensure that:
    a. DCP staff have been trained in all aspects of care for which they are responsible by way of the DCP Supervisors' signature on the Acute Care Plans;
    b. Nurses consistently document interventions carried out according to the Acute Care Plans, and when plans are completed.; and
    c. Nurses' who author the Acute Care Plans sign their signatures above their typed signatures.
12. The Nursing Department needs to ensure that Nurse Case Managers continue to strengthen comment sections and summaries of Annual and Quarterly Nursing Assessments to include whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working, and to recommend changes, if indicated, in strategies, support and/or services.
13. The Nursing Department's Nursing Case managers need to ensure that all chronic health conditions have a HMP, even it those conditions were stable, to ensure they remain stable.
14. The Nursing department needs to review their Annual and Quarterly Nursing Assessment Policy and Procedures and report forms to ensure the inclusion of SAM information.
15. The Nursing Department needs to include signature and date lines on the HMPs that ensures that they are reviewed and/or revised at the time Quarterly Nursing Assessment are completed.
16. The Nursing Department needs to ensure that interventions described in individuals' HMP are clearly documented in the Integrated Progress Notes when implemented.
17. Emergency equipment needs to be prepared, stored, and ready for rapid transport, for example by storage on an emergency cart or in a backpack.
18. CTD staff needs to re-in-service all Infirmary staff in CPR, equipments' function and proper use, as well as drill procedures. CTD needs to call Mock Medical Emergency Drills in the Infirmary frequently enough to ensure that all RNs competently pass the drills.
19. The Facility's responsible staff for Emergency Response Policies and Procedures needs to review and update the following policies and procedures to ensure continuity: Health Services: Conducting Mock Medical Emergency Drills, Revised: 07/24/08, I.18 actions During and Following a Medical Emergency (4444), Revised: 03/16/10, and Nursing: P.29 Emergency Response Procedure – Code Blue Drill, Date: 10/04.
20. The Facility needs to evaluate the Emergency Management Response system to ensure:
    a. Emergency Medical Response Policies and Procedures are revised and/or update to ensure continuity and meet acceptable standards of professional practice;
    b. Nurses, Physicians, and other ancillary personnel responsible for responding to medical emergencies participate in Mock Medical Drills;
    c. All personnel required to maintain CPR certification are up-to-date;
    d. Mock Emergency Medical Drills are reviewed by a designated committee that analyzes tracks, and trends facility-wide data to identify systemic issues that may require corrective action.
    e. The QA department monitors all aspects of emergency management response.
21. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria for determining risk to eliminate subjectivity, and to ensure that the Tool meets accepted professional standards of care. Falls risk should be included in the tool because of the risk for injuries
22. The Infection Control Committee needs to continue to review and/or revise all outdated Infection Control Policies and Procedures to ensure that

they are current and meet professional standards of practice.

23. The Infection Control Nurse needs to develop and implement written procedures for how communication flows to and from the Physicians, Case Managers, PST and other relevant Facility program staff.
24. The Infection Control Nurse needs to ensure that relevant individual-specific information relating to Infection Control communication is documented in the integrated progress notes.
25. The Infection Control Program needs to track, trend, and analyze data annually or over time to identify systemic trends, and use such data for making systemic improvement when indicated.
26. The Facility needs to ensure that the Hospital Liaison Nurse and NMT closely monitor hospitalized individuals to ensure that hospital staff are trained and follow individuals' PNMP.
27. The] Infection Control Nurse needs to collaborate with the NMT and HST to track, trend, and analyze pneumonia data to ensure that individuals' Health Risk Screening scores accurately represent their risk level for pneumonia, particularly aspiration pneumonia, and develop and implement aggressive preventative health care plans to closely monitor individuals at risk to prevent further episodes.
28. The Wound Care Nurse needs to work collaboratively with the Infection Control Nurse, Hospital Liaison Nurse, NMT, HST, and other relevant disciplines to conduct a root cause analysis to determine the causes for both facility and hospital (outside facility) acquired pressure sores. Then, based on findings a plan of corrective action to eliminate or reduce the occurrence of pressure sores should be developed and implemented .
29. The Infection Control Program needs to continue to increase the percentage of employees receiving influenza and H1N1 Vaccines.
30. The state and Facility need to evaluate the risk and benefits associated with staff wearing the blue identification jacket due to the potential to serve as a vector for infections, particularly as they may contain splashes of respiratory secretions as well as other infectious organisms because they are worn between individual contact and in public, and could stigmatize individual.
31. The Facility's Physicians, Infection Control Nurse, and Hospital Liaison Nurse, NMT, HST, and/or other related disciplines, need to evaluate probable causes for the high percentage of individuals diagnosed with HCAP.
    a. Efforts need to be made to work with the local hospitals to specifically and correctly diagnose the types of pneumonia acquired. It is important to know whether those pneumonias were related to aspiration, particularly since 73% of the individual were tube fed.
    b. Further efforts need to be made by the Hospital Liaison Nurse and NMT to closely monitor hospitalized individuals to ensure that hospital staff are trained and follow individuals' PNMP.
32. The Wound Care Nurse, Infection Control Nurse, NMT, HST, and other relevant disciples need to re-evaluate individuals risk level for pressure sores against reported incidents of reoccurring pressure sores.
33. The Infection Control Nurse needs to conduct unannounced environmental inspections to ensure an objective inspection.
34. The Facility needs to ensure that all required staff are current in infection Control training.
35. The Infection Control Committee needs to consistently examine causative factors for all infections regardless of whether they are clustered in order to take every means necessary to prevent infections.
36. The Nursing Department and Nurses Managers to needs to increase monitoring of medication administration practices of the staff nurses to ensure the following:
    a. Control drugs are always checked and signed by two nurses, even if a nurse should leave the shift early.
    b. Individuals are always positioned in an upright position with good bodily alignment for safe medication administration, whether in or out of bed while receiving medications.
    c. For individuals who have positioning plans for time out of bed, nursing needed to coordinate medication times to correspond with time out of bed. When necessary, the respective physician needs to be notified to determine if there is a need to adjust medication times to coincide with out of bed plans.
    d. Contaminated medications are not placed back into individuals' medication cart drawers and medication policy and procedures are followed for proper disposing/wasting medications.
    e. Individuals' privacy and dignity are respected at all times.

37. The Facility needs to ensure that nursing, pharmacy, physician, and other professional staff responsible for medication administration completely fill out the Medication Error Form and use the information to conduct a root cause analysis in tracking and trending medication errors in order to eliminate or reduce their occurrence.
38. The Facility's Chief Nurse Executive and Pharmacy Director need to collaborate to establish one Medication Error Policy and Procedure that nursing, pharmacist, physicians, and other professional staff responsible for medication administration use. If Nursing's Medication Error Policy and Procedure has been superseded by the pharmacies, it needs to be removed from the Facility's operational manual.
39. The Facility's Pharmacy and Therapeutic Committee needs to take a more active role in trending and analyzing medication errors in order to eliminate or reduce their occurrence.

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:** The following activities occurred to assess compliance: **Documents Reviewed**: 1. Medication Error Report Forms for the time period from 10/30/09 through 2/3/10. 2. Sign-in Sheet for Medication Error Committee Meetings of 10/19/09, 11/12/09, 12/17/09, 1/21/10, and 3/18/10 3. Medication Errors and Pre-sedation Data as reported by Charlene McCurry, Director of Nursing, September, 2009 4. Medication Error Committee Meeting Minutes, dated 10/19/09, 1/21/10, and 3/18/10 5. Sign-in Sheet, Medication Error Committee Meeting, 11/12/09 6. Medication Errors and Pre-sedation Data as Reported by Charlene McCurry, Director of Nursing, for September 2009 through February, 2010. 7. Medication Errors and Pre-sedation Data as Reported by Charlene McCurry, Director of Nursing, in Graph Form, Reporting by Type of Error (number of errors by extra dose, number of ,rrors by omission, number of errors by wrong administration technique, number of errors by wrong patient, number of errors by wrong time, number of errors by wrong dosage, number of errors by wrong route, number of errors by wrong drug), for the time period for September, 2009 through February ,2010 8. Medication Errors and Pre-treatment sedation Data as Reported by Charlene McCurry, Director of Nursing, Reporting in Graph Form, Number of People requiring Pre-treatment Sedation – Dental, and Number of People requiring Pre-Sedation for the time period from September, 2009 through February, 2010 9. Medication Errors and Pre-sedation Data as Reported by Charlene McCurry, Director of Nursing, in tabular form, by type of error, as well as number of individuals requiring pre-sedation for dental and medical procedures for the months of September, 2009 through December, 2009 10. Documentation Related to Medication Errors In-service, dated March, 2010, Prepared by: M. Shatz, Pharm.D., which includes Summary of Presentation, as well as pre and post tests 11. Example of Medication Adverse Drug Reaction Reporting Form 12. Single page Document labeled “High Risk Medication Errors”, which provides a description of those types of errors not dated 13. WORx Patient Profile Screen Print (Example of printout form from the Medication Interaction Automated Computer Checking), dated 4/27/10 for Individual #390 14. Examples of Richmond SSLC Single Patient Intervention Reports for the following Individuals: (Individual number will be followed by date in parentheses): #361 (4/27/10), #577 (4/28/10), #232 (4/22/10), #469 (4/22/10), #582 (4/22/10), #70 (4/20/10), #68 (4/20/10), #641 (4/20/10), #470 (4/20/10), and #110 (4/20/10) 15. Medication Cart Fill Face Sheet, example of blank document, not dated 16. “Medication Excess Form”, Examples of Completed Forms for Individual #303, (4/13/10), #346, (4/26/10). 17. Medication Shortage Form Examples for Individual #452, (4/17/10), Individual #68, (4/23/10).

	18. Packet Entitled Monthly Controlled Medication Audit, with five lists entitled, "Physical Inventory Count Sheets", with a "Run date: 3-25-10" 19. Copies of the "Quarterly Drug Regime Review" for the review period ending 4/30/10, which were completed on 4-26-10, and are signed by the Pharmacist Reviewer, but were not yet signed by the Primary Care Physician or the Psychiatrist for the following individuals: #513, #547, #316, #58, #559,#369, #246 (the Quarterly Drug Regimen Review for Individual #246 also contains an e-mail from Michael Shatz, Pharm.D., to David Partridge, M.D. and Ashok Jain, M.D., related to the Quarterly Drug Review and the dosage of Lamotrigine, as well as the response from the Primary Care Physician). For Individual #467, the Quarterly Report on Individual#467 also contains documentation of a related e-mail from Michael Shatz, Pharm.D., to the Primary Care Physician with regard to "significant thrombocytopenia – suggest repeat CBC with Diff." 20. A number of documents contained in a file labeled "Record of Clinical Activities by the Clinical Pharmacist 2009 – 2010". This file contains examples of Dr. Shatz's interactions with physicians with regard to feedback related to medication dosages, side effects, and laboratory values, inclusive of "Medication Adverse Drug Reaction Reporting Form", dated 4/26/10 and completed for Individual #467 with regard to the previously mentioned thrombocytopenia. The minutes of the Pharmacy and Therapeutics Meeting dated 3/30/10, which reports on both the prior Medication Error Committee meetings, a Drug Utilization Review of Benzodiazepine Usage at the Facility for the first quarter of 2010, which was prepared by Dr. Shatz; the review of Adverse Drug Reaction reports that were submitted to the Committee since the prior meeting, the status of the Polypharmacy Report, a notation that "there were a total of 7 orders identified by the Pharmacy as emergency (STAT) medications, and notification of "Approval of the Warfarin Safe Use Policy, developed by Dr. Shatz. " 21. This folder also contains the Benzodiazepine Usage Audit Report dated 3/29/10, prepared by Dr. Shatz. The results of the "Medication Audit Results for Lithium Audit conducted 12/22/09". Documentation of the Pharmacy Services and Safe Medications Quarterly Drug Regimen Review Audit from March 2010, covering the sections of "Lab Results, Therapeutic Values, Monitoring – Metabolic and Endocrine Risks"; "Polypharmacy Issues"; "Associated Risks with the Potential for Drug to Drug Interactions"; the category of "Are any Problems Noted Addressed Appropriately?"; and "MOSES/DISCUS as verified with each QDRR and a tracking tool is used to verify assessments are completed as appropriate." This document indicates that those areas were addressed in each of the 12 charts that were reviewed that month 22. This file also contains documentations of the in-services that Dr. Shatz has given to the Nursing Staff 23. Multiple notes and copies of e-mails from Dr. Shatz to Primary Care Physicians related to various pharmaceutical issues ranging from laboratory results that may be related to a medication, dosages of the medication that may be outside of accepted ranges, and blood levels related to the medication 24. Medication Room Controls, Audit prepared by Facility Support Services, HHSC, covering the first quarter of Fiscal Year 2010 25. Policies Related to Medication Error Committee Conduct and Reporting, dated 1/10/09 26. Medication Error Committee Reports from 7/16/09 through 1/21/10 27. Policy Related to Administration of Oral Medications, revised 2/12/10 28. Policy Related to Injections, not dated 29. Policy Related to "Medication Administration via Nasogastric Tube or Gastrostomy Tube", Revised 6-

	10-08 30. Policy Related to Administration of Topical Medication, not dated 31. Policy Related to a Medication Installation, Administration of Nose Drops/Nasal Spray, not dated. 32. Policy Related to Medication Administration involving installation of Eye Drops/Ointment, dated September, 2004. 33. Policy Related to a Medication Administration of Installation of Ear Drops, dated 2007. 34. Policy Related to Medication Administration of Rectal Suppositories, dated 2009. 35. Policy Related to Medication Administration for Off-Campus Activities, dated September 2004. 36. Policy Related to Administration of Oropharyngeal Inhalers, not dated. 37. Policy Related to Medication Administration for Therapeutic Home Visits, not dated. 38. Checklist for "Medication Administration Observation", revised February 2010 39. Medication Administration Times by Residential Unit, dated 3/3/10 40. Listing of Routine Enteral Feeding Times, dated 3/23/10 41. Pharmacy and Therapeutics Meeting Minutes from 1/12/10 Organizational Chart for the RSSLC Administration, dated March 2010 42. Review of the medical records for Individuals: #467, #726, #760, #8, #755, #714, #542, #641, #455, #630, #615, #525, #16, #644, #723, #585, #450, #320, #51, #800, #60, #181, #100, #264, #547, #146, #778, #328, #144, #32, #500, #2, #651, #476, #575, #342, #202, #173, #7, #765, and #169 **People Interviewed:** 1. Anto Parambil, R.Ph., Director of Pharmacy Date of Interview: 4/27/10 2. Michael Shatz, Pharm.D., MBA, Clinical Pharmacist Date of Interview: 4/27/10 **Meetings Attended, Observations**: Individuals: #751, #675, #106, #403, #635, #169, #159, #286, #724, #227, #184, #418, #173, #384, #402, #553, and #209, (Trinity C Residential Unit); #666, #386, #661, #215, #500, #477, #413, #470, #765, #360, #632, #324, #454, #284, #593, and #283, (Trinity A Residential Unit); #491, #463, #84, #482, #107, #6, #30, #351, #385, #330, #348, #233, #268, #551, #251, and #57, (Trinity B Residential Unit); #436, #621, #7, #40, #564, #125, #512, #535, and #571, (Trinity D Residential Unit); #301, #12, #729, #745, #265, and #603, (Trinity Program Room); #601, #164, #375, #719, #308, #428, #71, #157, #434, #377 #344, and #503, (Leone Residential Unit); #114, #202, #101, #200, and #328, (San Antonio Residential Unit); #550, (569 Tejas), #161, #98, and #220, (Guadalupe Residential Unit); #508 (Nueces); #767, #410, #213, #342, #781, #758, #396, #540, and #253, (Colorado Satellite Workshop Vocational Program); #796, #577, #138, and #791, (Main Vocational Workshop); #300 and #793, (Angelina Pre-vocational Program); #693, #716, #493, and #2 (Forever Young Day Program); #7, #678, #173, #169, and #500, (Neurology Clinic); #515, #476, #651, and #765, (Infirmary Unit).
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment:

	The Pharmacy Department at RSSLC recently employed a new Pharm.D., Dr. Michael Shatz. He has been working in this position since October 2009. Dr. Shatz has initiated many new initiatives that address provisions of the Settlement Agreement related to Pharmacy Services. These are discussed in detail in the narrative sections below. One of the most important of these initiatives was the introduction of a new methodology for reporting Adverse Drug Reactions (ADRs), which is intended to increase the reporting of these events. Future monitoring visits will investigate the trends in the reporting of ADRs to ascertain the efficacy of this process. There is substantial documentation regarding clinical interventions by the Pharmacy staff, which involves feedback to the prescribing physicians with regard to problematic medication orders, as well as the need for additional laboratory monitoring or in some cases, identifying a laboratory value that warrants attention and then referring it to the primary care physician. However, the vast majority of this documentation occurs outside of the clinical record in the form of the individual "Pharmacy Intervention" notes and e-mails. The Pharmacy Intervention notes would suggest that the primary means of this communication is through telephone discussions. The documentation of Pharmacy consultations that appear in the individual medical records is in the form of the Quarterly Medication Reviews that are performed by Dr. Shatz. These quarterly review forms are designed to require the signature of the reviewing Pharm.D., the primary care physician, and the psychiatrist for those reviews that relate to the use of psychotropic medication. The detailed review, which is discussed in the Psychiatry Section (and referred to below) indicated that there was only one example where a psychiatrist had signed a quarterly review document, which would suggest they are not routinely being reviewed by the psychiatrist. These quarterly reviews also represent the only formal documentation of the Pharmacy's role in the monitoring of polypharmacy related to the use of psychotropic medication. The Pharmacy does track the number of orders for emergency (STAT) psychotropic medication. However, there is no indication that the Pharmacy is involved in the formulation of these orders. Documentation of a critical review of the appropriateness of these STAT chemical restraint orders could not be identified. Overall, the addition of the Pharm.D. has increased the ability of the Facility to address the provisions that are discussed in the narrative section that follows. Future monitoring reports will assess for further progress in that regard.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make	The RSSLC has recently hired a Pharm.D., Dr. Michael Shatz, whose employment began in October 2009. During the 4/27/10 interview with Dr. Michael Shatz, he discussed the initiatives that he has implemented since assuming this position. These include clinical in-service trainings for nurses, case related medication feedback to physicians and nurses, as well as a major initiative to increase the reporting of adverse drug reactions. He has recently requested and received a second computer monitor, so that he can simultaneously review both an individual's medication profile and their laboratory values.	

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	recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The Pharm.D. has produced a number of e-mails, which document his interactions with the Medical Practitioners related to the requirements of this Provision, with regard to monitoring for medication side effects, dosage ranges, and laboratory testing. His correspondence also includes documentation of the response from the individual practitioners to these recommendations. The Facility also utilizes a computer-based system referred to as WORx, which automatically checks for interactions when a new prescription is entered into the system. This process was directly observed during a tour of the Pharmacy on 4/27/10. During this observation a medical technician entered a new medication order into the computer system to illustrate the manner in which the WORx operates. Specifically, an order for Cephalexin 500 mg was entered into the system for individual #390. The printout from the computer clearly indicates that the individual is allergic to sulfonamides, which is another class of antibiotic agent. Thus, the Facility has both automated and manual mechanisms for monitoring for medication side effects and other pharmacological parameters, and there is documentation of notification of the primary care physician of these findings.	
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.	The internal Pharmacy records, as well as the individual medical records, contain documentation of the Pharmacy's review of laboratory values, as well as medication blood levels where appropriate. The documentation of this process in the individual medical records appears in the quarterly Pharmacy review of Medication Profiles, as well as the documented case by case correspondence from Dr. Shatz to the individual primary physicians and their response. As noted above, Dr. Shatz has recently been supplied with second computer monitor so that he can simultaneously observe both the individual's medication profile and their most recent laboratory values.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics,	The primary evidence related to Pharmacy's involvement in the monitoring of the use of benzodiazepines, anticholinergics, and polypharmacy and related risks appears in the quarterly pharmacy reviews that are now prepared by Dr. Shatz. These individual clinically based reviews indicate the need for additional laboratory work, when necessary. Documentation could not be identified that would track the longitudinal use of benzodiazepines, anticholinergics, and polypharmacy in an on-going chronological manner, which would identify relevant trends. However, the minutes of the 3/30/10 Pharmacy and Therapeutics Committee does indicate that Dr. Shatz has completed a DUR related to benzodiazepines. As noted in Section J above, there is evidence that the Pharm.D. signs off on these quarterly reviews, as does the primary care physician; however, in the total sample that was reviewed in detail, there was only one example of the psychiatrist actually signing the quarterly review, and that was for only one out of three of those reviews. This would suggest that the prescribing psychiatrist is not	

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	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.	reviewing these documents, which are the primary source of communication from the pharmacist, other than specific e-mails, which are generated on a case-by-case basis. The role of the pharmacist, with regard to monitoring of (STAT) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long term treatment, is also not evident other than the following entry in the minutes of the 3/30/10 Pharmacy and Therapeutics Committee meeting: "Committee was notified that there were a total of seven orders identified by the Pharmacy as emergency STAT medications. Dr. Shatz represents Pharmacy on the Chemical Restraint Committee." The available documentation suggests that the Pharmacy Department is primarily involved in the monitoring of standing medication orders that are given on a daily basis. However, when the order for the STAT medication is entered into the Pharmacy system, the WORx computer system would automatically check for any potential negative interactions between the STAT medication and the standing medications, as well as any history that the individual had an allergic reaction to that medication in the past.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The communication between the clinical pharmacist and the primary care physicians concerning specific pharmacological recommendations related to an individual's medication profile is accomplished via either e-mail or telephone discussion. During the April 2010 tour the Pharmacy produced a file entitled "Pharmacy Interventions. " This file contained ten such intervention reports for the month of April, 2010. These reports contained the individual's name, age, gender, height, weight, medical record number, residential unit, date of admission, any medication allergies, and the primary medical and psychiatric diagnoses. The "Intervention Type" on all these reports is identified as "Patient Intervention". The name of the individual pharmacy staff who performed the intervention is identified, as is the date and time. This is followed by a description of the "Indicated Medication," the category and subcategory (for example, the category might be formulary conversion and subcategory being non-stock to stock item). This is followed by identification of the practitioner that the recommendation was made to, which is followed by a specific "Recommendation Description. " The reason for the action is also then specified. The exact means of communication is sometimes identified, but not always. The terminology used in the reports would suggest that this communication is accomplished via telephone discussion. An example of the nature of these interventions is provided by the report for Individual #577, dated 4/26/10 at 14:47 hours. The category is listed as "Therapeutic Consultation". The intervention was performed by Anto Parambil, the Facility Pharmacist. The recommendation was made to Dr. Nanthaphonge Chiranand, and the following documentation is listed under Assessment, "Simvastatin 10 mg p.o. q.d. was ordered: Dr. Chiranand, N., was notified the better effect of Simvastatin given at bedtime. Dr. Chiranand agreed to change the order to q.h.s." Another example relates to Individual #70, and is dated 4/20/10 at 16:30 hours. The intervention was performed by Bilu Kurian, of the Pharmacy department, and	

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		was director toward Dr. Wena Chiranand. The category is listed "Order clarification/confirmation." The recommendation description is as follows: "Doctor order to d/c Lisinopril, but client not on Lisinopril, called Dr. W. Chiranand, M.D. to clarify, she said d/c Vasotec, not Lisinopril." The final example, which illustrates the varying rationale for these examples, relates to Individual #470, and is dated 4/26/10 at 11:02 hours. The intervention was performed by Bilu Kurian, of the Pharmacy staff. The category of the intervention is listed as "Patient Care, " and was directed to Dr. Wena Chiranand. The "Recommendation description" was "Order for Ibuprofen 200 mg p.o. t.i.d. a.c. (before meals) times 2 weeks, ordered clarified and changed to Ibuprofen 200 mg p.o. t.i.d. p.c. (after meals) times 2 weeks. " The other source that would document a communication between the pharmacist and the primary care physician would be Dr. Shatz's e-mails. During the April tour a number of these were reviewed. The e-mails are invariably followed by a response e-mail from the physician that directly addresses Dr. Shatz's concern. During the extensive record reviews, documentation could not be found in the individual's record of either of these types of primary communication between the Pharmacy and the primary care physician. The documentation of the type of communication that does appear in the record are the Quarterly Medication Reviews, which as noted above, are uniformly present and up-to-date and signed off on by the clinical pharmacist and the primary care physician, but not the psychiatrist.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The review of the records identified above indicates that the MOSES and DISCUS are being performed on a regular basis. The MOSES is performed every six months or after a medication change by a member of the nursing staff, and the DISCUS performed by a member of the nursing staff every three months. The DISCUS is also performed for those individuals receiving Metoclopramide (Reglan), which appropriate given this medication's pharmacological profile which includes the blocking of dopamine receptors, and thus, can produce extrapyramidal motor side effects.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	During the 4/27/10 interview with Dr. Michael Shatz, he indicated that when he first assumed the position of the Clinical Pharmacist at RSSLC, he was immediately concerned about the relatively low rate of adverse drug reaction reports. Accordingly, he undertook a major initiative to educate both the nurses and the physicians about the reporting of adverse drug events. This initiative included an in-service on adverse drug reporting for the nursing staff. In addition, the minutes from the Medication Error Committee Meeting of January 21, 2010, contains the following relevant section: "Dr. Shatz, Clinical Pharmacist, provided us with a proposed medication adverse drug reaction reporting form, to expedite the reporting of adverse drug reactions (ADRs). The Pharmacy wants to create a simple system whereby possible or suspected drug reactions of any kind, (rash, headache, N/N, etc.) can be quickly reported. It is streamlined so as not to tie up	

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		nurses with a lot of paperwork and can be quickly completed. This is a required report to the FDA, and is also used in Pharmacy Tracking for DOJ. The MW (MedWatch) form will be done for serious reactions, but is too ponderous for minor reactions. The nurses will look over the proposed form and come to next Thursday's meeting (1/28/10) prepared to discuss it. "In addition, the minutes of the 3/30/10 Pharmacy and Therapeutics Committee meeting notes: Adverse Drug Reactions reports were presented to the Committee by Dr. Shatz. There were seven total for the first quarter. Committee approved the new simplified ADR reporting form. Physicians want ADR reported to them ASAP. Committee decided to add instructions on the form so that the physicians will be notified about the ADR". Future monitoring reviews will look for the presence of reporting trend data, which would document the efficacy of the efforts to increase the frequency of adverse drug medication reporting.	
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.	Drug Utilization Evaluations (DUEs) are the responsibility of the clinical pharmacist working in conjunction with the Interdisciplinary Team and the other members of the Pharmacy staff. Dr. Shatz (who has only recently assumed this position), has performed DUEs related to the use of benzodiazepines. The DUE process and status is discussed in the minutes of the 3/30/10 Pharmacy and Therapeutics Committee as per the following excerpt: "Drug Utilization review of benzodiazepines for the first quarter of 2010 was reported by Dr. Shatz. The results of the DUE for benzodiazepines suggest that the use of benzodiazepines in RSSLC is prudent, as is the selection of patients. Committee decided to select Phenobarbital, Lithium, and Cogentin as the drugs to be reviewed by Dr. Shatz for the second, third, and fourth quarters of 2010 respectively." Given the degree to which the Settlement Agreement focuses on the issue of polypharmacy with regard to psychotropic medication, a useful future DUE could be performed relative to this issue. A facility-wide DUE related to polypharmacy would also provide a baseline for tracking the trends in polypharmacy of psychotropic agents going forward.	
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 RSSLC provides extensive documentation with regard to the frequency and type of medication errors, as well as the response to those errors. These data are reported quantitatively in both tabular and graph form, and there is also a detailed discussion of each error in the Medication Error Committee meeting for that month. The Medication Error Committee meeting of 4/29/10 was attended by a large number of nursing staff. Dr. Shatz was also in attendance. The meeting was chaired by Charlene McCurry, R.N., C.E.N. There was a thorough discussion of medication errors that had occurred during the prior month and contributing factors. This discussion also included specific reference to the problems related to distraction of the nurse who is administering the medications due to the increased agitation of the individuals who are receiving medication during this time frame. Suggestions were offered by members of the Nursing staff for refining the process so that this confusion and distraction does not take place. A	

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		review of the Medication Error Committee meetings for the six months are uniform in the degree of details presented, both with regard to the frequency and type of errors, as well as the detailed description of specific individual events.	

Recommendations:

1. A comprehensive DUE related to polypharmacy of psychotropic medication that involves the entire population of individuals receiving psychotropic medication, would provide a baseline for monitoring the use of multiple psychotropic medications and/or more than one medication from the same class.
2. Distraction of the nurses by the agitation of individuals in the area proximal to the medication dispensing stations has been identified as contributing to the frequency of medication errors. Strategies for addressing this problem have been discussed and should be implemented to ascertain if they will be effective.
3. The aforementioned efforts to increase the reporting of adverse drug reactions should be maintained and empirically evaluated for efficacy.
4. The Pharmacy staff monitors the utilization of (STAT) or emergency medications; however, they are not involved in the decision making process as to which medication to use or the parameters related to their use in a specific situation. The addition of the Pharm.D., in conjunction with the increase in full-time psychiatrists, should facilitate increased collaboration in this regard. The Facility should implement practices to ensure this increased collaboration occurs.
5. The Pharmacy staff provided a great deal of valuable clinical feedback to the RSSLC Medical staff, which is documented in "Pharmacy Interventions" that are contained in the internal Pharmacy records, but corresponding documentation could not be located in the individual medical records. As the medical record format is being re-established it would be useful to determine if a system for integrating this information into the medical record could be incorporated.
6. The presence of a pharmacist at the Psychiatric Reviews would facilitate direct, timely communication between the pharmacist, the psychiatrist, and other members of the Interdisciplinary Team.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** • Reviews of Individuals #16, #755, ##52, #30, #455, #640, #99, #91, #437, #525, #786, #2, #598, #426, #162, #146, #301, #215, #12, #261, #468, #743, #800, #691, #627, #618, #663, #402, #7, #73, #597, #84, #145, #538, #535, #418, #478, #241, #621, #157, #719, #179, #267, #290, #71, #159, #553, #173, #392 • Settlement Agreement: Section XI. Physical and Nutritional Management, and P. Occupational and Physical Therapy • Current Census by Home • Common Elements of Physical and Nutritional Management (PNM) • Applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management • Physical Nutritional Management policy #012, 12/17/09 • Nutritional Management Policy #013, 12/17/09 • At-Risk Individuals Policy #006, 10/05/09 • Best Practice Guidelines (July 2008) • Credentials for staff as submitted • Continuing Education records for the speech and language therapists and the occupational therapist • PNMP Monitoring form • List of Therapy staff and PNM Team members • PNM assessments and updates completed in the last quarter • Habilitation Physical Management Monitoring Forms • Meal Observation Sheets • Physical/Nutritional Management Plan for each individual listed above • PNMP format • Dining Plan format • Occupational/Physical Therapy Services Policy#014P, 11/04/09 • List of Individuals with Other Ambulation Devices • List of Individuals with Orthotics and/or Braces • List of Individuals Who Use Wheelchairs as Primary Mobility • List of names: individuals who had 10% weight change in six months (undated) • List of names: individuals on modified diet textures and/or liquid consistencies downgraded in past 12 months • PNMP/NMC meeting agendas/minutes: January – December, 2009 • List of Hospitalizations and ER Visits • List of Pneumonia Diagnoses

	• List of individuals with pressure sores FY 2009 • Nutritional Management Screening Tools • List of all incidents or injuries since July 1, 2009 • Physical/Nutritional Management Plan for each individual • Dining Plans for all individuals **People Interviewed:** • Gary Sandler OTR, Habilitation Services Director • Charlene McCurry RN, Chief Nurse Executive • Wilma Parker RN, Nursing QA • Kimberly Randel RN. Infection Control • Carol Agu, QMRP Coordinator • Dr Chopra, MD, Radiology • Kendra Robbins, SLP **Meeting Attended/Observations:** • Wheelchair Workshop 4/26/10 • PSP (Individual #402)4/26/10 • OT/PT assessment (Individual #478) • Observations of living areas and dining rooms on Leon, Trinity, San Antonio, Neches, and Pecos • Nutritional Management Team (NMT) meeting 4/27/10 • Modified Barium Swallow Study • Wheelchair Clinic 4/28/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC has a team that meets twice monthly to address many issues associated with physical and nutritional. The team at RSSLC is known as the Nutritional Management Team. While the team had an Occupational Therapist, Speech Therapist, Dietitian, Physician, Nursing, and Case Manager; it did not contain a Physical Therapist or Behavior Analyst. Additionally, the team focuses primarily on nutritional issues and did not cover the physical aspects of physical and nutritional supports. A Physical and Nutritional Management (PNM) team also exists and consists of the Physical Therapist, Speech Therapist, and Occupational Therapist; however, this team does not meet monthly nor do they address issues on a system or center level. The PNM team focuses primarily on wheelchair and positioning assessments. The chairperson of the Nutritional Management Team is a well qualified Occupational Therapist as are members of the team; however, their knowledge of physical and nutritional supports is new and they are in need of support and additional education. The current PNM system is highly informal and does not contain clear pathways or procedures to follow as it relates to providing supports related to physical and nutritional management. The current system is considered informal due to the lack of clear policy and procedures regarding the identification and

	response of the team to PNM-related triggers as well as the frequency and depth of monitoring practices. A formal system will have clear processes that identify in detail the roles of all team members and their assigned roles and expectations. This lack of a formal process has resulted in a system that has potential but is often off course due to breakdown in communication and implementation. The current system of risk assessment is a concern as it does not accurately identify those who are at risk. RSSLC has multiple risk forms and processes that are not coordinated and often contradict each other. Multiple occurrences were noted where one risk system classified someone as a "high risk" when the other classified them as not being "at risk." Observations and reviews revealed implementation issues associated with the PNMP, lack of consistent competency based training and lack of a data system to help identify trends and shape future services.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional	RSSLC has a team that meets twice monthly to address many issues associated with physical and nutritional. The team at RSSLC is known as the Nutritional Management Team. While the team had an Occupational Therapist, Speech Therapist, Dietitian, Physician, Nursing, and Case Manager; it did not contain a Physical Therapist or Behavior Analyst. Additionally, the team focuses primarily on nutritional issues and did not cover the physical aspects of physical and nutritional supports. A Physical and Nutritional Management (PNM) team also exists and consists of the Physical Therapist, Speech Therapist, and Occupational Therapist; however, this team does not meet monthly nor do they address issues on a system or center level. The PNM team focuses primarily on wheelchair and positioning assessments. The chairperson of the Nutritional Management Team is a well qualified Occupational Therapist as is members of the team; however, their knowledge of physical and nutritional supports is new and they are in need of support and additional education. Per interview with the Habilitation Services Director, the NMT focuses on nutrition and the PNM team focuses more on physical aspects. Membership in the NMT included OT, SLP, nursing, dietitian, and physician. Per review of the NMT attendance sheets (past 12 months), there was no involvement of the Physical Therapist, and Psychologist, in the meetings. Primary attendees consisted of the Habilitation Director, Nurse, Physician, Dietitian, and OT. Due to the missing members, the NMT cannot be considered an appropriate PNM team. Membership in the PNM team included the OT, SLP and PT. Due to this team not having a nutritional component or members, it cannot be considered an appropriate PNM team as defined by the SA. Regarding documentation that members of the PNM team have specialized training or	

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	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.	experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management needs, resumes and CVs for NMT members were reviewed. All members of the team had obtained their appropriate licenses in their respective fields. Per interview with the Habilitation Services Director, it was stated that the therapists need to continue to receive additional trainings in an effort to obtain competence in the area of physical and nutritional supports. Per PNM state policy (CMGMT 32) "each regular member of the Nutritional Management Team (NMT) should complete ongoing training in the area of physical and nutritional management for persons with developmental disabilities." Per documentation provided by RSSLC, the NMT members are actively participating in trainings that are relevant to physical and nutritional supports but training outside of the state provided courses are minimal as were trainings more focused on the nutritional aspects of PNM (e.g., dysphagia, enteral nutrition). For example: • Habilitation Director (Gary Sandler) attended trainings regarding 1) Mat assessments, 2) Wheelchair Evaluation and Fabrication, and 3) Augmentative Communication Devices. • Speech Pathologist (Rochelle Kelly) attended training regarding Physical and Nutritional Management for SLPs. • Physical Therapist (Estrellita Posadas) attended trainings regarding 1) Wound and skin care system and 2) PNMP and Wheelchair Clinic Teleconference. Per state policy, NMT meetings were to be held at least monthly, with additional meetings held related to the following: eating/health problems, changes in risk, after medical or other diagnostic tests, and to address follow up activities. Per review of the NMT notes (April, 2009 to April, 2010), the NMT has focused primarily as a weight review. Choking issues and pneumonia issues are discussed but missing are the physical aspects of physical and nutritional management. As mentioned above, the NMT does not contain the ancillary members needed to fully address identified issues. For example: • Individual #16 was discussed at the 7/9/09 meeting because of aspiration incident secondary to rumination. The Psychologist was not a participant at this meeting. • Individual #755 was discussed at the 11/12/09 meeting regarding behavioral dysphagia; however, there was not a Psychologist present at the meeting. • Individuals #52, #30, and #455 were discussed at the meeting regarding weight gain and the need for increased physical exercise. Physical Therapy was not a participant at any of these meetings. • Individual #241 was discussed at the 4/27/10 meeting regarding rumination. No Psychologist was present at the meeting.	

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		Each of the PSPs reviewed reflected integration of the PNMP by referring to the PNMP as a support; however, the PNMP was not fully integrated as it did not contain plans for how the interventions are provided across settings or information on how the interventions improved the individual's life by mitigating his/her risk.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	A Nutritional Management Screening Tool is utilized to identify each individual's nutritional management risk. Risk is categorized across three levels: High (level 1), Medium (level2), and Low (level3). Per review, the screening tool focuses on, among other risks, aspiration pneumonia, GERD, choking, and diabetes, The screening's focus is too narrow as it does not include the physical aspects (e.g.., risk of falls, skin breakdown) of physical and nutritional management. The NMT screening tool is only completed whenever someone is referred to the NMT and is not provided on a consistent basis (i.e., annually) and is not tied to the screening associated with the HST meetings. A separate risk policy and process exists as well at RSSLC. This risk process is tied to the Health Status Team (HST) Meeting which meets a minimum of every 6 months for all individuals living at RSSLC. The risk screenings conducted as part of the HST include, among other risks, aspiration/choking, weight, cardiac, constipation, dehydration, and GERD. Overall Risk as well as individual risk is categorized across three levels: • High (level 1) applies to an acute or unstable condition. • Medium (level 2) applies to ongoing conditions that are stable but require ongoing supports. • Low (level 3) applies to conditions that are stable and do not require ongoing supports. These ratings assigned by the HST do not correlate with the Nutritional Management Screening Tool. For example: • Individual #640 was identified by the NMT as being a Level 1 aspiration risk while the HST identifies the individual as a level 3 aspiration risk. • Individual #99 was identified by the NMT as being a Level 1 weight loss risk while the HST identifies the individual as not being at risk. • Individuals #91 and #437 were identified by the NMT as being a Level 1 choking risk while the HST identifies both of them as not being at risk. • Individuals #525 and # were identified by the NMT as being a Level 1 aspiration risk while the HST identifies them as not being at risk. • Individual #2 was identified by the NMT as being a Level 1 choking risk while the HST identifies the individual as being a Level 3 choking risk.	

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		• Individual #598 was identified by the NMT as being a Level 1 weight loss risk while the HST identifies the individual as being a Level 3 weight risk. The NMT and HST risk screenings also do not correlate with regards to the frequency in which it is conducted or by the individuals who are completing the tools. For example, the HST screenings are commonly completed by the nurse quarterly while the NMT risk screening is completed by the OT on a PRN basis. Criteria for each level of risk do not correlate with one another. Assignment of individual risk (i.e., aspiration or choking) does not contain clear criteria in the determination of the degree of risk. These two separate assessments follow two different processes for completion leading to an increased risk of fragmentation between areas of practice. Currently, the levels of risk assigned by the HST are utilized primarily as a method to determine meetings or review and do not consistently represent an individual's potential of risk. For example: • Individual #418-Skin breakdown occurring 9/8/09 and 10/21/09. Identified as level 3 (low risk) on 11/17/09. • Individual #73-Aspiration Pneumonia occurring 6/2004, 3/2007, and 2/2010. Identified as level 3(low risk) of aspiration. • Individual #7-Aspiration Pneumonia occurring 3/8/10. Identified as level 3(low risk) of aspiration. • Individual #538-Aspiration Pneumonia occurring 1/4/2010. Identified as level 3(low risk) of aspiration. • Individual #597-Falls occurring 1/15/10, 1/16/10, and 1/27/10. Identified as level 3(low risk) of injury. Assessments are scheduled based upon the annual staffing schedule and not based on increased risk level. Interim assessments were noted to have been conducted based on referral or change in status. Annual updates are provided to individuals receiving direct services. These updates are primarily a documentation of status and do not provide analysis of findings or measurable outcomes for the year. There was not a clear process in place in which the PNM team is notified should a sign or symptom associated with aspiration occur. Currently, notification relies on DCPs determining an issue is severe enough to contact nursing, then nursing determining an issue is severe enough to contact the physician and make a referral. This results in clinical judgments regarding PNM being made by individuals who are not clinicians and too many opportunities of signs and symptoms that are not overt to be missed therefore resulting in a more reactive than proactive approach. During several meals on Trinity Leon, Pecos, and San Antonio, unsafe mealtime practices and coughing were observed	

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		but no interventions were provided. For example: • Individuals #426 and #162 were observed coughing multiple times during meal with no intervention. • Individual #146 dining plan stated staff should alternate liquids and solids. Staff was observed providing multiple bites without liquids. • Individual #301 dining plan stated the individual's cup should be filled only half full. Cup was filled to the top therefore increasing the risk of aspiration. • Individuals #215 and #12 dining plans stated staff should provide jaw support to help bring head to a more neutral position. Staff did not provide any cues or support. • Individual #426 dining plan stated the individual's cup should only be filled a ¼ full but her cup was completely filled. • Individual #261 dining plan stated staff should provide cues to stop overstuffing and eating too fast but no cues were provided. • Individual #468 dining plan states the individual should receive small bites and alternate liquids and solids. The individual was observed taking large bites with no alternating liquids.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	All individuals living at RSSLC had a document called a PNMP and dining plan; this includes individuals receiving enteral nutrition. The PNMP is not comprehensive due to the lack of information regarding oral hygiene, oral medication and behavioral issues associated with intake. The PNMP does contain information regarding positioning, assistive equipment, communication, transfers, mobility, dining equipment and the dining plan. Information missing on the PNMP includes: oral hygiene, oral medication and behavioral issues related to intake. This information is important as the risk of aspiration is not limited to only meals. PNMPs are discussed during the NMT meetings as well as through the PST process and annual PSP planning. Per records reviewed and PSP attended, PNMPs are reviewed as part of the PSP planning process. PNMPs reviewed indicated clinicians routinely modified the PNMPs to reflect a change in approach or equipment. Per interview with Habilitation Director, PNMPs are updated centrally and supervisors and PNMP coordinators are notified via email of the changes and the need to initiate training. PNMPs are revised based upon scheduled updates and notification of staff that an issue exists with the current plan in place. There is congruency between Strategies/Interventions / Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment._Concerns	

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		identified in the reviewed annual updates were addressed in the PNMP.	
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.	Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan; however, based upon observations of meals at Trinity, Leon, Pecos, and San Antonio, it was noted that implementation of the dining cards or PNMPs are sporadic. For example: • Individual #743 slid down in her chair resulting in increased pressure on the sacrum and unsafe positioning for intake. • Individual #800 was observed leaning to her left resulting in poor positioning related to respiration. • Individual #535 slid down in his bed resulting in poor positioning for respiration and increased sacrum pressure. • Individuals #159, #392, and #551 were in bed when per daily schedule they should have been in their wheelchairs. • Individual #553 was in left sidelying position when PNMP called for right sidelying. • Individual #173 was in right semi-sidelying position when PNMP called for left semi-sidelying. • Individual #351 slid down in bed resulting in less than 30 degrees of elevation during medication administration. • Individual #330 was in right sidelying position when PNMP called for left sidelying. • Individual #621 was observed slid down in bed when nurse was attempting medication administration. • Individual #691 received a Hot Dog that was improperly cut therefore increasing his risk of choking. • Individuals #627, #618, and #663 were observed taking large bites although their plans called for them to be cued to take small bites. • Refer to section 0.2 for additional examples. As the examples document, individuals were observed to be poorly positioned. PNMPs and dining plans are intended to address PNM risk across all settings. Per observation, oral hygiene and oral medication are not addressed as part of the PNMP. Per report, adaptive equipment identified as being needed for oral intake is consistently utilized when individuals travel off grounds for day trips; however, there is not a clear policy in place that confirms this practice. Per informal conversations with DCPs on Trinity, Leon, San Antonio, and Neches, they were fairly knowledgeable as many were able to articulate the type of adaptive equipment, the purpose of utilizing the equipment and its importance. The issue as	

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		stated above is that many DCPs were observed not following the strategies identified on the dining plans and PNMP.	
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.	The Facility reported that all staff have been provided with competency based PNM training and all staff participate in an annual PNM refresher course. In addition to the PNM training, staff also receive annual refreshers regarding Ambulation, and Lifting/Transfers. Training forms were not requested for this review; therefore further investigation will be needed during subsequent reviews. Per Habilitation Director, return demonstration or skills based competency based check offs are limited to the classes that focus on transferring individuals from position to position and the modification of fluid consistency. All other areas of PNM are not included in this category and all scored based on a multiple choice test resulting in an overall training system that lacks in an overall competency based approach. Per Habilitation Director, Habilitation Therapies staff provided competency-based training for home supervisors, and PNMP coordinators. These staff are then responsible to train the people who provide direct care. Documentation of the home supervisors' training was maintained by the therapy department, and sign-in sheets for in-services provided to direct care staff was maintained by the home. Staff training provided was not necessarily competency-based. Validation of this process will be necessary in subsequent reviews. There is not a clear process in place that ensures all staff (including pull staff) receive person-specific competency based training prior to working with the individual. Clinical staff provides training to the supervisors at the home and PNMP coordinators who then are responsible for training staff. There is not a method in place that helps the supervisors identify staff who have received the needed individualized training prior to working with individuals and as PNMPs are revised.	
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.	A system is in place to monitor staff implementation of the PNMPs; however, it is informal and, as noted in O4, ineffective at ensuring PNMPs are followed. Per report by the Habilitation Director, PNMP coordinators conduct monitors at every meal and Habilitation Therapy clinicians (SLP, OT, PT) are required to conduct a minimum of one monitor per week. While it is positive that therapists are participating in the monitoring, the frequency of the monitors as well as what is monitored is informal and does not provide a clear process to follow. Per Habilitation Director, dining issues identified by the PNMP coordinators are forwarded to the caseload OT and issues associated with positioning are forwarded to PT. Once this exchange occurs, there is no process in place for analysis of data. Furthermore, who was monitored was random and not based on level of risk. There was no process in place that provides for validation checks to ensure consistency	

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		across monitors. PNM policy (#012) speaks in general terms regarding what a monitoring system should consist of but does not provide information regarding frequency or distribution of monitoring based on identified risk level. Monitors primarily covered the presence of equipment and plans and focus mostly on mealtime. Effectiveness of the implemented plans as well as monitoring of areas outside of mealtime was not evident. Per Habilitation Services Director, all NMT members are required to conduct a minimum of one monitor per week; however, there is no process that clearly defines this process. Per review of the monitoring forms conducted from December, 2009 to March, 2010, SLPs, OT, PTS, RDs and PNMP coordinators participated in the monitoring of dining plans and PNMPs. There is no evidence that the PNMP monitoring forms are reviewed by the PNM team in an effort to establish trends or to ensure resolution of the issues identified in the monitors. There is no process that provides for the acquisition and analysis of monitoring data needed to identify needs for systemic changes. Not only was there no formal process to identify and initiate systemic change, there was not consistent evidence that concerns identified on monitoring forms were addressed in an expeditious manner. For example: • Individual# 701 was observed on 3/12/10. During dining observation, it was noted that the individual refused drinks if offered during the meal but accepted if offered at the end of the meal. The therapist monitoring stated that the dining plan would be altered to reflect the need for change. This never occurred as of 4/29/10. • Individual # 765 was observed on 2/4/10. During dining observation, it was noted that the individual was coughing on thin liquids and that Speech and Nursing would be notified. There was documentation of nurse being notified the next day but no further follow up was noted in the record. • Individual #91 had a choking event that occurred on 5/1/09; however, there was no evidence of response by the NMT or PST. Other deficiencies noted during monitoring are corrected within an appropriate period of time based on the level of risk that they pose. Per monitoring forms dated December, 2009 to March, 2010, equipment was repaired, replaced or resolved in an appropriate	

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		manner such as at the time of identification. There is no system that tracks these occurrences or the frequency or situation in which the issues occurred. Per report, supervisors were notified of any issues identified through the monitoring process; however, there was no formal or consistent documentation to verify this occurrence.	
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.	NMT meetings were held twice monthly and were based on a referral system. Issues discussed during this meeting include weight gain and loss, aspiration, choking, MBS studies, and NMT follow ups. Follow up with regards to incidents and the individual's progress with new interventions was consistent but there was little to no discussion of data trending and analysis. There was no evidence in the records submitted of monthly reviews by the PST or member of the Nutritional Management Committee that focus on the individual's progress or response to interventions provided by therapy or direct support staff. PNMP monitoring was conducted using the PNMP Monitoring form and the Dining Room Observation form. These two monitoring forms focused primarily on staff implementation and did not address an individual progress or status with provided therapy interventions. There is no evidence that the PNMP monitoring forms are reviewed by the NMT in an effort to establish trends or to ensure resolution of the issues identified in the monitors. Annual updates or assessments are conducted by OT/PT. SLPs provide updates annually if the individual is receiving direct services and a full assessment every three years if not receiving direct service.	
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 4/26/2010, there are 58 individuals living at RSSLC who require an alternate method of nutrition and hydration. RSSLC does identify issues related to the tube from a nutritional standpoint but does not provide any type of oral assessment or establish potential pathways to PO (oral) intake. Per record review of Individuals #402, #7, #535, and #99, issues related to enteral nutrition were noted in the PSP with regard to diet order, nutritional assessment, and other medically-related information; however, there was no evidence that team discussion had taken place with review of objective data to make the determination that in this case the gastrostomy tube continued to be appropriate.	

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		There was no evidence that clearly identified a process in which the continued need for enteral nutrition is discussed by the team State policy does not clearly define the frequency in which evaluations or assessments are conducted. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. Interventions to promote safe oral consumption are identified through the PNMPs and Dining Plans. These plans focus on interventions to be utilized in and outside of dining. As described in previous sections, there were multiple issues noted with the implementation of the support plans.	

Recommendations:

1. RSSLC should review their entire PNM system to ensure that the PNM team is a therapy-driven collaborative team that focuses on proactive preventative care. Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy. Therefore, RSSLC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that it identifies those who are at risk. Additionally, the level of risk should be openly shared with staff and used to help drive and shape future services. Risk levels should be identified based on the potential of harm. Interventions utilized to mitigate risk must be effective over an extended period of time prior to the risk being downgraded.
2. Include PT and SLP staff in NMT meetings and consider improved collaboration and streamlining of the HST Risk Screening Process.
3. The HST and NMT currently meet separately although they both cover and share much of the same information. Due to this redundancy and lack of a clear PNM team, it is recommended that RSSLC investigate ways to further integrate their function and develop a single team that covers all aspects of physical and nutritional management.
4. PNMPs should be revised so that behavioral issues associated with intake, oral hygiene strategies, and medication administration is included.
5. Develop a monitoring system that increases frequency of monitoring based on level of risk and ensures monitoring across all areas in which the individual is at an increased risk.
6. Establish measurable outcomes related to identified PNM concerns.
7. Care should also be taken to ensure that all staff are provided with individualized competency based training prior to working with an individual who is considered to be at an increased risk.
8. Ensure consistent validation of monitors to ensure accuracy.
9. The NMT should conduct trend analysis of all acquired to data in an effort to shape future services.
10. Improved use of the integrated progress note should become a standard to help identify issues and close the loop from onset of incident to conclusion.
11. Therapists should explore opportunities to participate in trainings outside of the state-sponsored courses to gain additional exposure to concepts surrounding physical and nutritional supports.
12. The NMT should consider developing cheat sheets relevant to the safe consumption of vending machine items and off campus dining. Cheat Sheets should focus on providing staff with guidance on how to modify common restaurant and vending items.

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:** • Reviews of Individuals #16, #755, #52, #30, #455, #640, #99, #91, #437, #525, #786, #2, #598, #426, #162, #146, #301, #215, #12, #261, #468, #743, #800, #691, #627, #618, #663, #402, #7, #73, #597, #84, #145, #538, #535, #418, #478, #241, #621, #157, #719, #179, #267, #290, #71, #159, #553, #173, #392 • Reviewed Settlement Agreement: Section XI. Physical and Nutritional Management, and P. Occupational and Physical Therapy • Current Census by Home • Common Elements of Physical and Nutritional Management • Applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management • Physical Nutritional Management policy #012, 12/17/09 • Nutritional Management Policy #013, 12/17/09 • At-Risk Individuals Policy #006, 10/05/09 • Best Practice Guidelines (July 2008) • Credentials for staff as submitted • Continuing Education records for the speech and language therapists and the occupational therapist • PNMP Monitoring form • List of Therapy staff and PNM Team members • PNM assessments and updates completed in the last quarter • Habilitation Physical Management Monitoring Forms • Meal Observation Sheets • Physical/Nutritional Management Plan for each individual • PNMP format • Dining Plan format • Occupational/Physical Therapy Services #014P, 11/04/09 • List of Individuals with Other Ambulation Devices • List of Individuals with Orthotics and/or Braces • List of Individuals Who Use Wheelchairs as Primary Mobility • Current Diet Roster (02/08/09) • List of names: individuals who had 10% weight change in six months (undated) • List of names: individuals on modified diet textures and/or liquid consistencies downgraded in past 12 months • PNMP/NMC meeting agendas/minutes: January – December 2009 • List of Hospitalizations and ER Visits • List of Pneumonia Diagnoses

	• List of individuals with pressure sores FY 2009 • Nutritional Management Screening Tools • List of all incidents or injuries since July 1, 2009 • Physical/Nutritional Management Plan for each individual • Dining Plans for all individuals • OT/PT Services Log FY 2010 **People Interviewed:** • Gary Sandler OTR Habilitation Services Director • Charlene McCurry RN Chief Nurse executive • Wilma Parker RN Nursing QA • Kimberly Randel RN Infection Control • Carol Agu QMRP Coordinator **Meeting Attended/Observations:** • Wheelchair Workshop 4/26/10 • PSP (Individual #402)4/26/10 • OT/PT assessment (Individual #478) • Observations of living areas and dining rooms on Leon, Trinity, San Antonio, Neches, and Pecos • Nutritional Management Team (NMT) meeting 4/27/10 • Modified Barium Swallow Study • Wheelchair Clinic 4/28/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC had three and a half Physical Therapists, two Physical Therapy Assistants, Six Occupational Therapists and four Occupational Therapy Assistants. The Occupational Therapists and Physical Therapists were the primary stakeholders of the PNMPs. Though staff received new employee training as well as annual refreshers, implementation of the PNMPs related to positioning was an issue identified by the monitoring team. Individuals were poorly positioned in bed while they received medication and enteral feedings and when seated for meals in the dining room. Individuals were also observed being provided with unsafe mealtime techniques. While monitoring identified some issues, like PNM, was ineffective in ensuring appropriate follow through of plans.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the	The census of RSSLC was 416 at the time of the baseline review. The Habilitation Director was an Occupational Therapist and has been at RSSSLC for the past two years. There were three SLPs, six OTs, four Certified Occupational Therapy Assistants (COTAs),	

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	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.	Three full time PTs and a contract PT who was considered part time, two PTAs, and 15 PNMP coordinators. There was one COTA vacancy at the time of the baseline review. Fabrication of all seating systems occurred on site at RSSLC's wheelchair shop. A vendor visited once per week to assist the team in ordering needed adaptive equipment. The wheelchair shop was responsible for working with the clinicians to identify needed systems to improve positioning and comfort. Per Habilitation Director and record review of the identified individuals above, each individual living at RSSLC had received a screening and/or an OT/PT assessment upon admission. More validation will be needed to properly assess whether change in status consistently leads to timely comprehensive assessments and whether assessments are done timely following PST referrals. All individuals receive a support from OT/PT in the form of the PNMP and/or dining plan. OT/PT assessments (i.e., Individual #478) are jointly conducted by both therapies. The Speech Therapist was observed as well during this baseline review to be actively participating in the joint assessment All individuals living at RSSLC have a PNMP therefore all individuals are receiving at minimum indirect services. Per Habilitation Director, individuals are provided with updates or a full assessment annually by the OT and PT. Fourteen of fourteen assessments reviewed clearly identified issues requiring additional assessments. Issues identified in the assessments largely consisted of the need to modify or fabricate new wheelchairs. Wheelchairs identified as needing further assessments or modifications were classified on a priority system. Per Habilitation Director, turnaround for full fabrication averaged approximately 4-6 weeks while minor modifications were made in a few days. OT/PT assessments and updates contained a list of medical diagnoses and health issues identified over the past year and relevant issues related to PNM and OT/PT (e.g., falls, skin breakdown). Medical issues and risk indicators were noted and rationale for many interventions and recommendations were provided.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and	Therapy Plans developed as part of the PSP included the dining plan, Positioning Plan and the PNMP. PNMPs are developed primarily by the OT and are implemented by the DCPs as are the other plans Based on the information provided, implementation dates were not evident. Per interview with the Habilitation Director, all PNMPs and dining plans were immediately	

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	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.	implemented upon development. Confirmation of timely implementation will be reviewed at compliance visits. Review of the PSPs revealed limited integration of the OT/PT assessment into the document other than being referenced if there was an indirect service or a restatement of the objective if direct services were provided by therapy. When listed there were no measurable objectives or clear functional outcomes listed within the PSP. Direct services provided by the therapist are limited and are primarily provided for acute issues. The majority of treatment is provided by staff and/or PNMP coordinators. As mentioned previously, measurable criteria were not always evident when services were not directly provided by OT or PT. For example, goal would simply state "the individuals will improve range of motion. " PNMPs, dining plans, and positioning plans reviewed contained information regarding the equipment needed to address the individual's needs. Rationales for the interventions listed in the assessments were incomplete or insufficient. OT/PT status review and plan updating. Review and updating is not documented as done as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. Monthly notes were only noted for individuals who were provide with direct OT or PT services.	
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.	Staff implements recommendations identified by OT/PT. As mentioned is section O.3, there were several instances where staff were observed not implementing the PNMPs or dining plans. This indicates the possibility that they did not receive competency-based training or re-training as needed. Competency-based training related to the implementation of OT/PT recommendations. Competency based training on implementation of treatment designed by OTs/PTs in the form of return demonstration was limited to transfers/lifting and the thickening of fluids. All other areas were tested through the use of written tests or in-services. Per Habilitation Therapy Director, trainings are provided to new employees and are refreshed on an annual basis. Individualized training was provided to the PNMP coordinators and supervisors who then were held responsible to complete the training at the level of the house. As mentioned previously, there was no clear process in place that ensured individualized training was provided to DCP prior to working with the individual. Staff verbalizes rationale for interventions. As mentioned in section 0.4, staff were not able to recognize when an individual needed repositioning or were in proper alignment.	

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		This would indicate that they did not know the rationale for the intervention.	
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.	System to routinely evaluate: a) Fit; b) Availability, c) Function; and d) Condition of all adaptive equipment/assistive technology. Per report, part of the PNMP monitoring as well as the dining plan observations include measures to ensure appropriate fit and function of adaptive equipment. As stated in section O.6, this system is informal and does not contain guidelines to ensure all individuals are routinely monitored and those who have an extensive history of maintain appropriate positioning are monitored with an increased frequency. A monitoring process and direction regarding its implementation. A clear policy does not exist that ensure all individuals are monitored and the criteria for who is monitored. Results of the monitors are not collected nor are data analyzed. For individuals at increased risk, staff receive training on positioning, including pulled and relief staff. There is not a formal process in place that guarantees that staff are trained prior to working with individuals Clear Documentation of responses to monitoring findings. Issues identified through the monitoring process are not consistently identified from identification to resolution. Upon interview with the Habilitation Therapy Director, many processes are informal and do not dictate clearly what is expected in terms of documentation. This type of informality results in an increased risk of issues falling through the cracks. For example, individual #91 had a choking event that occurred on 5/1/09; however, there was no evidence of response by the NMT or PST. Safeguards to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. There were 15 PNMP coordinators whose primary responsibilities are to provide training and monitoring. While monitoring is provided at all meals and throughout the day by the PNMP coordinators, the process is informal and does not guarantee all areas of the day will be monitored and all adaptive equipment will be accounted for on a daily basis. The process in place as of the baseline review is very informal thus lending to more opportunities for issues to surface. During multiple mealtimes as well as downtimes, issues were noted by the monitoring team that were not noticed by the PNMP coordinators, which results in questions regarding the validity of the monitors. Examples of issues identified are listed in section O.4 Person-specific monitoring that focuses on plan effectiveness and how the plan addresses the identified needs. There is no clear process in place that ensures all individuals are monitored and the method in which the individuals are chosen to be monitored. Monitoring focuses primarily on implementation and presence of plans and	

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		does not provide a proactive approach to plan effectiveness. Monitoring forms are only provided to habilitation services if there is an identified issue thus resulting in increased difficulty identifying how many monitors were conducted.	

Recommendations:

1. Analysis of the OT/PT staffing should be provided to ensure staffing levels are sufficient to meet the increased demands of the Settlement Agreement.
2. PNMP monitoring should be completed that ensures monitoring for all individuals and increased monitoring for those who are considered to be at increased risk. Monitoring should focus on all areas in which adaptive equipment is utilized or in areas where risk is increased.
3. Monitoring results should be collected and tabulated so that trending and analysis may take place to guide training and shape future services.
4. A training system should be considered that ensures all staff are regularly trained (Refer to recommendation in Section O).
5. Habilitation Therapy information should be integrated into the PSP and not just merely referenced. Justifications for the interventions and how these interventions play a role in improving the quality of life as well as how they are integrated into other areas of living should be included.
6. The current assessment format needs to be reviewed to determine if the current assessment format is sufficiently comprehensive to identify the needs of the individuals at RSSLC. Special care should be given to the areas of oral care, medication administration and oral motor.
7. A process should be developed that clearly identifies what is expected from staff regarding the documentation of incidents and how documentation should reflect the incident from onset to conclusion.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Dental Records Reviewed: #70, #174, #145, #281, #651, #7, #114, #84, #460, and #500 2. Dental Treatment Support Plans (DSPs) for individuals: #70, #174, #145, #281, #114, #84, and #500 3. Dental Records for Admissions, 09/12/09 through 12/28/09, for Individuals: #267, #469, #25, #643, #44, #513, and #92 4. Dental Appointment Schedule, 02/02/10 through 04/27/10 5. Dental Appointment – No Show Report, 02/02/10 through 04/26/10 6. Sedation for Dental List, 08/01/09 through 02/2010 7. RSSLC Dental Clinic Policy and Procedure Manual, Updated: 02/09/01 that includes: • Mission Statement • Goals and Objectives • Philosophy • Scope of Dental Services • General Policies • Infection Control Policy • Safety Policy • Needle Stick Policy • 24 Hour Coverage Policy • Hazardous Chemical List • Written Hazard Communication Plan • Written Exposure Control Plan • Bloodborne Pathogens • Quality Improvement Plan • Position Descriptions • General Anesthesia Procedures and Protocol • Medical Emergency Treatment Procedures • Forms Utilized • Certificates and Registration • Contracts with Other Institutions • Total Intravenous Anesthesia (TIVA) Procedures and Protocol for Oral Sedation - Draft –No Date 6. RSSLC Parental Sedation Intravenous (TIVA) Anesthesia Recovery – Proposed, Date: 05/01/10 7. RSSLC Policy J.11: Using Sedation for Medical/Dental Appointments (3/10/10) 8. RSSLC Policy J.13: Implementing Dental Treatment Support Plan (2/4/08) 9. Suction Toothbrushes – E-mail Memo from Carol Heath, DDS to #RSS All Users, 08/31/07 10. RSSLC Human Rights Committee Minutes, 12/10/10 **People Interviewed:** 1. Dr. Carol Heath, DDS 2. Wilma Parker, RN, BC, Quality Assurance Nurse

	Meeting Attended/Observations: None
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC had an onsite Dental Clinic. Dental Services staff was comprised of the Dental Director, one Dental Hygienist, with one unfilled Dental Hygienist position, two Dental Assistants, and a contract Anesthesiologist. The Anesthesiologist provides services two days per month, providing anesthesia to approximately eight to ten individuals during the month. Plans were to add another full time Dentist in May, 2010. RSSLC's Dental Clinic staff worked with the Behavior Analyst to develop desensitization plans for individuals who were identified as uncooperative and/or resistant to dental services. Of the total facility population, it was reported that approximately 125 individuals could not manage with only oral sedation and required Total Intravenous Anesthesia (TIVA). Reportedly, the use dental sedation was decreasing. The dental data related to the use of dental sedation were not formally analyzed or trended in a manner to discern whether a decrease in use of sedation was occurring. The facility's dental staff needs to collaborate with the behavioral analyst to continue to track and trend data related to the utilization of dental sedation, by type, and desensitization plans. These data need to be represented in a formal report. Review of the above individuals' records indicated that annual dental examinations were completed within their anniversary month of admission and/or the last annual dental examination. There was evidence that individuals received dental services timely and according to their recommended follow-up care or when emergency dental care was indicated. RSSLC's Dental Program did not have a formalized tooth brushing program but was in the process of starting one. The facility does not use suction toothbrushes for individuals at risk for aspiration because of concern that they may not be safe. Suction toothbrushes were used in most of the other State Supported Living Centers. It was suggested that the facility re-evaluate the use of suction toothbrushes for safety and effectiveness. RSSLC's Dental Clinic kept a paper calendar for scheduling appointments. If individuals refused their appointments it was documented in their dental records. Dental Appointment – No Show Reports were sent to the home. There was evidence in the individuals' dental records that appointments were rescheduled. RSSLC's Dental Clinic Policy and Procedure Manual has not been reviewed and/or revised since 02/09/01. Reportedly, the State Office was in the process of developing new dental policies and procedures. When these are finalized they will be incorporated into the facility's Dental Policy and Procedure Manual. The Dental Clinic was following a draft policy, procedures, and protocol for Total Intravenous Anesthesia (TIVA) Procedures and Protocol for Oral Sedation. Review of dental records of individuals who received some form of dental sedation, indicated that the draft policy, procedure, and protocol were followed.

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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.	RSSLC's had an onsite Dental Clinic. Dental Services was comprised of the Dental Director, one Dental Hygienist, with one unfilled Dental Hygienist position, two Dental Assistants, and a contract Anesthesiologist. The Anesthesiologist provides services two days per month, providing anesthesia to approximately eight to ten individuals during the month. Plans were to add another full time Dentist in May, 2010. Dental Services report to the Medical Director. Interview with Dr. Heath, DDS, included an overview of RSSLC's Dental Services. Dr. Health explained that of the total population at RSSLC, approximately 125 individuals could not manage with only oral sedation and required Total Intravenous Anesthesia (TIVA). Approximately 10 to 15 individuals would not receive TIVA because of medical conditions. Those individuals are sent to the University of Texas (UT) at Galveston Hospital, UT Dental Branch for dental care and treatment. Often there was a 12 month wait for services unless emergency care was needed. The Dental Clinic had ordered a wheelchair lift for individuals at risk for injury during transfer. Individuals who were too fragile or difficult to transfer were visually examined and provided oral care (tooth brushing) in their home. There was no formal tooth brushing program in the home. Dr. Heath stated that they were planning to start such a program. She stated that the direct care professionals (DCPs) need firmer guidance in oral care. RSSLC uses Oral Health Care Training by Specialized Care Co. Inc. training video that in Dr. Heath's opinion was not as good as the one through Special Care Dentistry Association. Dr. Heath would like to replace the existing training video with this training video. The dental staff worked with the DCPs in the clinic and in the homes to assist them with providing oral care. The facility needs to consider replacing the existing oral care training video with the Special Care Dentistry Association's Oral Care training video. According to Dr. Heath and review of her 08/31/07 E-mail memo to all staff, the facility does not use suction toothbrushes. The rationale presented in the memo stated, "An informal review suggest that aspiration actually increases with the use of toothbrushes. Whether this is because of a learning curve associated with the use of the brushes, some characteristic of the brushes themselves, or something altogether unrelated, we don't know at this time. Reports also suggest that these brushes are not as effective as hoped. We will not be using suction toothbrushes until the matters are clarified." Review of Management of Aspiration Pneumonia Risks: Information for Clinical Staff, Texas of Aging and Disability Services (www.texasqualitymatters.org), page 17, condones the use of suctions toothbrushes, "Brushing once to three times per day has shown to be effective. Tools currently available include toothbrushes with suction tubes attached to aid in removing secretions." The use of suction toothbrushes was a common practice in	

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		most SSLCs' for individuals at risk for aspiration. The nursing staffs were trained and responsible for using the suction toothbrushes. The facility needs to continue to research the safety of suction toothbrushes and consider implementing their use for individuals at risk for aspiration. Review of dental records and dental notes of Individuals #70, #174, #145, #281, #651, #7, #114, #84, #460, and #500, revealed that all consistently contained the following information: • Annual dental examinations were completed within their anniversary month of admission and/or the last dental examination. • Individuals received dental services timely according to their recommended follow-up care or when emergency care was indicated. • Documentation of routine dental services included but were not limited to: o Review of physical health impact on dental services. o Review of individual's medication. o Review of allergies. o General condition of current oral environment. o Findings of dental assessments. o Descriptions of any treatment provided. o When extractions were necessary and/or other restorative and preventative procedures were performed there was clinical justification documented describing the rational for each. o Plans of care were consistent with examination findings. o Oral hygiene instructions were provided to either the individuals or the staff accompanying the individuals at the time of their dental visit. Review of dental reports of Individuals #267, #469, #25, #643, #44, #513, and #92, who were admitted within the past six months, validated that they were seen within 30 day of admission and received follow-up visits, as indicated, in the chart below: **Admission Date / Individual # / Initial Visit Date / Last Visit Date** 09/21/09 / #267 / 09/30/09 / 03/15/10 09/23/09 / #469 / 10/13/09 / 09/28/09 / #25 / 10/13/10 / 02/16/10 11/02/09 / #643 / 11/16/09 / 03/08/10 11/17/09 / #44 / 11/24/09 / 03/08/10 12/14/09 / #513 / 12/15/10 / 01/12/10 12/28/09 / #92 / 01/11/10 / Six of the seven individuals had routine and preventative dental care. One had an	

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		emergency care due to an abscessed tooth that was extracted. There were no documented uses of physical restraints in any of the ten individuals' dental records reviewed; this will be reviewed further in compliance visits to ensure medical restraints are being documented. All dental records and dental notes were available to the PST. Two of the ten individuals were at risk for aspiration. Each of the two individuals had a plan addressing aspiration precautions to take during dental examinations and procedures. Sedation was used in eight of the ten individuals. When pre-treatment sedation was ineffective there was documentation describing the ineffectiveness of pre-treatment sedation in the dental records and/or dental notes with recommendations for TIVA. Dental notes were contained in the integrated progress notes for each individual. Some of the dental integrated progress notes contained blank spaces without consistently crossing out the undocumented portion of the note sheet. The facility's dental staff needs to properly cross out undocumented portions of the integrated progress notes. Each of the ten individual's dental records reviewed contained numerous refusals and/or missed appointments. It was rare to find that missed appointments were due to lack of staff. The Dental Clinic kept a paper calendar for scheduling appointments. Review of the Dental Appointment Calendar, 02/02/10 through 04/27/10, indicated that after the appointments were made, they were typed, and sent to each home one week before the appointments were due. If individuals refused appointments it was documented in their dental records. Behavior Incident Reports (BIRs) were completed regarding the refusals, and sent to their respective Qualified Mental Retardation Professionals and Behavioral Analysts at the end of the month. This information was used for developing and/or modifying their DSPs. In addition, a Dental Appointment – No Show Reports were sent to the home. There was evidence in the individuals' dental records that appointments were rescheduled.	
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	Review of RSSLC's Dental Clinic Policy and Procedure Manual revealed that it had not been reviewed and/or revised since 02/09/01. Dr. Heath stated that the state office was in the process of developing new dental policies and procedures. When these are finalized they will be incorporated into the facility's dental policy and procedures and the Manual revised in alignment with the state's policy and procedures. Dr. Heath explained that the Dental Clinic was following the draft policy, procedures, and protocol for Total Intravenous Anesthesia (TIVA) Procedures and Protocol for Oral Sedation. The facility's Dental Clinic Policy and Procedure Manual needs to be revised and updated in alignment with the Settlement Agreement (SA) and Health Care Guidelines (HCG).	

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	dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	Review of Individuals' #70, #174, #145, #281, #651, #7, #114, #84, #460, and #500 dental records and dental notes demonstrated that the draft policy, procedures, and protocol for Total Intravenous Anesthesia (TIVA) Procedures, Protocol for Oral Sedation, proposed policy for Parenteral Sedation Intravenous (TIVA) Anesthesia Recovery were followed as described for the eight of the ten individuals who received pre-treatment sedation and/or TIVA. Seven of the eight individuals who received some form of sedation had a DSP for desensitization, developed, implemented, and monitored by the Behavior Analysts and/or QMRPs. Two of the DSPs for desensitization were related to improving tolerance to toothbrushing. Three DSPs related to improving tolerance to toothbrushing in an effort to increase cooperation during routine dental procedure at the Dental Clinic. Two of the DSPs were specifically related to increasing tolerance for dental procedures. Individual #174's DSP was comprehensive and explicit in identifying supports, plan, and responsible persons. Dr. Heath stated the dental clinic works with the behavior analyst to develop desensitization plans for individuals who were identified as uncooperative and/or resistant to dental services. Refer to Provision J4 for information about typical desensitization plan procedures. Dr. Heath reported that the quality assurance review of number of individuals requiring some form of sedation has decreased with increased effort in developing and implementing desensitization plans. Dr. Heath reported that now more than one-half come to the dental clinic without sedation. Dr. Heath stated that the Behavior Analysts were tracking and trending these data. Trend data were requested in the document request. The information available for review was the Dental Clinic's "Sedation for Dental" monthly lists, September, 2009 through February, 2010, supplied through the document request. The monthly lists included the names of the individuals, their homes, those who had a DSP, and who received pre-treatment sedation and/or TIVA. The data were not analyzed or trended in a manner to discern whether a decrease in use of sedation was occurring. The facility's dental staff needs to collaborate with the behavior analysts to continue to track and trend data related the utilization dental sedation, by type, and desensitization plans. This data needs to be represented in a formal report. This issue will be further reviewed in future tours. RSSLC Policy J.11 using Sedation for Medical/Dental Appointments requires the Personal Support Team (PST) to consider five general questions that address considerations other than restraint. These include; what are the frequency and possible causes of behaviors	

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		that interfere with the individual's ability to receive routine medical/dental treatment, what does staff do to prepare the individual for medical or dental examinations in order to reduce the need for sedation, and similar questions. This policy refers to Policy J.13 Implementing Dental Support Treatment Support Plan. In a review of implementation of J.13 the monitoring team determined that the Dental Treatment Support Plan Checklist called for in the policy was, for the most part, not being used by PSTs. Please refer to provision C4 for additional information.	

Recommendations:

1. The facility needs to continue to research the safety of suction toothbrushes and consider implementing their use for individuals at risk for aspiration.
2. The facility's Dental Clinic Policy and Procedure Manual needs to be revised and updated in alignment with the SA and HCG.
3. The facility's dental staff needs to consider replacing the existing oral care training video with the Special Care Dentistry Association's oral care training video.
4. The facility's dental staff needs to properly cross-out undocumented portions of the integrated progress notes.
5. The facility's dental staff needs to collaborate with the behavior analysts to continue to track and trend data related the utilization dental sedation, by type, and desensitization plans.

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:** • Reviews of Individuals #16, #755, #52, #30, #455, #640, #99, #91, #437, #525, #786, #2, #598, #426, #162, #146, #301, #215, #12, #261, #468, #743, #800, #691, #627, #618, #663, #402, #7, #73, #597, #84, #145, #538, #535, #418, #478, #241, #621, #157, #719, #179, #267, #290, #71, #159, #553, #173, #392 • Communication Services Policy (# 016) • Speech Communication Device/Strategy Monitoring form (3/16/2009) • Augmentative and Alternative Communication Screening • Dysphagia Evaluation • List of individuals with AAC • List of individuals receiving direct speech services **People Interviewed:** • Kendra Robbins CCC-SLP • Gary Sandler OTR Habilitation Services Director • Discussions with various direct care staff on Leon, Neches, San Antonio, and Trinity **Meeting Attended/Observations:** • PSP (Individual #402)4/26/10 • OT/PT assessment (Individual #478) • Observations of living areas and dining rooms on Leon, Trinity, San Antonio, Neches, and Pecos • Nutritional Management Team (NMT) meeting 4/27/10 • Modified Barium Swallow Study
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC's approach to augmentative communication and assistive technology is fragmented and not team-oriented. RSSLC lacks sufficient coordination and collaboration between and among the various disciplines, especially with regard to the need for proper communication devices on wheelchairs and to address aspects of communication associated with behaviors. In addition, the center fails to provide sufficient assistive communication systems to all individuals who would benefit from such supports. Although it is positive that communication plaques were placed in many common areas, and all individuals have at least a communication dictionary, these were not observed to be used nor was the staff knowledgeable of the dictionaries. Currently, RSSLC does not have enough clinicians to provide adequate speech therapy to meet the needs of individuals who require these services.

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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 implementation of programs.	At the time of the baseline review, there were three SLPs providing services at RSSLC. Per review of their CVs and continuing education, they have received training in the areas of augmentative communication, physical and nutritional management for SLPs and attended the Texas Speech and Hearing convention over the past year. Although there is not an identified Director Of Speech Pathology; Kendra Robbins SLP served as the primary team leader. There was a concern that RSSLC does not employ as many Speech Language Pathologists as needed to fully support the individuals living at RSSLC. Currently, the caseload for the SLP is approximately 138.5 individuals per therapist. This large of a caseload may result in difficulty addressing all the individuals in a proactive manner. As of the baseline review, 66/416 individuals living at RSSLC had some form of communication device. Based upon information provided by the speech therapists at RSSLC, there are many individuals who are need but have not received the needed AAC interventions due to the lack of available staff.	
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.	Per interview with SLP, all individuals have been provided with speech assessments. All individuals have received a Speech-Language Assessment. The majorities of the individuals received these assessments during 2008 and are scheduled to receive another full assessment in 3 years which will be occurring around 2011. Individuals who received direct speech services received annual updates. Upon observation of records reviewed, 12/14 contained terminology which was difficult to measure, was vague or was incomplete. For example: • Individual #2 uses 10-20 functional words but the assessment does not provide a list or mention the functional words. • Individual #755 expressive language is commensurate with mental functioning but does not state the level of mental functioning. • Individual #765 expressive language skills are not included as part of the assessment. • Individual #701 expresses by vocalizations, crying, and facial expressions. The assessment does not state the communicative intent of these items Additionally, the speech assessment does not consider behavioral issues as identified by state policy #016. There was no system in place that clearly defined the collaboration between Psychology and Speech. Per interview with the Speech Therapist, the process is informal and does not occur on a consistent basis. Per SLP interview there are six individuals receiving direct speech services. These individuals are working with mid-high tech Augmentative and Assistive Communication (AAC). All other individuals who had AAC devices are not seen by the SLP. SLP referrals	

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		were not reviewed at this baseline; therefore this area will need to be addressed in additional reviews. There is not a clear policy in place that clearly defines either the assessment schedule or the depth of those assessments. For example, the policy followed by the therapists at RSSLC does not state how frequently individuals should be evaluated or whether they receive an update or full assessment. RSSLC does not have a Communication policy other than State Policy #016 dated 10/07/09. The state policy provides general guidelines but is not specific to or identical to what is implemented at RSSLC. Per SLP interview, all individuals living at RSSLC are provided with speech assessments. There is an AAC component to the existing Speech assessment but it is not comprehensive as it does not provide for exploration or trials of devices and does not clearly identify skills needed for AAC use. Individuals who are identified for additional assessment were not consistently provided with such assessments. For example, individual #290 received a speech assessment on 9/7/09 but did not receive an additional AAC assessment 60 days later as recommended in the initial assessment.	
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.	The PSP mentions if the individual is using an AAC but does not consistently state how the device is used or how the device improves the ability to communicate and enhance his/her daily life. Fourteen PSPs were reviewed to assess this section. Fourteen of fourteen PSPs (Individual #16, #755, #52, #30, #455, #640, #99, #91, #437, #525, #786, #2, #598, #426) contained reference or a brief statement of an individual's communication skills, such as, "communicates with facial expressions" or in other cases simply stated "the individual uses a communication board". Details regarding communication were not integrated into the PSP. Action Plans do not consistently integrate information from the communication assessments nor was there a process in place that ensures action plans are developed that correspond and include the training of the communication device. Of the 66 communication devices available to the individuals, all of them are portable and can travel to a variety of locations. The issues with the communication devices are that they are not readily available to the individual. The devices are missing (which Speech Therapy reports is an ongoing issue), the devices are not used, or the devices are in locations that are not accessible by the individual. Common area AAC devices were present in dining rooms and at the entrance of doors but like personal devices, these were not observed to be utilized.	

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		Personal devices had the potential to be meaningful; however, it was difficult to measure meaningfulness since there was no implementation of the devices observed. Common area devices, though not used, had the potential to be meaningful and useful to the individual if consistently used. Staff were provided with communication training during new employee orientation but were not provided with any type of annual refresher training. The training consisted of general information regarding AAC devices and the enhancement of communication. The training is informational in nature and does not contain a competency based component. AAC devices were observed in the dining rooms; however, it was unclear as to whether these were meaningful to the individual secondary to no usage observed during the baseline review and the message contained on the device. For example, the device on Pecos verbalizes "Sit down and enjoy your meal"; it is unclear as to who this message is for. It is unlikely that individuals would use this message to communicate with staff since staff were not eating at the time. If the message is intended for the individuals then it would be better served coming directly from staff.	
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.	Monitoring system that: a) Tracks the presence of the ACC; b) Working condition of the AAC; c) The implementation of the device; and d)Effectiveness of the device. Per the Speech Therapist, monitoring is conducted once a month and focuses on the presence of the device, the working condition, and implementation but does not assess whether the device is effective in assisting in the individual with improving their communicative abilities. The monitors are conducted by the three speech therapists and a PNMP coordinator. As with other areas of monitoring, data acquired from the forms are not gathered and assimilated for analysis or trending. Monitoring covering the use of the AAC during all aspects of the person's daily. There was no evidence of a process or policy that ensures augmentative equipment was monitored throughout all aspects of the individual's daily life. Validation Checks. There is no process in place that provides for validation checks to ensure consistency across monitors.	

Recommendations:

1. Analysis of the SLP staffing should be provided to ensure staffing levels are sufficient to meet the increased demands of the Settlement Agreement
2. Focus on improving communication during mealtimes as this is an opportune time for natural engagement

3. Review the current messages on the AAC devices in the common areas to ensure they are meaningful and utilized.
4. Expand the presence and use of AAC devices in common areas (such as living rooms and vending areas).
5. Develop a monitoring system that is regularly scheduled and ensures all devices and individuals are included in the process. Monitoring should focus not only on presence and working condition but whether the device remains appropriate, functional and meaningful. Additionally, monitoring should occur much more frequently than once per month.
6. Ensure devices are available and utilized across all settings (regardless of whether the device is high or low tech).
7. Ensure assessments are detailed and clearly provide rationale and justification for recommended strategies and interventions.
8. Initiate increased opportunities for social interaction and utilization of devices during day programming.

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:** Documents that were reviewed included the annual PSP, PSP updates, SPOs, PBSPs, 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, and behavioral and functional assessments. These documents were reviewed for the following individuals: #8, #16, #25, #44, #51, #70, #96, #107, #120, #149, #162, #193, #267, #315, #320, #429, #448, #450, #525, #531, #613, #630, #643, and #676 **People Interviewed:** Heather Blackwell - Director Vocational Services Bill Eckenroth - Director of Behavioral Services Cynthia Fannin - Director of Education and Training Ashok Jain, M.D. - Psychiatrist David Partridge, M.D.- Director of Medical Services Jane Purcell - Assistant Director of Programs Frank Rainer - Director of Recreation Gary Sandler - Director of Habilitation Therapies All Behavior Services staff Six QMRPs 17 Direct Care staff **Meeting Attended/Observations:** Peer Review Committee Human Rights Committee Psychiatric Assessment (Neches) PSP Observations of all workshops Observations of meals, program implementation and leisure activities in the following residences: Angelina, Colorado, Leon, Neches, Rio, San Antonio, Trinity,
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: The initial site visit to RSSLC provided an opportunity to obtain a benchmark or baseline measure of where the facility currently stands in relation to the delivery of services. Among what was observed and reviewed were several positive elements that should facilitate the efforts of RSSLC to comply with the Settlement Agreement. These positive elements included the following:

	• Fewer episodes of undesired behavior were generally observed in vocational workshops than other areas of the facility. Individuals employed at these workshops were noted to be happy and engaged in goal-oriented and productive activities. • Staff members at all levels were routinely observed to be highly motivated in meeting the personal needs of the individuals living at the facility. The efforts of staff members included such goals as ensuring that an individual attending public school was able to participate in prom, arranging for tickets to highly desired sporting and entertainment events throughout the Texas, and organizing unique events to be held at the facility such as horse shows and a symphony concert. • Skill acquisition programs, although areas of weakness were noted, possessed sufficient sophistication to provide a solid foundation for further development. • The Forever Young retirement program was observed to provide multiple activities, good rotation of attention, and multiple opportunities for choice and personal preference. • Jane Purcell, Assistant Director of Programs, was very enthusiastic regarding the individuals at the facility and what can be achieved. She placed a high priority on getting individuals out of their homes for training, leisure, etc. All of these positive factors contribute to the overall quality of life for individuals living at RSSLC. Unfortunately, multiple other circumstances observed at RSSLC indicate that the facility in general is poorly prepared to provide the minimum necessary level of services required by the Settlement Agreement. In numerous settings, staff of all levels was observed to be poorly prepared for providing services. In dining rooms, staff were frequently observed to be unaware of teaching opportunities, did not intervene when undesired behaviors were displayed, and often inadvertently acted to increase rather than decrease agitation and the potential for undesired behavior. In many circumstances, staff actions indicated a general lack of skills relating to applied behavior analysis. For example, staff often were observed to interact with individuals in ways that have been shown to maintain or strengthen problematic behaviors (such as unintentionally providing possible reinforcers following the behavior where the contingencies were obvious) and did not recognize their actions could be a reason that a behavior occurred or was maintained. In other situations, the minimal interaction between staff and individuals inhibited the opportunities for teaching and intervention. The lack of skills in relation to applied behavior analysis and other formal teaching procedures also contributed to noted weaknesses in skill acquisition programs. The majority of skill acquisition programs involved good organization, the basic elements of sound data collection, and a logical approach to teaching a skill. Despite these strengths, there was no indication that attempts were being made to identify and use effective and individualized skill acquisition training techniques. For example, programs included only a limited number of trials and a subjective process for selecting reinforcers rather than identifying reinforcers through reinforce and preference assessments. In addition, data collection did not include documentation of the type or frequency of reinforcement. This combination of strength and weakness suggests the need for further training and access to resources so that the Facility and its staff can build upon existing strengths.

	Observation also reflected that staff had not been provided sufficient training on specific formal programs. Staff typically could locate individual programs and data sheets, but often demonstrated that they were uncomfortable or unsure about implementing the programs. Additionally, staff at times presented concerns that the programs to be implemented were too advanced for the individual or were unaware of the basic skills being taught. As these issues were observed in numerous locations, it was suggested that this issue is relatively pervasive. The overall impression gained from observations and reviews regarding skill acquisition programs is that the majority of the staff at RSSLC want to provide meaningful services for the individuals living at the facility but have not been provided the skills and resources necessary to do so. Explanation of scores: During a site visit, a group of people is chosen to be reviewed. This group is called a sample. Each person in the sample group is rated on several items. These ratings can show how successful the center has been complying with the Settlement Agreement. The ratings can be a 0 (Not Successful), 1 (Partially Successful) or 2 (Fully Successful). Each table below has a column called Average Score. The Average Score is the average of each person's score on that item. The average can be from 0 to 2. A higher average score can show progress has been made meeting that item. Each table also has a column for Percentage FS. The Percentage FS is the percentage of the people in the sample group who was rated as 2 (Fully Successful). A higher percentage shows that more people in the sample scored a 2 for that item. An item with a higher Average Score can still have a low Percentage FS. This is because the two numbers show things in different ways. By comparing both numbers from site visit to site visit, progress can be measured in two different ways.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall	The data below reflect a review of the records of 24 individuals regarding assessment of personal skills and abilities. Substantial limitations were noted across the majority of areas requiring assessments. • Behavioral and psychology assessments have been discussed in Section K. • Psychiatric assessments provide abundant descriptive information. In many cases, the psychiatric assessments do not use this descriptive information as a foundation for more objective and empirical analyses. As a result, the psychiatric assessments frequently do not lead to supportable diagnoses or evidence-based approaches to treatment. • Other skill area assessments typically are descriptive in nature, including statements such as the	

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	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.	person is able to hold a cup or understand the concept of money. These assessments typically do not provide data to support these conclusions or describe the process by which these conclusions were reached. Due to these limitations, although some training programs may reflect needs identified in skill assessments, it cannot be stated unequivocally that the assessments are accurate or have identified real and meaningful needs. **Adequate habilitation training provided to individuals** — Average Score / Percent FS 1 Skill acquisition plans have been implemented to address needs identified in: — 1.00 / 0.0% a. Psychological assessment (K 5). — 1.00 / 0.0% b. Psychiatric assessment. — 1.00 / 0.0% c. Language and communication assessment. — 1.00 / 0.0% d. PSP — 1.00 / 0.0% e. Other habilitative, adaptive skill or similar assessments. — 1.00 / 0.0% f. Medical assessments. — 1.00 / 0.0% In 24 of 24 records reviewed, skill acquisition programs included diverse strengths and weaknesses. The majority of programs did reflect reliance upon some form of task analysis. These programs also included efforts to include the majority of basic components of a teaching program, such as behavioral objectives, operational definitions, specific instructions and appropriate consequences. These basic components in many cases lacked the sophistication necessary to achieve the goal of the program. Some examples are provided below. • Teaching procedures were noted to include typographical errors, varying formatting and vague wording that interfered with staff implementation. • The majority of skill acquisition programs included 1 to 3 trials per day or less. Teaching skills requires abundant opportunities for learning, often including 10 to 20 trials per session with at least one session per day. • Reinforcement for successful trials typically involved verbal praise. Reinforcement, especially when teaching new behaviors, should be powerful and varied to avoid satiation. Selection of reinforcers should be based upon empirical data and be driven by the responses of the individual. • Consequences for incorrect trials typically included verbal or physical guidance. There was seldom any indication that assessments had determined such consequences would not reinforce poor cooperation. • Documentation typically involved recording the level of prompting required for success and an area for comments. Adequate data collection should include such elements as the provision of reinforcement, incorrect responses, refusal, and displays of undesired behavior.	

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- All progress reports for skill acquisition programs included only tabular displays of data. Data should be presented in graphs that include a baseline and basic structural components.

	Adequate habilitation training provided to individuals		Average Score	Percent FS
2	Skill acquisition plans include components necessary for learning and skill development. At a minimum, these components include the following. (All items below must be FS for this to be scored FS)		1.00	0.0%
	a.	Plan reflects development based upon a task analysis.	2.00	100.0%
	b.	Behavioral objective(s).	2.00	100.0%
	c.	Operational definitions of target behavior.	1.00	0.0%
	d.	Description of teaching conditions.	1.00	0.0%
	e.	Schedule of implementation comprised of sufficient trials for learning to occur.	0.00	0.0%
	f.	Relevant discriminative stimuli.	1.00	0.0%
	g.	Specific instructions.	1.00	0.0%
	h.	Opportunity for the target behavior to occur.	1.00	0.0%
	i.	Specific consequences for correct response.	1.00	0.0%
	j.	Specific consequences for incorrect response.	0.00	0.0%
	k.	Plan for maintenance and generalization that includes assessment and measurement methodology.	0.00	0.0%
	l	Documentation methodology	1.00	0.0%

Due to the limitations noted in the assessments of skills, the identification of needs and the components of skill acquisition programs, at the time of the site visit it was unlikely that the majority of skill acquisition programs were effectively enhancing the skills and independence of the people living at RSSLC.

	Adequate habilitation training provided to individuals	Average Score	Percent FS
3	Overall, the set of skill acquisition programs promote growth, development, and independence	1.00	0.0%

Reviews of the records for 24 individuals, as well as observations of those and other individuals in a variety of settings reflected an overall inability to provide reasonable levels of individualized engagement. In several settings, there was a pervasive lack of engagement.

- In the Leon dining room, individual #162, who has a PBSP for pica, was observed engaging in pica without staff intervention. Additionally five of 13 individuals were observed engaging in stereotypic

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		behavior without intervention being provided. No prompting or redirection was offered by staff for any displays of poor posture, eating with fingers or minor displays of undesired behavior. • In the Trinity dining room, staff performed hand washing and meal activities with only minimal observed prompts, reinforcement or verbal engagement. Individual #134 has a program that includes verbal prompts for posture and the pace of eating. Staff provided interaction with Individual #134 only when the individual became loud and intrusive. No intervention or redirection was observed for stereotypic behavior, mild self-injury or other minor undesired behaviors. • In the Neches D classroom staff were observed attempting to prompt and engage several primarily non-responsive women. Although willing, staff lacking familiarity with basic focusing and reinforcement strategies. • In the Neches B home, one individual was observed sleeping, two individuals were not provided materials and engaged in frequent stereotypic behavior and a fourth individual was sleeping. Training programs were misfiled and staff reported having been provided only minimal initial training on the programs. • In the Satellite workshop, five of 24 individuals observed engaging in stereotypic behavior without redirection or intervention. In addition to providing sound skill acquisition programs, it is essential that efforts be made to ensure that formal and informal teaching is being provided consistently and correctly. Observations did not reflect a process by which RSSLC attempted to formally assess the implementation of skill acquisition programs or determine whether staff had the necessary skills and knowledge to conduct formal or informal teaching. In the examples offered above, staff members did not recognize or acknowledge the need to act differently until the situation was brought to their attention. **Adequate habilitation training provided to individuals** — Average Score: 0.00 — Percent FS: 0.0% 4 A plan is in place to address, monitor, and maintain reasonable levels of individual engagement in all settings at the facility, including residences, day programs, and work sites. The data below reflect a review of the records of 24 individuals regarding application of skill acquisition programs. Based upon these data and the observations noted above, there is little to suggest that the majority of skill acquisition programs or teaching sessions have incorporated individual preferences. Some records and staff interviews suggest informal preference or reinforcer assessments. **Adequate habilitation training provided to individuals** — Average Score: 1.00 — Percent FS: 0.0% 5 There is an adequate array of skill acquisition programs and work and leisure opportunities to:	

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<tr><td></td><td>a.</td><td>Incorporate individual preferences; and</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>b</td><td>Support active engagement in the absence of individual skill acquisition plans.</td><td>1.00</td><td>0.0%</td></tr>
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<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>
The data below reflect a review of the records of 24 individuals regarding annual assessments of needs. As indicated previously in this section, while annual assessments are conducted on an annual basis as part of the PSP process, these assessments lack the rigor and sophistication necessary to be considered valid assessments.
<table>
<tr><th></th><th colspan="2">Assessment for habilitation</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td colspan="2">With regard to living, working and leisure activities, records demonstrate annual assessment of each individual in a minimum of the following areas: (All items below must be FS for this to be scored FS)</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><td>Preferences</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>b.</td><td>Strengths</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>Skills</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>d.</td><td>Needs</td><td>1.00</td><td>0.0%</td></tr>
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<tr><td>S3</td><td>Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Include</td><td>Both observations and interviews with staff reflect that skill acquisition programs are not implemented</td><td></td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>consistently or as written. Teaching is often conducted in a haphazard manner in terms of schedule and teaching strategy. Cues, prompts and other elements of effective training are often not offered or are presented in an informal and inconsistent manner. No staff members were observed to be collecting data during the implementation of a skill acquisition program. As a result, there is little to suggest that the implementation of skill acquisition programs results in meaningful changes in behavior, independence or the quality of life for individuals living at RSSLC.

<table>
<tr><th></th><th colspan="2">Skill acquisition programs individualized and functional</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td colspan="2">Skill acquisition programs are targeting needs identified by assessments (K5)</td><td>1.00</td><td>0.0%</td></tr>
<tr><td>2</td><td colspan="2">Implementation of skill acquisition plans is adequate for skill development and learning:</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>a</td><td>Plan method is implemented as written. (All items below must be FS for this to be scored FS)</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td></td><td>As assessed by staff report.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td></td><td>As assessed by observation.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>b.</td><td>Plan is implemented according to the specified schedule.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>Reinforcement is used appropriately.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>d.</td><td>Prompting and practice are used appropriately.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>e.</td><td>Plan is practical and functional in the most integrated setting.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>f.</td><td>Data are graphed.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>g.</td><td>The plan is producing meaningful behavior change.</td><td>0.00</td><td>0.0%</td></tr>
</table>
</td><td></td></tr>
<tr><td></td><td>(b) Include to the degree practicable training opportunities in community settings.</td><td>At present, no individuals are employed at off-campus locations. A plan has been submitted to MOU for creating off-campus enclave employment at Marshalls. Staff indicates that jobs will be offered once the approval is obtained.

A wide-variety of community leisure and recreational activities are organized by RSSLC. These activities have been individual, such as an individual attending prom at her public school. In addition, numerous group activities have been organized, such as professional sporting events, concerts by pop artists and symphony orchestras, equestrian exhibitions, and cultural fairs. Leisure and recreational outings are also used to reinforce skill acquisition by including opportunities for money management, self-care and socialization.</td><td></td></tr>
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Recommendations:

1. Staff members tasked with the development of skill enhancement programs at RSSLC do not possess an adequate understanding of reinforcement techniques, preference assessment, prompting procedures, discrete trial training, behavioral momentum and other aspects of effective teaching. The Facility should develop and implement a competency-based training curriculum emphasizing applied behavior analysis, learning theory and the development of skill enhancement programs. In addition, the facility should implement routine monitoring of skill acquisition programs, as well as the implementation of those programs.

2. The staff members at RSSLC who are responsible for teaching lack the skills to do so effectively. The Facility should develop and implement a competency-based training curriculum for these employees emphasizing the skills necessary in the implementation of training programs. This training should include instruction on the technical aspects of teaching and documentation, as well as the less technical aspects such as building relationships, providing choice, encouraging motivation and making teaching enjoyable.

3. RSSLC should develop a process to monitor formal and informal teaching using a competency-based model, with the goal of enhancing staff skills and increasing individual skill acquisition.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10, and six attachments 2. Richmond State Supported Living Center (RSSLC)Policy And Procedures: • F.3 Participating in Annual Personal Support Plan Meeting • Policy F.18 Participating in Personal Focus Worksheet Meetings • G.5 Recommending and Choosing a Provider for Community Movement; • G.8 Withdrawal of Referral for Community Movement; • G.9 Placement/Program Review Team 3. 2008 Revised Texas Promoting Independence Plan 4. Personal Support Teams: PDP Process training materials, 2009 5. Community Integrated Discussion Record Instructions, dated March, 2010 6. List of alleged offenders committed to the facility 7. List of individuals placed in the community 8. List of individuals referred for community placement 9. List of individuals requesting community placement 10. List of individuals assessed for placement from 7/1/09-4/26/10 11. List of alleged offenders residing at the facility 12. Position Descriptions for Case Worker, Director of Social Services, QMRP, Post Move Monitor, Assistant Ombudsman 13. Personal Focus Worksheet: Individualized Assessment Screening Tool (PFW) for 4 individuals: Individual #117, #402, #559, #681 14. Personal Support Plans (PSP) for 19 individuals: Individuals #2, #62, #114, #130, #148, #264, #342, #363, #402, #421, #454, #459, #493, #572, #584, #596, #755, #776, #777, #778 15. Personal Support Plan Meeting Monitoring Checklists, including follow-up actions, for 8 individuals: Individuals #2, #5, #114, #134, #402, #437, #708, #776, #786 16. Draft Quality Assurance Instrument for PSPs based on Texas Settlement Agreement Monitoring Instrument, Section F 17. Draft HCS (Home and Community Services) Handbook, including the Person Directed Plan (PDP) Discovery Tool Form 8665-DT, dated June, 2010 accessed at http://www.dads.state.tx.us/HCSCMTransition/DRAFTHCSHandbook.pdf 18. Pre-Application Orientation for HCS providers accessed at http://www.dads.state.tx.us/providers/pao/index.html 19. Community Living Options Information Process (CLOIP) Worksheets for 3 individuals: Individuals #130, #148, #459 20. CLOIP Presentation materials provided by Texana Center, the Contract Mental Retardation Authority (MRA), including Texana Center Procedure 71.005, Community Living Options Information Process;

	Publication 257, Community Living Options Information Process for Legally Authorized Representatives of Residents in State Supported Living Centers; Publication 256, Community Living Options Information Process; MRA Service Coordinator Community Living Options Information Process Worksheet form; List of HCS Program Providers for Waiver Contract Area 5; List of Assigned Texana Community Access Service Coordinators by Unit/Home, and Publication245, Explanation of Mental Retardation Service and Supports 21. Attachment 1 to the Texana MRA contract with DADS FYs 2010 and 2011, Special Terms and Conditions 22. List of Community Tours dated 7/11/08-5/24/10,, including individual and staff attendees 23. Community Living Discharge Plan (CLDP) for 11 individuals: Individuals #22, #34, # 62, #226, , #496, #516, #572, #638, #648, #732, #742 24. Post Move Monitoring Reports for 13 individuals: Individuals #22, #34, #226, #341, #486, #496, #516, #572, #638, #648, #721, #732, #742 25. Permanency Planning Instruments for 8 individuals: Individuals #25, # 36, #44, #246, #455, #630, #643, #755 26. Permanency Planning Tracking System documents for November, 2009-April,2010 27. Self-Advocacy Meeting materials 28. RSSLC Statement Of Deficiencies And Plan Of Correction, Form CMS-2567, 01/08/2010 29. Information Letter No. 10-58, Request for Participation in Provider Training Needs Assessment Survey, dated April 26, 2010 **People Interviewed:** 1. Parent of Individual #681 2. Cynthia Newton, Director of Social Services (DSS) 3. Carol Agu, QMRP Consultant 4. Terri Carter, Post Move Monitor 5. Angie Penn, Social Worker (Case Worker) 6. Joan Poenitzsch, Director of Quality Assurance 7. Jim North, Program Auditor 8. Program Manager, Royal Investment Group 9. Lorri Haden, DADS Attorney 10. Community Access Manager and five Community Access Service Coordinators, Texana Center (Contract MRA) **Meetings Attended/Observations:** 1. PSPs for 3 individuals: Individuals #174, #402, #681 2. Post Move -Monitoring Visits for two individuals: Individuals #62 and #572 3. Self-Advocacy Meeting 4. Conference Call with DADS on 3/11/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment:

	The leadership at RSSLC expressed a belief in and commitment to facilitating services in the most integrated setting possible. The Facility has a relatively high rate of referral for community living and of successful moves to the community. The monitoring team saw a number of good practices in the area of serving institutionalized persons in the most integrated setting appropriate to their needs, but these were often the practices of certain individuals rather than systemic approaches. RSSLC is fortunate to have many seasoned and creative staff in key positions who will need to work closely together to develop the policies and procedures required for a cohesive and collaborative system. This system should build on the positive practices that are in place. The Self-Advocacy meeting held during the site visit was an excellent example of such a practice, with staff encouraging and supporting self-direction, thus enhancing the ability of individuals to make choices about community living. Discussion about who individuals could talk to if they felt there had been abuse, neglect or exploitation also made it clear group members were well-informed on this topic. The monitoring team saw tremendous skill and initiative on the part of a member of the Social Work staff in facilitating community placement for an individual. She knew the individual and the individual's mother well, understood what was important to them, and visited and researched homes in the community to find one that was a good fit. Another initiative to be commended was the series of steps DADS was taking to improve training for community providers. Other practices required further attention. There was an emphasis on promoting community awareness through the Community Living Options Discussion (CLOIP) tours, but the Facility needed to ensure individuals from all residences had equal opportunity to have these experiences. It also needed to provide additional experiential opportunities that are individualized to meet the learning needs of each individual. Discharge planning procedures needed to be tightened, but the post-move monitoring process was generally thorough, if not always timely. PSTs at the Facility had not yet demonstrated an understanding of how to fully implement the fundamentals of person-directed planning, beginning with the Personal Futures Worksheets (PFWs) and extending through the Community Living Discharge Plan (CLDP.) In the four PFWs reviewed, the PSTs failed to identify a single personal goal and only rarely were able to identify something an individual was proud of, whether the individual had anything s/he would like to learn to do, or whether the individual had anything s/he wanted to accomplish or achieve. These questions are at the heart of person-directed planning. If individuals living at the Facility have no goals, no desire to accomplish or to learn anything and little they are proud of, an optimal living option vision should start with trying to understand first if that is true, and if so, why and what can be done about it. If this is not accomplished, then the overall assessment of supports and services the individual might need in a community setting is questionable, or at least incomplete. There were also several issues identified that will require additional guidance and decision-making on the part of DADS. These included the need to assess and increase the availability of high-quality services and supports to ensure families of young people with extensive support needs do not find institutional services necessary; the need to continue to evaluate and enhance the current training and orientation for

	community providers; the need to examine the status of individuals who live in the SSLCs, but are not citizens and therefore do not have access to funding for community services; and the need to provide additional guidance to the facilities on a number of policy issues.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the 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.	The leadership at RSSLC, including staff in key management positions, expressed a belief in the potential value of community living and exhibited an enthusiasm for facilitating movement to community living for individuals living at the Facility. This was borne out by the relatively high rate of placement into community living options as well as the willingness to find appropriate homes in the community for individuals whose needs are more challenging. At least 23 individuals had moved to the community between October, 2009 and February, 2010, as reflected in lists provided by the Facility in response to the document request. There have been additional moves since February as well. This attitude toward placement was not completely universal among RSSLC staff. At one PSP attended, for Individual #402, the QMRP adamantly refused to consider community living even when prompted by the QMRP Coordinator, who was auditing the meeting as a part of the Facility's quality assurance procedures which are further described in Section T1b.1 There was additional work and training to be done to ensure all staff understand their roles and responsibilities in this regard. There was also evidence that RSSLC can provide crisis stabilization for an individual who had been living in the community and then facilitate an individual's return to an appropriate community setting. Individual #681 had lived in a community home for approximately a decade. According to the mother's report, problems arose in the community home that resulted in the individual losing skills and developing behavioral challenges to the extent that placement at RSSLC was sought. The mother very eloquently credited the Facility with restoring not only the individual's skills and good health, but also dignity. She also credited the Facility, particularly the Social Worker, with finding a new opportunity for community living that seemed to be a very good fit. The mother stated that she had not made this decision lightly, but felt the individual deserved the opportunity to live in a home like everyone else has the chance to do. Often, when individuals experience problems in the community, it can be difficult to find new opportunities or for parents to feel sufficiently comfortable to allow another move to occur. In an interview with the aforementioned Social Worker, it was clear that she deserved the credit the mother had bestowed. She knew the individual and the individual's mother well, understood what was important to them, and visited and researched homes in the community to find one that was a good fit.	

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		As required by this section of the Settlement Agreement, it is also the intent for the State, not just the Facility, to 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. The State has demonstrated in a number of ways that it is willing to take such actions, such as through its dedication of Home and Community Services (HCS) waiver slots to deinstitutionalization as described in the conference call on 3/11/10 and its overall plan for Promoting Independence. The State may also want to further evaluate to what extent supports and services are provided in the community in order to prevent unnecessary institutionalization, particularly in the case of people under the age of 21. The monitoring team reviewed eight Permanency Planning documents for individuals as a part of its effort to understand how the Facility assessed individuals for the most integrated setting possible. Perhaps the most striking impression from the review was the consistency among many of them regarding the reasons given for institutionalization and the description of services individuals and families received prior to making this often difficult decision. As examples, the following five individuals were reported to have been admitted as a result of a variety of challenging behaviors. In four of the five, there was documentation that the family no longer felt able to provide the level of care the individual required. In each of these five instances, the Permanency Plan reported minimal services were provided to the individuals and families, when intensive supports would have more likely been in order. More intensive and in-home supports may have allowed the individuals to remain at home or at least in the community. The five examples include: • Individual #755 was admitted because of escalating behaviors in the home and at school and a history of elopement. The family felt they were no longer able to provide the level of care that she required. The Permanency Plan documented the services she received prior to her admission were services through DARS and monitoring by a Psychiatrist on a monthly basis. • Individual #36 was admitted due to behavioral problems with increasing aggression, leading to frequent psychiatric hospitalizations and crisis intervention. The family no longer felt able to provide the level of care and support that the individual required. According to the Permanency Plan, the individual received Speech Therapy while attending school, but no additional supports were provided in the community prior to placement in the Facility. • Individual #643 was admitted to the Facility due to "behaviors." The nature of these behaviors and whether they warranted a need for institutional services were unspecified in the Permanency Plan. The only community service documented prior to Facility placement was service coordination. • Individual #246 came to live at the Facility when the family was no longer able to manage the aggressive behaviors nor meet the demands of care at home. The	

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		Permanency Plan documented the services received prior to placement were from the MRA Outreach program. • Individual #44 experienced aggression and property destruction in the family home and had increasing medical problems. The family felt it could no longer provide the level of care needed. Services and supports were reported to be service coordination and monitoring by a Psychiatrist and Neurologist. It was reported that community physicians were unable to provide needed care due to medical problems. The State should also evaluate whether the orientation and training provided to new vendors is adequate to prepare these entities to meet the needs of individuals moving from the Facility. Following attendance at a CLOIP tour in which the provider seemed to lack a certain understanding of the people to be served (see Section T1b.2), the monitoring team questioned a DADS attorney regarding what new provider orientation is required and/or provided by the state agency in order to be sure Home and Community Services (HCS) waiver providers are prepared to offer the supports, services and living environments needed by individuals moving from the Facilities. A number of activities and initiatives were ongoing or recently underway, as described below. According to the DADS website (http://www.dads.state.tx.us/providers/pao/index.html)to ensure providers are prepared, DADS requires a written resume for the designated program manager attesting to a minimum of three years work experience in planning and providing direct services to individuals with mental retardation or other developmental disabilities, including and three signed, verifiable professional letters of references. The website also states "(b)efore a HCS or TxHmL program provider applicant can submit an application packet to DADS, they first must complete all the requirements of the Pre-Application Orientation (PAO). DADS requires the following person(s) to complete the PAO before submitting an application: • **Owner/contact person:** Individual who should be contacted about waiver program services questions and issues. • **Program manager:** Individual, designated by owner/contact person, who is responsible for managing and overseeing the direct provision of services to individuals enrolled and ensuring the legal entity's compliance with certification principles and the terms and conditions of the contract. The Pre-Application Orientation consists of six modules: Module 1: Course Overview Module 2: DADS Overview Module 3: Programs Overview Module 4: Application Process	

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		Module 5: Additional Processes Module 6: Post Application The participant must achieve a score of at least 70% on the quiz at the end of each module in order to move forward in the process of certification. Applicants who were accepted by DADS were to be invited to attend the next scheduled Provider Applicant Training, organized by the DADS Waiver Survey and Certification (WSC) unit. The program manager would take an exam at this time. The content of this training was provided by the Settlement Agreement Compliance Unit Director, State Supported Living Centers Division. It appeared to focus heavily on administrative and billing requirements, but also included modules that addressed topics such as the requirements for reporting abuse, neglect and exploitation; behavior programs and restraint rules; and the roles and responsibilities of nurses and case managers. DADS is taking some additional actions to enhance training for community providers: • The monitoring team reviewed an April 26, 2010 Information Letter No. 10-58, Request for Participation in Provider Training Needs Assessment Survey. The letter indicated that its purpose was to invite Community Intermediate Care Facility with Mental Retardation (ICFs/MR), Community Living Assistance and Support Services (CLASS), Deaf Blind/Multiple Disability (DBMD), Texas Home Living (TxHmL), and Home and Community-based (HCS) providers to participate in a training needs assessment survey. The letter further explained "Senate Bill 643, 81st Legislature, Regular Session, 2009, states that the Texas Department of Aging and Disability Services (DADS) must evaluate the types of federal and state required training Community ICFs/MR, CLASS, DBMD TxHmL, and HCS providers need and whether that training is currently available. To obtain input from providers regarding training needs and barriers, a short survey has been developed in survey monkey for the identified provider types." The link to the survey (http://www.surveymonkey.com/s/SX7RT2T)was provided in the letter. • DADS had also developed a new Draft HCS Handbook. The Handbook includes with a letter of introduction by DADS Commissioner Chris Traylor, dated March 18, 2010, was accessed at http://www.dads.state.tx.us/HCSCMTransition/DRAFTHCSHandbook.pdf These initiatives are to be commended. DADS should ensure that it has a methodology to evaluate the outcomes of these activities in terms of provider preparation.	
T1b	Commencing within six months of	Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10 and RSSLC	

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	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:	Policy F.3, Participating in Annual Personal Support Plan Meeting, addressed the requirement that a discussion of living options occur at each annual plan meeting. The RSSLC policies could bear additional review and revision to ensure consistency with as well as to further operationalize DADS policy. In order to ascertain the adequacy of implementation of the policies, the monitoring team attended three PSPs and reviewed 19 PSPs, four PFWs and eight Personal Support Plan Meeting Monitoring Checklists. In addition, interviews were held with the DSS, the QMRP Consultant, Quality Assurance staff and a Social Worker.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	<u>Identification of Protections, Supports and Services:</u> The PSP is the central mechanism at the Facility for assessing the supports and services an individual would need to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting. Each PSP reviewed began with the section "what's most important to the person." As a general rule, this information did not serve as the starting point for the identification of the supports and services required in the community. PSTs did not seem to be prepared to connect the dots of what's important to the person with what supports and services would be needed and desired in the community. This is the essence of person-directed planning. The monitoring team also reviewed four Personal Focus Worksheets: Individualized Assessment Screening Tool (PFW.) This review also appeared to reflect a lack of understanding of Person-Directed Planning on the part of the PSTs. The PFW asks, among other things, the following questions: • Are there things you are proud of? • Are there things you would like to learn to do yourself? • Do you have any goals that we can help you achieve? • What does the person want to accomplish or achieve? In the four PFWs reviewed, the PSTs failed to identify a single personal goal. Of the four, there was only one note that an individual was proud of something, and that was her "personal belongings." In only one PFW did the PST answer yes to whether the individual had anything s/he would like to learn to do and that was documented only as "clothing." In response to whether the individual had anything s/he wanted to accomplish or achieve, there were three blanks and one note that the individual "is satisfied." If individuals living at the Facility have no goals, no desire to accomplish or to learn anything and little they are proud of, an optimal living option vision should start with trying to understand first if that is true, and if so, why and what can be done about it. Without this information, it is difficult to ensure that supports needed to ensure successful transition to community living are identified.	

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		The monitoring team was not able to observe a PFW meeting in process and will be interested in doing so at a future visit. The PFW process appeared to have been developed to enhance the focus on the individual's personal goals, desires, preferences and needs but also appeared, based on the evidence described above, not to have the desired effect. The Facility may want to consider examining the person-centered planning models in the literature to see what other strategies might be of use to make their processes more meaningful to individuals and to better prepare them to play a real part in their annual planning meeting. The supports and services being identified by PSTs were often a listing of what the individual currently receives at RSSLC. When considering the optimal living option vision and the kinds of supports and services that would facilitate that, PSTs should also be aware of and pay attention to the types of everyday activities that may be available to individuals who move to a community setting. For example, in large congregate settings such as RSSLC, individuals often do not have the opportunity to participate in making dinner, setting the table, and cleaning up afterward, which are things that are a part of the normal rhythms of life for most people. The opportunity to engage in and experience an everyday life like everyone else is one of the inherent benefits of moving to the community. Yet, the PSTs did not suggest these kinds of opportunities be provided in any of the PSPs reviewed. PSTs need to define the Optimal Living Option Vision as one in which people have these opportunities, in order to ensure community living options are developed that can offer an everyday life. In the Post-Move Monitoring visits attended during this site visit, no individuals were reported or observed to be engaging in this type of activity. At one site, the staff reported that all meals were prepared by one staff person during the week, and were often prepared at another location and brought over. The same staff person also purchased mostly frozen meals for weekends, which staff prepared. At the second site, visited as dinner was being prepared by a staff person, the two individuals in the home sat in the living room and did not even observe the activity, much less take part in it. The CLDPs for these individuals did not identify the increased ability to take part in such day-to-day activities as either an essential or non-essential support. The monitoring team understands there has been some discussion of moving the Optimal Living Option Vision and Community Living Discussion to the beginning of the PSP. It is recommended this be strongly considered. To do so would give the PSTs a much better framework for developing the PSP with the ultimate goal in mind. <u>Identification Of Obstacles To Movement To The Most Integrated Setting:</u> Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10 was	

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		consistent with the Settlement Agreement in requiring the identification of obstacles to movement to the most integrated setting as well as the identification and implementation of strategies intended to overcome such obstacles. RSSLC was also participating in a DADS-sponsored Community Integrated Discussion Record (CI) pilot, which began in March 2010. According to the CI Instructions-Revised 03-2010, the CI discussion record was to be used to identify an individual's preferences, strengths, skills, needs and barriers to community integration in the three areas of community functional living skills, working, and leisure activities. The process was intended to provide guidance for discussion during the PSP. Outcomes of the process were expected to be a more focused discussion during the PSP meeting, a required Action Plan in at least one of the three areas, and information that would allow the Facility and the State to better understand and address potential obstacles. An additional sheet had been added to the PSP format to facilitate and document this discussion. Observation of this process in two PSPs indicated it was not well integrated into the current community living options discussion and was being implemented as an additional step that often repeated the information from the latter section. While this effort has potential long term benefit, the PSTs observed appeared to understand the basic instructions of the pilot but not how it needed to be integrated in order to be an effective tool to identify and address barriers. DADS should consider how it might better use this tool as a truly integrated component of the community living options discussion and provide additional training on the entire integrated process. In the PSPs reviewed and observed, very few obstacles were identified in the PSPs reviewed or attended. Even when obstacles were specifically identified, even fewer specific strategies were identified to address them. In at least one instance, an action plan to increase community awareness was developed but not implemented. Individual #777 had a PSP on 7/14/09. The PST developed an Action Plan for scheduling Living Options tours in the community on a quarterly basis. As of 4/30/10, no visits had been recorded nor were any projected in the list of tours provided by the Facility. This was also an individual who was documented to have requested placement but not been referred by his PST, so the community tours would have been an opportunity to begin to honor this request. When asked about this, the DSS acknowledged the PST had allowed this to fall through the cracks. In some cases, obstacles defined were simply the characteristics of the individuals without any review of what supports were needed or whether these were available in community living. For example, the PSP for Individual #402 states the individual's "barriers/obstacles include" (following is a partial list): • Mental retardation, etiology unknown • Spastic quadriplegic cerebral palsy	

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		• Epilepsy • Dysphagia and G-tube feeding • GERD PSTs would benefit from some additional clarification from DADS regarding the requirement to identify barriers related to the opposition of families/Legally Authorized Representatives (LARs) . There are some potentially conflicting statements in various documents that may contribute to confusion on the part of the PSTs. In Attachment 1 to the Texana MRA contract with DADS FYs 2010 and 2011, Special Terms and Conditions, Section F, page 1-6, an expectation was stated that the S.S.L.C. IDT would develop, as part of the Personal Support Plan, an action plan to address increasing the individual's and/or LAR's awareness of the community living options. It further stated in Section 3), however, that "an action plan or goal/objective regarding the CLOIP is **not** required if the individual and/or their LAR is aware of community living options and prefers that the individual remain at the facility." (Emphasis added.) On the other hand, the Personal Support Teams: PDP Process training materials, 2009, did suggest that PSTs need to identify LAR opposition as an obstacle and develop a strategy to address it. Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10, gave only this guidance to the Facility: "The PST 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, pursuant to Section V of this policy, and shall identify, and implement strategies intended to overcome such obstacles." Section V addressed only the documentation procedure and does not offer any further guidance as to the PST process for considering and identifying obstacles related to the opposition of families/LARs, nor for identifying and implementing the strategies to address them. <u>Training and Quality Assurance:</u> The Facility has some processes in place to assess the PSTs skills in the implementation of the PSP as a whole, including the Community Living Options Discussion. Some training in the PSP process has been provided to PSTs and QMRPs by the Facility. Beginning in October, 2009 and continuing through April, 2010, sessions of a two-part training on Person-Directed Planning were provided to PSTs, including 23 QMRPs. In addition, an inservice training was provided for QMRPs on 4/14/10 on the topic of the New PSP Form/Settlement Agreement Monitoring Instrument. Twenty-one staff attended. PSPs are also monitored through the Personal Support Plan Meeting Monitoring Checklist. According to Quality Assurance staff and the QMRP Coordinator, they attend at	

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		least one meeting per week, concentrating on those facilitated by the four or five QMRPs they have identified as being in the most need of coaching. A Personal Support Plan Meeting Monitoring Checklist is completed and routed to the QMRP, the QMRP Coordinator, the Unit Director and the Administrator for review. Training needs are identified and training/coaching provided, sometimes immediately after the meeting. The monitoring team reviewed the Personal Support Plan Meeting Monitoring Checklists for eight individuals. Of these, five indicated some difficulty on the part of the PST in addressing community living options. In each instance, the Program Auditor or QMRP Consultant documented follow-up coaching. The Program Auditor stated that the Facility was going to begin using a version of the Settlement Agreement Monitoring Instrument for Section F as the PSP monitoring tool. In terms of the requirements of Section T of the Settlement Agreement, the Section F template may not adequately address all the components. The Facility should develop its own policy and procedure for PSPs and Community Living Options quality assurance that will address not only the requirements of the Settlement Agreement and DADS policy, but also its own specific and self-identified needs. The Facility should also take better advantage of the knowledge of the Post-Move Monitor to support the abilities of the PSTs to develop appropriate strategies for community living options and for quality assurance. According to the Facility's Position Description, the Post-Move Monitor's essential job functions include regularly consulting with the facility QMRP Consultant regarding the PST's identification of needed supports and services for persons referred for alternate placement, identification of barriers to alternate placement, and initialization of programming to overcome the identified barriers. The Post-Move Monitor is supposed to provide oversight and monitoring of both the Living Options discussions in the Personal Support Plan process and the CLDP process. She is also expected to participate in and serve as a resource to PST members in facility meetings related to community placement referrals, CLOIP issues, discharge planning meetings, placement returns, etc. These tasks were projected to consume approximately 30% of her time. In reality, in the early going since she took this position in December, 2009, the Post-Move Monitor reported she attended CLDPs, but had had little time to serve as a resource to the PSTs. This is likely to be a valuable resource in the future. The Post-Move Monitor could offer assistance such as: • Attending all PSPs when there is a likelihood that a referral for placement will be made to provide PSTs with information about available resources in the community; • Attending a sample of other PSPs to educate PSTs about how barriers, or perceived barriers, might be addressed in the community; • Attending and participating in QMRP and Social Worker meetings on a regular basis to educate and update; • Providing training to QMRPs, Social Workers and PSTs about how services and supports can be structured in the community.	

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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.	RSSLC is taking action to provide education about available community placements to individuals living at the Facility. The Facility provided a list of 15 training/educational opportunities that have taken place from 7/1/09-4/26/10. These included 14 tours of community programs and a Provider Fair held on 11/23/09. There were a total number of 102 individuals participating in tours during the period, and this number included several people who made more than one visit. A total of 78 staff participated in the 14 tours, although this was not an unduplicated count. Several staff participated in more than one tour, including one QMRP who made four tours during the period. There is a significant value to this repeated exposure for both staff and individuals, but particularly so for the latter group. A single tour and an annual contact with the Community Access Service Coordinator (CASC) from the Contract Mental Retardation Authority (MRA) is not likely to be sufficient for an individual with an intellectual disability with little previous experience with community living options to gain an understanding of what it might mean. RSSLC should be commended for encouraging this frequency of visits. The DSS noted that some residences were much better than others about scheduling multiple visits. The Facility should evaluate the reasons for this discrepancy and attempt to ensure, through policy and staff training, that all individuals have equal opportunity to experience community living options. The monitoring team was able to participate in a CLOIP tour during the site visit. Three individuals from the Facility attended. The home was the first to be opened by the provider and no individuals had yet to select it. There were several problems associated with the tour. The home was advertised as wheelchair accessible, but the ramp into the front door was poorly made and, in fact, dangerous as it tended to fold up in the middle when anyone walked on it. There was no ramp at the back door. One of the three bedrooms had an elevated area for the bed, with no means for a wheelchair to access it. The back yard, in addition to being inaccessible because there was no ramp at the door, had no patio area, and the ground was very uneven. There was rotted wood and hanging wires along the roofline. Finally, there was a dead cockroach in one of the bathrooms. The provider representative on site, who was reported to be the Program Manager, acknowledged the ramp at the front entry was poorly made and was planning to have it fixed; however, he seemed unaware of the need to have a ramp to the back door. He was very eager to receive suggestions from RSSLC and Contract MRA staff but did not appear to have sufficient knowledge of the population to be served and their potential needs. As described in Section T1a, the State should analyze its application process, and orientation and training for new providers to ensure they are adequately prepared to provide the types of homes, services and supports needed by individuals living at RSSLC. RSSLC also encourages and supports self-advocacy for individuals living at the Facility, which provides another avenue for enabling them to make informed choices about their	

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		preferred living options. The Self-Advocacy meeting held during the site visit was an excellent example of staff encouraging and supporting self-direction. The meeting was led by individuals and all of the participants were actively involved. Materials included how to submit a grievance or complaint and a national self-advocates' newsletter. There was a discussion about who individuals could talk to if they felt there had been abuse, neglect or exploitation, and it was clear the group members were well-informed on this topic. Individuals were also informed of self-advocacy activities and opportunities that may enhance their integration with peers living in the community and their exposure to the opportunities that community living may provide, such as a national teleconference series on employment for people with developmental disabilities and the Texas Advocates Conference, a statewide self-advocacy event to be held in August 2010. Arrangements were underway to facilitate participation of group members in both events. The Facility may want to further expand on this method of promoting awareness by developing some joint activities between the RSSLC self-advocacy group and other local community self-advocacy organizations. Such activities can provide a much more meaningful sense of what community living can look like and offer to an individual than an abstract brochure. Combined, the activities and brochures can complement each other. In interviews with the DSS, Post-Move Monitor and CLOIP staff, there was discussion about other types of awareness activities that might be undertaken to enhance the learning opportunities. CLOIP staff have attended one Parent's Association meeting. It would be advisable for CLOIP staff to regularly attend such meetings to provide information, to continue to expand their own understanding of the obstacles perceived by families/LARs and to further develop a relationship of openness and trust. The monitoring team also inquired of the DSS and the QMRP Coordinator as to whether individuals had the opportunity to visit with other individuals they may have known who moved to a home in the community. The RSSLC staff indicated they would arrange such a visit if it was requested but had not implemented such a strategy at this time. They reported feeling a certain constraint in this regard, as there is an expectation that all providers be given equal exposure. In fact, the DSS reported that tours were concentrating on new providers. There is a need to develop and provide such exposure for new providers, of course. At the same time, it is essential to develop an array of community living option experiences that are the most meaningful to the individuals. This should be the first priority when planning community living option experiences. The DSS and the CLOIP staff reported that they have a good working relationship and frequent interaction. It is recommended that these staff work closely with the QMRP Coordinator to develop a single, cohesive plan for increasing awareness of community living options that expands on the current approaches to offer meaningful, experiential	

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		opportunities that are individualized to the learning needs of the individual and to the specific needs of each family/LAR. In addition, PSTs will continue to need training in developing Action Plans for increasing awareness that also provide sufficient learning opportunities that are individualized to the person's learning needs.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	According to information provided by DADS during a conference call on 3/11/10, the assessment for placement process is the Community Living Options discussion that takes place at least annually as a part of the PSP as described in Texas DADS SSLC Policy 018: Most Integrated Setting Practices, 10/30/09, which has since been updated on 3/31/10. Under this definition, the facility would have assessed all individuals within one year of the Settlement Agreement date. The Facility provided a list of 318 individuals who have been assessed for placement from 7/1/09-4/26/10. The CLOIP Assessment is used as a part of the overall assessment for the most integrated setting that takes place as a part of the PSP. The CLOIP Assessment is completed annually in advance of the PSP and provided to the QMRP prior to the meeting. Unless the MRA CASC is requested not to attend by the individual or LAR, she attends and reviews her findings and recommendations with the PST. The MRA Service Coordinator Community Living Options Information Process Worksheet is used to document the activities the CASC undertook to inform the individual and family/LAR about community living options. Information from the Worksheet, including an assessment of the individuals' and family/LARs' awareness of and preferences regarding community living options, as well as their expectations for community living were incorporated into all PSPs reviewed since the effective date of the Settlement Agreement. The Worksheets reviewed also included comments from the CASC regarding supports and services the individual would need in a community setting. The three Worksheets reviewed were all completed by the same CASC, so it is not possible to generalize the impressions, but there was a tendency on the part of this MRA staff to suggest that the supports and service required in the community were the "same services and supports that were given" at RSSLC. The CLOIP process should reach beyond this to enhance the awareness of the PSTs about the possibilities that may be offered by community living. Given their familiarity with the HCS waiver services and the types of community living options available, the CASCs should serve as an educational resource to the PST and support their creativity in designing an optimal community living vision for each individual. The Permanency Planning Instrument for Individuals 18-21 Years of Age, DADS Form 2261, January 2008, is also used as a part of the process for assessing community living options for those 21 and under. The Permanency Planning process is to be conducted semi-annually by the Designated MRA. The Permanency Plan document is transmitted to the QMRP and is also reviewed during the PSP. In this document, Section 2. Goals for the Future include four possible goals: 1) bringing the individual to family/LAR home with	

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		access to needed services; 2) living with an Alternate Family with access to needed services; 3) moving to another living arrangement determined by the individual and LAR; and, 4) remaining in the current residence as determined by the individual and LAR. Of the eight Permanency Plans reviewed, all but one chose the fourth option, to remain at the Facility. Given the experiences many of these individuals and families had prior to placement at RSSLC, as documented in Section T1a, it is not surprising that they may feel sufficient resources are not available in the community. Developing a community living plan for these young people will require a careful and individualized examination of how the HCS waiver can be used to meet their significant needs and ongoing communication with the families/LARs. DADS should further evaluate the Permanency Planning process as implemented by the Designated MRAs to determine how the process can be used more effectively to propose a community living plan with sufficient supports and services for these individuals, and how this will be coordinated with the individuals' PSPs. From observations and document reviews as described in some detail in T1b.1 above, the Community Living Options discussion does not appear to be an effective assessment for placement at this time. Improvements to the process are recommended above in this Section and in Section T1b.1.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The monitoring team reviewed completed CLDPs for 10 individuals from RSSLC and the lists provided by the Facility of individuals who had been referred for movement to a more integrated setting and who had requested to move. The team also interviewed the DSS as to the CLDP process in use at the Facility. The Facility did not have additional facility-specific policy and procedure regarding the CLDP process at the time of the site visit. (The CLDP reviewed for the individual from BSSLC (#62) was included only in certain portions of this assessment, as it was not developed by RSSLC staff. These portions included the Post-Move Monitoring and the 45-Day assessments as they pertained to the Post-Move Monitoring.) RSSLC uses the basic format and forms for the CLDP, as prescribed in the State Policy on Most Integrated Setting 018-1. These generally adhered to the format with one exception: there were no signatures found for eight of the CLDPs, including no signatures that would document the participation of the Designated MRA. No CLDPs were held during the site visit, so the monitoring team was unable to assess this part of the process. As noted in section T1a, the Facility appeared to have a genuine interest in facilitating movement to the community, and this was affirmed by the outcome of the relatively high rate of community placement. The Facility had a process for tracking referrals for community living, which required the Social Worker to forward the referral by email to the DSS and to Medical Records by the end of the day. The QMRP had 72 hours from the time of the referral to submit the CARES form to Medical Records. The DSS reported that	

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		she and the Medical Records office cross-checked this information at the end of each week. Of the 318 individuals who were considered to have been assessed for community placement as described in T1b above, a total of 31 were referred for placement. Of these, the list documented 23 had moved to the community. Several more individuals who had been referred had also moved to the community since the list was prepared. There were also 20 individuals who had requested placement. While RSSLC has a relatively large number of both referrals and moves to the community, there were several instances of individuals falling through the cracks found by the monitoring team. One individual (#778) was noted in the assessment documentation provided to be "scheduling to refer-MRA not present" on 4/14/10. A review of his PSP, dated 4/14/10 documented that both the individual and mother were in favor of community placement and the PST determined that the most appropriate living option was Community referral. As of 4/30/10, a Community Living Options addendum meeting with the Designated MRA had not been scheduled. This was beyond the two-week timeframe within which this meeting should have occurred, pursuant to Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10. There was no documentation in the record regarding follow-up to schedule the meeting. The DSS was unaware of this, but did check with the Social Worker and reported that she was working on it. The DSS stated that no one was tracking the timeliness of the addendum meeting in such circumstances. The Facility should incorporate tracking of this information into its policy and procedure. Another individual (#584) had requested to move to the community and the PST had agreed this would be appropriate. The individual was reported to be an undocumented alien. Due to the individual's immigration status, the individual did not qualify for community Medicaid and therefore access to HCS-funded services. As a result, the individual had not been referred by her PST for placement. A staff person at RSSLC who knows the individual well had offered to become LAR if this would facilitate the opportunity for community living, but it was not clear whether this would provide the desired relief. This is a matter of concern as it may impair the individual's opportunity to move to a more integrated setting in the community due to a lack of a funding source, despite the wish to do so and the team's concurrence that this is appropriate. There were several individuals who had requested placement (#363, #755 and #777), but had not been referred by their PSTs, apparently due to family/LAR opposition. Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10 requires the following: "If an individual or LAR requests placement, the individual's PST will meet to discuss the request within two weeks of the request. The designated MRA, along with the LAR (if applicable), must be participants in the meeting." No evidence of such meetings was found for these individuals. The policy should clearly state if the	

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		expectation is that the PST will meet in response to a request to move to the community regardless of family, LAR or PST opposition. The DSS indicated that there was a strategy under consideration for the CLDP process to formally begin at the point of referral. She noted that there were times the CLDP did not take place until after a trial visit had already been accomplished. This is problematic because the selection of a provider, and the subsequent trial visit, should take into account the types of specific services and supports an individual will need and want If these supports and services are not identified, it would be difficult to evaluate the appropriateness of the provider and/or setting offered in the trial visit. Starting the CLDP process at the time of referral would also provide the Facility with more opportunity to track from that point on and avoid those instances in which something fell through the cracks. The monitoring team recommends this be considered.	
	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.	The CLDP process is a continuation of the Facility's responsibility to assess the needs of an individual who will be moving to a more integrated community setting, and to ensure that the community setting adequately meets those needs. The identification of essential and non-essential supports must begin by considering those things identified in the PSP and, in fact, the PST did appear to rely heavily on the PSP and the assessments associated with the PSP to guide the identification of the essential and non-essential supports. The potential problem with this was that the PSTs did not appear to be proficient at identifying the supports and services needed and desired in a community setting during the PSP, as described in Section T1b. The DSS stated that this identification of essential and non-essential services and supports had been challenging for the PSTs and they were continuing to work on it. Examination of this item of the Settlement Agreement will therefore be contingent to some degree on a positive evaluation of the items in T1b at some point in the future.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The staff assigned responsibility for the essential and non-essential supports were more often staff from the selected provider than Facility staff. It was not clearly stated that Facility staff had any responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness. Facility policy and procedure should specify the expectations in this regard.	
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be	The process for review with the individual and, as appropriate, LAR is unclear since there were no signatures on eight CLDPs, nor other documentation provided that would describe how the individual or LAR were informed of the outcomes. For the two CLDPs that did contain a completed signature sheet, the individuals and guardians were participants in the meeting itself. The Facility should ensure that signatures are obtained at the meeting and appended to the CLDP. If the review process takes place at another	

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	provided at the new setting.	time, it would be advisable to obtain the signatures at that point.	
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.	Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10 requires, in accordance with the provisions of the Settlement Agreement, 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. There is some concern that the 45 day assessments are not seen as an essential component of the CLDP process. When asked to provide copies of the most recent CLDPs, the Facility did not provide the assessments that were usually referenced in the document as attachments. Because the information in these assessments was not repeated on the CLDP form, the attachments were the only source of what could prove to be information that was critical to health, safety and a successful move to the community. When asked a second time, the assessments were provided and appeared to have been completed on a timely basis, but the concern remains that the information is not being viewed nor used as an integral part of the CLDP. To reinforce the concern regarding whether the 45 day assessments are being used as an integral part of the CLDP, the monitoring team requested the CLDP and all attachments for Individual #62, who had moved to a community setting in the RSSLC catchment area from Brenham State Supported Living Center (BSSLC). RSSLC was to provide Post-Move-Monitoring for the individual. The CLDP was available, but the attachments had not been provided by BSSLC, nor had RSSLC requested them. Particularly since the individual moved from another facility and was otherwise unknown to RSSLC, having as much information as possible about the individual's status and needs would be essential to the process of evaluating whether needs were being appropriately met. When asked, the Post Move Monitor initially stated she did not need the assessments. Upon further conversation, she acknowledged the assessments could be of value if any questions arose during the Post-Move Monitoring process. Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10 requires the Admissions and Placement Coordinator to provide a copy of the CLDP "and all supporting documentation" prior to the individual's move. The Facility should ensure this is incorporated into its policy as well as its practices. A sample of the 45-day assessment packages was reviewed for three individuals to determine how recent the documents were: • For Individual #496, the date of move to the community was 11/10/09. The CLDP was dated 11/06/09. The Date of IDT Review of Current Summaries/Assessments was noted in the CLDP to be 10/23/09. The last PSP was dated 12/22/08. Many of the assessments, including the Medical and Nursing Summaries, were from December 2008, almost a year earlier. Several key assessments such as Dental,	

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		Pharmacy, OT/PT and the Physical and Nutritional Management Plan had been updated in October 2009. • For Individual #648, the move date was 12/28/09. The CLDP was completed on 12/17/09. The date of the last PSP was on 2/18/09. The Date of IDT Review of Current Summaries/Assessments was noted in the CLDP to be 12/14/09. The Medical and Nursing Summaries included in the CLDP were dated 2/2/09, which again were approximately ten months old. The Program Plan included was dated 2/18/09, which would indicate that the individual's programs had not been updated for almost ten months. The oldest documents were Annual Employment and Annual Vocational Summaries from 2002 and 2003. • For Individual #638, the move date was 12/02/09. The CLDP was held on 11/19/09 and the Date of IDT Review of Current Summaries/Assessments was 10/23/09. The last PSP occurred on 5/07/09. The Annual Nursing Summary was on 4/29/09 and last Medical Summary was on 4/28/09. The Program Plan was from 5/07/09. By and large, the assessments were from the previous April and May. The most updated document was the Physical and Nutritional Management Plan, dated 7/25/09. For each of these individuals, the CLDP document indicated that the assessments were reviewed by the PST within 45 days prior to the individual's move of the community to determine whether they were still appropriate. Since some of the assessment material was from as early as 2003, the monitoring team would need to review the records 45 days prior to discharge and compare the assessment findings to the most recent information in order to verify the accuracy of these statements. This was not possible within the time constraints of the baseline visit and will need to be addressed in future visits. In the meantime, the Facility should consider whether certain assessments essential for health and safety, such as the Medical and Nursing Summaries, should be required to be updated, including the course of health care provided since the last assessment, within the 45-day timeframe. In addition, the monitoring team was not able to witness a CLDP meeting and will want to have this opportunity to assess the process as it occurs.	
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	In each of the 10 RSSLC CLDPs reviewed, the Designated MRA was appointed to complete an assessment of the community residence prior to the individual's move. In eight of these, there was no signature by the Designated MRA representative to document the acknowledgement and acceptance of this responsibility. No other documentation, such as the DADS Form 8630, Continuity of Care Pre-Move Site Visit Review Instrument for the Community Living Discharge Plan, which is used document the Designated MRA's pre-move visit to the proposed placement, was provided. This documentation may well exist, but was not submitted for review. The monitoring team will examine this item more closely at the next site visit.	

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	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.		
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	RSSLC did not provide any information about quality assurance policies, procedures and/or processes to ensure that community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible. The reviews of the CLDPs from this site visit, as described in sections T1d and T1e above, would suggest the Facility needed to develop or otherwise promulgate written quality assurance procedures that would ensure CLDPs are tracked from the process of referral through move to the community. This should include written procedures for ensuring, at a minimum: • PST recommendations for community living for individuals result in a timely meeting with the Designated MRA to consider making the referral; • Referrals are routinely tracked, do not fall off the radar screen and are completed within the 180 day timeframe unless a waiver is granted; • CLDPs provide the required 45-day assessment materials as attachments in a timely manner to all parties who will be involved following the individual's move; • CLDPs assign responsibility to Facility staff to ensure that all required activities are completed, even if a provider or MRA staff has primary responsibility for the activity; • Supports essential to an individual's health and safety are in place at the time the person moves from the Facility; and • CLDPs are complete and have all required signatures.	
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	RSSLC did not provide any type of assessment or analysis related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. The Facility is participating in a pilot program to use the PSP Community Living Options Discussion to further examine and gather data on barriers. This Community Integration pilot is further described in section T1b. There are other sources for identification of barriers that should be consulted as the Facility develops this comprehensive assessment. First and foremost, the Facility should analyze and incorporate the barriers perceived and/or encountered by individuals, families and LARs. For example, Individual # 681 was to be moving to a community home in the near future. In an interview, her mother explained that the individual had	

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	appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	lived in a community home for approximately ten years before she came to live at RSSLC. From that experience, the mother had the following observations: • The availability of medical care in the community is her greatest concern; • Safety runs a close second; • The State needs to check the homes more often, especially at mealtimes and for cleanliness; • There is very little activity on weekends; • Day programs need to be more structured; • Staff in the community homes and day programs need more training and materials to do their jobs. The Self-Advocacy group and the Parents' Association would provide additional avenues for obtaining this information. This should be accomplished using a formal methodology, such as survey and/or focus group, and not simply by relying on anecdote. The opinions and concerns of LARs are also documented in the CLOIP, Permanency Planning Instrument and PSP. This data should be sampled and examined for key trends. The Post-Move Monitor also has a wealth of knowledge about the obstacles that occur after a move to the community, gleaned from the Post-Move Monitoring visits. For example, she stated during an interview that transition to community Medicaid is often not timely. She also noted that providers had experienced difficulty in finding psychiatrists for individuals on Medicaid. The Post-Move Monitoring Checklists could be analyzed and common issues identified.	
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	The monitoring team reviewed the document the Facility provided in response to the request for the most recent Community Placement Report. It was undated. There were 23 individuals listed in the document, 13 of whom had moved to the community from 11/13/09, through 12/07/09. The remaining ten individuals had been referred but had not yet moved. The Community Placement Report may not have been complete. The Facility also provided a list of all individuals who had been recommended for community placement since 7/10/10, including their current residential status. It included 23 names of individuals whose residential status was noted as MR Community Placement. Some of those may have occurred after the Community Placement Report was completed, but there were some unexplained differences between the two documents. For example, there were two individuals on the list of those recommended for placement who were noted to have moved on 11/16/09, but neither of these individuals was listed in the Community Placement Report, even though this was within the timeframe of the latter document. The Facility should examine its data collection and management activities in this area to be sure all information is captured.	

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	Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
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	Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10, is consistent with the broad requirements of the Settlement Agreement. RSSLC did not provide any additional Facility-specific policy and procedure. The monitoring team reviewed the Post-Move Monitoring Checklists for 13 individuals, including the CLDP for 10 of those individuals, and interviewed the Post-Move Monitor and her supervisor, the DSS. The Post-Move Monitor was an experienced and qualified individual. She had experience as a QMRP at another SSLC and in the community. Most recently, she was an investigator for the Texas Department of Family and Protective Services. She began her duties in this position in December, 2009. The Facility used the prescribed Post-Move Monitoring Checklist from Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1 to document the monitoring reviews. It was not clear that the Facility had completed all of the Post-Move Monitoring according to the 7, 45 and 90 day requirements. The monitoring team reviewed all prior Post-Move Monitoring Checklists for previously completed visits for 13 individuals. During this review, the monitoring team found there were a number of Checklists missing: • Individual #496 moved on 11/10/09. A 45-day Post-Move Monitoring Checklists was provided for review, but not for the 7 or 90 day required visits.	

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	best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	• Individual # 648 moved on 12/28/09. A 45-day Post-Move Monitoring Checklists was provided for review, but not for the 7 or 90 day required visits. • Individual #638 moved on 12/02/09. A 45-day Post-Move Monitoring Checklists was provided for review, but not for the 7 or 90 day required visits. • Individual #752 moved on 11/16/09. A 45-day Post-Move Monitoring Checklists was provided for review, but not for the 7 or 90 day required visits. • Individual #226 moved on 10/30/09. A 45-day Post-Move Monitoring Checklists was provided for review, but not for the 7 or 90 day required visits. • Individual #34 moved on 10/26/09. A 45-day Post-Move Monitoring Checklists was provided for review, but not for the 7 or 90 day required visits. • Individual #516 moved on 12/17/09. A 45-day Post-Move Monitoring Checklists was provided for review, but not for the 7 or 90 day required visits. For individuals who had moved more recently, it appeared there was more consistency in the documentation provided. This may be reflective of the Post-Move Monitor coming on board in December, 2009 and the processes becoming more refined with experience.	
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.	The monitoring team accompanied the Post-Move Monitor on Post Move Monitoring (PMM) visits for two individuals. One was a 7-day visit for an individual (#62) who had recently moved from BSSLC, and one was a 45-day visit for an individual (#572) who had lived at RSSLC. In preparation, the CLDPs and any previous Post-Move Monitoring Checklists for each of the individuals were also reviewed. The Post-Move Monitoring Checklist was used to guide the reviews. The PMM visits attended took place in the individuals' homes. The Post-Move Monitor stated that she sees each individual in the home for both the 7-day and 90-day visits and goes to the day program site for the 45-day visit. The overall impression of the Post-Move Monitoring process is that it was generally thorough and detailed. The Post-Move Monitor spent time with the individual, and surveyed the individual's room and living area, including checking for the presence and appropriate care of the individual's belongings. She diligently assessed for the presence and implementation of the identified essential and non-essential supports as listed on the CLDP. She spoke with staff and questioned them to gauge their familiarity with and knowledge of the needs of the individual. She reviewed the documentation and affirmed with staff that the documentation was correct. The Post-Move Monitoring Checklists reviewed generally indicated that the essential supports and services listed in the CLDP were found to have been provided. When a support or service was found not to be available, there was documentation of action taken by the Post-Move Monitor as follow-up.	

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		There were two instances in which the Post-Move Monitor may have missed an indication that follow-up action was needed. In reviewing Individual #572's documentation, during this 90-day visit, the Post-Move Monitor did not note that the ICAP assessment that was forwarded to the provider at the time of the move was outdated and needed to be renewed. In addition, the Positive Behavior Support Plan in the record stated that Functional Communication Training would be the replacement behavior; however, no Functional Communication Training was being provided nor did the provider have any plans in place to provide it. The Post-Move Monitor did not address this.	
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.	RSSLC reported no alleged offenders residing at the Facility; therefore there is no basis to evaluate this provision at this time.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission;	The Facility reported that no individuals have been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10, does not provide any additional guidance to the Facility in this area. A review of the Form CMS-2567, Statement Of Deficiencies And Plan Of Correction, dated 01/08/2010, for RSSLC revealed that no deficiencies were found in the Facility's compliance with CMS-required discharge planning procedures.	

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	(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.		

Recommendations:

1. In keeping with the intent of the Settlement Agreement to 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, the State should further evaluate how supports and services are provided in the community in order to prevent unnecessary institutional services, particularly in the case of people under the age of 21. Offering more intensive and in-home supports may make it possible for more families to avoid having to make the difficult decision of placement. In addition, developing a community living plan for these young people who have been placed at the Facility will require a careful and individualized examination of how the HCS waiver can be used to meet their significant needs and ongoing communication with the families/LARs. DADS should further evaluate the Permanency Planning process as implemented by the Designated MRAs to determine how the process can be used more effectively to propose a community living plan with sufficient supports and services for these individuals, and how this will be coordinated with the individuals' PSPs.

2. Ensure that Facility Policy and Procedure is comprehensively reviewed and updated as needed to comport with requirements of Settlement Agreement and State-level DADS Policy 018.1 on Most Integrated Setting Practices.

3. DADS has a number of training activities and initiatives underway to ensure providers are well prepared to offer the supports and services needed by individuals moving to the community from the Facility. These initiatives are to be commended. DADS should ensure that it has a methodology to evaluate the outcomes of these activities in terms of provider preparation.

4. RSSLC should be commended for encouraging frequency of CLOIP tours to ensure individuals have a number of opportunities to learn about community living options. The DSS noted that some residences are much better than others about scheduling multiple visits. The Facility should evaluate the reasons for this discrepancy and attempt to ensure that all individuals have equal opportunity to experience community living options,

through policy and staff training.

5. It is essential to develop an array of community living option experiences that are the most meaningful to the individuals. This should be the first priority when planning community living option experiences. It is recommended that the DSS and CLOIP staff work closely with the QMRP Coordinator to develop a single, cohesive plan for increasing awareness of community living options that expands on the current approaches to offer meaningful, experiential opportunities that are individualized to the learning needs of the individual and to the specific needs of each family/LAR. In addition, PSTs will continue to need training in developing Action Plans for increasing awareness that also provide sufficient learning opportunities that are individualized to the person's learning needs.

6. It would be advisable for CLOIP staff to regularly attend Parents' Association meetings to provide information, to continue to expand their own understanding of the obstacles perceived by families/LARs and to further develop a relationship of openness and trust.

7. CLOIP Worksheets reviewed had a tendency to suggest that the supports and service required in the community were the same services and supports that were given at RSSLC. The CLOIP process should reach beyond this to enhance the awareness of the PSTs about the possibilities that may be offered by community living. Given their familiarity with the HCS waiver services and the types of community living options available, the CASCs should serve as an educational resource to the PST and support their creativity in designing an optimal community living vision for each individual.

8. The Facility may want to consider examining the person-centered planning models in the literature to see what other strategies might be of use to make their processes more meaningful to individuals and to better prepare them to play a real part in their annual planning meeting. Information and training modules may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html.

9. PSTs should be aware of and pay attention to the types of everyday activities that may be available to individuals who move to a community setting when considering the optimal living option vision and the kinds of supports and services that would facilitate that. PSTs need to define the Optimal Living Option Vision as one in which people have these opportunities, in order to ensure community living options are developed that can offer an everyday life.

10. The monitoring team understands there has been some discussion of moving the Optimal Living Option Vision and Community Living Discussion to the beginning of the PSP. It is recommended this be strongly considered. To do so would give the PSTs a much better framework for developing the PSP with the ultimate goal in mind.

11. PST members would benefit from intensive and ongoing training related to the general identification of barriers and the consequent design and implementation of strategies to reduce those barriers. The training should also focus specifically on the role and responsibilities of the team in the identification of family/LAR opposition as a barrier and in the development of strategies to resolve that barrier. Additional guidance from DADS at the State-level would also be useful. RSSLC was also participating in a DADS-sponsored Community Integrated Discussion Record (CI) pilot, a process intended to provide further guidance for discussion during the PSP. The PSTs observed appeared to understand the basic instructions of the pilot, but not how it needed to be integrated with the current process in order to be an effective tool to identify and address barriers. DADS should consider how it might use this tool as a truly integrated component of the community living options discussion and provide additional training on the entire integrated process.

12. PSPs are monitored, in part, through the Personal Support Plan Meeting Monitoring Checklist. The Facility was reportedly going to begin using a

version of the Settlement Agreement Monitoring Instrument for Section F as the PSP monitoring tool. In terms of the requirements of Section T of the Settlement Agreement, the Section F template may not adequately address all the components. The Facility should develop its own policy and procedure for PSPs and Community Living Options quality assurance that will address not only the requirements of the Settlement Agreement and DADS policy, but also its own specific and self-identified needs.

13. The Facility should take better advantage of the knowledge of the Post-Move Monitor to support the abilities of the PSTs to develop appropriate strategies for community living options and for quality assurance. The Post-Move Monitor is supposed to provide oversight and monitoring of both the Living Options discussions in the Personal Support Plan process and the CLDP process. She is also expected to participate in and serve as a resource to PST members in facility meetings related to community placement referrals, CLOIP issues, discharge planning meetings, placement returns, etc. These tasks were projected to consume approximately 30% of her time. In reality, in the early going since she took this position in December 2009, the Post-Move Monitor reported she attended CLDPs, but had had little time to serve as a resource to the PSTs. This is likely to be a valuable resource in the future. The Post-Move Monitor could offer assistance such as:

    - Attending all PSPs when there is a likelihood that a referral for placement will be made to provide PSTs with information about available resources in the community;
    - Attending a sample of other PSPs to educate PSTs about how barriers, or perceived barriers, might be addressed in the community;
    - Attending and participating in QMRP and Social Worker meetings on a regular basis to educate and update;
    - Providing training to QMRPs, Social Workers and PSTs about how services and supports can be structured in the community.

14. The DSS stated that no one was tracking the timeliness of the addendum meeting for referrals that occur when the Designated MRA is not in attendance at the PSP or at the time the PSP makes the decision to refer. The Facility should incorporate tracking of this information into its policy and procedure.

15. There were several individuals who had requested placement but had not been referred by their PSTs, apparently due to family/LAR opposition. Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10 requires the following: "If an individual or LAR requests placement, the individual's PST will meet to discuss the request within two weeks of the request. The designated MRA, along with the LAR (if applicable), must be participants in the meeting." The policy should clearly state if the expectation is that the PST will meet in response to a request to move to the community regardless of family, LAR or PST opposition.

16. In order to document participation in the development of the CLDP and ensure accountability for its implementation, ensure that signatures are obtained at the meeting and appended to the CLDP. If the review process takes place at another time, it would be advisable to obtain the signatures at that point.

17. The Facility should consider whether certain assessments essential for health and safety, such as the Medical and Nursing Summaries, should be required to be updated, including the course of health care provided since the last assessment, within the 45-day timeframe, rather than just reviewed.

18. Develop or otherwise promulgate written policies and quality assurance procedures to ensure CLDPs are tracked from the process of referral through the individual's move to the community. This should include written procedures for ensuring, at a minimum:

    - PST recommendations for community living for individuals result in a timely meeting with the Designated MRA to consider making the referral;
    - Referrals are routinely tracked, do not fall off the radar screen and are completed within the 180 day timeframe unless a waiver is granted;

- CLDPs provide the required 45-day assessment materials as attachments in a timely manner to all parties who will be involved following the individual's move, including the Post-Move Monitor, as required by state policy;
- CLDPs assign responsibility to Facility staff to ensure that all required activities are completed, even if a provider or MRA staff has primary responsibility for the activity;
- Supports essential to an individual's health and safety are in place at the time the person moves from the Facility; and
- CLDPs are complete and have all required signatures.

19. It was reported there were times the CLDP did not take place until after a trial visit had already been accomplished. Starting the CLDP process at the time of referral would also provide the Facility with more opportunity to track from that point on and avoid those instances in which something fell through the cracks. The monitoring team recommends this be considered.

20. Develop a methodology for the DADS- required assessment of barriers such that it can be used as a quality assurance tool, and one that can inform the development of Facility plans for raising awareness of staff, individuals living at RSSLC and their families/LARs. First and foremost, the Facility should analyze and incorporate the barriers perceived and/or encountered by individuals, families and LARs. The Self-Advocacy group and the Parents' Association would provide additional avenues for obtaining this information. This should be accomplished using a formal methodology, such as survey and/or focus group, and not simply by relying on anecdote. The opinions and concerns of LARs are also documented in the CLOIP, Permanency Planning Instrument and PSP. These data should be sampled and examined for key trends. The Post-Move Monitoring Checklists could be analyzed and common issues identified. In the long-term, this assessment should also be useful in formulating regional resource development strategies with providers and other stakeholders. The Community Integration Pilot may offer some lessons in this regard.

21. The Community Placement Report may not have been complete. There were some unexplained differences between a list of all individuals who had been recommended for community placement since 7/10/10, including their current residential status, and the Community Placement Report. The Facility should examine its data collection and management activities in this area to be sure all information is captured.

22. Examine the implementation of the Post-Move Monitoring Checklist to ensure its use as a meaningful tracking tool for both essential and non-essential services and supports. The Facility should consider entering the data from each visit in an electronic format that will allow for data tracking, data manipulation, reporting and analysis. This will enable the Facility to track corrective action in the short-term, but will also be useful for identifying quality improvement needs across, for example, provider compliance rates or supports availability.

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. List of individuals for whom an LAR has been obtained since 7/1/09 2. PSP Referral for Guardian form 3. DADS Form 2190, Capacity Assessment for Self-Care and Financial Management, November, 2007 4. Personal Support Plans (PSP) for 17 individuals: Individuals #2, #114, #130, #148, #264, #342, #363, #421, #454, #459, #493, #584, #596, #755, #776, #777, #778 5. Draft RSSLC Policies on Determining Need for Guardianship and Monitoring Guardianship 6. Draft HCS Handbook, including the Person Directed Plan (PDP) Discovery Tool Form 8665-DT, dated June, 2010 **People Interviewed:** 1. Cynthia Newton, Director of Social Services (DSS) 2. Angie Penn, Social Worker (Case Worker) 3. Pam Turner, Rights Officer **Meeting Attended/Observations:** 1. PSPs for 2 individuals: Individuals #402, #681
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RSSLC appeared to be taking a well-modulated approach to obtaining guardianship for individuals who lack functional capacity to render a decision regarding health or safety, as the Facility awaited further guidance that is reported to be forthcoming from DADS. The Facility was using what appeared to be a consistent, although informal, process for referring an individual for guardianship and prioritizing the needs of those individuals through the PSP. The Facility was actively seeking guardianship only for those who are determined through this process to be at the highest need. Policies and procedures had been drafted in some areas, such as Determining Need for Guardianship and Monitoring Guardianship, but the process for prioritization being used had not been committed to writing as of yet. The discussion and referral process being used during the PSP did not appear to be an adequate guide for assessment of an individual's functional capacity to render a decision regarding the individual's health or welfare. The DSS reported that a new Rights Assessment process was to shortly be circulated by DADS for comment that was expected to address at least some of the assessment issues. Two additional issues emerged during the discussions held with RSSLC staff during the site visit that will need to be examined further by the Facility and DADS. The first concern is the status of individuals who have been adjudicated incompetent by a court as a part of a guardianship process, but whose guardianship

	lapses or whose guardian dies. The individual is still considered legally incompetent, but no longer has an LAR to act on his/her behalf. Successor guardianship will likely become a more frequent issue as those living at RSSLC and their parents/guardians age. The second issue is the status of individuals who are undocumented aliens. This is a matter of concern as it may impair the individual's opportunity to move to a more integrated setting in the community due to a lack of a funding source. For the purposes of this section of the Settlement Agreement, the specific situation that came to the attention of the monitoring team involved a staff person who was willing to become the LAR for an individual who was reported to be an undocumented alien, if doing so would allow her to access funding for community placement or to expedite the individual's own ability to gain citizenship. It was not clear whether this would have the desired effect and should be investigated by DADS legal staff.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	RSSLC was using what appeared to be a consistent process for referring an individual for guardianship and prioritizing the needs of those individuals through the PSP, although these did not necessarily appear to be well-thought out. A statewide policy in this area had not yet been provided as guidance, but some Facility policies and procedures had been drafted. A draft Determining Need for Guardianship policy had been developed. This draft policy provided very little guidance to PSTs as to how it should assess the need for guardianship, and the extent of that need. The first step in the procedure stated: "The Social/Case Worker: a. Presents the PSP referral for guardian at the PSP and discusses/gains input from all disciplines. b. Forwards the completed PSP referral for guardian to the Director, Social Services" This was the extent of the guidance as to the determination of need for guardianship. The remainder of the policy described the actions that would be taken to obtain a guardian. The Facility was awaiting a statewide policy that was expected to be promulgated in the near future that should assist in determining an appropriate assessment process. In the review of the Person Directed Plan (PDP) Discovery Tool, Form 8665-DT, June, 2010, from a Draft HCS Handbook currently being circulated by DADS, the monitoring team found it included a section on Rights/Legal Status that provided a series of probes community interdisciplinary teams need to consider. Examples included: • Does the person need a guardian or other substitute decision-makers? **If indicated,**	

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		an assessment should be done to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. (Emphasis added) • Does the person have a court-appointed guardian? D**oes the person with a guardian participate in and influence decisions not limited under guardianship? Has the need for guardianship been periodically reviewed?** (Emphasis added) These probes reflected an understanding on the part of DADS that imposing guardianship on an individual is not something to be undertaken lightly. The questions would also be appropriate questions for PSTs at the Facility to ask themselves. To take it a step further in the interests of protecting the rights and autonomy of each individual served, guidance and training should be provided by DADS to the Facilities to prescribe a process for how an assessment should be done to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. The anticipated statewide policy should incorporate approaches in these areas. DADS also has a current Capacity Assessment for Self-Care and Financial Management (DADS Form 2190, November 2007) that includes a number of discrete probes about the capacity to make decisions in the areas of Mental Status, Personal Safety, Nutrition, Clothing, Health Care, Medications, Travel Safety, Motor Vehicle Safety, and Financial Management. This document was brought to the attention of the monitoring team by the RSSLC Rights Officer. It was not observed in any record reviewed and it is not clear how it may be being used, but it did offer some additional assessment criteria that may be useful in the development of an assessment approach The Facility did have what appeared to be a consistent process for prioritizing need for guardianship, using the PSP Referral for Guardianship form, but the process had not been committed to writing as of yet and must therefore be considered informal. The Priority Scale assigned a level of I, II, or III to individuals who are not able to give legally informed consent or have a guardian of the estate only. Priority I individuals are those without family/correspondent to advocate for them and having one or more of the following characteristics: • Have a pattern of injuries; • Are receiving (or are proposed for receipt of) a Positive Behavior Supports (sic); • Receive psychoactive medications; • Have serious ongoing medical needs;	

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		• Have severely impaired communications Priority II was assigned to individuals with family/correspondent that do not routinely and/or regularly visit or attend meetings to advocate for them, and having one or more of the above characteristics, while Priority III is assigned to individuals with involved family/correspondent and one or more of the characteristics. Priority III was also used for individuals who have no one to advocate for them or limited involvement by an advocate, but have none of the characteristics. The draft policy on Determining Need for Guardianship stated the DSS will send a letter to all Priority 1 primary correspondents regarding potential for guardianship or seek alternative guardianship when needed. It did not provide any information about actions to be taken for the Priority II and Priority III, if any. The potential danger in this situation is that PSTs had not been provided with a philosophical basis for limiting guardianship to the minimum necessary for an individual, nor adequate guidance as to how to assess that need. PSPs reviewed, as described in the next paragraph, indicated that PSTs did not fully have this understanding. Guardians had been obtained for three individuals since 7/1/09. A review of the PSPs for two of these individuals (#264, #454) revealed there was no discussion documented by the PST about the need for guardian, other than a mention that the primary correspondent had "renewed guardianship" for Individual #264. For the third individual (#421), there were conflicting references to whether his mother was primary correspondent or current guardian. There was no discussion of his need for guardianship. Of the other PSPs reviewed for this section, six had an LAR and no further review of the individuals' need for guardianship was made. Seven did not have an LAR. In six of the seven, the PST did not make any assessment for guardianship. In the seventh, the PST discussed guardianship as a potential avenue for the individual (#584), an undocumented alien, to achieve citizenship and the opportunity to be eligible for HCS funding in the community, but the PST did not complete any sort of assessment of the individual's functional capacity. (See section U2 below for further discussion of this individual's predicament related to her status as an undocumented alien.) In the final PSP reviewed, there were conflicting references as to whether the individual's mother was his LAR, but there was no assessment of his capacity related to his need for guardianship. Of two PSP meetings attended during the site visit and reviewed for this provision, both individuals had current LARs and there was no discussion to review the individual's need for guardianship. The PSP format was observed to be evolving over the past year. Many of the more recent PSPs had a section that specifically required discussion of identifying those individuals who would benefit from a LAR to assist in decision-making with regards to treatment	

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		and programming. As the review in the preceding paragraph suggests, this had not yet resulted in significantly increasing the time PSTs are devoting to the topic. The DSS reported that a new Rights Assessment process was to shortly be circulated by DADS for comment that was expected to address at least some of these assessment issues.	
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.	The Facility provided a summary of the activities it had taken to obtain LARs for individuals over the four months prior to the monitoring site visit. These included a variety of activities, from contacting primary correspondents to attending related meetings to working toward establishing a resource for successor guardianship, including: • The DSS held discussions with Brazos Bend Guardianship (BBG) and Harris County concerning funding from Health and Human Services (HHSC) for guardianships of SSLC individuals. • The DSS sent letters to the primary contacts for all individuals with a priority 1 need for a guardian. • The DSS attended a guardianship Advisory meeting in Austin to question about resources, etc. • The DSS spoke with the BBG Director and RSSLC Community Services Director for strategies to develop pro-bono lawyers, possible resources for guardians, etc. • The DSS obtained BBG's policy and procedure for their process to become successor guardian. • The DSS met with the BBG Director, who had agreed to start with receiving successor guardianship for 5 people, and is working with them now to finalize these guardianships. A number of the activities described above had to do with Successor Guardianship. This had become an important issue for the Facility. Individuals must be adjudicated incompetent in some area in order for an LAR to be appointed. For almost all individuals residing at RSSLC, the incompetence decision extends to most areas of their lives. In a number of instances, the guardianship had lapsed due to a failure of the LAR to process the renewals in a timely manner. This may leave the individual without anyone to make decisions for a period of time. In other instances, the parent acting as guardian may become ill or die without making any provisions for a successor. This problem is likely to grow as many parents of individuals living at the Facility are now elderly. DADS will need to consider this as a systemic issue and include some guidance for the Facilities in its forthcoming statewide policy. The draft policy for Monitoring Guardianship was reviewed. It assigned responsibility to the Social/Case Worker to monitor guardianships for the individuals they serve. Social/Case Workers were directed to contact the LAR one month prior to the expiration	

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		date as a reminder and to offer assistance. The Facility may want to consider whether this timeframe provides sufficient lead time for most LARs to take the needed action. This might include asking a sample of LARs what the most useful notice period might be, and might also give the Facility an opportunity to inquire about other obstacles LARs experience in renewing guardianship. The Facility should also consider a means for incorporating the tracking of guardianship expirations into its formal quality assurance processes. Another guardianship issue that emerged at RSSLC was whether a U.S. citizen could become a guardian for an individual who is an undocumented alien, and whether that would confer any benefits to the individual. Specifically, Individual #584 was reported to be an undocumented alien. She has requested community placement and her PST agrees this would be appropriate. Due to her immigration status, she did not qualify for community Medicaid and therefore access to HCS-funded services. As a result, she had not been referred by her PST for placement. A staff person at RSSLC who knows the individual well had offered to become her LAR if this would facilitate the opportunity for community living. Notwithstanding the issues of most integrated setting that must also be considered and are discussed in Section T1d above, DADS legal staff should investigate whether this avenue is possible and would provide any relief to the individual.	

Recommendations:

1. Facility PSTs should receive guidance and training from DADS to prescribe a process for how an assessment should be done to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. The anticipated statewide policy should incorporate approaches in these areas. The current Capacity Assessment for Self-Care and Financial Management (DADS Form 2190, November 2007) may offer some additional assessment criteria that may be useful in the development of an assessment approach.

2. Once the statewide policy and assessment process has been finalized, RSSLC should refine and develop facility-specific policies and procedures to operationalize the requirements. The current process for prioritization should be in written form, if only on an interim basis, to ensure it is implemented correctly and consistently.

3. Social/Case Workers would be directed by a draft policy for Monitoring Guardianship to contact the LAR one month prior to the expiration date as a reminder and to offer assistance. The Facility may want to consider whether this timeframe provides sufficient lead time for most LARs to take the needed action. This might include asking a sample of LARs what the most useful notice period might be, and might also give the Facility an opportunity to inquire about other obstacles LARs experience in renewing guardianship. The Facility should also consider a means for incorporating the tracking of guardianship expirations into its formal quality assurance processes.

4. DADS should consider the issues of lapsed guardianship and lack of an identified successor guardian as a systemic need and include some guidance for the Facilities in its forthcoming statewide policy.

5. Individuals living at RSSLC who are undocumented aliens are reported to not have eligibility for Medicaid waiver funding. Their access to community living may thus be restricted. One option considered for one individual was for a staff person who is an American citizen to become the LAR. DADS' legal staff should investigate and provide guidance as to whether this avenue is possible and would provide any relief to the individual in terms of community Medicaid eligibility.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DADS Policy Number 020: Recordkeeping Practices, dated 8/31/09 2. RSSLC Policy A.6: Recordkeeping, dated 2/3/10, including Abbreviations List, revised 4/19/10 3. RSSLC Filing and Retention Schedule, revised 3/24/10 4. RSSLC Current Microfilm Records on Rolls, no date 5. RSSLC Individual Record Index 6. RSSLC Person-Directed Planning Process monitoring tool and QSO Scoring Guide 12/09 (item #21) 7. Active Record for Individuals #342, #452, #538, and #614 **People Interviewed:** 1. Wanda Hartensteiner, Medical Records Director 2. Two night shift DCPs, a house supervisor, and two night supervisors at Nueces 3. Two night shift DCPs and a supervisor at Three Rivers **Meeting Attended/Observations:** 1. PSP Meeting for Individual #681 2. Trinity Building activity program on 4/29/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: DADS is in process of revising the policy for recordkeeping. RSSLC follows the current DADS policy and has established a Facility policy that adds local procedures. All records had sections and documents in the same order, were typed or written with non-erasable pen. They were in chronological order, but the order (new to old or vice versa) varied among sections. Some items were filed in wrong sections. Some signatures and legends were missing. RSSLC has not begun quality assurance reviews of random records but is waiting to begin after the statewide records policy is implemented. Two Medical Records staff spot check records and work with clerks to identify and make corrections and to use consistent filing practices. Use of records in decision-making is variable. Records were not referred to during PSP meetings, but a record was used to resolve a question during an HRC meeting. RSSLC also had a system called a virtual client folder (VCF). This electronic system had a great deal of information which could be available at any linked computer in the Facility. Clinical staff have access to the VCF. This system could be an entry into developing an electronic client record that would be widely accessible and would have timely information.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	RSSLC records follow the order in the Individual Record Index. An individual's active record consisted of at least two books. The Red book was the Residential Program Record; the Green book was Residential Medical Record. Of four records reviewed in detail, all four included an active record. Instead of an individual record book for use by staff providing daily direct services, each individual also had information in a Group Book. For all four records, all entries were either typed or written in ink. All entries were dated with date, month, and year. All entries within a section were in chronological order, but some sections are ordered from most recent to oldest, whereas others are ordered in the opposite direction. No record of the four was legible, accurate, and complete. For Individual #342's record, the CLOIP worksheet was in the assessment section rather than in the PSP section. The SPO section had no contents. The last PSP monthly review documented in the record was dated 1/25/10. For Individual #452, a dental sedation order was filed in the Diet Orders section. The record for Individual ##538 did not include a Contact Sheet at the beginning of Book 1, The record for Individual #614 did not include vocational assessment, employment assessment, or screening for consent. No record had signatures and had a legend if initials were used. For Individual #342, there were initials but no legend for the Daily Fluid Intake/Outake (sic) Sheet or MAR. For Individuals #452 and #538, the MAR did not include a legend. The Positive Support Plan Progress note of 1/4/10 in Individual #538's record was unsigned. Three of the four records (75%) had a table of contents at the beginning of each book, and the record was consistent with the table of contents. Some of the dental integrated progress notes contained blank spaces without consistently crossing out the undocumented portion of the note sheet. Staff at Nueces and Three Rivers could show me where Group Books were; these were readily accessible. In the activity areas at Trinity, Group Books were available and were referred to by activity staff. RSSLC also had a system called a virtual client folder (VCF). This electronic system had a great deal of information which could be available at any linked computer in the Facility. Clinical staff have access to the VCF. This system could be an entry into developing an	

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		electronic client record that would be widely accessible and would have timely information. It will be important to ensure that VCF records have the same version of each document when the new record policy is implemented.	
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.	RSSLC policy closely follows DADS policy. Additional information needed to operationalize the DADS policy was added to the RSSLC policy, such as correct and incorrect ways to make corrections, and other information was not included, such as using only identification numbers when referring to other individuals served. The monitoring team was informed that the format of the record will be changing as a statewide DADS policy is implemented. When a statewide policy is implemented, RSSLC should revise the facility policy and should ensure all requirements of the statewide policy are included. The revisions should continue to include facility-specific instructions needed to operationalize the statewide policy. Per report of the Director of Medical Records, the implementation plan includes identifying the logistics for transition from the current to the new record, training staff, ordering materials such as new labels, and monitoring the process. The target date for implementation is 10/1/10.	
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.	Per report of the Director of Medical Records, RSSLC has not begun quality assurance reviews of random records but is waiting to begin after the statewide records policy is implemented. Two Medical Records staff spot check records and work with clerks to identify and make corrections and to use consistent filing practices. They spot check to ensure Quarterly Drug Regimen Reviews (QDRR) are filed and notify Pharmacy of any problems they identify. The Person directed planning process monitoring tool, while not specifically intended to monitor recordkeeping, does have one item of review, #21: "Is the plan accessible to staff responsible to implement the plan?" Information from this item could be used as part of a quality review process for the unified record. Except for the QDRR checks, this is an informal process.	
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.	Use of records in making care, medical treatment, and training decisions is variable. At the PSP meeting for Individual #681, there was little reference to data found in the Active Record; the monitoring team could not make a conclusion as to whether the staff reporting assessments used information from the Record in developing those assessments. Utilization of records, including VCF records, will be reviewed at compliance visits.	

Recommendations:

1. DADS should continue development of the new policy. Prior to implementation, RSSLC should revise the Facility policy and should ensure all requirements of the statewide policy are included. The revisions should continue to include facility-specific instructions needed to operationalize the statewide policy. Implementation should include provisions for competency-based training of all staff who will use the records.
2. The Facility should ensure that VCF records have the same version of each document when the new record policy is implemented.

Health Care Guidelines

SECTION I: Documentation	
	Steps Taken to Assess Compliance: Records Reviewed: Individuals #84, #145, #281, 500, #174, #7, #614, #621, #114, #70, #651, and #535 Interviews: 1. Charlene McCurry, RN, BSN, Chief Nurse Executive 2. Valerie Kipfer, RN, BSN, MSN, State Office Nursing Coordinator
	Facility Self-Assessment:
	Summary of Monitor's Assessment: Review of the above individuals' records indicated that only physicians and dentist routinely documented in the SOAP format. The nursing staff did not document in the SOAP charting format. During the discussion with the Chief Nurse Executive and State Office Nursing Coordinator regarding the failure of RSSLC nurses to document in the SOAP charting format, it was explained the State Office will soon be finalizing which method of the charting the nurses will use state-wide, since there are many different accepted formats for charting. The monitoring team will follow-up on state-wide method of choice on the next tour. Review of Integrated Progress Notes revealed that they primarily contained documentation by nurses, dentist, and physicians. Notes written by the OT, stated, "refer to the OT Section of the record for the information." Late entries were properly notated. Gaps between entries were rarely found. Entries were almost always dated and timed. Entries were either written with a ball point pen or typed. Documentation of content was reasonably legible, except for signatures, titles, and initials. Signatures usually included the writer's first initial, last name, and title. Typically, entries were written in chronological order. The facility needs to ensure that all disciplines write legibly, particularly their signatures, titles, and initials. The facility needs to instruct all disciplines to write, chronologically, in the integrated progress notes as required by the SA and HCG for compliance. There was evidence from review of the above individuals' Annual and Quarterly Nursing Assessments, and accompanying HMPs, and Integrated Progress Notes that these records were used to make health care and training decisions. The facility's record order for all documents required filing the most recent entries in the back section of their respective tabs. Typically, charts sections are arranged with the most recent entries/documents filed in front. The facility needs to re-evaluate the order documents are place in the records.

Recommendations:
1. The facility needs to ensure that all disciplines write legibly, particularly their signatures, titles, and initials.
2. The facility needs to ensure that all disciplines write chronologically in the Integrated Progress Notes.

3. The facility needs to re-evaluate the order documents are place in the records.

SECTION II: Seizure Management	
	Steps Taken to Assess Compliance: Documents Reviewed: 1. Policy Related to Seizure Management produced in request for documentation of policies on Seizure Management, which is not dated, and which appears to be 5 pages copied from an unidentified text 2. Policy Related to Seizure Management, revised 6-30-08, which identifies origin as Nursing Procedure Manual 3. Records Reviewed: Individuals #7, #145, #500, and #535
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Individuals whose seizure disorder was stable had not been receiving routine annual neurological reviews on a regular basis; however, those individuals who had an active seizure disorder were being followed closely. The RSSLC primary care physicians are increasing their referrals to the Neurology Clinic, and this would appear to be to maintain an annual review for all of the individuals who have a diagnosis of a seizure disorder and are receiving anticonvulsant medication.

Recommendations:
There are no additional recommendations offered at this time.

SECTION III: Psychotropics/Positive Behavior Support	
	Steps Taken to Assess Compliance: Refer to Section J
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	RSSLC is in the process of adding two full time Psychiatrists and has also has two new consulting Psychiatrists. The Psychiatric Assessments performed by one of the new Consulting Psychiatrists clearly meet the standards set forth in the HCG. The current plan is for him to perform a thorough Psychiatric Assessment for each individual who is receiving Psychotropic Medication over the coming months. Baseline data has been obtained during this review (see section J 13 above) which will make it possible to monitor the facilities progress toward meeting the requirements of the HCG with regard to the appropriate use of Psychotropic Medication to treat identified Psychiatric Disorders. The current review indicates that for many individuals the Psychiatric Diagnosis of record cannot be supported by the behavioral symptoms described in the individual's record. In addition there is often no empirical evidence that the medication has been effective in addressing the behaviors that are described as being related to the identified Psychiatric Diagnosis. There is also evidence that the Psychiatrist is not routinely reviewing or signing the Quarterly Pharmacy Reviews that are performed by the Pharm. D. The MOSES and DISCUS assessments are

	being uniformly carried out at the specified intervals and there is evidence of signed informed consent documents for the use of Psychotropic medication for all of the individual records that were reviewed.

Recommendations: Refer to Section J

SECTION IV: Management of Acute Illness and Injury	
	Steps Taken to Assess Compliance: Record Review of Individuals # 138, #568, #404, #335, #419, and #569
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Refer to Sections M2, 3, 4, and 5 information

Recommendations: There are no additional recommendations offered at this time.

SECTION V: Prevention	
	Steps Taken to Assess Compliance:
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Refer to Sections M2, 3, 4, and 5 information

Recommendations: There are no additional recommendations offered at this time.

SECTION VI: Nutritional Management Planning	
	Steps Taken to Assess Compliance:
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.

	Summary of Monitor's Assessment: Refer to Section O.

Recommendations: There are no additional recommendations offered at this time.

SECTION VII: Management of Chronic Conditions	
	Steps Taken to Assess Compliance:
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Refer to Section M 1, 2, 4, and 5

Recommendations: There are no additional recommendations offered at this time.

SECTION VIII: Physical Management	
	Steps Taken to Assess Compliance:
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Refer to Sections O and P

Recommendations: There are no additional recommendations offered at this time.

SECTION IX: Pain Management	
	Steps Taken to Assess Compliance: Records Reviewed: Individuals #84, #145, #281, 500, #174, #7, #614, #621, #114, #70, #651, and #535

	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Review of the above individuals' Integrated Progress Notes did not indicate that when pain medications were administered that individuals were assessed for relief of pain. Individuals' Annual and Quarterly Nursing Assessments did not contain assessments for pain or HMPs for pain management. The Nursing Department needs to ensure that individual who are prone to chronic pain are assessed for expressions of pain and a HMP developed and implemented for pain management as well as when individuals are administered pain medication on an "as needed" basis that individuals are assessed for the effectiveness and their findings documented in the Integrated Progress Notes.

Recommendations: The Nursing Department needs to ensure that individual who are prone to chronic pain are assessed for expressions of pain and a HMP developed and implemented for pain management as well as when individuals are administered pain medication on an "as needed" basis that individuals are assessed for the effectiveness and their findings documented in the Integrated Progress Notes.

HCG appendix A: Pharmacy and Therapeutics	
	Steps Taken:
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.

Acronyms Used in this Report

AAC	Augmentative and alternative communication
ACLS	Advanced Cardiac Life Support
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
AMAP	Annual Medical Assessment and Plan
AP	Alleged Perpetrator
APS	Adult Protective Services
AWR	Average Weight Range
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Plan
CAAN	Campaign Against Abuse and Neglect
CASC	Community Access Service Coordinator
CEU/ceu	Continuing Education Unit
CI	Community Integrated Discussion Record
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Program/Community Living Options Discussion
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CPR	Cardiopulmonary Resuscitation
CTD	Competency, Training, and Development
CXR	Chest X-ray
DADS	Texas Department of Aging and Disability Services
DADTX	Department of Aging and Disability Texas –training database
DAP	Data-Assessment-Plan Format
DCP	Direct Care Professional
DD	Developmental Disability
DFPS	Department of Family Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DMID	Diagnostic Manual - Intellectual Disability
DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DSP	Dental Support Plan
DSS	Director of Social Services
FAI	Functional Assessment Interview
FLACC	Face, Leg, Activity Cry, and Consolability – Pain Assessment Scale
FTE	Full-time Equivalent
GERD	Gastro Esophageal Reflux Disease
GM/gm	Gram
HCAP	Hospital Care Acquired Pneumonia
HCG	Health Care Guidelines
HCS	Home and Community Based Services
HMP	Health Maintenance Plan

HRC	Human Rights Committee
HS/hs	Bedtime
HST	Health Support Team
IC	Infection Control
ICD	International Statistical Classification of Diseases and Related Health Problems
ICF/MR	Intermediate Care Facility/Mental Retardation
IM	Intramuscular
IV	Intravenous
LAR	Legally Authorized Representative
LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MERV	Minimum Efficiency Reporting Value
Mg/mg	Milligram
MD/M.D.	Medical Doctor
ML/ml	Milliliters
MOSES	Monitoring of Side Effect Scale for Psychoactive and Antiepileptic Medications
MRSA	Methicillin Resistant Staphylococcus Aureus
NA	Not Applicable
NMT	Nutrition Management Team
NOS	Not Otherwise Specified
OIG	Office of the Inspector General
O_2SATS	Oxygen Saturation
OT	Occupational Therapist
PAO	Pre-Application Orientation
PBS/PBSP	Positive Behavior Supports/Positive Behavior Support Plan
PFW	Personal Futures Workshop
PMM	Post-Move Monitoring/Post-Move Monitor
PNM/PNMT	Physical and Nutritional Management/Physical and Nutritional Management Team
PO	Oral/By Mouth
POI	Plan of Improvement
PSP	Personal Support Plan
PST	Personal Support Team
PT	Physical Therapist
PTA	Physical Therapy Assistant
QA/QE	Quality Assurance/Quality Enhancement
QDRR	Quarterly Drug Regimen Review
QMRP	Qualified Mental Retardation Professional
RN	Registered Nurse
RSSLC	Richmond State Supported Living Center
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator

SAM	Self Administration of Medication
SLP	Speech Language Pathologist
SOAP	Subjective Objective Analysis Plan (method of charting)
SVN	Small Volume Nebulizer
TB	Tuberculosis
TIVA	Total Intravenous Anesthesia
VCF	Virtual Client Folder
WCS	DADS Waiver Survey and Certification unit