United States v. State of Texas

Monitoring Team Report

Rio Grande State Center
August 23-27, 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 (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center (RGSC). 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 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 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, were considered baseline reviews. Compliance reviews begun in July, 2010, are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of Rio Grande State Center.

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.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in a section of the report for which another team member had primary responsibility. For this review of Rio Grande State Center, the following Monitoring Team members had primary responsibility for reviewing the following areas: Scott Umbreit reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, and supports, as well as quality assurance; Michael Sherer reviewed psychiatric care and services; Rod Curtis reviewed medical care and pharmacy services; Dwan Allen reviewed nursing care, dental services, and safe medication practices; Douglas McDonald reviewed

psychological care and services, and habilitation, training, education, and skill acquisition programs; James Bailey reviewed minimum common elements of physical and nutritional supports, as well as physical and occupational therapy, and communication supports; Rebecca Wright reviewed serving individuals in the most integrated setting and consent; and Michael Davis reviewed record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 might 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 August 23-27, 2010, the Monitoring Team visited Rio Grande State 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.

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) **Facility's Self-Assessment:** No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. The Facility provided a Plan of Improvement, which served as the Facility Self-Assessment. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;

(c) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;

(d) **Assessment of Status:** 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 Health Care Guidelines (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;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated for reviews beginning in July, 2010; 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.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, Individual #45, Individual #101, etc.). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Rio Grande State Center for their welcoming and open approach to this visit. It was clear that the State's leadership staff and attorneys as well as the management team at RGSC 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. Moreover, the facility made a number of staff members available to the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations. This was much appreciated and made possible an efficient and accurate review.

As a result, a great deal of information was obtained during this tour as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding numerous individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

Second, the monitoring team found management, clinical, and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at RGSC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite tour. All monitoring team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist RGSC in meeting the many requirements of the Settlement Agreement.

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at RGSC.

<u>Abuse, Neglect and Incident Management</u>

- The foundation for a well organized and effective system for abuse/neglect prevention and incident management was in place. Staff were well aware of reporting responsibilities and it was evident that regular reporting of incidents to DFPS occurs.
- RGSC conducted two meetings with the Parents Association that included presentations from DFPS, OIG, and the State Ombudsman to ensure family members are knowledgeable of the client protection system that is in place to keep people safe. They are to be commended for this initiative. RGSC had a focused meeting with the Parents Association on 4/17/10 on the topic of abuse/neglect. Representatives from the Office of Inspector General and the Texas Department of Protective and Family Services (DFPS) attended, made presentations, and answered questions. This was followed by a July 31, 2010 Parents Association meeting where representatives from the state Office of the Independent Ombudsman for State Supported Living Centers presented information and answered questions.

- Staff attended training on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation.
- No incidents of failure to report abuse and neglect were identified,

Nursing

- The State Office and the Nursing Departments had adopted and purchased the Health Care Protocols: A Handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and nursing care plan. The Nursing Department purchased handbooks for the nursing staff and they are in place. Nurses are beginning to use these materials as guides for developing nursing care plans.
- Since the baseline visit, the nurses were making progress in the management of individuals transferred to the emergency room and follow up on return to Facility.

Physical and Occupational Therapy

- Review of Physical and Occupational Therapy assessments provided evidence of active collaboration between OT and PT.
- There is evidence in OT/PT documentation that equipment prescribed is available; monitors documented that appropriate adaptive equipment and assistive technology supports were immediately available to all individuals reviewed.

Most Integrated Setting

- DADS Information Letter No. 10-62 provided HCS Program Providers with information on the Post-Move Monitoring Visit process; the requirement for the provider to make available to the PMM access to records and to the individual, the residence, and the day habilitation site; and steps to be taken if a support is not being provided. This clarification demonstrated the commitment of DADS to ensuring supports are provided as identified in the CLDP as well as giving the PMM a checklist of elements to review.

Consent

- The list included names of individuals, level of need, and comments related to the decision on level of need. The comments can be very helpful in identifying issues to be addressed.

Recordkeeping and General Plan Implementation

- RGSC had established a unified record that includes an Active Record, Individual Notebooks, and Overflow/Master Record. The new format established by DADS had been rolled out and a number of staff had been trained. The new format makes it much easier to find information in the record.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at RGSC:

Restraints

- The RGSC was not following the requirements of state policy by not using the mandated Restraint Checklist and Face-to-Face Assessment/Debriefing form. RGSC did not conduct and document restraint debriefings as required by policy.
- For the individual with the greatest number of restraints, RGSC has categorized these restraints as medical when they are in fact physical restraints. This resulted in the vast majority of restraint episodes at the RGSC not having the appropriate documentation and follow up

required for physical restraint. For this individual, less restrictive means to prevent potential for harm had not been used, and the monitoring team questioned whether these were truly crisis intervention.

- For the few other restraints used, RGSC primarily used chemical restraint. Only recently had the Chief Psychologist been consulted, as required by RGSC policy, prior to the administration of a chemical restraint to consider alternatives to chemical restraint.
- Nearly half of the individuals served received pretreatment sedation for dental work. RGSC had no strategies in place to reduce this.
- RGSC uses an electronic record to document restraint use. This documentation did not include all data items required by DADS nor did it always use terminology defined in DADS policy or the SA.

Abuse, Neglect and Incident Management

- UIRs for two of six serious injuries that occurred in the last six months could not be located by facility staff during the review.
- There was considerable concern with the reliability and validity of summary data appearing on logs and trend reports.
- Injury data in the 3rd Quarter Trend Report showed a significant increase in injuries.
- RGSC is seriously deficient in the conduct of internal monitoring/auditing of various management processes.

Quality Assurance

- RGSC conducted a great deal of QA related activity. Many monitoring tools were in the process of being implemented, Little of this work effort was organized into a system that presents useful information from which the need for performance improvement can be assessed and performance improvement initiatives can be made.
- Data in the Trend Reports reviewed are not entirely reliable. Conflicting data in different reports reviewed by the monitoring team called into question the accuracy of data on all reports.
- The number of injuries has been trending up at an alarming rate. There is no evidence that this was identified and addressed.

Integrated Protections, Services, Treatments and Supports

- Although the structure of an interdisciplinary team process was in place, most involvement was multidisciplinary rather than interdisciplinary and integrated.
- The monitoring team did not discover significant or consequential 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.

Integrated Clinical Services

- Although the structure of an interdisciplinary team process was in place, most involvement was multidisciplinary. That is, it is evident from document review and meeting observation that the standard method of operation is for different disciplines to do separate assessments and decision-making, reporting information and decisions, but not routinely integrating information to make joint or shared decisions
- Although data and information from assessments were likely available at planning meetings, they frequently were not discussed; instead, they were reported or summarized, with a clinician making a decision without team discussion.

Minimum Common Elements of Clinical Care

- Although data and information from assessments were likely available at planning meetings, they frequently were not discussed; instead, they were reported or summarized, with a clinician making a decision without team discussion.

At-Risk Individuals

- The system for identifying individuals who are at risk and why, and to plan, implement, and monitor measures to put in place to reduce risk for these individuals, is rudimentary. This item was difficult to assess due to the way individuals are assessed for risk. State policy identifies people whose risk is being managed effectively as medium risk, even if significant resources are needed on a consistent basis; even so, many of these people are rated as low risk.

Psychiatric Care and Services

- Diagnoses are made without adequate clinical support.
- Polypharmacy is used frequently, sometimes in the presence of a diagnosis that is not supported, and without interdisciplinary integrated discussion of other interventions.
- There was no indication that a meaningful process to review risks and benefits of non-emergency psychotropic medications had been developed or implemented by the Facility. Alternative treatments are not commented upon within the personal support planes, quarterly reviews or psychiatric evaluation.

Psychological services

- Although work is being done to increase skills of psychology staff and improve PBSPs, PBSPs do not yet meet requirements.
- The internal peer review process reported by the Facility did not reflect true peer review. The external peer review process was under development.
- Data collection continued to lack demonstrable reliability and validity. It is also unclear that existing data were used to make data-based treatment decisions.
- Intellectual and adaptive assessments were not completed at RGSC, and a large percentage of individuals had not had a psychological assessment completed in over a year that included current assessment findings, or a review of sufficiently recent assessments.
- Some improvement had been made in functional assessment, but these efforts were preliminary at the time of the site visit.
- For the individuals participating in counseling, the treatment process did not reflect an evidence-based approach to treatment and lacked clear, objective and measurable goals.

Medical Care

- Mechanisms in place were inadequate to diagnose, treat, and provide routine maintenance therapy and monitoring for progression of neuromotor and musculoskeletal conditions, including but not limited to, secondary complications of cerebral palsy, degenerative conditions such as arthritis and degenerative spine disease, congenital conditions of the skeletal system and fractures. This is a critical issue that must be addressed promptly.
- The Facility must enhance its ability to provide more meaningful clinical follow-up on health care issues, assess the underlying causes of medical conditions, better understand common and serious co-morbid medical conditions that occur more frequently in individuals with developmental disabilities and more closely monitor individuals for functional decline and progression of medical conditions.
- There is no meaningful team process involved and important clinical information is not adequately communicated in the personal support plan.
- Laboratory data, such as abnormal sodium levels and anemia, were not consistently addressed.

Nursing Care

- The Nursing Department needs to continue to improve the quality of the Comprehensive Annual and Quarterly Nursing Assessment, particularly in analyzing the assessment findings to ensure the nursing diagnoses reflects the entire individual's identified risk factors. Plans of care need to be developed for the identified nursing diagnoses that are individualized.
- The addition of a Hospital Nurse to ensure continuity of care, discharge planning, and to train nurses and direct care staff on any special needs individuals may have upon return home was a positive finding.
- This Nursing Department needs to, without delay, revise the policy and reporting in order to be in accordance with the Health Care Guideline. The nurses and direct care staff need to be re-trained in seizure management.
- The Nursing Department needs to conduct advanced training on Physical and Nutritional Management, particularly as relates to managing dysphagia issues, by a qualified specialist. This training needs to be arranged as soon as possible, included in nursing orientation, and re-training.

Pharmacy Services and Safe Medication Practices

- There is inconsistency among quarterly and annual pharmacy reviews, format issues of annual reviews and lack of an integrated team process for collecting and disseminating information data and other information.
- There is combined use of typical and atypical neuroleptics, without significant clinical justification for their use.
- A mechanism to promptly and efficaciously identify adverse drug reactions is not evident.
- Although the Facility has adopted the use of the DISCUS and MOSES assessments for drug monitoring and that they are incorporated into the quarterly pharmacy review process, there is no evidence that indicates that potential side effects for medications are being assessed at other times.
- The current pharmacy electronic prescribing system is cumbersome and may lead to error.

Physical and Nutritional Management

- The process for identification of risk and for addressing risks was inadequate. DADS is in process of reviewing and establishing new processes.
- PNMPs are not comprehensive due to the plans lacking information regarding oral care and medication administration strategies.
- PNMPs are not developed with clear input from the PST.
- Staff were observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline.
- Not all individuals receiving enteral feeding received an annual assessment that addressed potential pathways to PO status.

Physical and Occupational Therapy

- RGSC has a position open for a PT which should assist in increasing services to individuals but this position has not been filled as of this review.
- Assessments are completed in accordance to the schedule set forth by RGSC; however, assessments are not being consistently completed in response to a change in status.
- OT/PT Plans were not implemented as written.
- A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.

Dental Services

- Dental issues and services are significantly lacking as part of the IDT process. It is critical that the PST play a more active role in monitoring oral health concerns at the Facility.

Communication

- Individuals with identified language difficulties were not receiving active Speech Treatment or participating in a Speech program of any kind. RGSC recently hired a full-time Speech and Language Pathologist (SLP)
- Alternative and Augmentative Communication (AAC) devices are not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs
- There was no monitoring of the presence and working condition of the AAC devices nor was there monitoring of whether or not the device was effective and or meaningful to the individual.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were substantial limitations in formal assessment and skill acquisition plans.
- An annual assessment process did typically take place, but the process lacked rigorous and meaningful assessment.
- The Facility had made progress in providing community access and opportunities, but this process had not been sufficiently standardized or monitored to allow for a determination of substantial compliance.

Most Integrated Setting

- Although RGSC had taken many steps to encourage individuals to move to community living, the Facility had identified only two people in six months for referral to community living, and only one person had moved during the prior six months.
- Identification of supports in the Community Living Discharge Plan was not documented so that all needed supports were clearly listed; as a result, the Post-Move Monitoring visit did not review and verify presence of all needed supports.
- The Facility reported that no individuals have been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. The Facility did not currently have a policy and procedure in place describing how it would comply with the requirements of this provision if such a circumstance arose.

Consent

- Criteria for prioritization were stated neither in policy nor in documentation of training of staff who identified the levels of priority for individuals.
- Although actions had been taken to recruit guardians, these had limited effect. The Facility Director provides consents for a large percentage of the people served by the Facility.

Recordkeeping and General Plan Implementation

- Although RGSC had implemented the new format for records, and information was much easier to find, no records reviewed were completely legible, accurate, and complete.
- A very serious issue facing the Facility is the integration of the CWS as part of the Active Record in a way that makes information easier to access and supports rather than hinders integrated planning. The CWS format does not match all requirements of the Facility and the SA.

V. 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. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. Restraint records for individuals #3, #29, #55, #61, #80, #122, and #149 4. RGSC/PMAB training curriculum for Restraint: Prevention and Rules for Use at MR Facilities, revised 12/21/07; Supporting the Prevention and Safe Use of Restraint, 6/07; and, Applying Restraint Devices in Behavioral Emergencies, 2/6/06. 5. Training material used by Psychologist labeled" Restraint Methods and Justification" (undated) and accompanying training roster sign in sheet dated 8/10/10. 6. Minimum Training Requirements of State Supported Living Centers Revised 6/16/10. 7. Restraint Log 7/22/10 8. List of individuals who have received pretreatment sedation 9. Personal Support Plan for individuals #47, 60 #61, #80, #82, #121 #122, #145 and #149 10. Behavior Support Plan for individuals #61, #80, #122, and #145. 11. Levels of Supervision form 8/25/10 12. DADS Policy 001-Use of Restraint 8/31/09 13. RGSC SOP MR 300-01 Psychological and Behavioral Services 1/10 14. RGSC SOP MR 300-02 Prescribing Psychoactive Medication 2/10 15. RGSC SOP MR 500-07 Use of Mechanical Devices to Prevent Involuntary Self Injury and to Provide Postural Support 2/10 16. RGSC SOP MR 700-13 Levels of Supervision 2/10 17. RGSC SOP EC 200-06 Restraint/Seclusion Review Board 9/09 18. RGSC SOP NR 200-49 The Use of Restraint 8/20/10 19. RGSC SOP MR 700-14 The Use of Restraint 4/10 20. RGSC SOP MR 200-2 Restrictive Practices 2/10 **People Interviewed:** 1. Mary Ramos, Quality Management Director 2. Rosie Sanchez, QE Coordinator 3. Alondra Machado, Data Analyst 4. Megan Gianotti, Psychology Coordinator 5. Myrna Wolfe, Incident Management Coordinator **Meeting Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/23/10 *2.* Health Status Team (HST) 8/24/10

	3. Performance Improvement Council (PIC) 8/24/10 *4.* Personal Support Team annual meeting for individual #140 8/25/10
	Facility Self-Assessment: The Facility stated it is not yet in compliance with any of the provisions of this Section but have completed steps leading to compliance. Comments made by the Facility in the POI indicated many instances of thorough review and thoughtfulness. For example, regarding documentation of medication administered during restraint, the Facility reported that medications were documented but effectiveness was not. The Facility reported that policy had been updated. The monitoring team found that not all requirements of State policy were being implemented. The Facility reported that all instances of restraint were used as crisis intervention. The monitoring team observed in the case of the individual for whom the greatest number of restraints were used that less restrictive means to prevent potential for harm had not been used, and the monitoring team questioned whether these were truly crisis intervention. The Facility reported that all staff hired to work directly with individuals had completed competency-based training on use of restraints. The monitoring team confirmed that all such staff had received training but is not able to comment on the competency-based nature of the training.
	Summary of Monitor's Assessment: The RGSC was not following the requirements of state policy by not using the mandated Restraint Checklist and Face-to-Face Assessment/Debriefing form. RGSC did not conduct and document restraint debriefings as required by policy. Additionally, the RGSC did not consistently use terminology and definitions that mirror those in state policy and the Settlement Agreement. For example, the SA has four categories of restraint: chemical, mechanical, medical, and physical. RGSC mixed these four terms with the use of the terms "emergency, " "personal, " and "programmatic." This makes it difficult to review restraint documentation and determine what type of restraint was actually in place in a given circumstance. As a result, important information is often hard to find or nonexistent making internal assessment of restraint practices very difficult. The restraint landscape was dominated by one individual who accounted for 1091 of 1167 restraint episodes for the seven month data reporting period reviewed by the monitoring team. RGSC has categorized these restraints as medical when they are in fact physical restraints. This resulted in the vast majority of restraint episodes at the RGSC not having the appropriate documentation and follow up required for physical restraint. When restraint was used, RGSC primarily used chemical restraint. Ten of thirteen non-medical restraints

	since 3/1/10 (not factoring in the one individual) were chemical restraints. Only recently had the Chief Psychologist been consulted, as required by RGSC policy, prior to the administration of a chemical restraint to consider alternatives to chemical restraint. Nearly half of the individuals served received pretreatment sedation for dental work. RGSC had no strategies in place to reduce this. There was no restraint documentation in the individual's record or a notation of where to find it. RGSC uses an electronic record to document restraint use. This documentation did not include all data items required by DADS nor did it always use terminology defined in DADS policy or the SA. A review of restraint documentation, primarily the electronic restraint record, revealed many instances of incomplete, incorrect, or missing data indicating the need for an aggressive system of internal controls via monitoring and auditing of records and other documentation. There have been a number of personnel changes that likely have impacted improvement initiatives in this section of the Settlement Agreement. Most of these changes have been very recent and include: the resignation of the MR Services Director with the position being temporarily filled by another administrator; the resignation of the Training Director; the promotion of the QMRP Coordinator leaving that position temporarily vacant; and, the appointment of a Chief Psychologist. It is expected that as these organizational changes stabilize improvement plans will be more observable.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall 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	From record review and interview there was no indication that RGSC uses prone restraint. There is also clear recognition in policy that prone restraint is prohibited. One area of concern is noted. Individual #3 was restrained on 6/10/10 at 4:40am. On the print version of the electronic restraint record the entry for "Type of Personal Restraint" is "modified restraint – supine." Supine restraint, like prone restraint, is specifically prohibited in both state and RGSC policy. This was a medical restraint for a venipuncture and was characterized as due to an unanticipated dangerous behavior. There was nothing in the restraint documentation to indicate a post restraint review of a restraint not authorized by policy to ensure that its use was appropriate given the circumstance and viewed as an acceptable, and approved in this instance, policy exception. The monitoring team has considerable concern as to whether RGSC is limiting the use of restraint to instances where the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures have been	NC

#	Provision	Assessment of Status	Compliance
	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.	exhausted or considered in a clinically justifiable manner, for convenience of staff, or in the absence of or as an alternative to treatment. The deficiencies in behavioral supports (refer to Section K) and habilitation supports (refer to Section S) require improvement before assessments can be made as to the appropriateness of use of restraints in the context of SA requirements. Additionally, RGSC SOPP MR 700-14 (page 9 item F.6) requires that the Psychologist/Administrator on Call be consulted prior to the administration of a chemical restraint to determine if other interventions are available. Through interview it was discovered that the need to follow this requirement has recently been reinforced. A 7/28/10 consultation resulted in a chemical restraint being withheld for individual #101 as alternative effective strategies were identified and were effective. RGSC did not use the Restraint Checklist and Face-to-Face Assessment/Debriefing forms required by DADS Policy 001 – Use of Restraint. RGSC also did not have a restraint debriefing process required by policy. This results in the absence of considerable information typically found on these documents. This makes it very difficult for the monitoring team to assess compliance with the requirements of the SA. There was also confusing and/or contradictory information on the print version of the electronic restraint record. For example, individual #80 (restraint 5/17/10) noted use of a "vertical hold" in the "type of restraint" section of the document. A vertical hold was not defined anywhere in policy or PMAB training. On the second page of the form there was a notation "RN gave the chemical restraint: Haldol 5mg and Benadryl 50mg." Apparently this was actually a chemical restraint though not so identified in the documentation except for this note. RGSC uses an electronic record to document restraint use. Print versions labeled "MR Restraint" were made available to the monitoring team and presented as restraint documentation. This documentation did not include all data items required by DADS nor did it always use terminology defined in DADS policy or the SA. For instance, the DADS Restraint Checklist identifies three methods of restraint: physical (with eight possible subheadings), mechanical (with eight possible subheadings), and chemical. The electronic record created by RGSC, in the method of restraint section in the fifteen records reviewed had the word "personal" as the response. The Dads Restraint Checklist has entries to describe the reason for restraint. For example, there are five subheadings under the heading "behavior exhibited", and seven subheadings under the heading "medical/dental." The RGSC electronic record will simply have the word "medical" or "behavior exhibited" entered with no further information. There are other examples of incongruence between what is possible to be produced on the electronic record (from dropdown menu choices) and the larger range of choices allowed on the DADS Restraint Checklist. This is most	

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		evident in the section of the Restraint Checklist describing event codes and action/release codes (discussed in C2) and RN/LVN Restraint Physical/Mental Evaluation (discussed in C5). Based on the documentation provided to the monitoring team, there was little evidence found in the review of fifteen restraints that face to face assessments of any type were conducted. There were no face-to-face assessment forms. There was little evidence found in the fifteen restraints reviewed of debriefings required by DADS policy. In one instance (individual # 149 restrained 6/15/10) there was a form provided to the monitoring team entitled Emergency Restraint Monitoring and Debriefing Form. This is not the form required by DADS policy (form number 04282009R) and is not as complete as the DADS required form which includes three pages of information. The RGSC form, in the two instances it was located, consisted of one page of information. In reviewing the records of six individuals (#29, #55, #61, #80, #122, and #149) who were, among them, restrained a total of thirteen times since 3/1/10 there was nothing in the red restraint tab section of the record even though in the Order of the Record there was a clear requirement that anything missing from a tab should include a note describing where the information could be found. Staff using the record for assessment and planning could assume the individual was not subject to restraint when in fact they were. The process by which restraint episodes and corresponding documentation is reviewed needs improvement. The lack of a routine face-to-face assessment and debriefing immediately following each episode of restraint makes subsequent review problematic. A restraint episode received what appeared, through observation of the meeting, to be a nonsubstantive and somewhat cursory review at the Incident Management Team meeting. RGSC policy requires that a nonmedical restraint episode receive a team review within three days of occurrence, and there is a "management review" data item on the print form of the electronic restraint record although this review seems to occur well after the fact. For example, for individual #61's restraint episode of 5/18/10 the management review date was 7/21/10. Individual #29's restraint episode of 3/4/10 (final) did not have a management review completed at all. As RGSC revises its practices with respect to restraints it should include in its plan restraint review practices. For the period 1/1/10 through 7/21/10, RGSC reported the use of 1167 restraints, 1153 of which were medical restraints. 1091 of these medical restraints were attributable to one individual, # 47. For the most part, these restraints of this one individual consisted of	

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		hand or arm holds to facilitate feeding. The monitoring team does not believe that in most instances these restraints are properly categorized as medical restraints. As a result, the RGSC is seriously deficient in restraint practices and associated recordkeeping, required by the Settlement Agreement,, DADS state policy, and, RGSC SOP MR 700-14. • Finally, when restraint was used, RGSC primarily used chemical restraint. Ten of thirteen non-medical restraints since 3/1/10 (not factoring in the one individual) were chemical restraints. One individual (#80) was chemically restrained six times since 4/1/10. Individual #80 had experienced an increase in monthly displays of self-injury, from less than one to greater than 12, over the previous 12 months. Discussion suggested that sinus/nasal discomfort was frequently associated with displays of self-injury by this individual, such as the nasal expression of a large volume of black mucous during the most recent display of self-injury and frequently observed insertion of the index finger into the nose "almost up to the third knuckle." Discussion of possible medical interventions was very general, included comments such as "Oh, he does that all the time", and did not evidence integration between psychology and medical staff. Deficiencies in behavior supports (refer to Section K) and habilitation supports (refer to Section S) are likely contributing to what appears to be an over-reliance on the use of chemical restraint at the RGSC. Only recently had the Chief Psychologist been consulted, as required by RGSC policy, prior to the administration of a chemical restraint to consider alternatives to chemical restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	For individual #149 (restraint 6/15/10) the release code was "met criteria and was released." For individual # 61 (restraint 7/18/10) the release code was "met criteria and was released." In neither case was "criteria" defined in the restraint documentation provided to the monitoring team. In both cases the information on the printed version of the electronic record can be interpreted that both individuals were still in a highly agitated state. This is because the print version of the electronic record (unlike the Restraint Checklist) does not record the time each observation is made. A properly completed Restraint Checklist describes, through the use of time and code entries, what is actually happening in a way that allows anyone reviewing the documentation to make a reasonable assessment as to compliance with policy requirements. It is impossible to do this when reviewing the printed version of the electronic record.	NC
C3	Commencing within six months of the Effective Date hereof and with	RGSC had a comprehensive policy on the use of restraint. It was last revised in April, 2010. It largely mirrored the DADS policy on use of restraint. Significant operational deviations	NC

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	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.	from this policy are noted, most notably the lack of use of the Restraint Checklist and the Face-to-Face Assessment/Debriefing documentation required by the DADS policy. A review of a sample of staff training records indicates staff had been trained in the appropriate restraint-related policies. The training records of the two staff who applied restraints to individual #149 (restraint 6/15/10) were reviewed; they had completed all essential training. The monitoring team is not able to comment as to the competency-based focus of the training. The RGSC Training Director at the baseline review had left and her replacement resigned during the week of the review and was unavailable to interview. RGSC SOPP MR 700-14 (page 15 item J.5) requires a clinical review of each use of chemical restraint conducted by the Pharmacist and Psychiatrist. There was no indication that this occurred and through interview RGSC acknowledged they do not as yet have a process in place to achieve this. This provision requires that the Facility develop and implement policy; in this case, the policy was not implemented accurately.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	As noted in C1 there is one individual (#47) who was restrained 5-6 times a day presumably as a medical restraint. The monitoring team does not believe the vast majority of these restraints were medical restraints, that is, "necessary for the conduct of a specific medical procedure or only necessary for protection during the time that a medical or dental condition exists, for the purpose of preventing an individual from inhibiting or undoing medical or dental treatment." As described by staff, and through observation, the activity occurring that presumably made restraint necessary was enteral feeding, which in the opinion of the monitoring team is not a specific medical procedure, nor was it necessary for protection during the time a medical condition existed but instead was to prevent movement that disrupted the feeding. Refer to Section K, L, and M for additional comments regarding individual #47. Thirty two of 71 individuals were identified in the document request as requiring pre-treatment sedation (restraint) for dental appointments. Through interview, RGSC staff acknowledged they do not as yet have a system in place that would include treatments or strategies to minimize or eliminate the need for this form of restraint.	NC

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C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Face to Face assessments and debriefings were not being done according to DADS policy requirements. For some restraints there were PSP Addendums (individual #55 – restraint 3/29/10) or progress notes that indicated some of the points of inquiry found on a face to face assessment and debriefing occurred, however, they were not as comprehensive, or as timely, as the required face to face assessment and debriefing. Licensed Health care professionals were not documented as monitoring and/or documenting vital signs and mental status of an individual in restraint. Monitoring of vital signs and mental status was not documented on the printed electronic restraint record. For non chemical restraint the notations on the printed version of the electronic restraint record records a date/time of a post restraint physical but does not display vital signs or mental status. Through demonstration by a nurse who has entered data for the electronic restraint record it was apparent the electronic record data entry allows for these specific entries, and, through interview it was indicated that if vital signs and mental status information had been entered, they would have appeared on the printed version. With one exception the printed version of the electronic restraint record did not display vital signs or mental status data. The one exception was individual #80 (restraint 4/2/10) which stated "B/P: UNCOOPERATIVE" in the RN/LVN Post Restraint Physical section. This confirms what was reported through interview that entries for vital signs and mental status, if entered, will appear on the print version of the electronic record, and, therefore, that the printed copies provided to the monitoring team show that vital signs and mental status were not reported. The timeliness and thoroughness of post restraint examination was questionable. Individual # 149 (restraint 6/15/10) was released from restraint at 6:30pm and the post restraint physical was noted to begin at 6:35pm. The notation on the form was "refused to be checked, seen by staff that she is still upset" followed by a notation of "as reported by staff she had abrasion to her left elbow area." These entries would presumably have been made by the nurse. It is unclear if the nurse actually examined the individual or was relying on a staff report. There were no other entries indicating a later exam or any nursing follow up. It should also be noted that in the pre review document request the RGSC reported that no individual had any restraint related injury even though an injury is referenced on this restraint document. As noted in C.1, RGSC used chemical restraint in most occurrences of restraint other than for one individual. State policy, and RGSC policy, requires that when chemical restraint is used "evaluations by a licensed healthcare professional occur every fifteen minutes for two hours following the medication administration." The restraint documentation did not	NC

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		indicate this was occurring. The print version of the electronic restraint record typically indicated a RN/LVN post restraint physical occurring at, or nearly at, the same time as the medication administration. For instance, for individual #80 (restraint 6/10/10) the chemical restraint was at 12:15am and the post restraint physical was at 12:15am. For individual # 122 (restraint 5/1/10) the chemical restraint was at 9:30pm and the post restraint physical was at 9:35pm. For individual #61 (restraint 5/18/10) the chemical restraint was at 5:45pm and the post restraint physical was at 5:45pm. In no instance did the documentation provided to the monitoring team indicate these post restraint physicals documented vital signs and mental status. There was also no indication that the RN/LVN conducted additional checks at fifteen minute intervals for two hours as required by policy. RGSC SOPP MR 700-14 (page 15 item J.5) requires a clinical review of each use of chemical restraint conducted by the Pharmacist and Psychiatrist. There was no indication that this occurred and through interview RGSC acknowledged they do not as yet have a process in place to achieve this. The SA does not require review by the pharmacist; therefore, this was noted by the monitoring team but would not affect compliance with this provision. The Facility does need to follow its own policy. Documentation for the medical restraint of individual #47 (restraint 7/27/10), and the individual's Personal Support Plan (PSP), was reviewed. This individual was restrained physically 5-6 times a day. There was little documentation in the PSP regarding the almost ongoing use of restraint. Noticeably missing was any discussion, or documentation, with respect to physician expectations for schedule and type of monitoring as required by the SA.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene	The three instances of non chemical restraint which occurred since 3/1/10 were reviewed (individuals #55 – restraint 3/29/10, #61 – restraint 7/18/10, and, #149 - restraint 6/15/10). One restraint was one minute and two were five minutes. Because of the brief duration of each episode there would be no expectation for required opportunity for meals, toilet breaks, exercise, etc. The restraint documentation did not include level of supervision. There was no evidence that 1:1 supervision was provided as required by policy and the SA. There was no evidence that any alternative level of supervision for these individuals had been designated and approved. For individuals #61 and #149 two staff were listed as having applied the restraint suggesting 1:1 supervision was in place but 1:1 supervision was not documented on the restraint checklist.	NC

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	in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	Individual #55 was noted to be restrained at 11:45am and released at 11:46am. There was no notation as to which staff performed the restraint (bear hug). In the observation section of the form it was noted the restraint ended at 11:03am. The RN/LVN post restraint physical was noted to occur at 11:40am and contained the same lack of specificity as noted in C.5. In addition to highlighting the haphazard manner in which this documentation was prepared, this example also serves to re-enforce the need for an internal monitoring/auditing process to identify problems and initiate corrective action and additional training. None of the restraints were documented consistent with Appendix A of the SA.	
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:	Through interview the RGSC acknowledges they do not as yet have any review process in place to address this provision of the SA. Individual #80 met the criteria for this review having had chemical restraint on 5/17/10 (twice) and on 6/10/10. Individual #47 who had 5-6 medical restraints a day would meet this criteria if these restraints were properly classified as non medical restraint as the monitoring team believes they should be.	NC
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	The Facility did not collect data in enough detail to determine the cause of behavior provoking restraint. See information in Provision C1 for the example of Individual #80, for whom biological factors were not considered.	NC
	(b) review possibly contributing environmental conditions;	The Facility did not collect data in enough detail to determine whether environmental conditions affected behavior provoking restraint. See section K for recommendations regarding functional assessments of behavior.	NC
	(c) review or perform structural assessments of the behavior provoking restraints;	The Facility did not collect datain enough detail to determine the cause of behavior provoking restraint. See section K for recommendations regarding structural assessments of behavior.	NC
	(d) review or perform functional assessments of the behavior provoking restraints;	The Facility did not collect datain enough detail to determine the cause of behavior provoking restraint. See section K for recommendations regarding functional assessments of behavior.	NC

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	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	Sampled PSP Addendums would recommend PBSP changes in some cases. See section K for discussion and recommendations regarding deficient practices in PBSP planning.	NC
	(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	It did not appear that consistent data were being collected with respect to behavioral incidents and interventions. Because of this the relevancy of treatments and supports is questionable. Refer to section K for additional information.	NC
	(g) as necessary, assess and revise the PBSP.	PSPs were revised through the use of PSP Addendums. As noted in C.7.f the relevancy of these revisions is questionable. Addendums were done timely but there was no evidence that assessments were performed and PSBPs were revised based on new assessments.	NC
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the	As reported through interview RGSC has the expectation that each episode of non medical restraint be reviewed by the individual's Personal Support team (PST) within three days and changes made to the PSP as appropriate. This review would be expected to be	NC

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	circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	documented in a PSP Addendum. Individual #169 was restrained on 7/18/10. The PST with five members present met on 7/19/10 to review the circumstances of the restraint. Four action steps resulted from this review. Individual #149 was restrained on 6/15/10. The PST with four members present met on 6/16/10 to review the circumstances of the restraint. Two action steps resulted from this review. Although reviews occurred and resulted in action steps, the absence of the data contained in a Restraint Checklist and Face-to-Face Assessment/Debriefing form, and in the case of chemical restraint the absence of a Psychiatrist and Pharmacist review, suggests the PST is not able to address the issues associated with the restraint episode in a comprehensive manner.	

Recommendations:

1. Follow DADS policy on Use of Restraint and use the forms and processes in that policy to document restraint use and follow up to restraint use.
2. Reexamine RGSC policies on restraint (not just MR 700-14) to make certain no RGSC policy elements conflict with DADS policy on Use of Restraint and conversely all elements of DADS policy are reflected in RGSC policy.
3. Qualitatively improve the process for review of each episode of restraint. As RGSC revises its practices with respect to restraints it should include in its plan restraint review practices.
4. Ensure all restraints are properly classified as chemical, mechanical, physical, or medical and conduct the administrative activity appropriate to each type of restraint.
5. Ensure restraint documentation is placed in the individual record.
6. Develop treatments and strategies to minimize or eliminate the need for pre-treatment sedation.
7. Ensure RN/LVN post restraint release assessments are completed according to policy and documented correctly.
8. Develop a mechanism to comply with the RGSC policy requiring a clinical review of each instance of chemical restraint by the Psychiatrist and Pharmacist.
9. Generally improve the accuracy and thoroughness of all restraint related documentation.
10. Develop a system of internal monitoring/auditing of restraint related documentation to insure timely identification of problems and initiation of appropriate, and effective, corrective action plans.

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. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. RGSC SOP MR 200-3 Protection from Harm – Abuse, Neglect, and Incident Management dated 1/10 4. RGSC SOP EC200-33 DADS Video Surveillance Monitoring 4/10 5. RGSC SOP 100-01-B Reporting Unusual Incidents 6. RGSC SOP HR 100-27 Criminal History and Client Abuse and Neglect Checks 8/98 7. RGSC SOP MR 400-01 Injuries to Consumers 2/10 8. Nursing Referral form used to initiate injury reporting 9. RGSC SOP NR200-50 Reporting Patient/Individual Injury 8/10 10. RGSC SOP FW109-03-01 Procedures for Investigating Allegations of Sexual Assault or Sexual Abuse Allegations 11/92 11. RGSC SOP MR 700-15 Bedrails 2/10 12. DADS Policy 2.1 Protection From Harm - Abuse, Neglect, and Exploitation 6/18/10 13. DADS Policy 2.2 Incident Management 6/18/10 14. Abuse, Neglect, Exploitation training material dated 10/07 15. Poster used to inform staff, individuals, LARs, and visitors of A/N reporting responsibilities 16. Sample of MR Tracer Forms 17. Training transcripts of sample of employees 18. Training transcripts of facility and DFPS investigators 19. Sample of Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation forms 20. 2010 Unusual Incident Log 21. List of Peer caused injuries 1/1/10 to date 22. Injury Log 1/1/10 to date 23. Client Injury Assessment for #72 (injury 5/30/10), #58 (injury 3/27/10), #60 (injury 7/31/10), #145 (injury 7/31/10), #121 (injury 8/1/10), #80 (injury 8/4/10) 24. Client Injury Assessment and discovered injury review documents for individual #5 (injury 6/25/10, #55 (injury 6/25/10), #61 (injury 6/14/10), and #10 (injury 6/29/10). 25. MR Client Injury Assessment (notes 4 or more injuries to the same individual within rolling 30 day period) 26. UIRs for serious injuries 453625, 451261, 434925, individual #80 (no tracking number on UIR, date of injury 4/4/10), 37298063, 453625, individuals #10 and #60 (no tracking number on UIR, date of injury 3/17/10) 27. Department of Family and Protective Services Investigative Reports 36667051, 37144152, 37015229,

	36814054, 36749890, 36580969, 36525849, 36180710, 36491210, 36497134, 36517831, 34463189, and 36577409 28. Log of cases sent to the Office of Inspector General (OIG) and disposition 29. Log of employees reassigned due to investigations last six months 30. Sample documentation of employee discipline taken post investigation 31. Investigation file for individual #139, including DFPS case file and UIR file 32. Incident Management Review (IMRT) minutes from meetings on 7/19/10, 7/26/10, 8/2/10, 8/9/10, 8/16/10, and 8/23/10. 33. Training transcripts for DFPS investigators. 34. Training transcripts for RGSC staff authorized to conduct investigations. 35. FY10 RGSC Employee Satisfaction Survey **People Interviewed:** 1. Mary Ramos, Quality Management Director 2. Rosie Sanchez, QE Coordinator 3. Alondra Machado, Data Analyst 4. Megan Gianotti, Psychology Coordinator 5. Myrna Wolfe, Incident Management Coordinator 6. Yolanda Gonzalez, RN, Chief Executive Nurse 7. Jessica Juarez, QE Nurse 8. Marcy Valdez, RN, ICFMR Nurse Manager 9. Linda Lothringer, DADS SA Compliance Coordinator 10. Tom McClure, RGSC Attorney 11. Amor Escalona, RN 12. Ray Ramos, Safety Officer 13. Gloria Casas, Administrative Assistant, ANE **Meeting Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/23/10 *2.* Health Status Team (HST) 8/24/10 *3.* Performance Improvement Council (PIC) 8/24/10 *4.* Personal Support Team annual meeting for individual #140 8/25/10
	Facility Self-Assessment: The Facility reported that the Abuse/Neglect policy included all SO requirements. However, RGSC had not as yet revised its Abuse/Neglect policy to reflect changes made to the State policy. The Facility reported it could not document that all staff had received required training regarding abuse/neglect and incident management policies. The Facility reported that policy is in place to protect individuals when an allegation is made of abuse or

	neglect or another serious incident occurs, including removing alleged perpetrators from direct contact but documentation of compliance could not be provided. Review by the monitoring team confirmed that alleged perpetrators were routinely reassigned. The Facility reported that most aspects of timely investigation are in place, although policy revision needs to be completed. The Facility reported, and the monitoring team confirmed, presence of a process that ensures investigators are not in the direct line of those being investigated. The Facility reported having a system to track and trend unusual incidents and investigations. The monitoring team found examples of needed improvement in the trend report, and its use, therefore D.4 is not in compliance.
	Summary of Monitor's Assessment: The foundation for a well organized and effective system for abuse/neglect prevention and incident management was in place. Staff were well aware of reporting responsibilities and it was evident that regular reporting of incidents to DFPS occurs. There were issues with some aspects of the incident management system. For instance, the UIRs for two of six serious injuries that occurred in the last six months could not be located by facility staff during the review. There was an issue with the timeliness of DFPS response to some reported allegations. There was also considerable concern with the reliability and validity of summary data appearing on logs and trend reports (refer to D.4). Injury data in the 3rd Quarter Trend Report showed a significant increase in injuries. The number of reported injuries from January, 2010, through May, 2010, steadily increased. Sixty-seven injuries were reported in January, 88 injuries in February, 108 injuries in March, 105 injuries in April, and 132 injuries in May. RGSC had a system in place for the review of nonserious discovered injuries; however, it needs improvement in timeliness of review and level of administrative review. RGSC conducted two meetings with the Parents Association that included presentations from DFPS, OIG, and the State Ombudsman to ensure family members are knowledgeable of the client protection system that is in place to keep people safe. They are to be commended for this initiative. RGSC is seriously deficient in the conduct of internal monitoring/auditing of various management processes. A systematic auditing process would likely detect the same kind of issues found by the monitoring team. There have been a number of personnel changes that likely have impacted improvement initiatives in this section of the Settlement Agreement. Most of these changes have been very recent and include: the

	resignation of the MR Services Director with the position being temporarily filled by another administrator; the resignation of the Training Director; the appointments of a new Incident Management Coordinator and Facility Investigator: and, the resignation of a DFPS Investigator who had been servicing RGSC for years. It is expected that as these organizational changes stabilize, improvement plans will be more observable.

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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.	RGSC SOP 200-03 Protection From Harm – Abuse, Neglect, and Incident Management commits the facility to not tolerating abuse or neglect of individuals and obligates staff to report abuse or neglect. Most documents reviewed validated timely and correct reporting. There were exceptions.	SC
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:	RGSC SOP 200-3 was last revised in January, 2010. The policy largely mirrors the DADS state policy on the same subject that was in place in January. The state policy was revised in June, 2010. It was split into two policies: 1) 02.1 Protection From Harm – Abuse, Neglect, and Exploitation, and 2) 02.2 Incident Management. The current RGSC policy does not necessarily reflect changes in the DADS policy; for example, the new Incident Management policy VII.E requires the facility to establish an administrative review process for discovered, non-serious injuries of unknown cause. The RGSC SOP 200-3 does not address this topic. It should be noted RGSC had such a process in place even though their policy does not specifically require it. Because DADS had issued a policy update (6/18/10) the RGSC needs to review its SOP 200-3 to ensure all elements of the State policy are covered in the RGSC policy.	NC
	(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	RGSC policy and related staff training contains the necessary information to comply with this element of the SA and most documents reviewed validated timely and correct reporting. There were exceptions. Individuals #10 and #60 were involved in aggressive acts toward each other on 3/17/10 that resulted in a serious injury to individual #10 breaking two teeth. The incident occurred at 8:20pm. The nurse who assessed the injury at 8:57pm did not note any injury. The nurse who reassessed the injury at 8:00am the next day identified the injury and scheduled a dental appointment for later that day. The incident was not reported to DADS regulatory or DFPS until 7/15/10. The UIR did not have a tracking number on it.	NC

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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.	UIRs could not be located by the facility for two of six serious injuries noted on the injury log presented as part of the document request. Individual #72 was injured on 5/30/10 suffering a head injury requiring sutures. Individual #58 suffered a serious injury on 3/27/10 while on home visit. RGSC could not produce a UIR for either incident, leaving open the question of whether or not these injuries were properly reported and investigated.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	From document review and interview it is apparent staff identified as alleged perpetrators of abuse were routinely reassigned from individual contact. From interview it was reported reassigned staff were assigned to a Monday through Friday 8-5 shift in a non contact area. Notations to this effect were contained in the applicable UIR report. The shift change assignment facilitated staff availability to investigators for interview. The monitoring team did not identify any deviation from this standard practice. There is a concern as to how this information is tracked for future reference and quality assurance checks. The monitoring team document request asked for a log of employees reassigned due to allegations. The log provided summary information of 82 incidents which occurred between 1/1/10 and 7/29/10. It provided the names of alleged perpetrators along with other useful information. It did not contain a specific reference to the alleged perpetrator being reassigned and where the reassignment was. From this log one would not know whether the staff person had been reassigned or not. It was not apparent if these alternative work assignments were logged somewhere else in a central place for administrative review. UIRs for specific incidents did document that alleged perpetrators were reassigned as called for in policy.	NC
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	A sample of twelve training transcripts was reviewed and staff was noted to have completed Course ABU0100 Abuse and Neglect (a 30 minute class) and Course ABU1001 Revision Abuse and Neglect Reporting (a 15 minute class). The monitoring team reviewed what was presented in the document request as training materials for abuse and neglect training and determined the content included necessary material. The training transcripts reviewed demonstrated that both abuse and neglect classes were part of required training of new employees. The classes were offered with sufficient regularity to ensure staff can meet the annual retraining requirement of the SA.. There was also a course ABU2000 Reporting of Abuse and Neglect 2010 (a 15 minute	NC

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		class) that appeared on some transcripts. This was apparently a onetime refresher offered in January/February, 2010. It is not clear if this course was mandatory. All transcripts reviewed for staff employed prior to February, 2010, except one, indicated this course was completed. One Psychiatric Nursing Assistant II did not have completion of this course on her transcript. From this review the monitoring team cannot determine whether the time allowed for abuse/neglect training (45 minutes) is sufficient or that the training is competency based. The Training Director, who was relatively new to this assignment (he was the Incident Management Coordinator at the time of the baseline review) and resigned midweek of this review and was unavailable for interview.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	Notification of reporting responsibilities were included in the mandatory classes new employees were required to attend before working with individuals and in the annual retraining. Eight employee records sampled contained the signed statement entitled "Acknowledgment of Responsibility for Reporting Abuse, Neglect, and Exploitation. " No incidents of failure to report abuse and neglect were identified, so a review of personnel action was not applicable during this review. Documentation was provided to the monitoring team to demonstrate personnel action was taken in response to investigation findings. The monitoring team would like to point out an important issue related to the need to provide notification. One incident of failure to report timely a serious injury that resulted from peer to peer aggression was discovered and described in D.2.a. Depending on the circumstances peer to peer aggression can be viewed as abuse. In the ICFMR program particularly, facilities are being required to report peer to peer aggression as abuse. Citation of deficiencies can occur if a facility does not have clinically sound services and supports in place that would reasonably be expected to minimize aggression between peers. This incident, when later reported, was not coded as an allegation of abuse. It is of concern that the UIR documentation for this incident, once reported, did not demonstrate any effort on the part of the RGSC to identify what caused the extremely late reporting. Care should be taken to ensure any similar lack of diligence extends itself to abuse and neglect reporting responsibilities.	SC
	(e) Mechanisms to educate and	RGSC distributes a "Preventing Abuse is Everyone's Responsibility" document to family	NC

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	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.	members, LARs, and guardians. It is distributed in both Spanish and English versions. RGSC had a focused meeting with the Parents Association on 4/17/10 on the topic of abuse/neglect. Representatives from the Office of Inspector General and the Texas Department of Protective and Family Services (DFPS) attended, made presentations, and answered questions. This was followed by a July 31, 2010 Parents Association meeting where representatives from the state Office of the Independent Ombudsman for State Supported Living Centers presented information and answered questions. These are noteworthy initiatives and should continue. Additionally, efforts to reach out to family members who are not able to attend these meetings should occur. The facility did not identify, either in the document request or through interview, any initiatives to educate and support individuals living at the RGSC on these same topics.	
	(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.	RGSC had posters that were easy to understand and were posted. There was somewhat of a monitoring system in place to validate the presence of the postings. The Rights Officer conducts an "MR Tracer Form" at specified intervals. Staff knowledge was queried on a number of topics and certain observations were recorded. Item 21 on the MR Tracer Form is "check posters – are they current?" The Tracer Form for 8/18/10 had the response "not up due to painting dorms." This suggested to the monitoring team that responses are thoughtful and not merely a quick yes or no to get through the form. It is suggested this data collection item be more specific to the specific posters called for in the SA. RGSC may want to use other data elements on the form, or revise some data elements, to incorporate into its QA monitoring/auditing process.	SC
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	DADS Policy 02.1 Abuse and Neglect was revised on 6/18/10. Among the revisions were more explicit instructions to facilities in Section IV.E on reporting to law enforcement. Facilities are now to report any allegation of abuse or neglect that may involve criminal activity to DFPS (as they previously had been expected to) and DFPS will notify law enforcement and presumably work with law enforcement to coordinate investigatory efforts. This new process is included in a revised Memorandum of Understanding (MOU) between DADS, DFPS, and several other entities dated 5/28/10. This MOU is incorporated into DADS Policy 02.1 as a referenced attachment. RGSC has not as yet revised its policy to reflect these changes.	SC
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good	RGSC SOP MR 200-3 Section V prohibits retaliatory action against anyone reporting abuse or neglect in good faith. The policy requires that a person who feels he/she is being retaliated against is to contact the Superintendent or designee, which is typically	NC

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	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.	an executive level staff person designated to take calls on behalf of the Superintendent. The policy also identifies four additional offices, and phone numbers, that can be called for assistance. These are the Office of the Attorney General Consumer Protection Division, the Office of Independent Ombudsman, the Office of Inspector General, and DFPS. From document review and interview, there were no direct comments or notations to indicate instances of retaliation. The RGSC FY10 Employee Satisfaction Survey had one piece of data which may be relevant to this topic. The survey (which included all employees, not just MR employees) had 104 respondents. One point of inquiry is "I can report unethical practices without fear of reprisal." One would assume not reporting abuse and neglect, or retaliating against someone who does report, would be viewed as unethical conduct. 62% of the respondents strongly agreed or agreed with this statement. Conversely, 38% of the respondents had no opinion, disagreed or strongly disagreed with this statement. This question dealt specifically with "fear of reprisal." It is of concern that 38% of respondents could not agree with this statement. As this survey was done for all components of the Facility and the Facility did not provide information specific to the ICF/MR, there is no way to determine whether the results would be different only for the ICF/MR staff. Therefore, it remains unclear whether mechanisms in place to ensure there are no retaliatory actions are effective in doing so. Specific interviews of staff will be carried out at the next compliance visit.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Through interview RGSC indicated they have not put a process in place directed at this element of the SA.	NC
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:	The policies that are in place at the state office level address the important elements of the SA. The RGSC SOP MR 200-03 needs to be updated to ensure it contains all elements of the state policy which was revised 6/18/10. Injury data in the 3rd Quarter Trend Report showed a significant increase in injuries. The number of reported injuries from January, 2010, through May, 2010, steadily increased. Sixty-seven injuries were reported in January, 88 injuries in February, 108 injuries in March, 105 injuries in April, and 132 injuries in May. The vast majority of these injuries were not classified as serious.	NC
	(a) Provide for the conduct of all	The general framework for the conduct of investigations of abuse, neglect, and serious	NC

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	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.	injuries is embodied in RGSC SOP MR 200-3. It may need updating after the facility reviews it in the context of the updated state policy. RGSC also had a policy entitled Injuries to Consumers SOP MR 400-01 which includes a review process for all discovered injuries regardless of severity. This is an important element of protection from harm as investigation and review of non serious discovered injuries can often uncover instances of mistreatment of individuals. There were two issues identified by the monitoring team with this process at the RGSC. The review process did not extend beyond the living unit. The Incident Management Team, or someone outside the administrative jurisdiction of the living area, should review the documentation of reviews of discovered injuries to ensure they are complete and lead to reasonable conclusions. The reviews were not timely. For example, individual #5 was injured on 6/25/10 and the injury was not reviewed by the unit team until 6/30/10. The administrative check done by the Safety Office of this injury was not done until 8/21/10. This safety office check did not include a review of source documentation. The monitoring team does not consider the safety office check an adequate review of the quality of the unit team review of discovered injuries. The RGSC investigators and Incident Management Coordinator had experience working with people with developmental disabilities. Training certificates show all hadcompleted the Conducting Serious Investigations and Weighing Evidence and Drawing Conclusions training required by the state office and provided by Labor Relations Alternatives, Inc. Since the baseline review, the Incident Management Coordinator and the Investigators had been administratively relocated to the Quality Assurance office. This removed the possible conflict with the direct line of supervision issue described in the baseline report. Review of training transcripts indicated DFPS investigators are expected to complete Course 1273: MH & MR Overview – APS Investigator Role (a four hour class), Course 1190: MH & MR Investigations Policy-in-a-box: HB Section 3000 (a two hour class), and, course 1228: MH & MR 4000 Case Closure Policy-in-a-box (a two hour class). Four of the five DFPS investigator transcripts indicated completion of these courses. The other investigator transcript showed a course 1188 MH & MR Investigations ILSD (a course of 65 hours resulting in the issuance of continuing education credits). The monitoring team suggests dialogue at the state office level to clarify the minimum	

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		training requirements that are expected of DFPS investigators conducting investigations at the RGSC and the DADS SSLCs.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Through interview it was reported RGSC cooperated fully with DFPS, OIG, and others in investigations. From document review and interview there was no information detected by the monitoring team to suggest otherwise. The facility reported no feedback from DFPS or OIG indicating any lack of cooperation.	SC
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	As noted in D.2.g, there is a more closely defined process for the coordination of investigations between DFPS and law enforcement. Nothing was detected in the review of DFPS investigation files to suggest otherwise. The facility reported no feedback from DFPS or OIG indicating any lack of cooperation. There was one particularly good example of cooperation presented to the monitoring team. DFPS case 34463189 was completed with an unconfirmed finding. The OIG investigation of the same incident determined criminal activity on the part of the alleged perpetrator and asked DFPS to reopen the case. DFPS did so, completed some additional investigatory steps, and returned the case with a confirmed finding.	SC
	(d) Provide for the safeguarding of evidence.	Through interview, the facility investigators and Incident Management Coordinator understood the policy for safeguarding evidence. The Incident Management Coordinator had a locked locker in her office for the purpose of securing and safeguarding evidence.	SC
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate,	Investigations of serious incidents that are not reported as abuse/neglect were conducted by facility investigators in accordance with facility policy. For the most part these were investigations of serious injuries. These were not always done timely with appropriate documentation. Refer to D.2.a. The DFPS cases reviewed did not always commence within 24 hours of being reported. Cases were ordinarily completed within the required timeframe. . It was not unusual for more than 24 hours to lapse between date and time of DFPS notification and date and time of an initial face-to-face interview with someone at the Facility. For example, an allegation of physical abuse was reported to DFPS on 6/21/10 at 9:00pm and the initial face-to-face was at 6/23/10 at 1:30pm (case 36749890). An allegation of physical abuse was reported to DFPS on 7/24/10 at 11:57am and the initial face-to-face was at 7/26/10 at 2:00pm (case 37144152). There are also examples where the initial face-to-face was timely. Case 36491210 is an allegation of confirmed	NC

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	recommendations for corrective action.	emotional/verbal abuse. The incident was reported on 5/28/10 at 1:13pm and the initial face-to-face was done the same day at 4:49pm. The face-to-face was done with the victim, individual # 5. This technically met the 24 hour requirement. No further interviews were done until the morning of 6/4/10. The intent of fast response articulated in the SA was not met in this circumstance. Seven days had elapsed before any alleged perpetrator or witnesses were interviewed or any documents collected. This left too much time for witnesses to forget or reinterpret events, or collaborate with each other, or documents to be mishandled. The monitoring team questions this practice and believes DFPS, DADS, and DSHS should review expectations and develop a clear understanding of investigatory protocol especially in determining SA agreement compliance with the 24 hour requirement to commence an investigation. While DFPS policy allows for the initial facility notification of an allegation to be the start of an investigation, the monitoring team views the first attempt to gather information at the facility as a starting point for the investigation. This should include multiple work tasks such as interviews, document collection, and site observation. Several concerns that arise from the current practice include, the opportunity to tamper with evidence, the opportunity for collaboration between perpetrators and staff, and the victim's inability to recall events after time has lapsed. Therefore, while investigations may have met DFPS requirements, some did not meet requirements of the Settlement Agreement to commence the investigation within 24 hours. Furthermore, DFPS classified abuse and neglect cases as Priority I or II, allowing additional time for face-to-face contact in a Priority II case. The Settlement Agreement uses the terminology serious incident; all cases of suspected abuse or neglect are considered a serious incident by the monitoring team. The monitoring team believes further review of this policy is warranted.	
	(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	The DFPS cases reviewed contained for the most part the essential elements required by the SA. Reports followed a standardized format and included the data expected in the SA. Conclusions were drawn from the evidence and seemed logical and well reasoned. One item that was consistently absent was information regarding previous incidents associated with the alleged victim or the alleged perpetrator. RGSC cases reviewed were generally acceptable. The monitoring team did identify several examples of inaccurate information in UIR's indicating the need for closer monitoring of UIR reports.	NC

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	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.	• Individual #80 was injured on 4/4/10 and suffered a 3" laceration to the head. The UIR (which did not have a tracking number) indicated the injury occurred at 12:00pm. The narrative entry indicated the injury occurred at 12:10pm. There was also a narrative note in the Analysis of Findings/Causes/Issues referring to a medication reduction as possibly causing a behavioral outburst; however, the behavioral and psychiatric information presented in the UIR (which includes a column for medications/changes) did not indicate any medication change. • UIR 451261 described an injury that occurred at 9:33 am. The LVN was noted to have reported the injury to the doctor and administrator on call at 9:30 am. The monitoring team conducted a random and detailed review of one case file for individual # 139 (incident of 3/31/10). This case involved both a facility investigation and a DFPS investigation. Each file was well organized and it was easy to locate the various interview statements, investigation methodology, tracking of investigation benchmarks, and follow up. RGSC did not have a mechanism for conducting internal auditing of a sample of reports to verify they contained all the requirements of the SA. The management process of review by the Incident Management Coordinator and review by the Incident Management Review Team is intended to ensure that all reports are comprehensive and correct. As with any management process there needs to be a mechanism to validate, on a sample basis, that the management process is doing what it is intended to do. In this case, that means verifying compliance with every level of detail associated with this element of the SA.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	All reports flowed through the Incident Management Review Team after having been reviewed by the Incident Management Coordinator. The notes in the UIR typically indicated that both of these reviews occurred and the date they occurred. There was not any separate written documentation of review by the Incident Management Coordinator to ensure that investigation was thorough and complete and that the report was accurate, complete, and coherent.	NC

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	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Refer to D.3.g	NC
	(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.	Documentation was reviewed with respect to the last three confirmed cases of abuse/neglect. In each case, appropriate disciplinary action was taken. In one case a probationary employee was discharged, in another case confirmed physical abuse resulted in employee discharge, and in the third case confirmed verbal abuse resulted in a 10 day suspension. All actions were taken in a timely manner, The Incident Management Coordinator maintains a "Tracking Log for Recommendations" to track all recommendations resulting from incident and investigation reviews.	SC
	(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 monitoring team inspected the area where investigation records were maintained and interviewed the staff person responsible for the records. Investigation files were well organized and easily accessible. There were two UIRs that could not be located which was a bit puzzling given the attention to detail the file clerk displayed. Refer to D.2.a. RGSC was able to pull computer information that can sort investigation case numbers by particular staff members or individuals and produced documentation to validate this.	NC
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The Facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. There is some question as to the reliability of the data. For example, one log of injuries for the period 1/1/10 – 6/30/10 listed 774 injuries; 387 were discovered injuries and 387 were witnessed injuries. Sixteen injuries were classified as serious. Another log produced with the document request was supposed to include all incidents and injuries since 1/1/10. It listed 396 injuries. The trend report showed 500 injuries from 1/1/10 through 5/31/10. This meant RGSC would have to have had 274 injuries in June to validate the first log, or the data in the trend report was flawed. This is unlikely since the most injuries reported in the trend report for any single month was 132 (May, 2010). Because of these discrepancies, tracking or trending data cannot be considered reliable.	NC

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D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	The monitoring panel has had discussions with state office regarding how this provision of the SA will be assessed. This is necessary due to the confidentiality of the information, and the limited documentation that the state is allowed to maintain regarding the findings of background checks. To address this, the state will provide monitoring teams with names of staff responsible for the process, so that they can be interviewed, and spreadsheets for each facility to allow reviews to be conducted to ensure that all staff currently employed have had the necessary checks completed. Until such information is made available this provision cannot be rated as in compliance.	NC

Recommendations:

1. Review RGSC policies to ensure they incorporate all aspects of the DADS policy revisions which were issued 6/18/10.
2. Develop an audit process to determine whether significant injuries are reported for investigation (D.2.i of the SA).
3. Improve the discovered injury review process to be more timely and comprehensive.
4. The Incident Management Review Team, or someone outside the administrative jurisdiction of the living area, should review the documentation of reviews of discovered injuries to ensure they are complete and lead to reasonable conclusions.
5. Establish in policy what the RGSC administrative mechanism is to ensure that the Incident Management Coordinator has documented review of each investigation and has documented any deficiencies and how they were addressed.
6. Establish a methodology to ensure summary reports prepared for internal analysis do not contain conflicting or contradictory data.
7. Establish organized and systematic monitoring/audit processes to ensure management systems are operating correctly and issues are identified and corrected in a timely manner.
8. Revise the MR Tracer form item on posting of ANE information to be more specific to the specific posters called for in the SA.
9. Initiate conversation with DADS regarding coordinated discussion with DFPS about minimum training expectations for DFPS investigators and investigation protocol with respect to timeliness and responsiveness.
10. DFPS, DADS, and DSHS should review expectations and develop a clear understanding of investigatory protocol especially in determining SA

agreement compliance with the 24 hour requirement to commence an investigation.

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. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. Settlement Agreement Program Improvement Council (SA-PIC) minutes (undated) 4. Handouts for Performance Improvement Council (PIC) August, 2010 meeting 5. PIC meeting minutes 7/15/10, 6/17/10, 5/24/10, 4/22/10, 3/25/10, 2/18,10, and 1/21/10 6. 2009 Friends and Family Survey results 7. FY10 Employee Satisfaction Survey 8. Advocates meeting record 1/20/10, 2/26/10, 3/3/10, 4/21/10, 5/19/10, 6/16/10, and 7/28/10. 9. Sample MR Tracer Forms 10. RGSC Monitoring Tools Report 11. RGSC Trend Analysis Report 3rd Quarter 12. Nail care audit follow up email (7/23/10) 13. RGSC Improving Organizational Performance Plan Summary 11/09 14. Sample of completed SA monitoring tools 15. Governing Body meeting minutes (12/1/09) 16. RGSC Executive Committee minutes (6/29/10) 17. Active record for Individual #3 **People Interviewed:** 1. Mary Ramos, Quality Management Director 2. Rosie Sanchez, QE Coordinator 3. Alondra Machado, Data Analyst 4. Megan Gianotti, Psychology Coordinator 5. Myrna Wolfe, Incident Management Coordinator 6. Yolanda Gonzalez, RN, Chief Executive Nurse 7. Jessica Juarez, QE Nurse 8. Marcy Valdez, RN, ICFMR Nurse Manager 9. Robin Martin, RN, SA Section I lead 10. Amor Escalona, RN **Meeting Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/23/10 *2.* Health Status Team (HST) 8/24/10 *3.* Performance Improvement Council (PIC) 8/24/10 *4.* Personal Support Team annual meeting for individual #140 8/25/10
	Facility Self-Assessment:

	The Facility reported that it is not yet in compliance with any provision of this Section. The monitoring identified at least initial steps being taken to move towards compliance with each Action Step of the POI. The Facility tracks much data but improvements are needed in data organization and reliability to improve its usefulness in decision-making. The monitoring team found some data reports difficult to understand and correctly interpret without substantial clarifying discussion with RGSC staff. A process for data analysis was reported as in a developmental stage. The monitoring team observed evidence of this in the Performance Improvement Committee presentation by the QA Director. At this point data is collected and presented but there is limited analytical discussion that would lead to decision-making and improved services. As a process for Corrective Action Plans has not been developed and is not in place, other action steps in the POI related to corrective action plans cannot be in compliance
	Summary of Monitor's Assessment: RGSC conducted a great deal of QA related activity. Many monitoring tools were in the process of being implemented, Little of this work effort was organized into a system that presents useful information from which the need for performance improvement can be assessed and performance improvement initiatives can be made. There was no organized corrective action planning system in place. There is concern as to the degree RGSC leadership focuses on issues related to the Settlement Agreement. The minutes of the RGSC Executive Committee did not reflect substantive discussion of SA topics. The minutes of the Performance Improvement Council reflected some limited discussion of SA compliance issues. The PIC meeting observed by the monitoring team included presentation of data but little substantive discussion on SA compliance initiatives, compliance barriers, or new initiatives. Data in the Trend Reports reviewed are not entirely reliable. Conflicting data in different reports reviewed by the monitoring team called into question the accuracy of data on all reports. The number of injuries has been trending up at an alarming rate. There is no evidence that this was identified and addressed. RGSC did not, through its declaration in response to a document request, have a Quality Assurance Plan.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	RGSC tracked data required in the SA; however, the issues described in this section cause the monitoring team to question the reliability and validity of the data. Refer to D.4 in addition to comments in this section. Presentation of data on the trend reports needs to be improved through clearer report headings and/or footnote definitions or clarifying descriptions. For example, on the second page of the 3rd Quarter Trend Analysis Report there was a row labeled "Abuse/Neglect/Exploitation Counts by Month" with data entered for each month of FY2010. Below this was a row labeled "AN1A Counts By Month (count includes all people involved)" with data entered for each month of FY2010. The monitoring team thinks the proper interpretation of the data is the top number is the number of incidents in the month (e.g. 9 in March) and the bottom number is the number of people involved in the incidents (e.g. 36 in March). However, the bottom number could relate to category 1A abuse/neglect incidents only. Without more descriptive terms on the report it is difficult to know exactly what the data represent. The Injury Trending report also raised questions. On the bottom of the report there was a narrative description which read: "There were a total of 345 injuries involving 62 facility residents during the date range of 3/1/10 and 5/31/10. Of those 345 injuries, 237 were self caused, 54 were peer caused, and 54 were Other caused, which includes staff. 5 were serious, 131 nonserious, 189 required no treatment, and 0 were fatal." From this statement it appears a cause was identified for each and every discovered (i.e. not witnessed) injury, as the total of causes equals the total number of injuries, and there are no injuries classified as having unknown cause. This description did not in itself identify which injuries were witnessed versus discovered, but certainly, not every injury is witnessed. According to a log produced for the document request there were an average of about 55 discovered injuries a month at RGSC. It seems likely that the cause of at least some of these injuries would remain unknown. The findings reported in the description that a cause was identified for each injury raises the question of the efficacy of the review process of discovered injuries commented on in D.3.a. When the RGSC establishes a QA UIR audit/monitoring process it should include elements that address the concerns expressed by the monitoring team in this section.	NC
E2	Analyze data regularly and, whenever appropriate, require the	Per interview the RGSC did not have an organized system to review data and require the development and implementation of corrective action plans.	NC

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	development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	RGSC had two mechanisms in place that could be used for this purpose. One group was the Settlement Agreement Performance Improvement Council (SA-PIC) which was intended to focus on the monitoring done in conjunction with validating compliance with various elements of the SA. This was a very new process, as was the process of using monitoring tools and other audit procedures to internally assess compliance. Undated minutes of one meeting were provided to the monitoring team. The second group was the RGSC Performance Improvement Council (PIC) which was a long-established committee of the facility. Its membership was primarily senior management of the facility. The monitoring team was able to observe a PIC meeting during this review. A great deal of data was presented to the group but there was very little discussion resulting from the presentation of data. The existence of these two mechanisms for analysis of organizational performance is encouraging. The monitoring team would characterize both as needing developmental growth to demonstrate the degree of qualitative analysis, problem solving, and organizational change implied throughout the provisions of the SA. Injury data in the 3rd Quarter Trend Report showed an alarming increase in injuries. The number of reported injuries from January, 2010, through May, 2010, steadily increased. There were 67 reported injuries in January, 88 injuries in February, 108 injuries in March, 105 injuries in April, and 132 injuries in May. The trend report did not address this significant trend except to mention it existed. This would have been an excellent opportunity for in-depth discussion among leadership staff to identify issues potentially contributing to such a significant increase and steps that might be considered to do a better job of keeping people safe.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Through interview the monitoring team learned of a great deal of internal monitoring activity in various stages of implementation. Such activity would be expected to result in corrective action plans. The work in this area to date was characterized as not organized enough to present to the monitoring team. An example is documentation that was provided to the monitoring team in response to an onsite document request. A follow up item noted in the 3rd Quarter Trend report was that a specific program monitor was to audit nail care for 10% of the individuals on 7/5, 7/12, and 7/19. The documentation produced was an email from the program monitor to the QA office (7/23/10) which stated "I audited a total of forty people in the three week	NC

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		period. I did find some consumers with long nails; some nails were chipped and had sharp edges on them. Some had very short and clean nails and other had dirty nails too." While it is commendable that a need for auditing was identified, assigned, and completed the information resulting from the audit was not useful for corrective action. An audit of this type would typically be organized into a spreadsheet displaying review information such as living area, the names of the individuals checked, time of the check, columns to check nail condition, and other pertinent information. The information contained in the email was not very useful in assessing, or improving, organizational improvement, nor was there any indication of corrective action required, checks to ensure corrective actions were taken, or follow up to ensure nail care was improved	
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 E.3	NC
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Refer to E.3	NC

Recommendations:

1. Begin the process of developing a Quality Assurance program by identifying specific monitoring/auditing targets and putting in place an organized system for that component that generates reliable data and results in corrective action planning. Use each of these as building blocks to what can eventually become a comprehensive organized QA system.
2. Where forums already exist for the review of organizational performance, take steps to ensure these forums do more than just receive information/data. Problem solving dialogue should be required.
3. Make trend reports more useful through clearer report headings and/or footnote definitions or clarifying descriptions.

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. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. PSP monitoring checklist RGSC SOP MR 600-1 Person Directed Planning 2/10 4. RGSC SOP MR 700-001 Therapeutic Environment 2/10 5. RGSC SOP MR 700-02 Individual Support Activities 2/10 6. RGSC SOP MR 700 7. Personal Support Plan for individuals #47, #60 #61, #80, #82, #121 #122, #145 and #149 8. Behavior Support Plan for individuals #61, #80, #122, and #145 **People Interviewed:** 1. Mary Ramos, Quality Management Director 2. Rosie Sanchez, QE Coordinator 3. Alondra Machado, Data Analyst 4. Megan Gianotti, Psychology Coordinator 5. Myrna Wolfe, Incident Management Coordinator 6. Jessica Juarez, QE Nurse 7. Marcy Valdez, RN, ICFMR Nurse Manager 8. Robin Martin, RN, SA Section I lead **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/23/10 *2.* Health Status Team (HST) 8/24/10 *3.* Performance Improvement Council (PIC) 8/24/10 *4.* Personal Support Plan annual meeting for individual #140 8/25/10
	Facility Self-Assessment: The Facility stated it is not in compliance with either provision of this Section. The monitoring team concurs although some improvements in the PSP process were evident. At the time of the review RGSC had not yet been scheduled for training in the new DADS PSP process, and the training entitled Supporting Visions. Once this occurs the monitoring team would expect to observe continued improvement. The monitoring team, through observation of one PSP meeting, did note that the QMRP led discussion during the observed PSP annual meeting in a manner that facilitated input and discussion from team members. Based on interviews with staff and review of documents DADS has recently issued a new comprehensive

	policy on Personal Support Plan development that applies to all SSLCs. DADS created comprehensive training to go with this policy. This training is scheduled to roll out beginning in September. These efforts by DADS are intended to address several provisions of the SA.
	Summary of Monitor's Assessment: Little improvement was found in the overall PSP planning process at the RGSC compared to the baseline report. One PSP meeting observed by the monitoring team did show improved interaction among team members and collaborative discussion. The current PSP process, as implemented, met many of the technical requirements of the Settlement Agreement (SA); however, many of the elements required in Section F are not developed or not thoroughly implemented, making substantive assessment difficult. DADS has issued a new policy on PSP planning that is intended to ensure compliance with these, and other, provisions of the SA. DADS has also developed comprehensive training to go along with this policy. At the time of this review RGSC had not yet received this training. Comments in this section are limited because of this. Although the structure of an interdisciplinary team process was in place, most involvement was multidisciplinary. That is, it is evident from document review and meeting observation that the standard method of operation is for different disciplines to do separate assessments and decision-making, reporting information and decisions, but not routinely integrating information to make joint or shared decisions. Although data and information from assessments were likely available at PSP meetings, they were not discussed by the team; instead, they were reported or summarized, with a clinician making a decision prior to the PSP meeting without team discussion and input. Through document review, interview, and meeting observation, the monitoring team did not discover significant or consequential 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:	Although the structure of an interdisciplinary team process was in place, most involvement was multidisciplinary. That is, it is evident from document review and meeting observation that the standard method of operation is for different disciplines to do separate assessments and decision-making, reporting information and decisions, but not routinely integrating information to make joint or shared decisions. DADS has issued a new policy on PSP planning that is intended to ensure compliance	NC

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		with the provisions of the SA. DADS has also developed comprehensive training to go along with this policy. At the time of this review RGSC had not yet received this training.	
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 PSP process was lead by a QMRP. The QMRP led discussion during the observed PSP annual meeting in a manner that facilitated input and discussion from team members but there was not discussion during the PSP meeting about how information from different assessments complemented or was inconsistent with information from other assessments, or how such information was integrated into planning. . This particular team meeting included the individual's father and focused on the individual's desire to move from RGSC. From document review, there is information that different assessments had been completed but little evidence of integrated cross disciplinary involvement in the assessment process by those completing the assessments.	NC
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.	From document review attendance by appropriate people at a PSP meeting seems evident. There is one notable exception. Psychiatric Nurses Assistants (PNA) from multiple shifts were not always present. For example, the attendance sheet for individual #122 (PSP date 11/19/09) indicated one direct care staff in attendance. The attendance sheet for individual # 80 (PSP date 6/17/10) indicates one PNA in attendance. The attendance sheet for individual # 121 (PSP date 8/18/09) indicates one PNA in attendance. Although the SA does not require specific numbers of individuals to attend and participate and does state that attendance shall be dictated by the individual's preferences and needs, the PNAs who provide direct support each day have a great deal of information about an individual's preferences, needs, and response to interventions. The monitoring team suggests that efforts be made to ensure at least two PNA's are present at every PSP meeting to facilitate input into the planning process. The PSP meeting observed by the monitoring team included one staff person who was specifically invited by the individual. This was an example of including Individual #122 as an active member of the PST. Moreover, at the request of the individual, the meeting did not begin until the individual's father arrived. Habilitation therapies (PT, OT, SLP, and RD) had limited involvement in PSP annual meetings. Therapists did not actively participate in the PSP meetings although the individuals may have identified issues relevant to their field. This was identified through interviews with therapists and observation of Individual #140's PSP. Therapists stated the reason behind not attending was due to not having time. Areas relevant to PNM	NC

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		were read with minimal discussion without the presence of the staff that were most knowledgeable of the subject matter. Refer to Provision O.1.	
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.	Some assessments were done routinely, such as DISCUS and MOSES assessments of medication side effects. Others were done annually as part of the PSP process. Others, such as formal preference assessments and functional analyses, were done intermittently. The scheduling of assessments seems connected more to policy (such as requirements for certain assessments prior to PSP meetings) than to significant changes in an individual's life. For example, many psychological assessments had not been updated in over a year, regardless of change in status of individuals. Moreover, individuals had numerous falls without updating of assessments. Individuals had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. From document review there is information that different assessments had been completed but little evidence of integrated cross disciplinary discussion is documented by those completing the assessments. Because documentation often did not clearly identify how strengths, preferences, and needs were identified from assessments, and because the rationales for interventions were not always provided, it was not possible to determine how assessments led to action plans. For example, for individual #82 (PSP date 6/22/10) there was a detailed listing of what is most important to the person and how that is supported. The section of the PSP that displays assessments/services the person uses/needs rarely included, for any assessment, statements as to services the person uses or needs. For example, the comment in the Positive Assessment of Living Skills Summary (PALS) merely stated "completed." Also, in Section R, there are examples in which no rationale was provided for selection and use of Alternative and Augmentative Communication (AAC) devices were integrated into PSPs. Review of all documents related to Individual #19's PSP indicates a lack of understanding of the individual's health care needs by the team. No relevant health care information was delineated or commented upon, within the personal support plan. Furthermore, the possible contribution of health care conditions to problem behaviors was not discussed by the PST.	NC
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and	Although data and information from assessments were likely available at planning meetings, they frequently were not discussed; instead, they were reported or summarized, with a clinician making a decision without team discussion.	NC

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	supports to be provided to the individual.	From record review and interview the quality of behavioral and other data continued to be questionable. Data quality needs to improve to facilitate improved decision-making by the team. Information from reports provided by clinical disciplines and at PSP meetings was not discussed or evaluated thoroughly enough to develop and implement a PSP that met all significant needs of the individuals. Note the example in F1c of Individual #19.	
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).	The PSP is the document in which supports based on preferences and needs are listed along with goals for learning. It is the starting point for identifying what supports must be provided for community living and for assisting people to gain skills that will provide greater opportunities to move into more integrated settings. As described in Section T, PSP development does not generally address barriers to movement to community living other than training or therapy needs of the individual. Goals are not selected with an eye toward the supports available from community living providers or development of skills that are relevant to increasing opportunity to move to a preferred environment. For example, for individual #80: • A support identified for safety related to the individual's wandering from home environment. No SPO or other intervention was identified to address this issue. • A Learning Objective for the Desired Outcome "To increase skills that will be used in a less restrictive environment" was to "blow nose into tissue." Another was to "shave all areas of face." Neither was identified as supports needed for success in community living.	NC
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:	DADS has issued a new policy on PSP planning that is intended to ensure compliance with this and other provisions of the SA. DADS has also developed comprehensive training to go along with this policy. At the time of this review RGSC had not yet received this training.	NC
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:	DADS has issued a new policy on PSP planning that is intended to ensure compliance with this provision and other provisions of the SA. DADS has also developed comprehensive training to go along with this policy. At the time of this review RGSC had not yet received this training.	NC

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	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	Formal assessments of preference, strengths, and needs did not always occur and were not noted to be used in PSP planning. For example: • Individual #118's mobility assessment only stated that a merry-walker is utilized and did not provide information regarding why there is a need for such device. • Individual #16's mobility assessment only stated that a gait belt is used and did not provide information regarding why there is a need for such device. • Individual #86's mobility assessment did not provide detailed information regarding ability to ambulate. • There were no examples of assessments of preferences to identify consequences that might serve as reinforcement.	NC
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	These were generally present. However, there was no single place in which all goals, treatments, and strategies are presented in the PSP . This makes it difficult to read a PSP and determine whether there are adequate efforts to meet preferences and needs and to overcome barriers to living in the most integrated setting. Better organization of information in the PSP document would facilitate team discussion focusing on integrated planning in the PSP meeting. DADS is rolling out a new PSP policy and procedures. The monitoring team will review at the next compliance visit to determine whether the new process makes clearer all the goals, objectives, treatments, and necessary supports so an integrated picture of these can be seen.	NC
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	When planning was done, it was generally discipline specific rather than integrated. From observation of meetings, it was apparent that the goals, treatments, and strategies were not determined in a manner that integrates them so they complement and build upon each other. For example, PSPs contained reference or a brief statement of an individual's communication skills; such as, "communicates with facial expressions" or in other cases would simply stated "the individual uses a communication board." Action Plans did not consistently integrate information from the communication assessments nor was there a process in place that ensured action plans were developed that corresponded and included the training of the communication device. See Section R.3 As an example, for Individual #58, as noted in Provision Q1 , lack of integrated planning of dental services was demonstrated because the PSP does not comment on issues	NC

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		related to recurrent breaking of the individual's dentures.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Methods were not written in a manner that was clear and complete enough to promote consistent implementation. Objectives and data to be taken were often defined in ways that did not make reliable implementation and observation likely. Refer to sections K and S.	NC
	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	Although RGSC provided opportunities for community involvement in both work and leisure, many interventions, strategies, and supports need improvement. For example, Vocational Services staff described plans to develop community-based vocational training; discussions had already been initiated with community service providers and companies.	NC
	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.	Objectives and data to be taken were often defined in ways that did not make reliable implementation and observation likely. Refer to sections K and S. Statements regarding health status in nursing assessments frequently used vague terminology rather than reporting clinical indicator data.	NC
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	There was no single place in which all goals, treatments, and strategies are presented in the PSP . This makes it difficult to read a PSP and determine whether there are adequate efforts to meet preferences and needs and to overcome barriers to living in the most integrated setting. Better organization of information in the PSP document would facilitate team discussion focusing on integrated planning in the PSP meeting. Decisions by clinicians (e.g., dental pretreatment sedation) were often not reflected in the PSP. Changes in health status and intervention were often not reported to the PST until regularly scheduled meetings such as PSP annual meetings and HST meetings.	NC
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two	PSPs were accessible in the active record. They did not always clearly specify the services and supports to be provided and who was responsible. Services were found in various sections of the active record. For example, skill acquisition/ habilitation goals were	NC

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	years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	separate from PBSP goals, which limit the holistic understanding of how these relate to each other. Habilitation Therapy information was referenced in the PSP, however the rationales and descriptions of interventions regarding use and benefit were not clearly integrated into the PSP therefore resulting in an incomplete document that was difficult to understand and not functional for staff or the individual.	
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 information above, the lack of understanding for PST members to function in an integrated setting, limited the ability for the PST to look at the individuals in a holistic manner and gauge the person's progress, or lack of progress, and make changes when needed in a meaningful way. The information contained in the PSP was too general and non specific. Provision K4 and the discussion of Individual #80 in Provision K3 provide examples of lack of progress without consideration of alternative treatment and intervention. Progress notes reflected lack of treatment efficacy with no resulting change in intervention.	NC
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with	General training was provided to staff through classes conducted by the Facility's training department. The method for training staff on a specific individuals plan was dependent on the plan component. Through interview the processes described varied by plan component. When staff received training on an individual's skill acquisition plan the general method was for the QMRP to meet with the supervisory staff at each dorm and whatever staff were available to review the program and data sheets. Dorm supervisory staff was expected to train remaining staff. Training in nursing care plans followed a protocol similar to QMRP training in skill	NC

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	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.	acquisition programs. This meant that training on complex health care issues was provided by people who did not have the requisite skill to provide this training. Nurses go over the care plans with the direct care supervisors on all shifts and sign the care plans and training roster, then the direct supervisors train their staff. This is poor practice. The supervisors are not qualified to train and evaluate staff knowledge and skills for complex health care issues. Furthermore, refer to Provision M3 for examples in which documentation of training of PNAs on complex health issue was not available. Provision of person-specific training and training to staff on PNMPs in response to changes to plans of care was not able to be validated due to RGSC's inability to produce training records.	
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.	Individual #3 was admitted to RGSC in May, 2010. The PSP was developed within 30 days as required. Although the PSP was in the active record, most assessments that would have been used in PSP planning were not found in the active record. The PSP stated that the psychiatric and psychological assessments were "pending." A Positive Behavior Support Plan (PBSP) was implemented more than 30 days following the PSP development, but it was not listed in the PSP or in a PSP Addendum. The Annual Medical Evaluation done August 17, 2010, stated "30-d staffing" but actually occurred 90 days after admission. Records reviewed indicated PSP's are routinely revised through the use of PSP Addendums. The monitoring team did not compare PSP dates to validate an annual revision.	NC
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	Through document request and interviews, RGSC indicated there had been no monitoring of PSP meetings since the baseline review. This was attributable to staff turnover and the anticipated changes to the PSP process coming from state office.	NC

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	provisions of this section.		

Recommendations:

1. Implement the new DADS PSP policy as soon as possible after receiving training.
2. In implementing the new policy consider some type of peer review process to facilitate good learning across teams, facilitated by whoever the facility would consider its master trainer on the PSP policy.
3. In addition to whatever is required in the new policy, consider criteria and methods by which to include necessary professional clinicians in PSP meetings as appropriate to the needs and preferences of individuals.
4. Establish a comprehensive and efficient team process, enabling all members of the PST to ask relevant questions and provide meaningful information to other PST members. PST members must provide the PST with accurate and complete information. PST members must be facilitated to ask questions and identify how information from different assessments can be drawn together to provide a holistic plan.
5. Improve methods for data collection, tabulation, and use for all program plans.
6. Review and revise the assessment process to ensure individuals receive necessary assessments and reassessments as their status changes

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI), dated 5-17/10 2. PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in other sections of this report. 3. Active Record for Individual #3 **People Interviewed:** 1. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report. **Meetings Attended/Observations:** 1. Personal Support Plan annual meeting for individual #140 8/25/10 2. Human Rights Committee (HRC) 8/26/10
	Facility Self-Assessment: The Facility reported that it did not yet comply with either provision of this Section. Many action steps in the POI related to providing specific clinical services in an integrated manner. Comments on status invariably related to recent hiring or attempts to fill positions. While it is true that providing services in an integrated manner can be more time consuming, especially early in the process of developing integrated services, due to the need for cross-disciplinary program development and review of individuals, other time-consuming activities can be reduced (such as reading reports during PSP meetings). The monitoring team is concerned that the focus of the self-assessment was on providing services (important, and covered in other Sections of this report and the POI) rather than on actions to increase the interdisciplinary integrated approach. The Facility reported that there was evidence that the pharmacist and prescribing medical practitioners collaborated. The monitoring team found that physicians consistently considered and followed recommendations provided by the pharmacist as part of regular reviews. The Facility accurately reported that communication on changes in services and individual's status among clinicians and between clinicians and other PST members was not yet occurring adequately.
	Summary of Monitor's Assessment: There was little indication that planning among the clinical disciplines involves collaborative and integrative planning that allows for the selection of treatments and interventions that complement each other and have the greatest likelihood of success.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	There was little indication that planning among the clinical disciplines involves collaborative and integrative planning that allows for the selection of treatments and interventions that complement each other and have the greatest likelihood of success. Therefore, this provision is not compliant. A Positive Behavior Support Plan (PBSP) for Individual #3 was implemented more than 30 days following the PSP development, but it was not listed in the PSP or in a PSP Addendum. For Individual #19, staff, in general, were unaware of her condition and related much of her behavior issues to unwillingness to participate in activities, when it was evident by observation that the individual has physical challenges, and behavior manifestations that most probably result secondary to physical discomfort. The team did, however, discuss behavioral issues when the individual struggles with staff and resists assistance during ambulation and transfers, but they did not entertain potential causes of the individual's resistance, such as pain and discomfort. It was apparent by review of the personal support plans and addendum support plans that health care issues were not routinely or efficaciously addressed within a the context of a team approach. Communication programs were not integrated into the PBSP as indicated. Thirteen of the 13 records for those individuals who had dual issues reviewed (100 %), indicated lack of integration of the communication program and the PBSP. There was not a clear interdisciplinary and integrated plan for appropriate selection of psychotropic medication, behavior support services, or the combination as required by Provision J9. Discussion of services for Individuals #10, #107, and #145 included the following statement (also stated in the minutes) without any further discussion of its appropriateness by any member of the committee: [Individual] "will continue on behavior support plan as an adjunct to psychoactive medication." This implies that the first line of intervention for behavior problems had routinely been psychotropic medication, and that behavioral supports were seen merely as something to be included, either because it was required or because it might provide additional effectiveness. It does not indicate that an integrated planning approach that focused on the advantages and risks of each approach and their relationship to assessments of the individual had been routine. This finding is further supported by the observation that only recently had the Chief Psychologist been consulted, as required by RGSC policy, prior to the administration of a chemical restraint to consider alternatives to chemical restraint.	NC

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		For Individual #76, for whom an Axis 1 diagnosis was provided but not supported in the records (refer to Provision J2), the evaluation did not indicate or propose functional assessment to assess whether this behavior is maintained by environmental conditions rather than being related to a diagnosable illness. For the issue of weight control, there was not evidence of an integrated review and plan that would include nutrition, activity, physical therapy, review of medication, and other issues. Individual #140 was 15% over the upper limits of desired weight range. The nurse did not note any collaboration with the PNMT or PST regarding weight management. Individual #140 was reported to have experienced 37 falls in the past year; falls were described as trips and slips with no serious injuries noted from falls. There was lack of notations regarding collaboration with the PNMT or PST regarding fall prevention. Individual #140 was receiving Lithium, Tegretol, and Risperdal, all of which have the potential to cause an unsteady gait and increase risk of falls.	
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.	Recommendations were generally reviewed and signed or initialed. PST documentation did not generally reflect reasoning for choosing to adopt or reject recommendations. The Records Audit procedure will provide an opportunity to monitor to ensure review and documentation is done.	NC

Recommendations:

1. Ensure that all policies regarding treatment planning reflect the need for integration across disciplines.
2. Establish a process and guidelines for referral of recommendations from non-Facility clinicians to the PST.
3. Develop and implement policy and procedures for review and decisions regarding recommendations from non-Facility clinicians.
4. Implement quality assurance monitoring to assess both that recommendations from non-Facility clinicians are reviewed by Facility clinicians and the PST as appropriate and that these reviews involve thoughtful evaluation to ensure that treatment meets the needs of individuals served.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI), dated 5-17/10 2. PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in other sections of this report. 3. Active Record for Individual #3 **People Interviewed:** 1. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report. **Meetings Attended/Observations:** 1. Personal Support Plan annual meeting for individual #140 8/25/10
	Facility Self-Assessment: The Facility reported it was in compliance with one provision of this Section but not yet in compliance with other provisions. The Facility reported that diagnoses clinically fit the corresponding assessments or evaluations and are consistent with the Diagnostic and Statistical Classification of Mental Disorders and the International Statistical Classification of Disease and Related Health Problems. The monitoring team found psychiatric diagnoses that were not supported by the individuals' records. The Facility reported that quarterly psychotropic medication reviews were conducted with the input of the pharmacist and that the Primary Care Physician (PCP) reviewed these reports and addressed recommendations by the pharmacist. The monitoring team confirmed that these reviews were conducted but found that there are no formal processes in place for review by the physician of abnormal drug levels. The Facility accurately reported that much required documentation was not compliant but also stated that initial training on nursing assessment had been done. In reference to timely treatments and interventions and to use of clinical indicators of effectiveness, Facility comments focused on staff vacancies in clinical areas.
	Summary of Monitor's Assessment: Assessments and evaluations were not performed in response to changes in individuals' status. As a result, treatments and interventions were not clinically appropriate to the individual's current status. Quarterly health assessments have improved and provide one approach to identifying change in health status, but

	changes that were noted in health status did not always lead to change in treatment. Because of lack of adequate assessment and use of clinical indicators and data to evaluate effectiveness, treatments and interventions could not be demonstrated to be clinically appropriate or were not modified in response to changes in status..

#	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.	There were numerous examples across most disciplines in which assessments or evaluations were not performed in response to changes in an individual's status. • Seven of ten individuals had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. • Individual #10 had falls occurring on 5/18/10 and 6/25/10 but there is no discussion of this during the 6/29/10 meeting. • Individual #140 had falls occurring on 5/13/10, 5/14/10, 5/23/10, 6/9/10, 6/22/10, and 6/24/10. The PNM team did not meet to address this issue until the regularly scheduled meeting on 6/29/10. • Individual #29 had a choking incident on 5/31/10. The PNM team did not initiate a meeting to discuss the incident nor was there evidence in the PNM minutes of discussion at the regularly scheduled meeting on 6/29/10. • For Individual # 19, there was no evidence within the clinical record or acknowledgment by relevant professional staff, that routine diagnostics or consultations had been provided to assess and monitor for functional decline, as a component of chronic care management .	NC
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Diagnoses did not always clinically fit the criteria for the Diagnostic and Statistical Manual of Mental Disorders. • The Psychiatric evaluation for Individual #76 indicated an axis I diagnosis of schizophrenia, an axis II diagnosis of moderate mental retardation and an axis III diagnosis that included hypothyroidism and mild obesity. Quarterly psychotropic medication reviews since January, 2010, demonstrated inconsistency with accurate diagnosis that included various axis I diagnosis, such as psychotic disorder NOS, Schizoaffective disorder, and catatonic episodes. Axis II diagnoses ranged from moderate to profound mental retardation, depending on the report. Importantly, nowhere within the psychiatric evaluation, including the chief complaint, mental status evaluation or case formulation, was there evidence to support an axis I diagnosis.	NC

#	Provision	Assessment of Status	Compliance
		• For Individual #5, despite being prescribed medication for EPS, the MOSES side effects scale indicated no issues with regard to musculoskeletal or neurological signs or symptoms.	
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.	Because of the lack of adequate assessments, treatments and interventions often could not be shown to be clinically appropriate. In addition, due to the lack of appropriate clinical indicators of effectiveness, appropriateness of the treatment could not be clearly demonstrated. Refer to Provisions J2; K1, K4, and K5; L1; M1; P1 and P2; Q1; and R3 for examples of treatment that was delayed or not provided or was not based on adequate clinical and interdisciplinary assessment.	NC
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.	This provision is not in compliance for the following reasons: • Vague terms rather than clearly defined terms or data are used to describe effectiveness. Refer, for example, to the discussion of the content of nursing assessments in Section M. • Responses to medication may not be evaluated. Individual #140 was receiving Lithium (Lithium level was documented as elevated on 7/2/10), Tegretol, and Risperdal. The nurse failed to consistently list responses to all medications. • As noted in J9, there was a lack of clinical data in some cases to support use of psychotropic medication. • In OT/PT assessments, Oral Motor section of the report was primarily a summary and does not provide objective measurable data.	NC
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.	Although no overall system to monitor health status is in place, the Quarterly Nursing Assessments have shown improvement and provide one approach to monitoring health status. Not only must monitoring be done, but to be considered effective, it must also affect treatment. Changes in health status, monitored and noted or not, did not always result in changes in treatment and intervention as noted below in Provision H6.	NC
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	There were numerous examples of treatments and interventions that were not modified in response to clinical indicators. These can be found in many provisions. Individuals #19 and #140, cited in Provision G2, are examples.	NC

#	Provision	Assessment of Status	Compliance
	clinical indicators.		
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.	Per report of the Facility, clinical policies and procedures are undergoing revision. As indicated throughout this report, integrated clinical services are not yet routine throughout the Facility.	NC

Recommendations:

1. The Facility should complete revision of policies regarding implementation of integrated services and follow these revisions with staff training on the policies and on how to carry out integrated planning.
2. Each discipline should review national standards to identify clinical indicators that could be selected.
3. Treatment plans and PSPs should include information on the clinical indicators to be monitored for specific treatments and interventions.
4. At PSP planning meetings and other treatment review meetings, the discussion of clinical indicators should be routine, and documentation of decisions should reflect how those decisions were affected by this discussion.

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. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. RGSC SOP MR 400-02 At Risk Individuals 1/10 4. RGSC SOP MR 700- 09 Fall Risk and Prevention 5. RGSC SOP NR-200-78 At Risk Patient/Individuals 11/09 6. POI Section I Trend Analysis 7. Handouts from 8/24/10 Health Status Team meeting 8. Health Status List 8/23/10 9. HST meeting minutes 4/7/10, 4/22/10, 5/5/10, 5/21/10, 5/26/10, 6/16/10, 6/30/10, and 7/15/10 10. Active Records for Individuals #3, #29, #107, #113, and #140 **People Interviewed:** 1. Mary Ramos, Quality Management Director 2. Rosie Sanchez, QE Coordinator 3. Alondra Machado, Data Analyst 4. Megan Gianotti, Psychology Coordinator 5. Myrna Wolfe, Incident Management Coordinator 6. Yolanda Gonzalez, RN, Chief Executive Nurse 7. Jessica Juarez, QE Nurse 8. Marcy Valdez, RN, ICFMR Nurse Manager 9. Robin Martin, RN, SA Section I lead **Meeting Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/23/10 2. Health Status Team (HST) 8/24/10 3. Performance Improvement Council (PIC) 8/24/10 4. Personal Support Team annual meeting for individual #140 8/25/10
	Facility Self-Assessment: The Facility reported it is not in compliance with any of the provisions of this Section but has completed steps leading to compliance. The monitoring team concurs. The facility has used the risk assessment process mandated by DADS with mixed results. Tracking of immunizations is producing positive performance results. Other risk screening activity does not always clearly identify those individuals at risk. The monitoring team does not find the Facility to be in substantial compliance because of the inherent deficits of the risk identification process described in the baseline report.

	Summary of Monitor's Assessment: RGSC used a number of tools that either were used specifically to identify risk or could be. These were primarily in the nursing and PNMP area. They were not used in a coordinated manner that allowed clinicians to collaborate in an interdisciplinary manner to assess risk and jointly develop strategies to mitigate risk. Individuals who are at a "high risk" were not being identified and therefore may not be receiving the care and treatment required to prevent future illness. While most individuals had a PNMP, the PNMPs are not considered to be appropriate due to oral hygiene, medication administration, behavioral information, and signs and symptoms associated with aspiration or decline not being included as part of the document. Additionally, the assessment process involved in the development of the PNMPs was flawed secondary to little input being provided by therapy regarding positioning for GERD management, oral hygiene techniques, water safety and presentation of medications. If there was a change in care, all plans relevant to that individual were not always updated and trained in an efficient manner.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	A system was in place for risk screening. Many elements lacked objective criteria and relied too heavily on clinical judgment. This resulted in too few people being identified as high risk. There were two main issues with the DADS At Risk policy. One is that the Facility incorrectly followed the policy as RGSC individuals at low risk when they should have been placed at medium risk according to policy. Second, the policy as written is flawed in its ability to identify those who are at a high risk of physical and nutritional decline, injuries due to behavior problems, or other areas of risk. In its current state, the policy identifies individuals 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. For people with dysphagia, following the policy as written would result in RGSC having their entire population with a few exceptions listed as medium risk since the remaining individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at RGSC. Similar concerns are found related to polypharmacy, behavior problems, and other issues. DADS reported revision of this policy is currently in process.	NC
I2	Commencing within six months of the Effective Date hereof and with	The identification of risk level was problematic and did not adequately address risk identification or respond to changes in an at-risk individual's condition.	NC

#	Provision	Assessment of Status	Compliance
	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.	Examples of risks levels that were identified inappropriately included: • For Individual #3, the Health Risk Assessment (HRA) tool item on Aspiration stated "no" to "steal food." The PBSP for this individual has in the definition of the target behavior of "stealing" that this includes "taking food from another person" and states in the Rationale that the individual "has a history of stealing food…" For the same individual, the HRA, PSP, and Occupational Therapy (OT)/ Physical Therapy (PT) evaluation all mention chopped food texture, but no risks are described in any documents to justify the need for the texture modification. The same individual takes a laxative daily but is rated at lowrisk for constipation and takes antiseizure medication for a diagnosed seizure disorder but is listed as low risk for seizures. • Individual #113 was evaluated on 3/30/10. A Swallow Study completed on 7/29/10 showed penetration of thin liquids but was still listed as "low risk" of aspiration. • Individual #29 had a choking incident occur on 5/31/10 but was listed as not being at risk for choking. • Individual #140 had 12 falls occurring from May 2010 to July 2010 but was listed as being at a "low risk" of injury • Individual #107 has a BMI greater than 30 but was listed as being "low risk" for weight. Refer to I1, O1, and O2 for additional examples. Furthermore, as documented in Provision O2, changes in at-risk condition often did not trigger interdisciplinary assessment.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk,	Although there were many actions taken to address risks for individuals, including preventive interventions, these were not addressed through a systematic risk assessment and management process. Identification of risk level is problematic and does not adequately respond to changes in an at-risk individual's condition, and numerous examples are found of lack of change in risk level following changes in status. As noted throughout this report, assessment often did not involve interdisciplinary process, nor were plans integrated into the PSP	NC

#	Provision	Assessment of Status	Compliance
	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. The Risk Policy should be reviewed and revised by DADS and implemented with appropriate training at RGSC.
2. RGSC should review all risk levels and identify risks as dictated in policy until the policy is revised.
3. The State and Facility should use nationally recognized standardized risk assessment tools and standards where available and appropriate.
4. After the Risk Policy is revised, an audit system should be put into place to monitor appropriateness of risk levels and of the actions taken to address higher levels of risk.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. The following records of individuals #5, #33, #76 and #139 were reviewed: • DISCUS • MOSES • All psychiatric assessments and reviews for the past 12 months • Current medication list • Laboratory results for the past 12 months • Personal support plans • Addendums to personal support plans 2. List of individuals who have received pre-treatment sedation for dental or medical care **People Interviewed:** 1. Babu Draksharam, MD, contract psychiatrist 2. David Moron, MD, Clinical Director **Meeting Attended/Observations:** 1. Observation of individuals at homes 501 and 502 and at their vocational program
	Facility Self-Assessment: The Facility reported accurately that the psychiatrist does not actively participate in the interdisciplinary process. There are numerous findings in this report that confirm this concern. The pharmacist did attend the PSP meeting held during the visit, which is a positive step. The Facility reported that it is not yet in compliance with the requirement that psychotropic medications be used based on clinically justifiable evaluation and diagnosis. The monitoring team concurs as several cases were found in which evaluations did not include adequate information to justify diagnoses and use of medication. The Facility reported accurately that it has not yet included in the PSP procedures to minimize use of pre-treatment sedation that are coordinated with other medications, supports, and services. The Facility reported accurately that it does not yet have in place a facility-wide system to monitor use of psychotropic medication, including polypharmacy, and to take corrective action as needed. The monitoring team confirmed this and noted concerns with extensive use of polypharmacy. The Facility reported that it has a process for coordination between the psychiatrist and neurologist when prescribed for both seizures and mental health disorders but that it is not yet fully implemented. The

	monitoring team did not confirm that this coordination was in place.
	Summary of Monitor's Assessment: **Provision J1** At the time of the review all practicing psychiatrist had documentation to support the necessary credential to practice psychiatry in Texas. **Provision J2** The monitor team has determined that the Facility is not in compliance with Provision J2. The use of polypharmacy that without clear documented rational, unsubstantiated diagnosis and meaningless target symptoms/signs are examples why this provision has not been met. **Provision J3** The Facility is not in compliance with Provision J3. The justifiable use of polypharmacy and neuroleptics is not evident. **Provision J4** The Facility is not in compliance with Provision J4. There was no evidence of effective desensitization programs or other means to reduce use of pre-treatment sedation. **Provision J5** The quality of psychiatric services at the Facility indicates the need for additional resources to provide psychiatric care. Provision J5 is not in compliance. **Provision J6** Provision J6 is not in compliance by the Facility. The Facility is not providing psychiatric care at the level of acceptable practice standards. **Provision J7** was not rated. **Provision J8** Based on review of psychiatric records, there is no evidence that indicates that the Facility integrates psychiatric services as required by provision J8. For this reason the Facility does not comply with Provision J8 **Provision J9** The review team has determined that the Facility is not in compliance with Provision J9. The evaluating psychiatrist does not actively entertain least restrictive treatments or venues when attempting to formulate a case.

	Provision J10 There was no indication that a meaningful process to review risks and benefits of non-emergency psychotropic medications had been developed or implemented by the Facility. Alternative treatments are not commented upon within the personal support planes, quarterly reviews or psychiatric evaluation. **Provision J11** The use of same class polypharmacy is problematic at the Facility, despite a mechanism to monitor polypharmacy. The review team has determined that the current process of monitoring polypharmacy is non functional and that the Facility is not in compliance with Provision J11 **Provision J12** The review team has determined that the Facility does not regularly monitor individuals for adverse drug reactions other then for scheduled reviews; hence, the Facility is not in compliance with Provision J12 **Provision J13** The review team has determined that the IDT and ISP does not meaningfully address psychiatric issues and finds the Facility not in compliance with Provision J14. **Provision J14** In the opinion of the Review team, consents for the purposes of psychotropic medications were not obtained. It is imperative that all serious and common side effects, all alternative treatments, including no treatment, potential benefits and risks of treatment, and the off labeled use of medications used for psychiatric purposes be well explained to the legally responsible person and documented as part of the consent process. **Provision J15** At the time of the review, there was no evidence to indicate that the psychiatrist actively participated with the PST when using antiseizure medications for behavior and anticonvulsant purposes. The Facility is not in compliance with Provision J15.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	At the time of this review, all providers of psychiatric services had appropriate credentials and were licensed to practice medicine.	S
J2	Commencing within six months of the Effective Date hereof and with	Review of clinical records at the Facility, including a comprehensive review of psychiatric records of Individuals #5, #33, #76 and #139, clearly indicate that provision J2 is not in	NC

#	Provision	Assessment of Status	Compliance
	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.	compliance. To best delineate important issues, the following examples are presented: The psychiatric record of individual #76 was assessed by the monitoring team. The Psychiatric evaluation dated March, 15, 2010, indicated an axis I diagnosis of schizophrenia, an axis II diagnosis of moderate mental retardation and an axis III diagnosis that included hypothyroidism and mild obesity. Quarterly psychotropic medication reviews since January, 2010, demonstrated inconsistency with accuracy of diagnosis. The diagnosis for both Axis I and Axis II varied from quarterly to quarterly and with the Annual without clinical documentation to support the observed change. Importantly, the Axis II diagnosis for mental retardation, which should be static, was listed differently from report to report, ranging from moderate to severe mental retardation. Importantly, nowhere within the psychiatric evaluation, including the chief complaint, mental status evaluation or case formulation, was there evidence to support any axis I diagnosis. Under the heading of "chief complaint," the psychiatric evaluation states that the individual had resided at the facility for almost 17 years and that "I do not foresee any changes as far as residency is concerned. " Under the heading "case formulation," the evaluation indicates that the individual takes medications regularly and "there are no problems with that, " "he can pretty well take care of himself such as bathroom, showers, and eating in the dining room" and "usually, but seldom, if someone provokes him, he will get into a verbal argument. " Under the heading "thought content," the evaluation indicates that he does not have any homicidal or suicidal ideations and the "hallucinations and delusions are very difficult to assess, " "the staff tells me he does not have any. " The evaluation is completely devoid of information that can support or substantiate an axis I diagnosis. Moreover based on the documented information, it is difficult to understand why this person cannot be at least considered for a more integrated setting, such as a group home. Specific to obsessions, the evaluation indicates that the "client will hold his breath for a few seconds and then let it go. " There is no documented evidence to suggest a meaningful evaluation of this mannerism. The evaluation also determined that the individual is not dangerous to others and that "he may strike out but not too hard. " Any form of physical assault to others must be considered serious and appropriately addressed. Equally, the record indicates that the individual only "strikes out" when provoked, so the issue remains, how is the Facility protecting the rights of this individual, as well as the rights of others who reside there? Furthermore, the evaluation did not indicate or propose functional assessment to assess whether this behavior is maintained by environmental conditions rather than being related to a diagnosable illness.	

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		Despite no credible documented justification in the body of the psychiatric evaluation to support the diagnosis, the individual remains on significant psychotropic polypharmacy, which includes chlorpromazine and lithobid. Although the psychiatric evaluation only indicated chlorpromazine and lithobid, the quarterly psychotropic medication review of February 22, 2010 and subsequent reviews indicate that the individual is also on Trileptal, for psychosis. Specific to psychiatric signs and symptoms being monitored, as delineated in the quarterly psychotropic medication reviews of September 7, 2009 and June 3, 2010, are concerning and should be further explained. Signs and symptoms that include "refusals to attend programming, standing staring not responding to staff, inhaling/exhaling deep breath (exaggerated breathing)" could be secondary to underlying medical issues, such as pain and cardiovascular conditions. The monitor team did not find evidence to indicate that a comprehensive evaluation of this behavior was undertaken. The review team recognizes that many individuals with intellectual disabilities manifest different symptomatology of psychiatric illness then that of the general population; however, such signs and symptoms must be carefully evaluated, and re-evaluated over time. The use of chlorpromazine, trileptal and lithobid suggests that the individual has a significant psychopathology; however, this is not reflected in the psychiatric evaluations, nor are the risks and benefits of the medication carefully explored or explained within the concept of the team. Many of the reported signs, and symptoms experienced by the individual could be explained by a medication induced delirium and other medication related side effects; this issue was not entertained by the psychiatrist, other physicians, by the interdisciplinary team process or in pharmacy reviews. Importantly, the individual is experiencing chronic anemia with a hemoglobin of 11.3 (normal 14.0 – 18.0) and a low normal mean corpuscle volume of 83.8 (normal 80 -100). The current psychiatric records, and the pharmacy reviews did not comment on anemia. With regard to past psychiatric illness and family psychiatric illness, the psychiatric record is misleading. In portions of the evaluation there are comments that there is no available history; however, family members visit him at the Center and on occasions take the individual home and on outings, hence, there is ample opportunity to discuss past histories with family members. Also, there is no discussion of developmental history, and the social history component of the evaluation is not adequate. The psychiatric evaluation dated March 10, 2010 of Individual #139 demonstrates an evaluation process that is fragmented and does not comply with standard of care	

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		practice within a developmental disability setting. Direct observation by the monitoring team of the individual corroborates Dr. Draksharham's assessment of the individual's pressured speech and movement issues; however, the MOSES and DISCUS reports indicate that these issues are not present. This is a major discrepancy that indicates poor reliability of the raters. The movement issues have not been clearly defined within the psychiatric record. Specific to pharmacotherapy, the individual is prescribed two antipsychotic medications, Haldol Decanoate, an injectable first generation antipsychotic, and Seroquel, an oral second generation antipsychotic. The individual is also prescribed Klonopin and Benadryl for sedative properties. The use of two antipsychotics is questionable and the clinical rational is not outlined in the records reviewed. Upon review of the psychiatric records of Individual #5, the MOSES side effects scale of January 8, 2010, was not completed by the physician who signed the report. This Individual is also on two antipsychotic medications, Haldol and Seroquel and again, the combined use must be questioned. The Individual is administered Cogentin for extra pyramidal syndrome (EPS); however, despite being prescribed medication for EPS, the MOSES side effects scale of January 8, 2010, indicated no issues with regards to musculoskeletal or neurological signs or symptoms. A current psychiatric evaluation was not available for the monitoring team's further review of this Individual. Review of the psychiatric records of Individual #33 demonstrate another situation where a typical and an atypical antipsychotic medication was prescribed, and without a rational explanation for the combined use. The MOSES side effect scale dated January 8, 2010, indicated that the individual is sedate and has abnormal mouth, and tongue movements and the DISCUS of January 15, 2010 indicated some grimaces, abnormal blinking, tongue tremors;, however, there were no indications that further assessment or close monitoring of these emerging symptoms should occur. The psychiatric evaluation dated March 13, 2010, was not well formulated and lacked continuity. The record indicated obesity as a major concern; however, there is nothing documented that suggests that the Facility is assisting the person with this serious condition, especially when the individual is on medications that can promote obesity and diabetes. Following a review of the Facility's use of psychotropic medications, the use of first generation antipsychotics, especially when combined with a second generation antipsychotic must be carefully reviewed by the Facility. The lack of meaningful clinical evidence to support psychotic disorders in the cases reviewed, indicate that the use of	

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		antipsychotic medications maybe used for other reasons, such as aggression, non-compliance and sleep related issues.	
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.	All individuals reviewed had an Axis I diagnosis to justify the prescribed medication; however, the accuracy of the diagnosis and the consideration of other treatment programs must be reviewed. Because of issues outlined in provision J2, the monitor team has determined that provision J3 is not in compliance.	NC
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	Thirty-two of 72 individuals residing at the Facility were reported to have used pre-treatment sedation for medical or dental services. There was no evidence of effective desensitization programs or other means to reduce use of pre-treatment sedation.	NC
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or	The Facility is making attempts to hire a full time psychiatrist. Currently there is a contract psychiatrist who provides full-time psychiatric services and an alternate psychiatrist that serve as back up, however, standard of care practices remain a major issue for the Facility. Poorly formulated case reports, lack of supporting evidence to	NC

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	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.	support the diagnosis, poorly constructed target symptoms, and the use of significant psychotropic polypharmacy without documented rational explanation to support such use are rate limiting examples of why the Facility must be enabled to hire a well qualified and full time psychiatrist.	
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.	Based on review of psychiatric records, as outlined in Provision J2, the facility is not in compliance with provision J6.	NC
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)	At the time of this review, there were no new admissions or newly diagnosed individuals to assess the Facility's compliance with provision J7. Records of individuals who had been in residence were not reviewed at this visit.	Not Rated

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	in a clinically justifiable manner.		
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Upon review of the psychiatric records of Individuals #5, #33, #76 and #139, there is no evidence to indicate that the Facility had developed and implemented a system to integrate pharmacological treatments with behavioral and other interventions. For examples, please refer to Provision J2.	NC
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	Review of clinical records and the personal support plans of individuals #5, #33, #76 and #139, indicated that the least intrusive and most positive interventions to treatment, among other issues of Provision J9 were not met by the Facility. Poorly substantiated diagnosis, polypharmacy, lack of critical data to support the administration of medication, and limited behavior supports contribute to failure of Provision J9	NC
J10	Commencing within six months of the Effective Date hereof and with	Following review of the psychiatric records and personal support plans for individuals #5, #33, #76 and #139, there was no indication that a meaningful process to review risks	NC

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	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.	and benefits of non-emergency psychotropic medications had been developed or implemented by the Facility. Alternative treatments are not commented upon within the personal support planes, quarterly reviews or psychiatric evaluation. When restraint was used, RGSC primarily used chemical restraint. Ten of thirteen non-medical restraints since 3/1/10 (not factoring in the one individual) were chemical restraints. One individual (#80) was chemically restrained six times since April 4/1/10. Deficiencies in behavior supports (refer to Section K) and habilitation supports (refer to Section S) are likely contributing to what appears to be an over-reliance on the use of chemical restraint. Only recently had the Chief Psychologist been consulted, as required by RGSC policy, prior to the administration of a chemical restraint to consider alternatives to chemical restraint.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Review of the psychiatric and pharmacological records of individuals #5, #33, #76 and #139, indicated significant issues with regards to intraclass polypharmacy, primarily with regard to the use of combined typical and atypical antipsychotics. For examples, please refer to Provision J2. Based on these findings, the Facility does not comply with provision J11.	NC
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	Following review of the psychiatric records, including the Moses and DISCUS assessments of individuals #5, #33, #76 and #139, the MOSES and DISCUS are obtained at least quarterly; however, as delineated in provision J2, the quality of the raters ability to complete the assessment is questionable. Also, when side effects were noted on the assessments, there was no documentation that more frequent follow-up was necessary.	NC

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	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.		
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	After review of the psychiatric records of individuals #5, #33, #76 and #139, there was no evidence that indicated compliance with provision J13. Review of the target signs and symptoms, reported outcomes and case formulation did not support the axis I diagnosis. The IDT and the ISP did not routinely and meaningfully review efficacy or objective psychiatric symptoms.	NC
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	Review of the personal support plans, psychiatric records and available consent forms for individuals #5, #33, #76 and #139, indicated that a comprehensive mechanism to ensure that all risks, and benefits, alternate treatments and off label use of psychotropic medications was not in place. The monitor team did not identify a process that clearly and concisely reported to the legally responsible person, these very important issues. The use of a medication, especially for psychiatric conditions, that are not FDA approved	NC

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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.	as a treatment, must be well communicated as part of the informed and signed consent. Alternative treatments and potential outcome of not treating is also an important aspect of signed informed consent for the use of psychotropic medications.	
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.	There was no evidence to indicate that the PST process was utilized to coordinate the prescribing of medications by the neurologist and psychiatrist.	NC

Recommendations:

1. A comprehensive review of the current psychiatric evaluation process must be completed. The psychiatric evaluation reports do not meet professional standard of care.
2. Current psychiatric diagnoses of individuals at the Facility must be re-evaluated for accuracy, and meaningful target signs and symptoms be identified to corroborate the diagnosis and to be used to monitor efficacy of treatment efforts.
3. The use of psychotropic medication for people with intellectual disabilities must be closely monitored, and its use justified, and well documented. Importantly, risks, and benefits must be clearly explained within the context of the interdisciplinary team process. It would be advantageous if the Facility would review the current literature specific to treating people with intellectual disabilities and co-morbid psychiatric conditions.
4. The reliability of Raters for the MOSES and DISCUS assessments should be reviewed. Competency based in-service training should be offered regularly to Raters and all Physicians at the Facility.
5. To enhance psychiatric services, the Facility must be enabled to hire a full time psychiatrist.
6. It is highly recommended that the Facility initiate a prompt peer review of the current practicing psychiatrist by a board certified psychiatrist and ensure that a regular peer review process is well maintained at the Facility

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. 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 for the following individuals: #1, #2, #3, #5, #10, #15, #27, #31, #35, #36, #47, #59, #62, #63, #66, #69, #76, #77, #80, #82, #84, #88, #91, #96, #98, #107, #133, #140, #145, and #149 4. Counseling/psychotherapy plans for individuals #69 and #107 **People Interviewed:** 1. Megan Gianotti, M.Ed. – Behavioral Services Director 2. Cheryl Fielding, Ph.D. – BCBA consultant 3. Myrna Wolfe – Incident Management Coordinator 4. David Moron, MD – Clinical Services Director 5. Babu Draksharam, MD – Contract Psychiatrist 6. James Arnold – RGSC Patient Rights Officer 7. Direct Care Professionals: Approximately 15 staff members in both residences. **Meetings Attended/Observations:** 1. Behavior Management Committee meeting (08.24.2010) 2. Psychotropic Medication Review (08.26.2010) 3. PSP for Individual #140 (08.25.2010) 4. Observations of meals, transition activities, and programming activities in both residences. (08.25, 08.26)
	Facility Self-Assessment: The Facility indicated that almost all provisions of the SA were not yet in compliance, although a number of actions had been taken toward compliance. The areas for which the Facility reported compliance involved the hiring of a Director of Behavioral Services, the implementation of monthly PBSP data graphs, and the maintenance of the required number of psychology assistants. The monitoring team agreed that steps had been taken to satisfy the requirements for Director of Behavioral Services, data graphing and Behavioral Service staffing. In each case, a determination of substantial compliance was premature. The Facility reported efforts to increase the number of BCBA-certified staff and to provide training to increase the skills of psychology staff; the monitoring team found that initial steps had been taken and agreed with the Facility's assessment that these were not yet complete.

	Summary of Monitor's Assessment: **For Provision K.1:** This provision was determined to be not in compliance. A Chief Psychologist has been hired, but the person has not yet completed the BCBA credential. As no BCBA is employed by RGSC, it was not possible to demonstrate that PBSPs were developed by qualified staff. **For Provision K.2:** This provision was determined to be not in compliance. RGSC successfully appointed Ms. Megan Gianotti to the position of Behavioral Services Director. Ms. Gianotti is currently enrolled in BCBA courses while participating in supervision, and does not meet all requirements stipulated in the SA. Additional time will be needed to determine if the steps taken by the Facility are sufficient to achieve substantial compliance regarding this Provision. **For Provision K.3:** This provision was determined to be not in compliance. The internal peer review process reported by the Facility did not reflect true peer review. The external peer review process was under development. **For Provision K.4:** This provision was determined to be not in compliance. Data collection continued to lack demonstrable reliability and validity. It is also unclear that existing data were used to make data-based treatment decisions. **For Provision K.5:** This provision was determined to be not in compliance. Intellectual and adaptive assessments were not completed at RGSC, and a large percentage of individuals had not had a psychological assessment completed in over a year that included current assessment findings, or a review of sufficiently recent assessments. Some improvement had been made in functional assessment, but these efforts were preliminary at the time of the site visit. **For Provision K.6:** This provision was determined to be not in compliance. Issues discussed in Provision K5 indicate that RGSC does not provide psychological assessments that are current, accurate and based upon complete clinical and behavioral data. **For Provision K.7:** This provision was determined to be not in compliance. Psychological evaluations completed at the time of admission reflect the same substantial limitations as those evaluations completed for other individuals living at the Facility. **For Provision K.8:** This provision was determined to be not in compliance. For the individuals participating in counseling, the treatment process did not reflect an evidence-based approach to treatment and lacked clear, objective and measurable goals. **For Provision K.9:** This provision was determined to be not in compliance. Although the Facility typically required some form of consent and approval for restrictive interventions, the quality of the assessments

	and interventions reviewed did not meet acceptable practice under applied behavior analysis. **For Provision K.10:** This provision was determined to be not in compliance. Efforts to improve data collection had been implemented, but insufficient time had passed to allow for adequate assessment. Data continue to lack demonstrable reliability and validity. It is also unclear that existing data are used to make data-based treatment decisions. **For Provision K.11:** This provision was determined to be not in compliance. At the time of the site visit, only three PBSPs had been developed using an enhanced behavior assessment process. Additional time will be needed to determine if this Provision is in compliance. **For Provision K.12:** This provision was determined to be not in compliance. Plans are underway to provide training, but this has not been implemented yet. **For Provision K.13:** This provision was determined to be not in compliance. Progress has been made toward increasing the number of staff with the BCBA credential, but the numbers do not currently meet the criteria reflected in this Provision.

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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 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.	At the time of the site visit, all individuals deemed by the facility to require a behavioral intervention had a PBSP in place or under review for implementation. This reflects an improvement over conditions at the time of the baseline visit when many individuals who exhibited undesired behavior did not have PBSPs or for whom the PBSPs were outdated. The implementation of PBSPs for all individuals with an identified need addressed only one aspect of this Provision. By the admission of the Facility, and supported by record reviews, the primary emphasis of the effort by the Facility was to ensure the presence rather than the quality of PBSPs. As discussed in Provisions K4, K5, K6, K7 and K9, many components of effective behavior analysis and intervention were not adequately utilized in the development of these PBSPs. As a result, the probability that these PBSPs would promote the acquisition of desired, functional, and adaptive behaviors remained at best unknown. In addition to the emphasis upon quantity rather than quality of PBSPs, the lack of demonstrably sound behavior assessment and intervention practices arose due to the lack of demonstrably competent staff. By the time of the site visit, the Facility had employed Megan Gianotti as the Director of Behavioral Services. Ms. Gianotti displayed	NC

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		good leadership skills and basic knowledge of applied behavior analysis during the site visit;. She was also enrolled in BCBA courses and was participating in BCBA supervision. Ms. Gianotti, in addition to the consulting BCBA who was available only 4 hours per week, was the only member of the Behavioral Services staff with basic knowledge of applied behavior analysis. As a result, the Facility was unable to provide sufficient staff that were competent to complete the task of developing and implementing adequate behavior interventions. The Facility had taken steps to fulfill the requirement for demonstrably competent staff. As indicated, Ms. Gianotti had been hired and was working toward certification as a behavior analyst. In addition, the Facility had implemented aggressive recruitment efforts and was finalizing the hiring of additional Behavioral Services staff. These new additions to the Behavioral Services staff lacked basic knowledge of applied behavior analysis, but had committed to achieving certification as behavior analysts. Additional review will be necessary to determine the success of the Facility in its efforts to employ competent staff, as well as effectively utilize those staff in the development of behavior assessments and interventions.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	As indicated in Provision K1, RGSC had employed Megan Gianotti, M.Ed. as Director of Behavioral Services at the time of the site visit. Ms. Gianotti was a long-term employee of RGSC prior to accepting the role of Director of Behavioral Services. Prior to her employment at RGSC, she had worked with individuals diagnosed with autism spectrum disorders, developing and implementing behavior interventions. During multiple interviews, Ms. Gianotti demonstrated enthusiasm toward her responsibilities. Her comments suggested that she possessed the insight and leadership necessary to successfully implement the provisions of the Settlement Agreement for which she was responsible. Two events noted during the site visit exemplified Ms. Gianotti's abilities and leadership. • During a PSP meeting for Individual #140 on August 25th, Ms. Gianotti advocated for a less restrictive approach to addressing the individual's frequent changing of clothes than had been presented by the QMRP. Ms. Gianotti later discussed that, rather than unnecessarily changing clothes, Individual #140 independently changed her clothing after urinating in her clothing due to physical problems with bladder control. • Individual #47 had been involved in over 1000 applications of physical and mechanical restraint over the past several months, primarily due to perceived	NC

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		resistive behaviors during times when tube-feedings were conducted. The Facility had defined these applications of restraint as medical necessity. When offered the opportunity during the site visit, Ms. Gianotti introduced changes in the approach to feeding that allowed Individual #47 to often participate in meals free from restraint. Additional reviews will be necessary to determine whether the employment of Megan Gianotti as Director of Behavioral Services meets this provision of the Settlement Agreement.	
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	At the time of the site visit, the Facility had in place a policy for peer review. RGSC reported that internal peer review had commenced on July 20, 2010. A meeting of the Behavior Management Committee was held on August 24th; The Behavior Management Committee is the title of the committee tasked by the Facility with internal peer review. Individuals #80 and #107 were presented at the meeting, Based upon observations of the Behavior Management Committee meeting, there was little indication that the Facility comprehends the nature or objectives of peer review or has effectively implemented an internal peer review process. Limitations noted in the internal peer review process included the following. • Case presentation was comprised essentially of a general discussion of non-clinical issues surrounding PBSPs combined with a reading of the written PBSP. Minimal detail regarding assessment or intervention procedures was introduced, and no discussion of the validity or reliability of data was offered. Any discussion of response to intervention involved comments such as, "In general {the individual} is doing well." • Individual #80 had experienced an increase in monthly displays of self-injury, from less than one to greater than 12, over the previous 12 months. Discussion suggested that sinus/nasal discomfort was frequently associated with displays of self-injury by this individual, such as the nasal expression of a large volume of black mucous during the most recent display of self-injury and frequently observed insertion of the index finger into the nose “almost up to the third knuckle.” Discussion of possible medical interventions was very general, included comments such as "Oh, he does that all the time", and did not evidence integration between psychology and medical staff. • Individual #107 was experiencing symptoms of mental illness. The presented PBSP involved general discussion to be provided by staff. Very little structure was included	NC

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		in the implementation process, and it was suggested that staff will know what to discuss with the individual. No one on the committee voiced concerns about the limitations of the intervention process and how those limitations would prevent determining if the process was successful. At the time of the site visit, the external peer review process had just commenced and lacked a formalized approach to process and documentation. The general plan consisted of the review of PBSPs by Dr. Cheryl Fielding. Dr. Fielding, a consultant to the facility providing 4 hours of service per week, holds a doctorate in psychology as well as being board certified in behavior analysis. Additional review will be needed to determine the viability of the external peer review process.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	In late July of 2010, a new data collection process was implemented at RGSC for all individuals who had a PBSP. The data collection process consists of a total frequency count conducted across regular intervals in a scatter plot format. Staff that completed the frequency counts were also responsible for recording antecedents and consequences for each behavior display recorded. As less than a month of data had been collected at the time of the site visit, it was not possible to conduct a thorough evaluation of the data collection process. The Facility acknowledged that inconsistencies had been noted in the data collected thus far, and that training for staff on data collection had been recently implemented. Additional reviews will be necessary to determine the quality of the new data collection process. The review of Facility monitoring of PBSP efficacy was complicated by the recent change in data collection procedures. The most recent PBSP progress notes at the time of the August site visit were reviewed for 30 individuals. This review yielded the following information. • 29 of 29 (100%) progress notes utilized graphs to display treatment data. • 27 of 29 (93%) progress notes reflected lack of treatment efficacy with no resulting change in intervention. Examples of this issue include the following. o Individual #149 experienced fluctuations in the frequency of aggression from zero to 24 over 12 months. No additional assessment or intervention change was introduced. o Individual #15 evidenced in increase in psychiatric symptoms following the addition of Haldol and an increase in Geodon. The increase in symptoms continued for four months, following which Haldol was	NC

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		decreased from 10 to four milligrams daily. Symptoms and behavior improved somewhat but no further changes in the treatment regimen were introduced during the following four months. o Individual #96 demonstrated a substantial drop in ratings of mania without recent changes in psychotropic drug regimen. No supplemental assessment of the environment or symptoms was conducted, suggesting that the role of psychotropic drug therapy had not been adequately explored in order to determine beneficial effects upon psychiatric symptoms. o Individual #59 experienced a substantial drop in aggression and psychopathology followed by a rebound over several months. No changes in medication were reflected in the record, suggesting weaknesses in assessment, diagnosis or data collection. No supplemental assessment of the environment or symptoms was conducted, suggesting that the role of psychotropic drug therapy had not been adequately explored in order to determine beneficial effects upon psychiatric symptoms It should be noted in all 29 progress notes reviewed that data graphs focused only upon psychotropic drug treatments despite each of the individuals involved also receiving behavior interventions. This is of concern, as it suggests that the primary mode of treatment for individuals living at RGSC, regardless of whether the target of concern involves mental illness or learned behavior, is psychotropic medication. A related concern was that, despite indications that the benefits of psychotropic drugs had not been adequately explored, such drugs were continued for 27 of the 29 individuals who were reviewed. Psychotropic drugs often introduce unwanted and potentially dangerous side effects. Where such drugs are shown to be of benefit, justification for use can be based upon the benefits outweighing the risks. When evidence does not support the benefit from psychotropic medications and those medications are continued, the argument can be made that the individuals have not received adequate protections due to being exposed to substantial and unnecessary risks. This was the case at RGSC. The prescribing of psychotropic medication is within the purview of the psychiatrist. There is an interdisciplinary obligation, however, to ensure that all interventions are appropriate for the treatment targets, necessary, safe and effective. In order to fulfill this obligation, current accepted practice mandates that a comprehensive assessment of	

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		behavior and psychopathology is completed by the psychologist, psychiatrist and other members of the interdisciplinary team prior to the initiation of psychotropic medication. Such assessment facilitates the differentiation between learned behaviors and symptoms of mental illness, suggests the appropriate intervention modality for each target and identifies valid data collection procedures and treatment expectations. The interdisciplinary team is then tasked with monitoring the efficacy of the treatment regimen according to the treatment expectations established by the psychiatrist and psychologist. When the established treatment expectations are not met, the interdisciplinary team directs the psychologist and psychiatrist to conduct the necessary reviews and assessments to determine if a change in the treatment regimen is warranted. Based upon the findings presented above, it was evident that the facility did not consistently make use of assessment and treatment data in determining the benefit from or need for specific interventions. • 25 of 29 (86%) progress notes did not differentiate between treatment targets. One of the key features of applied behavior analysis is the use of an empirical or scientific process to ensure that interventions produce observable and measurable changes in the targeted behavior. This requires that the target of the intervention consist of a single behavior or a group of behaviors, called a functional class, that have been proven to serve the same purpose under the same conditions. In order to determine the success of the intervention, measurements and treatment decisions must focus only upon the specific behavior or functional class. Frequently at RGSC, data and progress notes did not focus upon the specific behavior or functional class, instead presenting a more general review of a variety of behaviors. Because the same intervention might have various effects on these behaviors, grouping them into one aggregate data point may mask the effect of the intervention.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors,	At the time of the site visit, approximately 40% of the individuals living at RGSC had not received a psychological assessment or update in over a year. Of the remaining 60% of individuals, psychological assessments did not include intellectual or adaptive assessments completed or reviewed according to current standards of practice. The Facility indicated the intent to obtain the services of a psychological consultant in order to meet the requirements of Provision K5, but plans had not been finalized at the time of the site visit. Additional reviews will be necessary to assess progress in this area. The Facility also indicated that a new process and format for structural and functional	NC

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	and of other psychological needs that may require intervention.	assessment had been implemented. This process included a requirement for direct and indirect assessment, an enhanced review of personal history, additional investigations of the role of biological factors and mental illness, and specific hypotheses regarding the function of undesired behavior. This is a positive step toward enhancing the delivery of behavioral services at RGSC. At the time of the site visit, the new structural and functional assessment process had been implemented with three individuals; two people newly admitted to the facility and a third for whom a PBSP revision had been requested. The third person, Individual #80, was selected for review purposes. The findings of the review, included below, suggested that further refinement and training were necessary. • Although discussed generally at several points in the assessment report, the specific targets were not identified or operationally defined. Without the clear identification of targets, comprehensive and valid assessment cannot be achieved. • The investigation of the influences of mental illness consisted primarily of a review of previously offered diagnoses and the psychotropic drugs currently prescribed. There was no indication of attempts to ascertain the validity of mental illnesses diagnoses or identify behavior correlates for the symptoms upon which the diagnoses were based. • Preliminary observations and existing records suggested that self-injury served different purposes under different conditions. This was not more fully explored. • The concepts of motivating operations, setting events, antecedents and precursor behaviors were at times used interchangeably even though each is a distinct concept. • The results of the Motivational Assessment Scale were not definitive, but further investigation to determine function was not conducted. • The entire assessment process, although including at least nominally the necessary components, lacked the empirical rigor necessary to the development of an effective PBSP. Observations, interviews and record reviews revealed that substantial weaknesses existed in the process of diagnosing mental illness and developing acceptable interventions. Most often, diagnoses of mental illness are based upon subjective opinion rather than a formal and objective assessment process. On occasion, diagnoses are changed arbitrarily or based upon the observation of a single behavior or event. Examples of limitations in the process of diagnosing mental illness are presented below. • 0 of 29 records (0%) reviewed included a screening for or assessment of mental	

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		illness utilizing tools designed for people with intellectual and developmental disabilities. • According to statements offered by staff, Individual #80 was given a diagnosis of Impulse Control Disorder after a single episode of self-injury. Preliminary evidence suggested the self-injury might have been the result of sinus congestion and infection. The use of a coherent assessment process including functional and structural analysis led to a different decision regarding the appropriate diagnosis and treatment options.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Based upon the information presented in K5, documentation in the record reflects assessment findings that cannot be demonstrated to be current, accurate or complete.	NC
K7	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.	Records reflect that individuals newly admitted to the Facility have a psychological assessment completed within 30 days of admission. Records do not reflect that individuals admitted to the facility routinely receive an intellectual or adaptive assessment at the time of admission regardless of the amount of time since the most recent assessment. Acceptable practice dictates that an intellectual assessment should be conducted at a minimum of every five years with adaptive assessments to be conducted annually. RGSC does not possess the ability to conduct intellectual assessments, preventing the Facility from meeting this element of acceptable practice. Assessments of adaptive skills are conducted at RGSC, although records do not reflect that an annual schedule for adaptive assessment is used. Reporting of adaptive assessments typically consists of only a presentation of scores and levels without additional interpretation of personal strengths and limitations in relation to programmatic needs.	NC
K8	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	At the time of the site visit, two individuals living at RGSC (individuals #69 and #107) were involved in counseling or psychotherapy. Both individuals received counseling services in the community from a consultant. Facility reports and a review of documentation did not reveal the use of evidence-based practices in relation to counseling/psychotherapy services. • Neither of two counseling interventions (0%) included clearly defined and	NC

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	in such a way that progress can be measured to determine the efficacy of treatment.	measurable goals, nor were there fail criteria, such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention.. • Neither of two counseling interventions (0%) included strategies to measure the acquisition of skills rather than reductions in undesired behavior, such as social skills and problem-solving skills. • The monitoring team did not find information that counseling included initial analysis of problem or intervention target, and a plan of service (e.g., curriculum or approach, frequency or planned number of sessions, statement of skill or intervention target) integrated with the PSP.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	The Facility has a PBSP in place for each individual identified as requiring behavior intervention. At the time of the site visit, no PBSPs had been developed by staff with board certification in applied behavior analysis. Three PBSPs had been developed utilizing a new structural and functional assessment process and under the supervision of a BCBA. Based upon the information presented in Provision K5, PBSPs at RGSC typically did not reflect acceptable practices in applied behavior analysis. • Although discussed generally at several points in the assessment report, the specific targets were not identified or operationally defined. Without the clear identification of targets, comprehensive and valid assessment cannot be achieved. • The investigation of the influences of mental illness consisted primarily of a review of previously offered diagnoses and the psychotropic drugs currently prescribed. There was no indication of attempts to ascertain the validity of mental illnesses diagnoses or identify behavior correlates for the symptoms upon which the diagnoses were based. • Preliminary observations and existing records suggested that self-injury served different purposes under different conditions. This was not more fully explored. • The concepts of motivating operations, setting events, antecedents and precursor behaviors were at times used interchangeably even though each is a distinct concept. • The results of the Motivational Assessment Scale were not definitive, but further investigation was not conducted. • The entire assessment process, although including at least nominally the necessary components, lacked the empirical rigor necessary to the development of an effective PBSP.	NC

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		Consents and approvals are routinely obtained for PBSPs, restrictive procedures and the use of psychotropic medication. Due to pervasive weaknesses in the assessment process, it is likely that limited understanding of the individual's treatment targets is gained and only minimal support for intervention strategies can be provided. • One of 29 records reviewed (3%) included results obtained from a process or instrument recognized as being able to identify potential functions of a behavior. • None of 29 records reviewed (0%) reflected the use of more rigorous or empirical procedures necessary to clarify potential functions and address limitations inherent to indirect functional assessments. • In 25 of 29 records reviewed (86%), intervention targets were presented and monitored as a group regardless of differing function, topography or other characteristics. Without comprehensive assessment, and the resulting poor support for provided interventions, it is unlikely that the information contained in the consent and approval documents is valid, that treatments for which consent and approval have been requested can be supported, and that the those who have been requested to provide consent have been provided with adequate information upon which to base a decision. Specifically, informed consent requires that the consenter be provided with sufficient information about the proposed intervention to formulate a decision about whether or not to grant consent. In most situations, the consenter must be provided with the following information. • Implications of going without treatment and of treatment being postponed for different periods • The range of accessible diagnostic or treatment options • The benefits each option offers • The possibilities of diagnostic false results or treatment failures • The risks and discomforts of diagnostic or treatment options even when successful • Short-term injuries that diagnostic or treatment failures may cause • Long-term effects of diagnostic or treatment options, favorable and unfavorable, separating probabilities from possibilities It is the responsibility of the Facility to conduct the assessments essential for informed consent. Due to the limitations noted in the assessment and monitoring process, RGSC	

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		had consistently failed to meet the obligation of providing sufficient information to the consenter. As a result, the Facility consistently failed to obtain valid and informed consent. In addition to obtaining informed consent, it is the responsibility of the Facility to ensure that PBSPs, as well as other interventions deemed necessary and appropriate by the PSP conform to current acceptable practices in applied behavior analysis. Acceptable practice includes ensuring timely response to real or potential risks to the individual. Record reviews revealed circumstances in which the Facility did not act in regard to a known risk to an individual. • In 27 of 29 records reviewed (93%), psychotropic medication continued to be prescribed without clear evidence of benefit outweighing the inherent risks of the drugs. • Individual #47 had restraint applied in excess of 1000 times without a functional assessment to investigate the function of the behavior resulting in restraint.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	In late July of 2010, a new data collection process was implemented at RGSC for all individuals who had a PBSP. The data collection process consists of a total frequency count conducted across regular intervals in a scatterplot format. Staff that completed the frequency counts were also responsible for recording antecedents and consequences for each behavior display recorded. RGSC should be commended for attempting to expand data collection and achieve frequency counts for targets of interventions. It should be noted, however, that total frequency data collection, even if successfully implemented, which can be tremendously difficult, is not by itself sufficient for the measurement of treatment efficacy. Steps must also be taken to ensure that the data collected are valid and reliable. This requires formal checks to ensure that data are being collected as intended, that the data collection methods are appropriate for the type of behavior being measured, and those data collection procedures are defined in sufficient detail to ensure that separate observers will achieve a high degree of agreement between their data. At the time of the site visit, RGSC had not implemented the steps necessary to ensure the reliability and validity of the data collected. • None of 29 records (0%) indicated that inter-observer agreement checks had been implemented. • None of 29 records (0%) included the checks identified in the above paragraph to ensure that data are reliable and valid.	NC

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		• None of 29 records (0%) revealed a process to ensure the validity of intervention targets or the appropriateness of specific data collection procedures. RGSC has achieved substantial progress in the monthly graphing of treatment data. All individuals receiving behavior or psychotropic interventions have data graphed on a monthly basis. In addition, these graphs typically include data available from the previous 10 to 12 months. Despite this progress, observations and record reviews revealed several problems with the graphs and the graphing process. • 14 of 29 graphs (48%) included data regarding symptoms of mental illness. It was unclear how the numbers on the graph related to mental illness, i.e. frequency vs. severity rating. • Five of 29 graphs (17%) had the labels for the two vertical axes switched. • 29 of 29 graphs (100%) did not routinely include lines or other standard practices to indicate when treatment conditions, environmental conditions or other relevant factors had changed. • None of 29 graphs (0%) included inter-observer agreement or data integrity data.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	At the time of the site visit, the majority of PBSPs had only recently been developed. Training on these PBSPs was scheduled to commence the week following the site visit. It was therefore not possible to effectively determine the ability of staff to explain or implement PBSPs. • 15 of 15 staff asked (100%), reported that the training on PBSPs would begin the next week. At the time of the site visit, the Facility did not have in place a system to monitor or ensure treatment integrity.	NC
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of	See provision K11.	NC

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	the specific PBSPs for which they are responsible and on the implementation of those plans.		
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, one staff member, Megan Gianotti, was enrolled in a BCBA program. The Facility was finalizing the hiring of two additional Behavioral Services staff, both of whom would be eligible for BCBA courses. Certification for all qualifying positions in Behavior Services would allow for a ration of 1:27. If all staff in qualifying positions were credentialed with BCBA, there would exist one psychology assistant for every two BCBAs.	NC

Recommendations:

1. Training for Behavior Service staff should be expanded to include the scientific method and an empirical approach to treatment. The application of applied behavior analytic interventions relies upon knowledge of scientific principles. Staff should be fully familiar with the basics of scientific investigation, such as the need for objective and reliable data, the use of consistent and controlled implementation of interventions and the manner in which data from interventions should be interpreted.
2. Additional review of the internal peer review process is warranted. Efforts should be made to ensure that peer review is coordinated by a BCBA and that the emphasis of peer review remains upon the development of clinically sound behavior interventions.
3. Additional steps should be taken to ensure that treatment data reflect relevant aspects of the behavior being measured. Frequency counts can be sufficient for many behaviors, but other targets, such as symptoms of mental illness and prolonged episodes of self-injury require other modes of data collection. A data collection system should be devised that helps the Behavior Services staff to select a data collection method that best suits the behavior rather than using the same data collection strategy for all behaviors.
4. Efforts should be made to formalize the assessment and diagnosis process for mental illness. This assessment and diagnosis process should include the use of instruments designed for use with people with intellectual and developmental disabilities make rigorous use of functional assessment to differentiate between learned behaviors and internally driven symptoms of mental illness, and include procedures for the clear identification of targets best used for the measurement of treatment efficacy.
5. Training with the interdisciplinary teams should be implemented to increase their understanding of evidence-based practices and the need for clear and measurable treatment goals. Training should include tools for facilitating the interdisciplinary teams in monitoring response to treatment.
6. A review of non-PBSP intervention procedures, such as counseling and psychotherapy, should be conducted with the goal of establishing clear guidelines for evidence-based practice.
7. Specific policies for graphic presentation of behavioral data should be established. These policies should address the presentation of psychotropic drug treatment, documentation of condition changes, and the selection of colors and symbols for use in graphs to minimize confusion.
8. The current process of including all undesired behaviors in a single treatment plan without clear indications how the targets for intervention are related should be reviewed. The universal use of single treatment plans can reduce the ability to focus upon specific functional classes and identify when a particular treatment modality has been effective or ineffective.
9. A comprehensive review of the consent and approval process should be conducted. An emphasis should be placed upon determining if data

collection and assessment weakness mean that individuals and LARs do not have adequate information to provide truly informed consent.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed**: 1. The following Clinical documents of Individuals #4, #5, #15, #16, #31, #33, #35,# 47, #51, #58, #61, #66, #76, #77, #80, #86, #97, #107,#116, #118, #126, #139, #140, and#143: • Annual personal support plan • Seizure records and logs • Neurology consults • Physician annual examination • Problem list • EEG reports • Laboratory result • Annual pharmacy review • Quarterly drug review • Physical therapy report • Physician notes • Physician orders • Imaging reports • Swallowing assessments • Nursing notes • Personal support addendum reports • Me book • CWS data print outs of nurses notes • One-to-one monitoring report 2. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Medical Emergency Response, Policy Number: 044, Date: July 21, 2010, Supersedes : Emergency Drill Procedure 3. RGSC Training Due/Delinquent List for Basic Life Support for Health Care Providers (Cardiopulmonary Resuscitation and Automated External Defibrillator) and Basic Cardiopulmonary Resuscitation, August 31, 2010 4. RGSC Mock Medical Emergency Drill Sheets for El Paisano and La Paloma, August 25, 2010 and August 26, 2010 5. RGSC Daily Oxygen Cylinder Logs, August 1, 2010 through August 23, 2010 6. RGSC Automated External Defibrillator and Accessories Checklists, January 1 ,2010 through August 22, 2010 7. RGSC Mock Drill CPR Training/Course Sign-in Sheet, August 26, 2010 **People Interviewed:**

	1. Meeting with David Moron, M.D, Clinical Director to discuss functional operation of health care services, 9/1/10 2. Meeting to review psychiatric services, peer review process and general medical issues; David Moron, M.D, Clinical Director; 9/2/10 3. Meeting with Anne Ikponwomba, Director of Pharmacy, to discuss pharmacy operations, pharmacy reviews, electronic order entry, quarterly pharmacy reviews, polypharmacy issues and pharmacy committee structure, 9/2/10 4. Meeting to discuss care related issues of individuals #116 and #118, with Yolanda Gonzalez, RN, Marcy Valdez, RN and Jessica Juarez, RN, 9/2/10 and 9/3/10 5. Meeting to discuss physical therapy issues; Rose S. Bazan, P.T, Contract Physiotherapist; 9/3/10 6. Jamie Flores, MR Program Director 7. Yolanda Gonzales, RN, Chief Nurse Executive 8. Lorraine Hinrich, Consultant for Plan of Improvement 9. Ricardo, Zuniga, Vocational Services Assistant Director 10. Exit meeting with administrative staff, 9/3/10 11. Direct Care Staff at El Paisano and La Paloma **Meeting Attended/Observations:** 1. Introductory meeting with administrative staff, 8/31/10 2. Observations of individuals at living area 501 and 502 and Vocational-Education program, 8/31/10, 9/1/10, 9/2/10 and 9/3/10 3. Mock Medical Emergency Drill, El Paisano, August 25, 2010
	Facility Self-Assessment: RGSC reported that many areas of medical care were in compliance with the provisions of the SA including the Health Care Guidelines (HCG). The monitoring team found significant areas of noncompliance with the HCG, including some that may have led to lack of adequate care and poor health outcomes. Section L1, subsection 1, the Facility indicates that it is compliance with regards to providing adequate routine, preventive and emergency medical care. The monitoring team found examples of lack of aggressive care, lack of response to abnormal lab results and drug interactions, lack of attention to neuromuscular and musculoskeletal issues, and lack of attention to polypharmacy for seizure control. This is an essential issue for immediate attention. Section L1, subsection 3, the Facility indicates compliance with ensuring that 100% of the records reviewed show that initial seizure evaluation or the evaluation of a change in seizure pattern is appropriate and thorough. The monitoring team did not confirm compliance. Recommendations made by the neurologist were not consistently incorporated into the clinical management of the individual.

	Section L1, subsection 4, the Facility states that it is in significant compliance with regards to having a neurologist actively involved in the management of seizure disorder. Although there was active involvement by a neurologist, recommendations made by the neurologist were not consistently incorporated into the clinical management of the individual. Section L1, subsection 5, the Facility states that it is in significant compliance in providing neurology consultation services for individuals who have poorly controlled seizure disorder. Some individuals are on significant polypharmacy for seizure control; however, the PSP and addendum to the PSP did not show that this issue was addressed Section L1, subsection 6, the Facility indicates significant compliance in providing neurology consultations for persons with well controlled seizures at least every two years. The monitoring team confirmed this. Sections L1, subsection 7, the Facility states significant compliance by having the physician and/or PharmD/Pharmacist evaluate the total medical regimen of individuals with seizures. At the time of the review it was determined by the monitor team that "medications" were clearly reviewed by the pharmacists, however there was no evidence per review of progress notes that comprehensive review of the individuals health status was reviewed by clinical staff. Section L1, subsection 10, the Facility indicates compliance that it considers the risk/benefits of newer treatment modalities for those with poorly controlled medications. Section L1, subsection 11, the Facility indicates compliance by ensuring that use of anticonvulsant medications is appropriate for specific seizure type. The monitoring team identified concerns with the general use of polypharmacy and the continued use of older generation anticonvulsants, such as Phenobarbital and Dilantin, without clear and rational justification for their continued use. Section L1, subsection 13, the Facility states compliance by ensuring appropriate blood levels are obtain when necessary. The monitoring team found very significant concerns with toxic blood levels for which no action was taken. It is not adequate simply to obtain the blood levels; instead, the Facility staff must review the blood levels, identify those that require changes in treatment, and involve the PST in review of risks and benefits of alternatives. Section L1, subsection 14, the Facility reports compliance by obtaining screening blood tests for physiological side effects of AEMs. Frequency of drug monitoring should be more closely monitored and all abnormal results must be well documented by the physician in the progress note. Abnormal results should be vetted through the interdisciplinary team process. Section L1, subsection 20, the Facility reports compliance by referring individuals with diagnosed seizure

	disorder but being seizure free for five years, to a neurologist for consideration to wean off AEDs. The monitoring team confirmed this. Section L1, subsection 21, the Facility reports compliance by ensuring that medication reductions are implemented slowly and monitored closely. At the time of the review the monitor team was unable to confirm this provision. Section L1, subsection 22, the Facility indicates compliance with the PST consideration of of human rights issues for individuals taking AEMs and experiencing significant side effects. Although there may have been initial review, the monitoring team did not find ongoing PST consideration of the risks and benefits of AEM prescribing. Risk and benefit review is a requirement for the "informed" component of informed consent. Section L1, subsection 25, the Facility states compliance by ensuring that a pre-transfer diagnosis prior to transfer to a hospital. The monitoring team could not confirm that all necessary transfer information was consistently sent to the hospital and/or emergency room because the information was not consistently documented in the Integrated Progress Notes. Section L1, subsection 34, the Facility indicates compliance by ensuring that there is documentation in the integrated progress notes that the physician was notified timely upon the individuals return to the Facility. The monitoring team could not confirm that all necessary transfer information was consistently sent to the hospital and/or emergency room because the information was not consistently documented in the Integrated Progress Notes. Section L1, subsection 36, the Facility indicates compliance with regards to following up on individuals returning to the Facility following a hospital admission. The monitoring team could not confirm that all necessary transfer information was consistently sent to the hospital and/or emergency room because the information was not consistently documented in the Integrated Progress Notes. Section L1, subsection 39, the Facility states compliance by considering the need for a CBC, following a surgical procedure. The monitoring team could not confirm that all necessary transfer information was consistently sent to the hospital and/or emergency room because the information was not consistently documented in the Integrated Progress Notes. Section L1, subsection 40, the Facility indicates compliance by ensuring that the PCP summarizes the hospitalization of an individual in the integrated progress note within 72 hours of return from the hospital. The monitoring team concurs that an progress note is written within 72 hours following return of an individual from a hospitalization, however, the notes are less then adequate and do not provide a comprehensive overview of the hospitalization. Many important diagnostics that were completed at the hospital were not reflected within the progress note. This has serious implications for individuals served.

	by the Facility. Section L1, subsection 41, the Facility indicates compliance by ensuring that 100% of individuals reviewed had physician orders which were carried out. Of the clinical records reviewed, physician orders where review and signed off as initiated by nursing staff. Section L1, subsection 47, the Facility states compliance by ensuring appropriate discharge communication was carried out for those discharged to the community. The monitoring team did not confirm this. For one individual, documentation of the need for a specific essential examination was not found in the the CLDP table of support needs which did not mention the need for medical follow-up for a health condition (although it was listed as a diagnosis in the medical information on the CLDP, and the need for monitoring on a periodic basis was identified in the Medication History and under Special Medical Needs). The community provider did arrange the medical follow-up, which was verified by a report from a physician; it is unclear how this was communicated to the provider.
	Summary of Monitor's Assessment: **For Provision L1,** Based on the monitor team's review of Provision L1, the Facility is not in compliance. The Facility must enhance its ability to provide more meaningful clinical follow-up on health care issues, assess the underlying causes of medical conditions, better understand common and serious co-morbid medical conditions that occur more frequently in individuals with developmental disabilities and more closely monitor individuals for functional decline and progression of medical conditions. It is evident that there is no meaningful team process involved and important clinical information is not adequately communicated in the personal support plan. Some individuals are on significant polypharmacy for seizure control; however, the PSP and addendum to the PSP did not show that this issue was addressed. Laboratory data, such as abnormal sodium levels and anemia, were not consistently addressed, drug-drug interaction, such as the significance of Lamictal and Depakote, and other interactions were not addressed in the record. **For Provision L2,** Provision L2 is determined to be not in compliance. The Facility has yet to develop a mechanism that enables a peer review process that includes non-Facility physician case review. **For Provision L3,** Provision L3 is determined to be not in compliance. The Facility continues to work on developing a mechanism that will ensure that a data driven quality enhancement program is developed within the next six months, and the Facility has dedicated specific staff to accomplish its development and implementation. **For Provision L4,** Following a comprehensive evaluation of clinical practice at the Facility, it is determined that the Facility is not in compliance with Provision L4. Physicians and other health care professionals must enhance their understanding of medical conditions as they related to people with developmental disabilities.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	To assess compliance of acute, routine, preventive health care, and seizure management, the monitoring team observed individuals at their homes and place of vocation. Based on clinical findings, 25 individuals (#4, #5, #15 ,#16, #31, #33, #35, #47, #51, #58, #61, #66, #76, #77, #80, #86, #97, #107, #116, #118, #126, #139, #140, #143) were selected for continued observation throughout the review process. Following a comprehensive review of the provision of medical care at the Facility, the monitor team determined that the Facility is not compliant with section L1. Issues including continuity of care, integration of health care matters into the team process, follow-up on acute and chronic health care conditions, failure to fully assess and determine the etiology of medical conditions, assessment and long-term monitoring of common conditions affecting people with disabilities, have been identified as rate limiting issues at the Facility. The following examples outline specific issues and concerns as delineated. Of particular issue was individual #19, who was observed at the vocational program and home. At the vocational program, the individual was observed sitting in her wheel chair with her head flexed to her chest, seat belt in place and a gait belt positioned around her chest, compressing her breast. Multiple staff, including Rose Basan, PT, and Dr. Devera, were asked specifically about individual #19s physical abilities, and it was apparent by the review that historically this individual could and would walk independent of staff and other support mechanisms. Over the years the individual has regressed functionally to the point of being mostly limited to a wheel chair and requiring significant physical support to stand and ambulate, even for a few steps. At the living area, Dr. Devera performed a physical exam of the individual's extremities, included deep tendon reflexes. The individual was noted to have significant spasticity, clonus, exaggerated reflexes and marked Babinsky reflex. The physical therapist, direct care staff, and Dr. Devera all concurred that the individual could not walk for any distance, without significant physical assistance to actually hold her up. The annual physical exam from 2009 documents her ability to walk with assist from the living room to the hallway and then her room. The exam documented in the annual exam of 2009 also documents a fairly normal neurological exam of the extremities stating, symmetrical DTRs, no clonus or Babinsky and the "coordination is intact"; however, the report documents ataxia and "the spine is impaired." A comprehensive review of all available clinical records was completed, which delineated several other health care concerns. 1. In a neurology report dated February 25, 2009, the diagnosis of advanced Cerebral Palsy with gait and cognitive dysfunction was indicated; however, in	NC

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		the current record, there is no diagnosis that indicates a neuromotor or musculoskeletal condition. 2. The individual's physical regression was not noted in the clinical record, nor was there a comprehensive physical therapy assessment that delineated the physical decline found in the records. Importantly, specific maintenance therapies were not provided for her neuromotor condition. Staff, in general, were unaware of her condition and related much of her behavior issues to unwillingness to participate in activities, when it is evident by observation that the individual has physical challenges, and behavior manifestations that most probable result secondary to physical discomfort – this finding was corroborated by Dr. Devera and Rose Bazan, Physiotherapist. 3. There is no evidence within the clinical record or acknowledgment by relevant professional staff, that routine diagnostics or consultations had been provided to assess and monitor for functional decline, as a component chronic care management. 4. A recent imaging study of the chest, dated July 7, 2010, commented on degenerative spine disease of the cervical spine. Degenerative spine disease could manifest in the gradual deterioration of the individual's condition and cause significant pain and discomfort. 5. Importantly, many potential medical conditions were identified within the body of various imaging reports that were not addressed within the clinical record or recognized by relevant staff. Examples of such issues include: a. In addition to bilateral pneumonia, which was diagnosed on a chest x-ray of July 7, 2010, chronic obstructive pulmonary disease was also suggested. b. A CT scan of the chest was attempted on July 20, 2010, to help differentiate an unusual lesion noted on a previous x-ray that was suspicious for possible tuberculosis or another less ominous but serious condition. The CT was unsuccessful because of movement artifact. No further follow-up was obtained, nor was the facility aware of the potential infection control issue. c. To evaluate for recurrent urinary tract infections, a CT of the abdomen	

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		and pelvis, without contrast, was obtained on December 31, 2009. Results indicated marked stool throughout the small and large bowel, bibasilar scaring or atelectasis of the lungs, bladder wall thickening and distention of the bladder. The clinical record was void of any comments, orders or evidence of further work-up for any of the findings. Of particular concern is bladder wall thickening and distention of the bladder, which could indicate a condition known as neurogenic bladder, or other more serious condition. Also, the amount of stool noted in the bowel is significant and warrants assertive management, including close monitoring for potential bowel impaction and obstruction. d. An EKG was obtained in 2007 that indicated "Q waves" in the inferior leads and possible myocardial infarct. A second EKG was obtained in 2010 that was suggestive of a possible "old myocardial infarct". " The quality of the diagnostics was good. The clinical record was without any comment or follow-up to this potentially serious issue. 6. Review of all documents related to the individual's personal support plan indicates a lack of understanding of the individual's health care needs by the personal support team. No relevant health care information was delineated or commented upon, within the personal support plan. The team did, however, discuss behavioral issue when the individual struggles with staff and resists assistance during ambulation and transfers, but they did not entertain potential causes of the individual's resistance, such as pain and discomfort. It is apparent by review of the personal support plans and addendum support plans that health care issues are not routinely or efficaciously addressed within a the context of a team approach. To further explore the management of acute, chronic and preventative health care issues, Individual #118 was observed at home and noted to be using a wheel chair and assigned a one-to-one staff person for supervision and support. The individual was recently discharged from the hospital after a surgical procedure to treat an intestinal volvulus. A CT of the abdomen and pelvis was obtained upon admission to the hospital and noted significant fecal impaction and possible pneumotosis of the intestine. Additional findings of the CT scan included fluid in the inguinal canal or bilateral undescended testicle, pneumonia, and cholelithiasis of the left kidney. The clinical record was without comment on the nature of any of these conditions, nor was there meaningful follow-up noted in the post hospital review or by the team process.	

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		Additional findings were noted in the clinical record that were not entertained in the overall management of care, nor addressed by the team process: 1. Radiology report that demonstrated old, healed fractures of the ribs. 2. Chronic hyponatremia that was not addressed by the physician. Nursing services did, however, provide an in-service about hyponatremia, and the person was placed on a fluid restriction. This condition may be caused by medications and the decision whether to continue the medication versus treat the hyponatremia should be well explored and documented. 3. The individual had a mild anemia, with a subtle macrocytosis (MCV 100.1). The anemia was commented upon by the physician but the etiology, especially with a macrocytosis component should be sought. 4. Dental records indicated poor oral hygiene and the individual was prescribed an oral antiseptic daily; however, this important issue was not incorporated into the PSP and direct care staff were unaware of the condition. 5. Following a dental exam on February 14, 2010, a white plaque lesion with irregular borders was identified, and the Dentist referred the individual to an oral surgeon. The referral was evaluated by the team, which noted that the individual would require anesthesia and consent was necessary. The team was unaware of the actual reason for the referral and documented in the PSP addendum that the need for consent was to treat dental caries. No further action steps were taken, and as of this review, the individual had not been seen by the oral surgeon. When interviewed, Dr. Devera acknowledged the lesion but indicated that she had examined the individuals tongue and the lesion had resolved. At a minimum, this important condition should be well documented in the clinical record and reviewed by the team process. 6. There was inconsistency within the clinical record regarding urinary continence. The personal support plan and some documentation by the physician indicated "incontinence"; however, the nursing assessment of August 18, 2010, indicated that the individual is "continent." Continence is an important clinical issue that needs to be evaluated and well appreciated by direct care staff. Upon review of the personal support plan of July 27, 2010, several inconsistencies were noted. The individual has sustained multiple fractures in the past (multiple ribs, left hip, left humerus), has an abnormal gait, severe tonic clonic seizures, and ataxia. Despite	

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		known medical risk factors and being prescribed sedating medications, the individual was determined to be at low risk of injury. The individual was identified as being low risk for osteoporosis; however, the individual has many conditions that predispose to osteoporosis including, limited ambulation, history of multiple fractures, and noted "osteopenia" on an x-ray. The team also gauged the individual as being low risk for constipation, however, the individual is prescribed multiple medication, leads a sedentary life style, and has apparent neuromotor disease, which can all contribute to constipation. Post hospital follow-up was not adequately attended. Following re-admission to the facility, secondary to a serious bowel condition, the personal support addendum dated August 26, 2010 documented the need to monitor for bowel movements, monitor for fever and vomiting and indicated specific measures for staff to monitor (fever, vomiting, breathing problems, and to encourage liquids). The recommendations did not comment on the importance of monitoring for pain and discomfort nor specifically to monitor for bowel movements. The addendum did not review the condition, possible predisposing causes of the condition, and long-term prognosis. Importantly, when direct care staff were observed and interviewed about the individual, they were unaware of what signs and symptoms to monitor for. Nursing staff were very knowledgeable of the individual's condition; however, they did not have appropriate tools to effectively and efficiently monitor the individual. According to nursing staff interviewed, there were no mechanisms to effectively monitor vital signs, such as temperature graphs, nor efficient mechanisms to monitor bowel or bladder function, such as a log to monitor for an acute condition. The electronic documentation system, CWS, was reported to be ineffective. The review team assessed the CWS and noted it to be cumbersome to use and to make access to information needed for decision-making difficult in its current form. Users of the system must actually go through each and every daily entry to retrieve necessary clinical information. For example, the review team asked to see the documented temperatures of the individual since discharge from the hospital. In order to obtain this information, the nurse had to access each and every entry since the person was discharged from the hospital. Other very important clinical information was not captured within the CWS documentation system, including bowel and bladder tracking, pain assessment, ability to search for specific clinical information was not possible. Review of a "fall assessment" completed on July 27, 2010, was noted to be significantly inaccurate and detrimental to the individual. The following issues were identified and discussed by the review team with administrative leadership: 1. Decision making and problem solving was deemed to be "no problem. " The	

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		individual has a diagnosis of severe mental retardation and is not able to make complex decision about health and welfare. 2. No musculoskeletal conditions were identified; however, the person is known to have had multiple fractures, has paraparesis (per a neurology report), and has had a hip arthrosis. 3. Although the assessment indicated no orthostatic hypotension, there was no evidence that orthostatic blood pressures have been obtained. 4. The assessment reported no balance issues; however, there was a known diagnosis of ataxia. 5. No medication issues associated with falling were noted; however, the individual was prescribed medication that can cause unsteady gait and imbalance, including antiepileptics and benzodiazapines (both of these medications were actually checked on the fall risk assessment as not being prescribed when, in fact, review of the medication administration record indicated that these medications had been and continued to be prescribed. 6. The assessment stated that there had been no complications from falls; however, the individual was known to have experienced several fractures secondary to falls. Individual #140 was observed at the living area and noted to have a very unsteady gait and required the use of an ankle-foot orthotic (AFO); however, the AFO was not in place. When staff assisted the individual with the device, it was evident that the brace had resulted in mild abrasion of the skin, which was complicated by psoriasis. Also noted were two subtle bruises over the right and left arms, which were not documented, nor was an injury report completed. The review team reported the bruises to administration. No suspicion of abuse was determined by the review team, based on the location and appearance of the bruises. This particular individual highlighted the need for enhanced monitoring of chronic and acute health care conditions. Individual #139 was observed at home, lying on a sofa and in a fetal position rocking back and forth, while engaged in self stimulating behavior. A direct care staff providing support for the individual was unaware of the individual's support needs and was unable to retrieve such information in a meaningful way. Such information was contained in the individuals "me" book, which was not readily available, even after a fifteen-minute	

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		search. The records of five individuals were reviewed to assess seizure management (#116, #118, #61, #107, #86). Based on the documents reviewed, it was apparent that an accurate diagnosis for seizure disorder was documented well, within the clinical record. It was most apparent that a neurologist was actively involved in the management of seizure disorder. The neurology consultant's reports provided excellent documentation of the consultants understanding of the individual's seizure disorder, provided a focus physical assessment, and gave clear recommendations. The monitoring team noticed, however, discrepancies within the seizure records and logs. Information entered into the CWS did not always corroborate the number of seizures noted on the written seizure record/log. Recommendations made by the neurologist were not consistently incorporated into the clinical management of the individual. The seizure review form was not consistently completed. Monitoring labs were consistently obtained; however, abnormal results, especially hyponatremia, were not consistently addressed in the clinical record. A more complete review of seizure issues was not possible because requested data, including quarterly drug reviews, were not provided. With regard to seizure management, overall, the Facility continued to make strong advancement in practice areas. Subtle enhancement will bring overall care into significant compliance. Two individuals have had enteral feeding tubes surgically inserted. The review team conducted a comprehensive review of Individual #47. Review of the clinical record indicated that this individual was known to have dysphagia for many years. A swallowing assessment completed on November 11, 2009 documented oral and pharyngeal abnormalities and the need for PEG placement; however, further in the report, under the comment section, the clinician documented that the person had been tolerating his diet and honey thickened liquids for 12 years and suggested that a PEG placement may not be necessary in this particular case. A barium swallow study was completed on April 24, 1997, which documented abnormal findings suggestive of dysphagia. By review of the record and discussion with Dr. Devera, a PEG was inserted following the November, 2009, swallowing study. It was apparent following discussion with Dr. Devera and from review of the clinical record, that a comprehensive evaluation as to the etiology of the individual dysphagia was never entertained by the clinical staff, nor the team. Questions such as "why now, " "is the dysphagia worsening and if so, "why," and "what alternative treatments may be beneficial" should have been discussed and documented. Consultation with specialists, such as experts in movement disorders, gastroenterology and ENT, were not obtained. Clinicians and the PST did not comprehensively follow-up on this condition for many years, despite the issue of	

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		dysphagia being noted in the clinical record. At the time of this review, the review team did not assess competency of clinical staff's ability to monitor for residuals, PEG placement, and positioning issues. Specific to the management of musculoskeletal and neuromotor conditions at the facility, based on review of physical therapy assessments, observational assessment of individuals at the their homes and vocational program, interview with clinical leadership and with the Facility's part-time physical therapist, Rose Bazan, mechanisms in place were inadequate to diagnose, treat, and provide routine maintenance therapy and monitoring for progression of neuromotor and musculoskeletal conditions, including but not limited to, secondary complications of cerebral palsy, degenerative conditions such as arthritis and degenerative spine disease, congenital conditions of the skeletal system and fractures. This is a critical issue that must be addressed promptly. The current use of technology at the center indicated the need for a comprehensive review. Appropriate technology is paramount to providing quality health care services. The review team had opportunities to evaluate the use of glucometers, tympanic thermometers and the Facility's computer based documentation system (CWS). Currently, each living area used a single "home" style glucometer to determine glucose levels of persons with glucose intolerance. This devise required daily calibration by nursing staff. Manual calibration and accuracy of results at either the higher or lower ends of calibration may be areas of concern. The use of tympanic thermometers at the Facility should be reviewed. Tympanic thermometers generally require exposure of the individual's tympanic membrane. Some individuals with intellectual and other disabilities have anatomical variances of their external auditory canal, and, or experience frequent cerumen impaction, both of which may alter the results obtained by tympanic thermometers. A combination of other methods for monitoring temperature for both routine and especially acute monitoring purposes should be evaluated. Electronic health care records (EHR) are of increasing importance for all health care facilities and providers. Electronic health care records enable efficient and effective collection of important health care data, especially when there are enormous amounts of critical information to be analyzed. The current system used to collect clinical data (CWS), is not certified by the Certifying Commission for Health Information Technology (CCHIT), and is not appropriately designed to collect important clinical information, enable data analysis or allow for efficient access to information. The CWS system did not allow for an on-going record of all users who access the system over time (each and every entry). Nursing staff, physicians, pharmacist and clinical leadership at the Facility	

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		all shared significant concerns over the functionality of the CWS system, elaborating on its inefficiency and hindrance to the delivery of clinical care. The Facility must be acknowledged for its attempt at developing a electronic health care record, and progress must be continued to ensure that an efficient and efficacious EHR system is eventually realized. During the review, every medical component of the active record reviewed was noted to be in excellent condition and order. Importantly, the record department was efficient and promptly able to retrieve requested clinical documents. RGSC had not conducted Mock Emergency Medical Drills since November 2009. The Facility was not aware of the omission until monitoring team requested completed Mock Medical Emergency Drill Sheets for the past three months. Facility staff were not sure of the reason for the omission. They stated the omission was due to the resignation of the staff who conducted the drills and that no other staff had been assigned to perform the drills. On the morning of August 25, 2010, this issue was discussed with Jamie Flores, MR Program Director who immediately assigned the Vocational Services Assistant the responsibility for conducting Mock Medical Emergency Drills. Subsequently, Mock Medical Emergency Drills were initiated on August 25, 2010 at 11:00 a.m. and conducted on all shifts in El Paisano and La Paloma as well as on the day shift in Vocational Services area. All drills were completed by 4:33 a.m. on August 26, 2010. Review of the completed drills sheets indicated: Mock Medical Emergency Drills conducted on all three shifts in El Paisano were considered passed. Mock Medical Emergency Drills conducted on all three shifts in La Paloma revealed the day shift failed the first drill; the drill was repeated and was considered passed. The evening and night shift drills were considered passed. The Mock Medical Emergency Drill conducted in the Vocational Services area failed to pass; the drill was repeated and considered passed. The Facility was operating on the old Emergency Drill Procedure. The monitoring team requested an impromptu Mock Medical Emergency Drill in El Paisano at 1:29 p.m. (at shift change), August 26, 2010. The drill was conducted and failed to pass. Actions failed by the staff included: Failure to simulate a 911 call, the nurse did not know how to use the AED, cycles of chest compressions and breaths were not performed correctly, the first person discovering the manikin did not call out for help, several staff in the area did not immediately respond to the scene, rather they continued to engage in personal conversations ignoring the drill, emergency equipment such as the oxygen tank, ambu bag, one-way mask, suction machine, and AED were not brought to the scene immediately. After prompting the AED was brought to the scene but the nurse had to be instructed how to open and use. The AED pads expired August 10, 2010. After the failed drill the Vocational Services Assistant	

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		Director immediately retrained all staff present at the drill, as was evident from review of the Mock Drill – CPR Training Sign-in sheet. The drill was successfully repeated at 1:58 p.m., August 26, 2010. This exercise demonstrated the necessity for the Facility to ensure that Mock Medical Drills are conducted as defined in the Medical Emergency Response Policy using the revised Medical Emergency Drill Checklist. The Facility needs to integrate into their policies the revised state Medical Emergency Response Policy without delay and ensure that all required staff are trained on the policy. The Facility needs to ensure quarterly trend analysis reports are prepared, and corrective actions are completed, and information is shared with the State Office Quality Enhancement Coordinator according to policy. The Facility received the revised Medical Emergency Response Policy and Mock Medical Emergency Drill Sheet from the State Office on July 23, 2010. This policy had not been implemented due to pending integration into facility policy. Review of the RGSC Training Due/Delinquent List, printed August 2, 2010, indicated that one staff was due August 25, 2010 for Basic Life Support for Health Care Providers - Cardiopulmonary Resuscitation CPR and Automated External Defibrillator (AED) and CPR: Basic. No additional information was available by the end of the tour, August 27, 2010, to confirm or deny that such training occurred. The Nursing Department needs to ensure that when AEDs are checked that the expiration dates of the AED pads are also checked and replaced by the expiration date. The Facility needs to continue to ensure that all required staff are trained on the revised Medical Emergency Response Policy and are up to date on Basic CPR and/or Basic Life Support for Health Care Providers (CPR/AED) training. Review of the AED Daily Checklists and Daily Checklists indicated they were checked daily for the period reviewed. These separate checklists did not include checking all of the required emergency equipment, e.g., suction machines. The Facility had one suction machine for the two living units. The Nursing Department needs to have another suction machine available so that each living unit has ready access to suction machines when needed. The Nursing Department needs to consolidate all emergency equipment items onto one checklist. Additionally, a procedure for checking emergency equipment needs to be developed and implemented, All nurses responsible for checking emergency equipment should be trained on the procedure. The procedure also needs to include a routine monitoring requirement by the Nurse Manager or designee to ensure that all emergency equipment are checked. When the monitoring team checked the location of emergency equipment in El Paisano and La Paloma it had not been aggregated into one common location for ready access as	

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		was recommended at the baseline tour. When inquiries were made regarding the procurement of the recommended portable emergency bags, the Chief Nurse Executive stated that the bags had been ordered in May, 2010. Until asked about the status of the order it was apparent that Nursing Department had failed to follow-up on the status of the order. The monitoring team requested the status of the order. It was discovered that the bags had been received but it took some effort to locate where the bags were delivered. When the bags were finally located they had been delivered to Vocational Services but no one had notified the Nursing Department. When the Nursing Department located the bags they discovered the wrong style bags had been ordered. A new purchase order was submitted to the Purchasing Department for the correct style bags. When ordering medical equipment and supplies the Nursing Department needs to assign the responsibility and accountability of tracking orders through to receipt to a designated staff within the Nursing Department. Since the baseline review the Facility had procured portable oxygen tanks for the El Paisano and La Paloma. Review of the nursing training records indicated that the nursing staff had been competency-based trained on the use of the oxygen tanks. The Facility had also ordered and procured most of the recommended professional grade medical equipment. Welch Allyn portable blood pressure and pulse oximeter stands were available in the treatment and medication rooms in El Paisano and La Paloma. Delecto chair scales were available in El Paisano and La Paloma. The monitoring team tested one of the chair scales. The scale did not work because the 9-volt battery that powered the scales was dead. Nursing staff were unaware of the dead battery. The Nursing Department needs to require nursing staff to routinely check all battery operated medical equipment to ensure they are operational and batteries are replaced when indicated. The Facility needs to consider purchasing rechargeable batteries for such use.	
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.	The review team met for an extended period with Dr. Moron to learn of current peer review practices at the Facility. At present, there was a mechanism for peer review; however, an "external" process involving on-Facility physician case review was not in place at this time. Dr. Moron is actively addressing this issue and raised concerns about challenges attempting to identify professional resources with expertise in developmental medicine that could support the facility. The use of a robust Telehealth network was raised as a possible solution.	NC

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L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	During discussion with Yolanda Gonzales, RN, Chief Nurse Executive, Marcy Valdez, RN, Nurse Manger and Jessica Juarez, RN, Quality Assurance Nurse, the monitoring team understood that processes to better collect and analyze data are being developed at the center. The Facility had recently hired an additional staff person, Mary Matabalan, who will specifically address hospitalization-related issues. The Facility is diligently addressing data base issues and identifying solutions and means to create meaningful data base solutions to address quality assurance assessments. The Facility is critically assessing current database systems, including the main clinical documentation database, CWS, and the WORx pharmacy system. It was evident to the monitoring team that the Facility is invested and actively moving towards enhancement in this area.	NC
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility did not yet have all policies updated but, in collaboration with DADS central office, continues to review and enhance policies and procedures to ensure provision of medical care is consistent with current and acceptable professional standards of care. This is a lengthy process and the work completed to date was commendable. Dr. Moron cited several examples of collaborative efforts with DADS including regular telephone conferences with central office and clinical director meetings. This provision will continue to be monitored in subsequent reviews.	NC

Recommendations:

1. The facility must enhance management issues related to acute, chronic and preventative health care issues.
2. Incorporating health care management into a comprehensive and efficient team process, enabling all members of the team to at least annually meet and meaningfully discuss the health care needs of the individual, is essential to providing quality care. Members of the PSTmust be well prepared for the annual PSP meeting. All practitioners must have reviewed and completed necessary assessment and physical examination, prior to the meeting. Direct care staff and administrators must ask relevant questions and provide meaningful information to practitioners. Practitioners must provide the team with accurate diagnosis, differential diagnosis, review of diagnostics and consultations, medication assessment and specific ways to monitor and report relevant health care issues. All members of the team should be actively engaged during the team meeting. Questions such as why a medical condition occurred, how can it be treated, what long-term monitoring and reporting practices should be in-place, are necessary consultations or second opinions entertained, is the diagnosis accurate, are all abnormal diagnostics and consult recommendations appropriately

addressed, are medications reviewed for necessity, and potential side-effects are some of the important issues that should be reviewed during the annual team meeting. The personal support plan must be comprehensive with regards to health care concerns.

3. The use of technology should be reviewed, ensuring that the most appropriate technology is employed at the center. Specific to tympanic temperatures, accuracy must be assessed. Some individuals could participate with oral temperatures, which may be more accurate. In the case of acute illness, accurate and frequent body temperature is critical in monitoring the wellbeing of the individual served. In such cases, rectal temperatures may need to be considered. The facility should consider the use of professional point-of-care glucometers, which auto calibrate and enable nursing staff to enter a personal access code. Such devices can provide health care professionals with long-term data for management of glucose intolerance and their accuracy may be more consistent, especially at higher and lower range of glucose monitoring. An electronic health care record (EHR) is essential in modern day clinical application, especially in intermediate and long-term care settings. When considering and EHR, it is essential to consider the "primary care applications" necessary to provide health care services to individuals served. Unlike at acute and behavioral health hospitals, individuals who reside in facilities that support people with intellectual disabilities have many co-morbid and serious chronic medical conditions and are served for long periods of time. It is critical that any EHR used, should well support primary care issues. Many "high-quality", modern, and certified EHRs will allow incorporation of other databases and behavioral health care templates. Ensuring full HIPAA compliance, robust primary care application, HL7 data sharing, user development of templates, long-term secure data storage, and a mechanism to monitor all users (user footprint) for each and every time the user accesses the system and specifically what was attended, are critical factors when implementing an EHR. When choosing an EHR, the facility should consider the cost-benefit of developing its own system versus purchasing a known, certified product that can cost effectively meet the Facility's needs. In addition to an EHR, the Facility will need many databases to address quality assurance and many other applications. When developing a database, the facility must think comprehensively and not develop individual databases for a specific application. Instead, the Facility should consider its comprehensive needs and consider developing a mechanism to incorporate one database for multiple applications. Perhaps working with other Facilities, or through the Central Office, will better allow for necessary professional and technical resources to be obtained to develop a comprehensive, functional system that meets the needs of all Facilities and Central Office and can help to assure high quality services and supports for individuals served at RGSC.
4. Physical therapy and related assessment must be enhanced. Robust assessment process for individuals with acute and chronic health care issues must be adopted at the Facility, and all persons residing at the Facility should receive regular screening for function decline. On-going therapy for acute and chronic conditions must be developed and incorporated into the overall health care plan of the many individuals with musculoskeletal and neuromotor conditions. A consultation base with orthopedists, neurologists and physiatrist should be developed. Other treatment options such as surgery and baclofen pumps should be at least considered in the overall management of persons with serious neuromotor and musculoskeletal conditions. Direct support staff should be trained better in the transfer and transport of persons with advanced disease and the use of hydraulic lifts should supersede two and three person transfers. Any individual with signs or symptoms of worsening condition, must be re-evaluated by clinical experts.
5. It is essential that when a new clinical condition arises, such as the need for long-term therapy or treatment (e.g., enteral tube placement) or serious acute condition (such as the findings of an acute myocardial infarct on an EKG), a comprehensive review and evaluation should be performed with the appropriate diagnostics and consults to ensure accuracy of the diagnosis and treatment. Questions such as why did this occur; what can be done to prevent this from happening; what is the underlying cause; what types of supports will be needed long-term; what is the prognosis; and what consultants, diagnostics and second opinions should be sought should all be routinely entertained following the development of a new acute or chronic condition.
6. When addressing corrective measures and enhancements of clinical services, focus should be first and foremost on the individual. The QA process should be enhanced to ensure that conducting routine and comprehensive chart reviews and obtaining periodic second opinions to assess the completeness and accuracy of the physical assessments, diagnosis and treatment approach are done. This approach will more accurately enable

leadership to better understand the end result of the enhancement process.

7. To better help understand the more serious and common conditions associated with many individuals who have intellectual disabilities, it may be advantageous for the State system to develop core groups of professionals, that could address specific issues, such as aspiration/pneumonia; swallowing disorders, neuromotor and musculoskeletal issues; seizure disorder; bowel and bladder related issues.
8. Dysphagia and the risk of choking and aspiration must be assertively managed at the Facility. Physicians, nurses and direct care professionals must be provided regular competency based training on the many issues associated with dysphagia. Importantly, all individuals should be assessed regularly for dysphagia, aspiration, and choking. When an individual is suspected or diagnosed with dysphagia, aspiration or choking, a comprehensive evaluation should be obtained that includes more than a swallowing study. Evaluations to determine the etiology of the problem must be performed and may require the assistance by various consultants, such as a movement specialist or ENT, additional diagnostics, and comprehensive review by the team process. Issues such as a new neurologic insult, or medication effect. Refer to recommendations in Section O for additional detail.
9. Individuals with either imminent end-of-life conditions, or other conditions that would result in excruciating pain, permanent injury, or death if reanimation attempts were made, should be considered for partial or no-code following a life threatening event, such as if the individual's heart or breathing stops. This should only be considered after an extensive review of the individual's health care issues, which should be corroborated by a licensed physician external to the Facility and State and after consideration by the team process, which includes the individual and the legally responsible person, and in compliance with State laws and regulations.
10. With regard to peer-review, it is essential that a non-biased, professional, peer-review process be developed to assess clinical operations and physician performance at the Facility. With regard to professional performance of a clinician, peer-review must be of like professionals. In other words, physicians must assess physicians, and like-wise for other clinical professionals at the Facility. A non-physician administrator can assess the performance of the physician in terms of adherence to Facility policies and procedures. Identifying professional resources is challenging; by incorporating the use of teleheath technology, in the context of a comprehensive peer review process, the Facility maybe more apt to identify external professionals to perform peer-review activities. In such a situation, the external professional could visit the Facility on an annual basis and follow-up or perform specific reviews via telehealth. It is important that when identifying external professional resources, that such professionals have significant insight into clinical issues of adults with developmental disabilities and Facility operations.
11. Facility needs to ensure that Mock Medical Drills are conducted as defined in the Medical Emergency Response Policy using the revised Medical Emergency Drill Checklist.
12. The Facility needs to integrate into their policies the revised state Medical Emergency Response Policy without delay and ensure that all required staff are trained on the policy.
13. The Facility needs to ensure quarterly trend analysis reports are prepared, corrective actions are completed, and information shared with the State Office Quality Enhancement Coordinator according to policy.
14. The Facility needs to ensure that when AEDs are checked that the expiration dates of the AED pads are also checked and replaced by the expiration date.
15. The Facility needs to continue to ensure that all required staff are up to date on Basic CPR and/or Basic Life Support for Health Care Providers (CPR/AED) training.
16. The Facility's Nursing Department needs to have another suction machine available so that each living units as ready access to suction machines when needed.
17. The Facility's Nursing Department needs to consolidate all emergency equipment items onto one checklist. Additionally, a procedure for checking emergency equipment needs to be developed and implemented. All nurses responsible for checking emergency equipment should be trained on the procedure. The procedure also needs to include a routine monitoring requirement by the Nurse Manager or designee to ensure that all emergency

equipment are checked.

18. When ordering medical equipment and supplies the Nursing Department needs to assign the responsibility and accountability of tracking orders through to receipt to a designated staff within the Nursing Department.
19. The Facility's Nursing Department needs to require nursing staff to routinely check all battery operated medical equipment to ensure they are operational and batteries are replaced when indicated. The Facility needs to consider purchasing rechargeable batteries for such use.

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. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. RGSC ICF Nursing Manual, Pending Approval 4. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Guidelines for Comprehensive Nursing Assessment, Date: October 2009 5. RGSC Facility Priority Checklist Annual Competency Evaluation, for Nurses 6. RGSC Physical and Nutritional Management Policy and Procedure, Date Established: December 2003, Date Revised: January 2010 7. RGSC MR Nursing Staffing Analysis 8. RGSC Nurse Operation Officer/Hospital Liaison Job Description 9. RGSC MR Nursing Staff Monthly Meeting Minutes, January 28, 2010, February 25, 2010, March 25, 2010, April 13, 2010, RGSC P & T Sub-Sub-Committee Meeting Minutes, March 17, 2010, May 12, 2010, RGSC Medication Management Committee Meeting Minutes, February 9, 2010,April 8, 2010, May 27, 2010 10. RGSC Nurses' Training Records, January 2010 through June 2010 11. RGSC Registered Nurses Roles and Responsibilities at Various Meetings 12. Texas Department of Aging and Disability Services, State Supported Living Centers Policy Number: 044: Medical Emergency Response, Date: July 21, 2010 – Received State Office Policy July 23, 2010, Pending Integration into Facility Policy 13. RGSC Mock Medical Emergency Drill Sheets, August 25, 2010 through August 26, 2010 14. RGSC Mock Drill CPR Training/Course Sign-in Sheet, August 26, 2010 15. RGSC Daily Oxygen Cylinder Logs, August 1, 2010 through August 22, 2010 16. RGSC Automated External Defibrillator Checklists, January 1, 2010 through August 22, 2010 17. RGSC Training Due/Delinquent for CPR Training – Employee, August 31, 2010 18. RGSC Incident Management Review Team Meeting Minutes, June 29, 2010 through July 20, 2010 19. RGSC Infection Control – Confidential ICP Nurse Educator Individual Client Report (an Excel database to used to collect data for Section I – Risk Indicators): Initial Chart Review FY10 Section I, Trend Analysis Report and Database for SSLC Services 20. RGSC Safety/Risk Management/Infection Control Committee Minutes, January 14, 2010, February 11, 2010, March 11, 2010, April 22, 2010, and May 13, 2010 21. RGSC March and April Infection Report 3rd Quarter 2010 and May, June and July 2010 22. RGSC Environment of Care Manual Surveillance, Prevention and Control of Infection Manual 23. RGSC Infection Control Training Material 24. RGSC Infection Control Monthly Surveillance Checklist (completed), May 5, 2010 through July 16, 2010 25. RGSC Enterprise Course Due/Delinquent List for Infection Control Training, July13, 2010

	26. RGSC Medication Administration Record Audits, April through July, 2010 27. RGSC Quality Assurance Nursing Audits, December 2009 through July 2010 28. RGSC Nursing Audit Performed Using the Settlement Agreement Monitoring Tools, July 5, 2010 29. RGSC Medication Administration Observations, November 11, 2009 through July 28, 2010 30. RGSC PSP Staffing Dates, 2010 31. RGSC Pre-treatment Sedation Report, August 5, 2010 32. RGSC Premedication for Medical and Dental Procedures, Date Established: November 2004, Reviewed January 2010 33. RGSC MediMAR, Training Manual 34. List of Individuals with Seizure Diagnoses Using Maroon Spoons for Medication Administration 35. RGSC Memorandum, August 24, 2010, to all ICF/MR Nursing Staff, From Marcy Valdez, Nurse Manager, Regarding Cleaning Maroon Spoons 36. RGSC Medication Error Reports – draft vs. final, April 2009 through April 2010 37. RGSC Medication Errors Reports, Last 10 Reports 38. RGSC Medication Investigation Report 39. RGSC Health Status Risk List, August 23, 2010 40. RGSC Supplemental Plan of Improvement 41. RGSC Active Record Order and Guidelines 42. RGSC Hospital Visits/Admissions, January, 2010 through July, 2010 43. RGSC Appointment Tracking Sheet, August, 2010 44. RGSC Premedication for Medical and Dental Procedures, Dated Established: November 2004, Reviewed January, 2011 45. RGSC Standard Operating Procedure NR 200-04, Date Established: August 1987, Revised August 20, 2010 46. RGSC Record Reviews for Individuals: #93, #91, #140,#5, #145, #23, #47, #126, #80, #118, #61, #26, #94, #2, #29, #10, #12, #150, and #5 **People Interviewed:** 1. Yolonda Gonzalez, RN Chief Nurse Executive 2. Mary Doris Matablan, RN, Nurse Operation Officer/Hospital Liaison 3. Jessica Juarez, RN, Quality Assurance Nurse 4. Marcy Valdez, RN, Nurse Manager 5. Mary Ramos, Quality Assurance Director 6. Maria Dill, M.D., Medical Director 7. Jaime Flores, MR Program Director 8. Martha Thompson, RN, Infection Preventionist Control Nurse 9. Robin Martin, RN, Infection Control Preventionist/Nurse Educator 10. Anne Ikonmwonba, Pharmacist 11. Erlinda DeVera, M.D. Staff Physician **Meeting Attended/Observations:**

	1. Entrance Meeting, August 23, 2010 2. Medication Management Team Meting, August 25, 2010 3. Medication Administration Observation, La Paloma, August 26, 2010 4. Enteral Feeding Observation, El Paisano, August 26, 2010 5. Positive Behavior Support Team Meeting, August 25, 2010
	Facility Self-Assessment: The Facility stated it is not yet in compliance with any of the provisions of this Section but has implemented a number of actions to lead toward compliance. The Facility reported several actions related to progress in all areas. • Facility stated records reviewed showed they were in compliance with regard to: Demographic information recorded on the Quarterly Nursing Assessments, Quarterly Nursing Assessment completed by a Registered Nurse, Skin Integrity Assessment completed quarterly or when clinically indicated. The monitoring team was able to confirm that Annual and Quarterly Nursing Assessments were completed by a Registered Nurse. The monitoring team could not confirm that demographic information was recorded on all sheets of the Annual and Quarterly Nursing Assessments. Complete demographic information was frequently missing after the first page of the Annual and Quarterly Nursing Assessment sheets; when the addressograph imprint card was not used, only the individuals' first initials and last name were written on the sheets. Some sheets were entirely missing demographic information, or the imprint sheet was improperly stamped, or the ink was so faint it was not possible to read. The monitoring team confirmed that Skin Integrity Assessments using the Braden Scale were consistently completed on Annual and Quarterly Nursing Assessments. The monitoring team could not confirm that Skin Assessment were completed using the Braden Scale when there were changes in skin integrity. • Facility stated records reviewed showed they were following Facility policy and procedure related to restraint use and assessment of individuals' current status and/or changing needs. The monitoring team could not validate that nurses consistently followed the Facility policy and procedure related to restraint use. • Facility noted they were in compliance with regard to: Documentation that the Registered Nurse and Primary Care Physician reviewed the common long term effects of medications, e.g., psychotropic and antiepileptic medications. The monitoring team attended a PBST meeting where individuals' medications were discussed but this did not provide documentation that this activity was consistently completed. • Facility noted they were in compliance with regard to: Assessments of individuals' unique physical/behavioral expressions of pain, nurses promptly reported individuals' signs and symptoms [of acute illnesses and/or injuries] to medical personnel, and nurses and direct care staff provided safety measures to prevent falls or injuries in individuals was receiving sedating opioid analgesics. The monitoring team was unable to confirm due to review of records for individuals who received sedation for dental and medical procedures.

	• Facility noted they were in compliance with regard to: Documentation showing that nursing staff were knowledgeable of signs and symptoms of individuals' onset of complications or lack of therapeutic response and promptly communicate findings the Primary Care Physician and/or other clinical staff for evaluation and treatment, and documentation that the Primary Care Physician responded promptly for care and follow-up. The monitoring team was able to confirm that nurses assessed individual with signs and symptoms of acute illnesses and/or injuries and contacted the promptly contacted the physician. Telephone orders were given but the monitoring team could not confirm that the physician promptly went on site to assess the individuals. • Facility noted they were in compliance with regard to: Sending pre-transfer diagnoses, latest history and physical, profile sheet, and list of current medications with individuals' to hospitals and/or emergency rooms, upon discharge a complete medical and nursing assessments were performed, documentation was in the Integrated Progress Notes that the physician was notified timely upon individuals' return, the physician summarized treatment received during hospitalization and new orders were written as indicated, e.g., medication and treatment changes. The monitoring team could not confirm that all necessary transfer information was consistently sent to the hospital and/or emergency room because the information was not consistently documented in the Integrated Progress Notes. • Facility noted they were in compliance with regard to: Collecting infections and communicable diseases data, data were analyzed for trends, inquires are initiated for undesirable trends, corrective actions were implemented to address undesirable trends, conducted monitoring activities to determine whether remedies to address undesirable trends were achieved consistent with generally accepted professional standards, data generated from the Infection Control Department was included in the Facility's overall Quality Assurance data, documentation that nursing staff participated in the Infection Control Program, records showed that competency-base training for Infection Control issues was included in new employee orientation and as needed, there was a system in place that monitors to ensure Infection Control practices were used at the unit level, and Infection Control policies, procedures, and protocols were in alignment with standards of practice and Centers for Disease Control guidelines. • Facility noted they were in compliance with regard to: Records showed that all medical orders comply with Pharmacy and Therapeutics Guidelines, including Appendix A of the Healthcare Guidelines, and use of approved abbreviations. Records reviewed showed that the Primary Care Physician orders clearly stated the exact parameters for monitoring and what changes should be brought to the attention of the physician. Records reviewed showed that any incomplete or unclear orders were referred back to the ordering Primary Care Physician for clarification. • Facility noted they were in compliance with regard to: Records reviewed showed that medication errors were promptly identified and reported according the Facility Medication Error Policy and Procedures. Records reviewed showed that a system was in place to ensure that trends were identified and appropriate corrective actions were taken. Review of records showed that in the Integrated Progress Notes by the nursing staff the Primary Care Physician's orders were followed and the

	individual closely monitored. Records reviewed showed that corrective action and follow-up was taken and/or incident report form was completed indicating the severity and frequency of the medication error. Records reviewed showed that the Narcotic Logs were appropriately signed indicating that the narcotic counts were correct as counted by the on-coming shift and off-going shift medication nurses. Team member could not confirm this action step because review of the last 10 Medications Error Reports made available for review did not include the date and time errors were committed or reported. • Facility noted they were in compliance with regard to: Medication Administration Observations the nursing staff followed correct practices for administering medications according to Facility Medication Administration Policy and Procedures, appropriately implements any self-administration of medications programs, and/or records reviewed and/or observations completed showed that if a medication errors were made a Medical Error Reports were initiated. Team member could not confirm this item because the Facility policy had not been updated. The Medication Administration Observation Form associated with the Medication Administration Policy did not contain all the necessary items to accurately monitor medications. • Facility noted they were in compliance with regard to: Records reviewed and/or observations made showed that the followed correct Medication Administration Policy and procedures for administering medications via G-tube. Records reviewed and/or observations showed that nursing staff instructed the direct care staff on maintaining the individual in an upright position for 45 minutes or as ordered. Records reviewed and/or observations showed that the nursing could describe signs and symptoms of aspiration. Team member could not confirm this action step as proper procedure was not followed for administering enteral feeding in the individual observed. • Facility noted they were in compliance with regard to: Records reviewed showed that individual's response to STAT medications was noted in the Integrated Progress Notes and/or similar documentation tool. Team member cannot confirm this action step because there was no STAT medication ordered in the records reviewed. • Facility noted they were in compliance with regard to: Records reviewed showed that there was a nursing procedure for administration of medications in accordance with current, generally accepted professional standards of care. The State Office was developing policies and procedures governing nursing service, including administration of medication. Team member could not confirm this item because the Facility policy had not been updated. The Medication Administration Observation Form associated with the Medication Administration Policy did not contain all the necessary items to accurately monitor medications. The Facility reported, and the monitoring team confirmed, Annual and Quarterly Nursing Assessment were completed by Registered Nurses. Skin Integrity Assessments using the Braden Scale were completed quarterly. Nurses promptly reported sign and symptoms of acute illnesses and injuries and to the physician. Nurses promptly notified the physician when individual return from the emergency room and/or hospital. All new employees received competency-based Infection Control training during

	orientation and were retrained annually, including Standard Precautions. The Facility reported they had adopted the Health Care Protocols: for DD Nurses to assist with developing care plans a nationally recognized protocol. This was a positive step forward in meeting Provisions Section M.3.
	Summary of Monitor's Assessment: At this review none of the Provisions were found in compliance. There were elements of progress found in all of the Provisions. A finding of progress does not imply that compliance was met. Furthermore, many newly implemented procedures were too new to demonstrate compliance. Since the baseline review the Nursing Department had made numerous improvements to move forward toward compliance with the Settlement Agreement. According to the Facility's Supplemental Plan of Improvement (POI) many of the improvements grew out of the recommendations made by the monitoring team during the baseline review. The Facility's Nursing Department now had nursing coverage on the 10-6 shift. Two management level nurses had been hired, one as a Nurse Operation Nurse/Hospital Nurse and the other as an Infection Preventionist/Nurse Education. On June 5, 2010, the Quality Nurse Assurance and Nursing Department had begun to implement the Settlement Agreement Monitoring Tools to use as their Preview Process. Nursing staff had begun to attend and participate on the Positive Behavior Support Team (PBST). The nursing assessment had been added to the Personal Support Plan (PSP) Assessment Section. The Nursing Services Manual was in the process of eliminating policies and procedures that were no longer operational and integrating new State Office Nursing Policies. The Lippincott Nursing Manual, 9th Edition had been adopted and purchased for nursing procedures. Healthcare Protocols: for Developmental Disability Nurses were purchased and put in place in the units to assist with the development of care plans. A centralized database was developed and implemented for scheduling and tracking all medical and dental appointments. The SOAP (Subjective, Objective, Assessment, and Plan) method of charting was implemented. Consistent with the findings from the baseline review, there continued to be several significant areas that need improvement to be in compliance. The Nursing Department needs to continue to improve the quality of the Comprehensive Annual and Quarterly Nursing Assessment, particularly in analyzing the assessment findings to ensure the nursing diagnoses reflects the entire individual's identified risk factors. Plans of care need to be developed for the identified nursing diagnoses that are individualized. The use of the SOAP method of charting needs to be reinforced. The nursing assessments reviewed the PSP nursing assessment and Annual and Quarterly Nursing Assessment Summaries typically contained general statements,. The nurses need to include more

	substantive information regarding the health status of each of the identified risk factors and/or health conditions they are managing through plans of care, The Annual and Quarterly Nursing Assessments reviewed were handwritten, except for one, and difficult to read due to poor hand writing quality, coupled with the limited space available on which to write. The Nursing Department needs to collaborate with the PNMT to ensure that individuals' who require alternate textures, consistencies, special oral presentations, adaptive equipment, and positioning have the information included on their PNMPs. Additionally, the nursing staff needs additional training on Physical and Nutritional Management, particularly as relates to assessing and managing dysphasia issues, by a qualified specialist. The manner in which direct care staff were trained on the HMP and ACP was discussed with the Chief Nurse Executive. She stated that the nurses go over the care plans with the direct care supervisors on all shifts and sign the care plans and training roster, then the direct supervisors train their staff. This is poor practice. The supervisors are not qualified to train and evaluate staff knowledge and skills for complex health care issues. There was no documentation found in the Integrated Progress Notes available for review that the nurses had trained the direct care in post surgical care. The Infection Preventionist/Nurse Educator had developed a comprehensive auditing tool for monitoring risk indicators and infection control issues. This tool will provide the Facility an efficient and effective method for identifying risks indicators and infection control deficiencies that require corrective action. The Initial Chart Review FY 10, Trend Analysis Report and Database for SSLC Services Tool for data collection of risk indicators related to the items in Settlement Agreement Sections I.1 and 2 and M. 5 had begun to be entered and analyzed in the computerized database. Team member determined it to be an excellent system worthy of being shared with other SSLCs. Since the baseline review the Nursing Department had changed from annual medication administration observation to quarterly, and more often if necessary. The nursing staff had received re-training on medication administration practices and documentation of medication. The MARs were being audited monthly by the Nurse Manager and/or designee. These were positive measures to assist in moving toward compliance. Seizure management by the nursing and direct care staff was the most deficient area of practice. Nurse and direct care staff failed to adequately assess and document seizure activity. The Seizure Management Policy was not in accordance with the Health Care Guidelines and the Seizure Record was inadequate to accurately capture all pertinent seizure data. The policy needs to be revised without delay and the nurses and direct care staff re-trained in seizure management.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Since the baseline review, the Nursing Department has employed a Registered Nurse (RN) IV who serves as the Nurse Operation Officer and Hospital Liaison who reports to the Chief Nurse Executive. Another RN IV was employed who serves as the Infection Preventionist and Nurse Educator. This RN IV reports to the Medical Director. There was one Nurse Manager. Review of the Facility's Staffing Plan as of June 30, 2010 indicated there were 13 fulltime RN positions, of which eleven were filled and two were vacant; eight full time Licensed Vocational Nurses (LVN) with no vacancies. Interview with the Chief Nurse Executive indicated that minimum staffing patterns have been maintained for the last six months. According to RGSC's Clinical Disciplines Staff to Patient Ratio Reports of July 29, 2010, the following ratios of nurses to individuals were listed as: 24:3 ratios for the 6-2 shift, 24:3 ratios for the 2-10 shift, and 28.80:2.5 ratios for the 10-6 shift. Since the baseline review, the 10 to 6 shift was now covered by use of agency nurses. She continues to actively recruit and interview to fill vacant RN positions. The Chief Nurse Executive expressed the need for a RN IV position to serve as a Campus Nurse. The Nursing Department did not have designated Nurse Case Manager per se. The RNs were responsible for completing Annual and Quarterly Nursing Assessments, developing, and implementing Health Maintenance and Acute Care Plans. Because of the weight of responsibility and accountability the Nurse Manager job requires, the Nursing Department needs to consider adding another Nurse Manager so that El Paisano and La Paloma each have a Nurse Manager. Additionally, the Nursing Department needs to consider adopting a Nurse Case Manager system like the SSLCs. Although RGSC has a census of 72 individuals the health care responsibilities to provide day to day health care to individuals, coupled with administrative responsibilities, ICF/MR Regulations, Joint Commission, and the Settlement Agreement, necessitates adequate nursing leadership at all levels of the Nursing Departments. At the time of the review RGSC had a census of 72 with 31 individuals residing in El Paisano and 41 individuals residing in La Palmao. The Nursing Department had one Nurse Manager responsible for oversight of both units. The Chief Nurse Executive was responsible for all nursing services at the Facility, e.g., Intermediate Care Facility/Mental Retardation (ICF/MR), Mental Health Hospital, and Outpatient Clinic. The Chief Nurse Executive Nurse reports to the Facility's Superintendent while the Nurse Manager and the nursing staff report to the Program Director. Given the weight of responsibility and accountability the Chief Nurse Executive has for administering and managing nursing services for the ICF/MR services and compliance with the Settlement Agreement, coupled with the responsibility for Mental Health Hospital and Outpatient Clinic; the Facility needs to consider a full time Chief	NC

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		Nurse Executive solely for ICF/MR services and compliance with the Settlement Agreement. Because of the weight of responsibility and accountability inherent in administering and managing nursing services, the Chief Nurse Executive needs to have direct line of authority for all nursing staff. Since the baseline review, the Quality Assurance Nurse and Nurse Manager began using the Settlement Agreement's Monitoring Tools in June, 2010. Audits were completed using all of the Monitoring Tools that were applicable for two individuals' records. When the Quality Assurance Director was asked why only two records were audited, it was explained that the Performance Improvement Council decided that review of two records with the Monitoring Tools would provide an adequate baseline for performance. Quarterly audits were planned but may be changed to monthly. It was commendable that all of the Monitoring Tools were used to audit two individuals' records. There was no trend analysis developed for degree of compliance established as a result of the audits. The use of the Monitoring Tools was the first step in becoming familiar with the instruments. As the Facility gains more experience with the use of these tools, instructions need to be developed and implemented for each tool as well as for establishing inter-rater reliability at 85% or above. Development of such procedures needs to be done in collaboration with the State Office to ensure that all Facilities use the same audit criteria and documentation to evaluate outcomes consistently across the state. The monitoring team discussed with the Quality Assurance Nurse and Chief Nurse Executive the quality of the audit data necessary to determine compliance with the Settlement Agreement. Simply having checked that an item on the Monitoring Tool was present does not necessarily determine compliance. Critical thinking must be applied to the item audited to ensure that the documentation reviewed or observations made meet the clinical needs of the individual and was in accordance with the Settlement Agreement and Health Care Guidelines. The monitoring team could not determine whether the audit provided adequate review of content as well as presence of items; this will be reviewed at the next compliance visits when more examples are available and the system has had a chance to mature. RGSC's Nursing Department had adopted the Settlement Agreement Monitoring Tools to use for their Peer Review Process. Review of the nursing training records revealed that Peer to Peer (Quality Review nursing process) was completed on June 16, 2010. Beyond the completed Monitoring Tools the Nurse Manager did in conjunction with the Quality Assurance Nurse no other peer audits were available for review. This was a new process for the Nursing Department that requires the development and implementation of instructions. The Nursing Department needs to develop a Nursing Peer Review	

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		Committee that reviews and analyzes audit data derived from the peer review in an effort to identify and solve problematic areas of nursing practice as a means to improve the quality of nursing services provided. As the process matures, data generated should facilitate improvements in nursing practice and begin to move the Nursing Department toward compliance with the Settlement Agreement. The Nursing Department's current policy regarding Nursing Peer Review that addresses peer review from an investigative standpoint needs to be revised to reflect peer review from a quality improvement process; as defined by the American Nurses Association (ANA) in 1988. According to the ANA definition, "peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer review in nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice." Since the baseline review the Nursing Department had made numerous improvements to move forward toward compliance with the Settlement Agreement. According to the Facility's Supplemental Plan of Improvement (POI) many of the improvements grew out of the recommendations made by the monitoring team during the baseline review. On June 5, 2010, they implemented the Settlement Agreement Monitoring Tools to use as theirReview Process. Tools were used to audit two individuals' records. Plans were to audit two individuals' records each quarter. Nursing staff had begun to attend and participate on the Personal Behavior Support Team (PBST). The nursing assessment had been added to the Personal Support Plan (PSP) Assessment Section. The Nursing Services Manual was in the process of eliminating policies and procedures that were no longer operational and integrating new State Office Nursing Policies. The Lippincott Nursing Manual, 9th Edition had been adopted and purchased for nursing procedures. Healthcare Protocols: for Developmental Disability Nurses were purchased and put in place in the units to assist with the development of care plans. A centralized database was developed and implemented for scheduling and tracking all medical and dental appointments. The SOAP (Subjective, Objective, Assessment, and Plan) method of charting was implemented. Maroon spoons were purchased and put into use for those individual who needed them for safe administration. Physical and Nutritional Management Plans (PNMPs) were placed in the Medication Administration Records (MAR) and Treatment Books for individuals who required such plans. Not all of the individuals who have special needs for alternate texture, consistency, oral presentation techniques, adaptive equipment, positioning, and special oral hygiene needs had that	

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		information added to the PNMP. Professional grade diagnostic equipment had been ordered and most items received. La Paloma and El Paisano now have portable oxygen tanks for emergency response, electronic operating digital chair scales, portable digital blood pressure, oximeter, and thermometers apparatuses in both the treatment and medication rooms. Each unit had a state of the art electrocardiograph machine installed and calibrated during the time of the review. Each unit had an electrically operated examination table ordered for the treatment rooms. They were due to be delivered August 31, 2010. When monitoring team asked the Chief Nurse Executive and Nurse Manager about the purchase of the order for the portable Emergency Response bags, they were unaware of the status of the order and had not followed-up on the order. The Nurse Manager immediately attempted to locate the bags. She reported that someone in the Purchasing Department had signed for the bags but did not know were they were delivered. After three days of inquiries by the team member as to the status of the bags, with no results, it was suggested by team member that the status of order be pursued with the Purchasing Department. The team member Chief Nurse Executive discussed the status with the Facility's Accounting Assistant who located the bags in Vocational Services. When the Emergency Response bags were delivered to the Nursing Department, it was discovered that the portable Emergency Response bags ordered were the wrong style. Subsequently, the correct style bags were immediately reordered. This demonstrated the failure of the Nursing Department to follow-up and track orders for much needed medical equipment. The Nursing Department needs to assign a dedicated staff member to track purchase orders for medical equipment through to receipt of purchase. Other areas of improvement included monthly audits of MARs, change from annual Medication Administration Observations to quarterly and as needed, and additional training of the nursing staff to assist in meeting compliance. Such training included: Competency-based training for Nursing Care Planning – Healthcare Protocols: for Developmental Disability Nursing, Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Guidelines for Comprehensive Nursing Assessment and use of Comprehensive Nursing Assessment Form, Medication Administration Process, Medication Administration Record, POI , Section M. Nursing care, Guidelines for Evidence of Compliance, Dental (Oral) Hygiene, Use of Welch Allyn Digital Blood Pressure Apparatus , Use of Oxygen Tank, and MediMar Refresher. The monitoring team verified that this had occurred through review of completed MAR audits and training records. The Facility needs to conduct advanced training on Physical and Nutritional Management, particularly as relates to managing dysphagia issues, by a qualified specialist. This training needs to be arranged as soon as possible, included in	

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		nursing orientation, and re-training. While RGSC's use of an electronic system was commendable it was difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of individuals' clinical picture. Some of the clinical data was entered into the Clinical Work Station (CWS), while other clinical data was contained on hard copies in a record binder. This posed a barrier when integrating clinical data into a useful manner. While completing record reviews for the Integrated Progress Notes for the last six months related to nursing care, each and every single entry had to be accessed, aggregated together, and printed. It was not functionally practical to access chronologically notes for other disciplines to evaluate nursing's integration of services with other disciplines. The CWS system was not user friendly and had the potential for vital health related data to be over looked in making critical clinical decisions. The Chief Nurse Executive and Nurse Operation Officer agreed with the difficulty the CWS system posed. The Facility had made numerous adjustments in an attempt to improve the CWS but without some additional program software added to the system there was little more that could be done to improve the current system. As the CWS presently functions it was not practical for long-term care facility use in tracking care and health status of individual.. Review of the past six months records for individuals #93, #139, #91, #140, #145, #23, #47, #126, #80, #118, 61, ##94, #2, #29, #12, #150, and #5 desensitization plans., and #10 with focus on acute illnesses, injuries, hospital/emergency visits, and pre-treatment and post-treatment sedation for dental and medical procedures revealed the following trends. • The Facility continues to operate on the RGSC Premedication for medical and Dental Procedures, Date Established: November 2004, Reviewed (but not revised) January 2010. The Facility had not integrated and implemented the recently developed State Office policy for Pre-Sedation and Post-Sedation Procedures. Nor was there evidence found in the records validating that their existing policy was being implemented as stated, "The PST will review every medical and dental appointment for which pre-medication is being considered. The team will consider a wide range of alternatives and develop interventions in an-attempt to prevent medication. If all less restrictive attempts fail, approval from the Human Rights Committee and informed consent from the legally authorized representative will be obtained." Review of records for individuals' receiving pre-treatment sedation for medical and/or dental failed to validate that the policy was followed. None of the individuals reviewed had Desensitization	

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		Plans in place. Individuals transferred for off-site treatment and/or procedures did not consistently have the time, mode of transportation, or name of staff accompanying the individual documented in the nurses' Integrated Progress Notes. Example: o The Integrated Progress Notes indicated that on July 27, 2010, the nurse called the Dentist Office for an appointment for individual #150's loose tooth. The note related that the Dental Office was closed and would be called the next morning for an appointment. On July 28, 2010, at 12:45 p.m. the note stated that individual #150 had returned from the appointment. There was no Integrated Progress Note indicating the time individual #150 left for the appointment, mode of transportation, or staff accompanying the individual. Upon return, individual #150's vital signs were taken, assessment for bleeding and swelling and pain was completed. The 1:25 p.m. note indicated that the physician was notified of individual #150's return from the dentist after having had a tooth extracted and health status. The nurse secured and carried out Physician Order's for antibiotic therapy and pain medication. Individual #150's pain FLACC (A standardized Pain Assessment for five categories (F) face; (L) Legs; (C) Cry; and (C) Consolability. Total score results uses 0 – 10 scale parameters.) Pain score was assessed at five. Tylenol 600 mg PO (per oral) was administered. Individual #150 was not reassessed for bleeding, swelling or pain until July 29, 201 at 10:44 p.m., approximately nine hours after the initial assessment post return for tooth extraction. Individual should have been reassessed at least every four hours for bleeding, swelling, and/or other complications resulting from the tooth extraction. o The Integrated Progress Notes indicated that on April 15, 2010 at 8:40 a.m., individual #145 was administered Ativan 2 mg (milligram) PO and vital signs were taken in preparation for a Gastrointestinal Consult. At 9:40 a.m., individual #145 was given Chloral Hydrate 1 GM (gram) and vital signs were taken. The Integrated Progress Notes contained no further documentation regarding nursing assessments, time departed, mode of transportation, or staff accompanying individual #145 to the appointment Individual #145 returned from the appointment at 12:45 p.m. At that time vital signs were taken and individual #145	

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		was reported in no distress. The assessment failed to state the level of mental alertness, physical condition, and ambulatory status. There were no further mental or physical assessments completed. The combination of Ativan and Chloral Hydrate constitutes a significant dose of sedation that may not have worn off after three hours. Individual #145 should have continued to be assessed until returning to baseline. o The Integrated Progress Notes indicated that on March 4, 2010 at 8:30 a.m., individual #2 was administered Ativan 2 mg PO for a dental appointment. At 8:45 a.m. individual #2 was administered Chloral Hydrate 1 GM and vital signs were taken which revealed a blood pressure of 143/85 and pulse of 99 beat per minute. There was no documentation that the nurse notified the physician of the elevated blood pressure and pulse rate (standard normal blood pressure 120/80 and 60 – 80 pulse rates). There was no documentation regarding mode of transportation or staff accompanying individual #2 to the appointment. The Individual returned from the dental appointment at 10:30 a.m., was reported to be awake and in no distress, and vital signs were 137/92 with a 92 pulse rate. There was no documentation that the nurse notified the physician of the elevated blood pressure and pulse. There were no further nursing assessment recorded. Again, the nurses should have continued to take vital signs and assessed mental, physical and mobility status until they were confident that baseline status had been achieved. o Since the baseline visit, the nurses were making progress in the management of individuals transferred to the emergency room and follow up on return to Facility. This was demonstrated by review of Individual #10's record related to a head injury sustained on July 3, 2010, resulting in a laceration requiring sutures in the emergency room. Records were reviewed July 3, 2010, through July 6, 2010, and included the Integrated Progress Notes, Nursing Assessment/Evaluation, and RN Neurological Assessment for Head Injury Form. There was evidence of a complete and thorough physical and neurological assessment at the time of the injury. The physician was promptly notified and ordered individual #10 to go the emergency room. Individual #10 was transferred to the emergency room via dorm van accompanied by staff. Transfer	

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		documents were sent by the staff. The nurse notified the sister of the injury and emergency transfer. Upon return there was documented evidence that nurses carried out and documented care according to protocol until individual return to baseline. o Reviewed individual #29's pre and post hospital admission for a cholecystectomy July 28, 2010 through August 4, 2010. Protocol for acute illness (post surgery) was consistently carried out and documented. The Hospital Nurse's communication and documentation was thorough. There was documented evidence in the Integrated Progress Notes that the Hospital Nurse had trained the direct care in post hospital care. The addition of a Hospital Nurse was a positive finding since the baseline visit. Because individuals with intellectual and developmental disabilities have complex health care needs it was important to have close communication with local hospital personnel when individuals are admitted to ensure continuity of care, discharge planning, and to train nurses and direct care staff on any special needs individuals may have upon return home. o Review of individual #118's records regarding a hospitalization for exploratory lap for reduction of intestinal volvolus. According to the Integrated Progress Notes on August 19, 2010 at 12:22 a.m., individual #118 began having nausea and vomiting with complaints of stomach pain, with vital signs recorded as temperature 96.8, pulse rate 69, and respirations 18, assessed bowel sounds were hypoactive in all four quadrants, and no stool felt upon digital check. Individual #118 had another episode at 1:56 a.m. The nurse notified the physician of the vomiting and gave an order for Phenergan 25 mg PO and to repeat in one hour if no change. The Phenergan was given as ordered. Individual #118 was assessed again a 3:00 a.m. and was resting. At 4:25 a.m., individual #118 was reported with no complaints, no distress, and no further vomiting episodes. At 12:51 p.m., vital signs were: blood pressure 109/72, pulse rate 80, and temperature 95.8°. Individual #118 was complaining of being cold and was given an extra blanket. A late entry note stated at individual #118 had cluster seizures from 8:55 a.m. to 9:45 a.m., vital signs were taken, and no injuries were observed. Individual #118 looked tired as ask to go to bed. There was no further information documented until 9:35 p.m. when the nurse documented	

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		individual went to the emergency room at about 5:45 p.m. There was no transfer note available to review. Another late entry note for August 19, 2010 at for 5:00 p.m., stated that the hospital called and said individual #118 was to be admitted to the hospital. Required Facility staff were notified of hospitalization and paperwork sent to the hospital. The next note written on August 20, 2010 at 1:14 a.m., stated that individual #118 was admitted to the hospital on August 19, 2010 at 11:55 p.m. with a diagnosis of nausea and vomiting and chest pain. It was a concern that the Facility physician did not immediately assess individual #118 when notified by the nurse at the onset of acute symptoms of nausea and vomiting and hypoactive bowel sounds in all four quadrants with no stool found in the in the rectal vault upon digital examination, and with a low grade temperature, or send to the emergency room, or at the very least evaluate the next morning. It was 24 hours after the acute onset of symptoms that individual #118 was admitted to the hospital. There was no documented evidence in the nursing Integrated Progress Notes available for review that indicated the physician had examined individual #118 or what prompted the emergency room visit. The clinical indicators should have alerted the physicians of the potential for an intestinal volvolus. Intestinal volvolus frequently occurs in individuals with developmental disability and has contributed to the cause of death in many cases. Individuals who were predisposed to intestinal volvolus, can later develop volvolus that can result in necrosis of the affected intestinal wall, acidosis, and death, usually from sepsis; therefore, acute volvulus requires immediate surgical intervention. Progress Notes indicated that Individual #118 was discharged from the hospital on August 25, 2010 status post exploratory laparotomy secondary to volvulus of mesentery and intestine with initial ischemic bowel which recovered after reduction of volvulus. Review of the Hospital Nurse's notes indicated daily or more frequent communication and visits to the hospital. There was no documentation found in the Integrated Progress Notes available for review that the nurses had trained the direct care in post surgical care. The Integrated Progress Notes reviewed, August 25, 2010 through August 26, 2010, indicated that the nurse assessed and provided care to the surgical incision according to Physician Order's every shift for three day. The nurses should have developed and implemented an ACP for post surgical care	

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		based on nursing protocols. o The monitoring team attempted to review seizure records for compliance. Seizure Records (paper copies and CWS generated), nursing Integrated Progress Notes, and Physician Orders.were reviewed. After concerted effort to correlate this documentation to gain a current picture of individuals and assess compliance, the monitoring team concluded it was not possible to do because of the incongruence between the documents reviewed. Therefore, any degree of progress toward compliance could not be assessed. The best example was #118 who had frequent cluster seizures. Aside from the incongruence between the records, multiple other problems were identified: Documentation for dates, times and duration of seizures, description of seizures activity, actions taken, and signatures of staff completing the Seizure Record were not consistently recorded. The nursing staff failed to provide a complete and accurate description of seizure activity and actions taken in the Integrated Progress Notes. The Standard Operating Procedure 200-04 Seizure Management, Date Established August 1987, Revised August 2010 and the Seizure record 5-81 were outdated although the revision date was August, 2010. It was not in accordance with the Health Care Guidelines. This Nursing Department needs to, without delay, revise the policy and reporting in order to be in accordance with the Health Care Guideline. The nurses and direct care staff need to be re-trained in seizure management. The above records were difficult to review due to their entry into the CWS system. Each single entry had to manually found and aggregated, and printed to piece together the sequence of events. It was possible that some of the missing data mentioned above was not located for printing for review. Time did not permit nor was it feasible to search and locate each discipline's entry that might have been involved in the care of the individuals reviewed. In general the nursing documentation of assessments showed some improvement in the quality of the content. This was particularly true for notes written in the SOAP format. Notes written in the SOAP format began to appear in the notes the first of August. Late entries notes were entered correctly but occurred frequently. It was plausible that the late entries were due to lack of computer access. The Nursing Department needs to assess the reason for the late entries.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18	Since the baseline review, the State Office had revised the Guidelines for Comprehensive Nursing Assessment as well as the Comprehensive Nursing Assessment form. RGSC's Nursing Department had integrated the revised guidelines into the Facility's Policy	NC

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	months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Manual. The RN staff just recently had been trained on the revised guidelines The RNs began using the revised Comprehensive Nursing Assessment form in August, 2010. This form was used for both Annual and Quarterly Comprehensive Nursing Assessments. The monitoring team reviewed records for individuals: #91, #139, #140, #145, #126, #118, #10, and #5 with focus on their current Personal Support Plans. Annual and Quarterly Nursing Assessment and corresponding Health Maintenance Plans and Acute Care Plans for compliance purposes showed that the Integrated Progress Notes for those records during the last six months showed slight improvements since the baseline visit. The Nursing Assessment section that was missing from the Personal Support Plans at the baseline visit was recently added. The nursing assessments reviewed the PSP nursing assessment and Annual and Quarterly Nursing Assessment Summaries typically contained general statements, e.g., "Individual remained medically stable throughout the year. Will continue to monitor and manage. Reviewed labs, consults and hospital admissions." The nurses need to include more substantive information regarding the health status of each of the identified risk factors and/or health conditions they are managing through plans of care, individuals' response to care, effectiveness of the plans, and recommendations for changes and/or additions to care plans based on changes in the individuals' health status. Complete demographic information was frequently missing after the first page of the Annual and Quarterly Nursing Assessment sheets; when the addressograph imprint card was not used, only the individuals' first initials and last name were written on the sheets. Some sheets were entirely missing demographic information, or the imprint sheet was improperly stamped, or the ink was so faint it was not possible to read, e. g., individual #126. The Nursing Department needs to ensure that all records contain demographic information. Eight of eight (100%) individuals' records reviewed for of the Quarterly and/or Annual Nursing Assessments were completed timely in accordance with their Personal Support Plan schedule. All nursing assessments, except for one, were handwritten. They were difficult to read due to poor hand writing quality, coupled with the limited space available on which to write. The handwritten assessments were discussed with the Chief Nurse Director who explained that many of the older nurses were not comfortable with using the computer. In addition, she explained there was only one computer available in the each nurses' station and expressed the need for an additional computer in each of the nurses' stations. Since there were two or more nurses working at the same time, the lack of adequate computers made it difficult for the nurses to timely enter routine notes as	

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		well as complete the nursing assessments and care plans. Since the baseline review, some improvement was noted in the quality of the Annual and/or Quarterly Comprehensive Nursing Assessments. Most of the improvement was related to the assessments completed since July, 2010. Many newly implemented procedures were too new to demonstrate significant improvement. Examples of detailed findings from individuals' Annual and/or Quarterly Nursing Assessments included: • Individual #140's Annual Comprehensive Assessment, August 15, 2010, reflected general improvement in quality of the assessment but continued to demonstrate the need for further improvement in some of the Sections : o Current Active Medical Diagnoses: Were listed. o Consult Section: Contained a description of all consultations, results, and summary of outcomes. o Diagnostic testing/Screening Section: Included all tests and screening and results with a summary of significant findings regarding follow-up for the elevated Thyroid Stimulating Hormone (TSH) and Lithium test results. o Medication Review Section: Included allergies and checked that the MOSES/DISCUS had been completed but failed to discuss the therapeutic effectiveness of psychoactive medications. Individual #140 was receiving Lithium (Lithium level was documented as elevated on 7/2/10), Tegretol, and Risperdal. The nurse failed to consistently list responses to all medications. The effectiveness of medications was not addressed in the dedicated columns. The treatment for psoriasis was summarized. It was noted that the physician declined to okay the intradermal injections for treatment of psoriasis because they were too expensive. Psoriasis has the potential to cause severe itching and discomfort and needs aggressive treatment when acute flair-ups occur. Cost of treatment should not prohibit treatment. Decline of treatments must only be based on clinical judgment. o Nutrition and Weight Management Section: Contained the results for dining observations, weight information, and summarized the fact that individual #140 was overweight per BMI. It was explained that individual #140 purchased foods from vending machines and family also brought food. Team member calculated that individual #140 was 15% over the upper limits of desired weight range. The nurse did not note any collaboration with the PNMT or PST regarding weight management. o Tertiary Care Review: Individual #140 did not receive tertiary care during the review period. o History, Functional and Psychosocial Section: Contained appropriate	

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		information in the check boxes, with the comment that individual #140 received per necessary medication for menstrual cramps. Summary lacked notation describing the frequency and description of the severity of menstrual pain or how pain was expressed. Sleep history check box was marked for sleep interruption but failed to describe the sleep interruption or indicate the average number of hours of sleep per night. History of fractured left humerus with closed reduction and fracture of the left clavicle were not listed on the summary. Individual #140 was reported to have experienced 37 falls in the past year, falls were described as trips and slips with no serious injures noted from falls. There was lack of notations regarding collaboration with the PNMT or PST regarding fall prevention. Individual #140 was receiving Lithium, Tegretol, and Risperdal, all of which have the potential to cause an unsteady gait and increase risk of falls. Team member counted 22 falls between March 6, 2010 and August 26, 2010 in the Integrated Progress Notes. o <u>Infection and Immunization Section:</u> Completed appropriately, no need for summary information. o <u>Physical Assessment Section:</u> ▪ Vital Signs: Completed and were within normal limits. ▪ Skin and Nails: The check boxes related to individual #140's health status were marked appropriately. The nurse noted several tiny bruises on the upper extremities and described psoriatic plaques on forearms, right lower leg, scalp, and left ear canal, with pimple like lesions on both breast. There was lack of notation regarding the etiology of the pimple like lesions on breast or plan of care. ▪ Braden Scale was completed with a score of 23. ▪ EENT/Head and Neck: Contained check boxes marked appropriately according to individual #140's health status, no need for summary information. ▪ Cardiac: Contained check boxes marked indicating there were no cardiovascular problems. Individual #140 had a diagnosis of hypertension, was receiving Norvasc, and required blood pressure and pulse monitoring before medication in the morning, two hours after medications, and at bedtime. The physician was to be notified if the measurement was greater than 160/90 or lower than 100/60. Blood pressure and pulse measurements were not documented in the summary. In the Extremities Section of the assessment, individual #140 was reported to have edema of the lower extremities, requiring the use of Thrombo Embolic Deterrent (TED) hose.	

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		▪ Respiratory: Contained check box marked appropriately according to individual #140's health status, no need for summary information. ▪ Gastrointestinal: Contained check box marked appropriately according to individual #140's health status. Check box for elimination was marked with a note that individual #140 received daily laxative. There was lack of a summary statement describing bowel patterns or Bowel Management Program. Individual #140 receives Lithium, Tegretol, and Risperdal, all of which are prone to cause constipation. ▪ Musculoskeletal – Extremities: The check box was only marked for edema of the lower extremities. There was lack of notation describing the degree of edema or how much of the lower extremities were involved or the etiology of the edema or plan of care, except that individual #140 refuses to wear TED hoses. There was lack of discussion as to reason TED hoses were necessary or collaboration with the PST, PNMP or PBST to strategize on a plan to encourage wearing the hoses. A description of individual #140's abnormal gait pattern was described but there was no explanation for the etiology of the problem or discussion of collaboration with the PST or PNMPT regarding a plan of care to prevent falls or assist with ambulation. Individual #140 was reported above as having 37 falls over the past year. Team member counted 22 falls reported in the Integrated Progress Notes between March 26, 2010 and August 26, 2010. ▪ Neurological: Contained check boxes marked appropriately according to individual #140's health status, no need for summary information. ▪ Genitourinary: Contained check boxes marked appropriately according to individual #140's health status, except for the check box marked for Dysmenorrhea. There was lack of notation describing dysmenorrhea or a treatment plan for managing menstrual pain. o <u>End of Life Planning:</u> Contained check box marked for full code status. o <u>Nursing Problems/Diagnosis:</u> ▪ Impaired skin integrity related to psoriasis lesions on forearms, anterior right leg, and bilateral breast. ▪ Imbalanced Nutrition: More than body requirements related to poor dietary habits, sedentary activity, and hypothyroidism. It was not clear to team member what the nurse meant by the term "more than body requirement"; This was a "canned" statement used in many of the nursing diagnoses and HMPs and does not adequately describe the individual's nutritional status. ▪ Ineffective health maintenance related to presence of moderate mental retardation.	

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		▪ Ineffective tissue perfusion related to venous stasis as individual tends to stand on left leg for a period of time than right leg for presence of brace. ▪ Obstetrical (sic: monitoring team believes this should be gynecological) pain related to monthly menstrual cramps. ▪ Risk for altered tissue perfusion related to impaired circulation from hypertension. The Assessment failed to include nursing diagnoses for constipation and risk of side effects and/or adverse reactions to psychoactive medications. Nursing diagnosis for ineffective health maintenance related to presence of moderate mental retardation was too non-specific to be meaningful. Although not related to this provision, the monitoring team would also suggest the Facility revise language to the more current usage of the term intellectual and developmental disabilities as opposed to mental retardation when making a nursing diagnosis. o <u>Nursing Summary:</u> ▪ *"Progress: Individual #140 is doing fairly well this year. Has had multiple falls and mostly related to gait. Individual #140 is awaiting to be seen by a physiatrist, as mentioned, awaiting for the contract. Individual#140's psoriasis to certain body parts are not getting better as well, will do periodic follow up with dermatologist. Evaluation with Dr. V. current for thyroid problem. Hypertension is under control. No noted seizures since 1989.* ▪ *SAMS Status: Low rating as of 5/25/10 review. Current review rating this month of August not available in the chart, will follow up.* ▪ *Nursing Problems: Continue with current plan of care.* ▪ *Recommendations: Complete revision to care plans. Continue with health maintenance and monitoring, fall precautions. Periodic evaluation by dermatologist. Follow up contract status with Dr. G."* The nurse's formulation of the Nursing Summary was too general, nonspecific, and did not provide an accurate description of individual #140's heath status or effectiveness of the nursing interventions related to care plans and therapeutic response to medications or treatments. The nurse failed to summarize the number of falls and the management outcome for the falls. Using the term "doing fairly" was not the professional terminology expected of a RN. Simply carrying out physician orders was not an independent nursing function. The recommendation for revising care plans was not specific enough for other PST members to know what care plans were revised nor was the statement specific enough regarding the continuation of health maintenance plans. The assessment and summary gave no indication of collaboration with other PST or	

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		PNMT members regarding falls and weight management. The summary failed to discuss the status of individual #140's Self-Administration of medication. • Individual #5's Quarterly Nursing Assessment, May 19, 2010, was completed on the old assessment form, handwritten, and difficult to read. The assessment reflected general improvement in quality but continued to demonstrate the need for further improvement in some of the Sections : o Current Active Medical Diagnoses: Not listed. o Consult Section: Included all consults and recommendations. o Diagnostic testing/Screening Section: Contained a description of lab results. Summary noted labs were due every six months for lipid profile, HGB, A1C due in August 2010. o Medication Review Section: Included allergies. Summary failed to include current medications, only medication changes o Nutrition and Weight Management Section: Contained the results for dining observations, weight information, and summarized dietary information. Individual #5 had a diagnosis of type II Diabetes Mellitus but there was lack of summary regarding compliance and or tolerance of the 1500 calorie diet or collaboration with the dietitian or PNMT. o Tertiary Care Review: There were no tertiary visits during the reporting period. o History, Functional, and Psychosocial Section: Contained appropriate information in the check boxes. Summary contained a comprehensive history of surgeries. o Infection and Immunization Section: Immunizations were up to date except for PPD that was documented on March 9, 2009. At the time the Quarterly Nursing Assessment was completed it was two months past due and should have been noted with corrective action taken to update the PPD. o Physical Assessment Section: ▪ Vital Signs: Were completed and with in normal limits. ▪ Skin and Nails: The check boxes related to individual #5's skin were described as having multiple scars to the abdomen and on different sites, e.g., upper extremities. Individual #5 has a maladaptive behavior of constantly picking the skin. The summary did not included information regarding status of skin integrity in relation to the maladaptive behavior. The nurse failed to include the diagnosis and treatment for cellulitis on the lower left leg on February 22, 2010. ▪ Braden Scale completed with a score of 23. ▪ EENT/Head and Neck: Contained check boxes marked appropriately	

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		according to individual #5's health status, no need for summary information. ▪ Cardiac: Contained check boxes marked appropriately according to individual #5's health status, no need for summary information. ▪ Respiratory: Contained check boxes marked appropriately according to individual #5's health status, no need for summary information. ▪ Gastrointestinal: Contained check boxes marked appropriately according to individual #5's health status, except for bowel elimination that was marked with a note that laxative was taken daily. The summary failed to describe bowel patterns or Bowel Management Program. There was no collaboration documented collaborating with the PST or PNMP to prevent or reduce the use of routine laxatives. Individual #5 receives Haloperidol, Seroquel, and Topirmate, all of which were prone to cause constipation. ▪ Musculoskeletal – Contained check boxes marked appropriately according to individual #5's health status, no need for summary information. ▪ Neurological: Contained check boxes marked appropriately according to individual #5's health status, no need for summary information. ▪ Genitourinary: Contained check boxes marked appropriately according to individual #5's health status. o <u>End of Life Planning:</u> Contained check box marked for full code status. o <u>Nursing Problems/Diagnosis:</u> ▪ Same care plan for Imbalanced Nutrition, Management for Infection and Diabetes. ▪ Revise plan on Ineffective Health Maintenance and risk for falls. Nursing Diagnosis failed to include risk of side effects and/or adverse reactions to psychoactive medications. o <u>Nursing Summary:</u> ▪ *"Individual #5 is clinically stable. No serious medical issues or concerns this quarter except for cellulitis. Continue with monitoring, fall precautions."* The formulation of the Nursing Summary was too general, nonspecific, and did not provide an accurate description of individual #5 heath status or effectiveness of the nursing interventions related to care plans and therapeutic response to medications or treatments, particularly psychoactive medications and medication for diabetes. Blood sugar levels were not summarized. Using the term "clinically stable" was not an adequate description. Individual #5 had maladaptive behaviors of picking at the skin. Cellulitis of the left lower leg was diagnosed on February 22, 2010. The status of the cellulitis should have been included in the summary. Skin integrity issues should be addressed aggressively	

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		because of the diabetic condition as well as behaviorally. The assessment and summary gave no indication of collaboration with other PST, PNMT and PBST members regarding individual #5's diabetic and behavioral status. The summary failed to discuss the status of individual #5's Self-Administration of Medication. • Individual # 126's Annual Nursing Assessment, July 15, 2010, was completed on the old assessment form, handwritten, and difficult to read. The assessment reflected general improvement in quality but continued to demonstrate the need for further improvement in some of the Sections : o Current Active Medical Diagnoses: Not listed. o Consult Section: Included all consults and recommendations. There was no summary statement indicating return appointments. o Diagnostic testing/Screening Section: Contained a thorough listing of all labs and results. Summary noted labs were due every six months for lipid profile, HGB, A1C due in August 2010. The summary did not discuss low sodium. o Medication Review Section: Included allergies. Failed to include current medication, only medication changes. PRN/Emergency Medications were list and the reason stated. o Nutrition and Weight Management Section: Contained the results for dining observations, weight information, summarized dietary information, and noted that individual #126 was edentulous. o Tertiary Care Review: Contained information regarding a visit for cataract day surgery. o History, Functional and Psychosocial Section: Contained appropriate information in the check boxes. Summary contained history of cataract surgery January 7, 2010 and history of excision of lipoma on the back. o Functional Status: Check boxes marked appropriately for individual #126's health status. Summary indicated need for assistance with activities of daily living. o Infection and Immunization Section: Immunizations were up to date. No summary necessary. o Physical Assessment Section: ▪ Vital Signs: completed and were within normal limits. Summary stated there was no evidence or signs of pain. ▪ Skin and Nails: Contained appropriate information in the check boxes for individual #126's health status. Summary stated fingernails and toenails were trimmed. Individual #126 was cooperative.	

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		▪ Braden Scale completed with a score of 21. ▪ EENT/Head and Neck: Contained check boxes marked appropriately according to individual #126's health status, no need for summary information. ▪ Cardiac: Contained check boxes marked appropriately according to individual #126's health status, no need for summary information. ▪ Respiratory: Contained check boxes marked appropriately according to individual #126's health status, no need for summary information. ▪ Gastrointestinal: Contained check boxes marked appropriately according to individual #126's health status, no need for summary information. ▪ Musculoskeletal – Contained check boxes marked appropriately according to individual 126's health status, no need for summary information. ▪ Neurological: Contained check boxes marked appropriately according to individual #126's health status, no need for summary information. ▪ Genitourinary: Contained check boxes marked appropriately according to individual #126's health status no need for summary information. ▪ <u>End of Life Planning:</u> Contained check box marked for full code status. ▪ <u>Nursing Problems/Diagnosis:</u> ▪ Impaired verbal communication. ▪ Ineffective Health Maintenance due to severe mental retardation Nurse failed to include nursing diagnosis for hypothyroidism. Individual #126 receives Levothyroxine and requires routine TSH lab work. <u>Nursing Summary:</u> ▪ *"Individual #126's has been medically stable during the previous year. Will continue to manage and monitor lipids, per MD. Will continue with health maintenance plan."* The formulation of the Nursing Summary was too general, nonspecific, and did not provide an accurate description of individual #126's heath status or effectiveness of the nursing interventions related to care plans and therapeutic response to medications or treatments. Using the term "medically stable" was not an adequate description. Simply carrying out physician orders was not an independent nursing function. The summary failed to discus the status of individual #126's Self-Administration of medication. • Individual #118's Annual Nursing Assessment, July 9, 2010, was completed on the old form, handwritten, and difficult to read. The assessment reflected general improvement in quality but continued to demonstrate the need further improvement in some of the Sections :	

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		o Current Active Medical Diagnoses: Not listed. o Consult Section: Included all consults and recommendations. o Diagnostic testing/Screening Section: Contained reports of all lab tests and results. There was no summary statement regarding follow-up lab work. o Medication Review Section: Included allergies. Summary failed to include current medications, only medication changes, and per necessary medications and reason. o Nutrition and Weight Management Section: Contained the results for dining observations, weight information, risk for choking, and summarized dietary information. o Tertiary Care Review: Outpatient visit to rule out Cerebral Vascular Accident due to altered mental status and another visit for prostate biopsy. o History, Functional and Psychosocial Section: Contained appropriate information in the check boxes. Summary contained history of hemiarthroplasty and amputation of left middle finger surgeries. o Infection and Immunization Section: Immunizations were up to date except for PPD that was documented on March 30, 2009. At the time the Quarterly Nursing Assessment was completed it was four months past due and should have been noted with corrective action taken to update the PPD. o Physical Assessment Section: ▪ Vital Signs: Completed. Summary indicated that individual #118 denied any pain. ▪ Skin and Nails: The check boxes were marked appropriately related to individual #118's health status. The summary described a scar on left elbow and a long linear surgical scar on right the hip. ▪ Braden Scale completed ▪ EENT/Head and Neck: Contained check boxes marked appropriately according to individual #118's health status, no need for summary information. ▪ Cardiac: Contained check boxes marked appropriately according to individual #118's health status. Summary stated unremarkable findings. ▪ Respiratory: Contained check boxes marked appropriately according to individual #118's health status. Summary stated with normal limits. ▪ Gastrointestinal: Contained check boxes marked appropriately according to individual #118's health status. Summary stated unremarkable. The nurse should have made a summary statement regarding dysphagia status. ▪ Musculoskeletal – Contained check box marked appropriately according to individual #118's health status. The nurse should have made a summary	

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		statement regarding the diagnoses of kyphoscoliosis, chronic ataxic gait, and osteoporosis. ▪ Neurological: Contained check boxes marked appropriately according to individual #118's health status, no summary information. The nurse should have written a summary regarding seizure status and treatment. ▪ Genitourinary: Contained check boxes marked as asymptomatic when individual#118 had a diagnosis of urinary incontinence and should have had a summary statement describing incontinence status and management plans. o <u>End of Life Planning:</u> Contained check box marked for full code status. o <u>Nursing Problems/Diagnosis:</u> ▪ Potential for injury related to seizures. ▪ Mobility impairment ▪ Electrolyte imbalance related to low serum sodium. ▪ Impaired health maintenance related to mental retardation. Nurse failed to include nursing diagnoses for urinary incontinence, hypothyroidism, osteoporosis and dysphagia. Nursing diagnosis for ineffective health maintenance related to presence of moderate mental retardation was too non-specific to be meaningful. <u>Nursing Summary:</u> ▪ *"Individual #118 has been stable but has had several seizures this past year. Neurologist following up and adjusting medications as needed. Individual#118 has also had low serum sodium and is also being addressed by our M.D. and (*cannot read) *continues on the merry go walker, helmet for* (cannot read)*. Fears have decreased. Individual #118 also kept* (cannot read) *and doctors appointment for the year. Will continue with health maintenance and the present plan of care."* The formulation of the Nursing Summary was too general, nonspecific, and did not provide an accurate description of individual #118's heath status or effectiveness of the nursing interventions related to care plans and therapeutic response to medications or treatments, particularly with regard to seizure status and management. The number of seizures for the past year was not stated. Mobility issues were not discussed. The summary did not address individual #118's risk for choking, injury, or urinary tract infections. While some of the risk factors identified earlier might have been reduced to a low level individual #118 may now have an overall low level risk score or the chronic health conditions may be stable, it does not remove the potential for these issues to become unstable or regressive. The best way to prevent such from happening is	

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		to ensure that all risk factors have a Health Maintenance Plans that are individualized and based on sound clinical practice that involves collaboration with all relevant PST members. The assessment and summary gave no indication of collaboration with other PST, and/or PNMT members regarding the development of integrated plans of care. Using the term "stable" was not an adequate description of individual #118's health status. Simply stating that individual #118 was being followed by physicians was not an independent nursing function. The summary failed to discus the status of individual #118's Self-Administration of medication. Individual #145's Quarterly Comprehensive Nursing Assessment, July 28, 2010, was completed on the new form, handwritten, and difficult to read. The assessment reflected general improvement in quality but continued to demonstrate the need for further improvement in some of the Sections : o Current Active Medical Diagnoses: Were listed. o Consult Section: Included all consults and recommendations. o Diagnostic testing/Screening Section: Contained reports of all lab test and results. The summary stated pending lipid profile results ordered by M.D. o Medication Review Section: Included allergies. Include all current medications, dose, and route, reason, response and effectiveness. Provided a summary of the effectiveness of the combined use of Ativan and Chlorate Hydrated for sedation purposes. o Nutrition and Weight Management Section: Contained the results for dining observations, weight information, and summarized dietary information. o Tertiary Care Review: Provided a detailed description of an outpatient clinic visit for EGD with a thorough explanation of result of EDG. o History, Functional, and Psychosocial Section: Contained appropriate information in the check boxes with additional information written beside the block. Summary contained history of exploratory lap for transverse colon resection with anastomosis, 6/4/09. o Functional Status: Contained appropriate information in the check boxes appropriate for individual #145's health status. Summary described past soft tissue injuries. o Infection and Immunization Section: Immunizations were up to date, pending varicella titer. o Physical Assessment Section: ▪ Vital Signs: Completed and were with in normal limits. Summary indicated that individual #146. The summary indicated there were no issues of	

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		maladaptive behaviors.. ▪ Skin and Nails: The check boxes were marked appropriately related to individual #146's skin and nails status. The summary described a scar on left wrist and abdomen. Summary described discoloration of right second toe and left third toe. ▪ Braden Scale score 23 ▪ EENT/Head and Neck: Contained check boxes marked appropriately according to individual #146's health status. Summary stated that individual #146 was uncooperative with the head exam. ▪ Cardiac: Contained check boxes marked appropriately according to individual #146's health status. Summary stated findings were unremarkable. ▪ Respiratory: Contained check boxes marked appropriately according to individual #146's health status. Summary statement not included. ▪ Gastrointestinal: Contained check boxes marked appropriately according to individual #146's health status. Summary statement not included. ▪ Musculoskeletal – Contained check boxes marked appropriately according to individual #146's health status. ▪ Neurological: Contained check boxes marked appropriately according to individual #146's health status, no summary information. ▪ Genitourinary: Contained check boxes marked appropriately according to individual #146's health status. o <u>End of Life Planning:</u> Contained check box marked for full code status. o <u>Nursing Problems/Diagnosis:</u> ▪ Ineffective health maintenance related to cognitive impairment secondary to mental retardation. ▪ Impaired nutrition more than body requirements related to sedentary activity level, poor dietary habits, medication side effects, (cannot read) related to seizure history and visual impairment secondary to cataract. o Nursing diagnosis for ineffective health maintenance related to cognitive impairment secondary to mental retardation was too non-specific to be meaningful. <u>Nursing Summary:</u> ▪ *"Heath risk – low risk rating during the last status meeting on 5/19/10.* ▪ *SAMS status – not on this program.* ▪ *Progress – Had a successful M.D. visit and procedure this quarter, had an EGC/colonoscopy as outpatient and finding and recommendation received and followed. Overall individual, individual is clinically stable. Su Clinica informed to set an appointment for a successful procedure already done.*	

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		▪ *Nursing problem - continue with current care plan.-* ▪ *Recommendations – follow-up with Su Clinica as for dental visit. Continue with current health management and monitoring, seizure precaution."* The formulation of this Nursing Summary shows improvement from the baseline review. Summary should include heath status as relates to the effectiveness of the nursing interventions, care plans, and therapeutic response to medications or treatments, particularly with regard to seizure status and management. Overall low level risk score or the chronic health conditions may be stable; it does not remove the potential for these issues to become unstable or regressive. The best way to prevent such from happening is to ensure that all risk factors have a Health Maintenance Plan that are individualized and based on sound clinical practice that involves collaboration with all relevant PST members. The assessment and summary gave no indication of collaboration with other PST, and/or PNMT members regarding the development of integrated plans of care. Using the term "stable" was not an adequate description of individual #118's health status. Simply stating that individual #118 was being followed by physicians was not an independent nursing function. Review of the above Annual and Quarterly Comprehensive Nursing Assessments began to show some improvement, particularly those completed within the past two months. From the review of the above assessments the trend that emerged consisted of the same issues identified in the baseline review. The areas that need continued improvement relate to completing a thorough assessment of all aspects of individual's physical, mental, and behavioral health, collaborating with PST, PNMP, and PBST to develop a comprehensive plan of care derived from the assessment that was individualized to meet the individual's unique needs. The nursing summaries need to include heath status as related to the effectiveness of the nursing interventions, care plans, and therapeutic response to medications or treatments, particularly antiepileptic and psychoactive medications. Overall low level risk scores or chronic health conditions that may be stable, it does not remove the potential for these issues to become unstable or regressive. The best way to prevent such from happening is to ensure that all risk factors are included in a Health Maintenance Plan that is individualized and based on sound clinical practice that involves collaboration with all relevant PST members. The assessment and summaries of the assessments reviewed gave no indication of collaboration with other PST, and/or PNMT members regarding the development of integrated plans of care. Using the terms "clinically stable" or "doing fairly well" is not sufficient to describe the health status of the individual. Many nursing interventions are listed as "to follow physician orders." Simply stating	

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		that an intervention is to follow physician orders is not an independent nursing function. Nursing interventions are an interdependent function that nurses must do without orders from a physician, like performing physical assessments, developing, implementing, evaluating health care plans, and training direct care staff. These are required nursing responsibilities. Nurses are expected to use critical thinking in analyzing assessment data and designing interventions expected of professional nurses.	
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.	Since the baseline, review, the Nursing Department had put many procedures in place to improve nursing practices. In an effort to improve Health Management and Acute Nursing care the State Office and the Nursing Departments had adopted and purchased the Health Care Protocols: A Handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and nursing care plan. The Nursing Department purchased handbooks for the nursing staff and they are in place. Nurses are beginning to use these materials as guides for developing nursing care plans. Since many of the procedures and trainings occurred within the last two months, and are ongoing, not enough time has elapse to show significant improvement and demonstrate substantial compliance. A sample of the Health Maintenance Plans (HMPs) and Acute Care Plans (ACPs) were reviewed for the individuals' who's Annual and/or Quarterly Comprehensive Nursing Assessments were reviewed above. The HMPs and ACPs were matched up with the nursing diagnosis listed on the nursing assessment. The nursing staff were using the Health Care Protocols: Handbook for DD Nurses, as was evident in review of individual #5's ACP for Cellulitis, July 28, 2010. The care plan was more comprehensive than the ones previously used; however, it was not individualized. While it was helpful to use these protocols for a guide, they serve only as a guide, and to meet the unique needs of the individual they must be individualized. There was no signature for the direct care supervisor or signed training roster that validated that direct care staff had been trained on individual #5's ACP for Cellulitis. Reviewed individual #5's Integrated Progress Notes for July 28, 2010, one entry was documented for that day and it failed to contain documentation validating that the direct care staff had been trained on the Cellulitis ACP. Individual #5' cellulitis to the left lower leg was being treated according to Physician Orders. Reviewed the Integrated Progress Notes through August 7, 2010 until individual #5 finished a 10 day course of antibiotics and the cellulitis was resolving. Documentation was never found addressing training of the direct care staff. The Cellulitis ACP was never signed as being resolved through August 27, 2010 when the tour ended. Individual #5's ACP for Head Injury, June 29, 2010, had not been individualized and was grossly inadequate. The ACP for Head Injury did have the signature of all three	NC

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		direct care supervisors validating that the direct care had been trained on the ACP. There was no documentation in the Integrated Progress Notes validating that the ACP was initiated. Reviewed the Integrated Progress Notes through July 6, 2010, until the stitches were removed from the laceration; however, did not find verification that the ACP was initiated. As of August 27, 2010, the nurses had not documented that the problem was resolved on the ACP. The monitoring team reviewed Individual #145's ACP for Gastritis, date April 16, 2010. The ACP for Gastritis contained the direct care staff supervisors' signatures for all three shifts validating that the direct care had been trained on the ACP. Individual #140's HMP was reviewed, dated August 15, 2010, for Weight – Over. There were no direct care supervisors' signatures on the HMP verifying that the direct care staff were trained. The HMP had not been individualized. Review of individual#140's Integrated Progress Notes were reviewed and there was no documentation in the record that the HMP had been initiated, Reviewed individual #140's HMP for Hypertension, dated May 19, 2010. There were signatures for the direct care supervisors present on the HMP. The HMP for Hypertension was the older version. Integrated Progress Notes May 19, 2010 through May 31, 2010, included no documentation validating that it was implemented. The monitoring team reviewed Individual #140's HMP for Constipation, dated May, 19, 2010. There were direct care supervisors' signatures on the HMP verifying that direct care staff were trained on the HMP. Integrated Progress Notes, May 19, 2010 through May 31, 2010 included no documentation validating that the HMP was initiated. It could not be discerned by review of the Integrated Progress Notes that ACPs or HMPs were implemented. The manner in which direct care staff were trained on the HMP and ACP was discussed with the Chief Nurse Executive. She stated that the nurses go over the care plans with the direct care supervisors on all shifts and sign the care plans and training roster, then the direct supervisors train their staff. This is poor practice. The supervisors are not qualified to train and evaluate staff knowledge and skills for complex health care issues. This practice should cease and the nursing staff on each shift should be informed that they are responsible for conducting the training and ensuring that the direct care staff are competent to carry out the assigned. The Nursing Department needs to ensure that the protocols adapted from the Health Care Protocol: for Handbook for Nurses are individualized to meet the unique needs of individuals, that nursing staff are retrained in its use, and when used ensure that the nurses follow the protocols as a standard of practice, ensure that the nurses on each staff are responsible for training the direct care staff, and keep a training roster to validate that the training occurred. The Chief Nurse Executive agreed and will begin having the nurses on each sift train the	

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		HMPs and ACPs. The Nursing Department needs to purge the older versions of the generic care plans so that they will not inadvertently continue to be used. The Nursing Department needs to collaborate with other disciplines when developing health care plans so that an interdisciplinary team approach is used consistently as required by Settlement Agreement Sections G and F.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The Facility's Supplemental POI indicated that the State Office had approved the use of the Lippincott Manual of Nursing Practice 9th Edition for nursing procedures and protocols. As well as the Healthcare Protocols: for Developmental Disability Nurses. The Nursing Services Manual was in the process of eliminating policies and procedures that were no longer operational and integrating new State Office Nursing Policies. The Lippincott Nursing Manual, 9th Edition had been adopted and purchased for nursing procedures. Healthcare Protocols: for Developmental Disability Nurses was also purchased and put in place in the units to assist with the development of care plans. A centralized database was developed and implemented for scheduling and tracking all medical and dental appointments. The SOAP (Subjective, Objective, Assessment, and Plan) method of charting was implemented. Review of the Nursing training records indicated that the nursing staff had been trained on the above information prior to implementation. While the Nursing Department had adopted and implemented the Health Care Protocols for DD Nurses, they failed to individualize the generic protocols to meet the individuals' unique health care needs. The Nursing Department had adapted and implemented of the SOAP method of charting but were not consistently using this method of charting. The use Health Care Protocols and SOAP method of charting was recently implemented and the nursing staff needs to gain more experience with these items to ensure that the protocols are consistently individualized and the SOAP method of charting is consistently used. When this is consistently accomplished the Provision will be considered in substantial compliance.	NC
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	Since the baseline review the Facility had employed an Infection Control Preventionist/Nurse Educator who reports to the Medical Director. The Infection Control Preventionist had been employed for approximately three months and had already developed an Excel database to collect, track, and calculate the percentage of compliance for each item of required data related to risk factors for the Facility's POI, Settlement Agreement, and Health care Guidelines. At the time of the review the	NC

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	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.	Infection Control Preventionist thoroughly explained and demonstrated the use of the database titled Initial Chart Review FY 10, Trend Analysis Report and Database for SSLC Services. Status of compliance of assessments for risk factors and/or treatment plans, if applicable, for the 15 individuals reviewed to date included: • I-1A – Health Status Team – Interdisciplinary Team (HST-IDT) Risk level: 93% • I-A1:1 - Immunization status: 100% • I-1A:2, 3 – Influenza: 100% • I-1A:4,5 – Tetanus: 100% • I-1A:7 – Pneumococcal: 93% • I-1A:11 – Varicella: 0% • I-1A:12-16 Hepatitis B: 14% • I-1A:17-22 – Tuberculosis (TB): 79% • I-2A:4,5 – Diabetes: 50% • I-1A:6,7; M5, J1; M1-15, 16 – Hypertension: (no data entered) • I-1A:8 ; M5 -15 Gastroesophageal Reflux (GERD): 100% • M5H-1d – Cardiac: 75% • I-2A-12 – Infections (includes all reportable communicable diseases and infections): (no data entered) • SA II.M; HCG;VII.C.2e.f – Urinary Tract Infection: 0% • I-1A:1d – Infection Control Preventive (ICP) Risk; 100% Total compliance score to date: 70% The Initial Chart Review FY 10, Trend Analysis Report and Database for SSLC Services Tool for data collection of risk indicators related to the items listed above as entered and analyzed in the computerized Excel database was determined as an excellent system. To date approximately 15 of 72 individuals' records had been reviewed and relative data entered. For the 15 records reviewed there was documented evidence that the Nurse Manager was notified of deficiencies along with recommendations for corrective action and timelines for completion. Because this was a recently developed and implemented system, not all records had been reviewed for the requirements of this section; it was not possible to determine substantial compliance. As individuals' records are reviewed, deficiencies identified, corrective actions taken, this section of the POI and Settlement Agreement should steadily progress toward full compliance. This system for collecting, analyzing and trending risk indicators was exemplary of self monitoring and worthy of sharing with other SSLC Facilities. The Infection Control Program continues to track all infections including reportable	

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		communicable diseases, such as, Methicillin-resistant Staphyloccus Aureus (MRSA) Hepatitis A, B, and C., Human Immunodeficiency Virus (HIV), positive tuberculin skin test, Hemagglutinin Type 1 and Neuraminidase Type 1 (H1N11), Clostridium Difficile (C-Diff), and Sexually Transmitted Diseases (STDs). One case of MRSA was reported in third quarter. No reportable communicable diseases were reported for May, June, and July 2010. There were no active cases of reportable communicable reported during the review. According to the RGSC Infection Control Reporting Form IC-1, this form was to be used to maintain a log of and report of all In-patient infections. In cross checking the log for the period of July 26, 2010 through August 8, 2010, infection treated with antibiotics were not reported nor were there Integrated Progress Notes reporting the infection to the Infection Control program. Examples: on July 28, 2010 individual #5 was diagnosed with cellulitis of the left lower extremity and was treated with antibiotic. .On April 21, 2010, individual #118 was diagnosed and treated with antibiotics for an upper respiratory infection. The Nursing Department needs to ensure that the Infection Control Reporting Form IC-1, is completed for all infections and reportable communicable disease. When reportable communicable diseases are report they must also be immediately called into the Infection Control Program. Dr. Dill stated that overall the Facility did not have too many infections, therefore, they were not required to have a Facility generated Antibiogram. The Facility was required to use their community hospitals Antibiogram because they were aware of the organisms in the area and what antibiotics they are susceptible to. Since the baseline review there had been no changes in the Infection Control Program's policies and procedures or in their training materials. Review of Infection Control's training records as of July 13, 2010, indicated that of the 125 staff listed, only three staff were delinquent in the required retraining. The Infection Control Program's RN/Infection Control Preventionist continues to conduct monthly infection control surveillance checks in all Facility areas including observations of staff hand-hygiene performance measurement/criteria. This was validated though review of Infection Control Monthly Surveillance Checklists and Hand-Hygiene Performance Measurement/Criteria Checklist for May, June and July 2010. When deficiencies were identified responsible supervisors/managers were notified in writing of findings. Example: On June 25, 2010, El Paisano's infection control	

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		surveillance found: One outdated drug, both exam rooms were cluttered due to the massive amount of material needed to give treatments and little to no cupboard space. Desk in the nurse's station was held together with tape. There were paper products on the grass behind El Paisano. The employee lounge needs log for refrigerator and freezer cleaning. Although the Infection Control Preventionist notified in writing El Paisano's unit supervisor and nurse manger of the identified deficiencies, there was no plan of correction offered nor was there evidence available to validate that correction actions were taken as a result of the notification of the deficiencies. The Facility's Infection Control Program needs to ensure that when supervisors/managers are notified of infection control surveillance deficiencies there is validation that the deficiencies were corrected. During the tour of El Paisano, the monitoring team validated the Infection Control Preventionist's findings through observation that both exam rooms were cluttered due to large amounts of material and equipment needed to give treatments with little to no cupboard space and that the desk in the nurse's station was held together with tape. Observation in both El Paisano's and La Paloma's treatment rooms and nurses' stations revealed the same issue with overcrowding of medical material and equipment, e.g., large exam tables, electrocardiography (EKG) machines, portable blood pressure apparatuses, treatment med carts, standing and setting scales, and other assorted medical equipment. There was scarcely enough room in the treatment rooms for the health staff to walk around the exam table much less examine individuals with mobility and/or other complex health and behavioral issues. Almost no cupboard space was available for storage. Such a working environment had the potential to cause hazard when examining and treating individuals. Observed in the very small nurses' station were several small desks, all in poor repair, along with large refrigerators/freezers for storage of food stuffs for individuals, smaller refrigerators and other assorted medical material for medical use. The overcrowding and poor repair of the small desks did not create an organized and productive work environment for nurses to work. The Chief Nurse Executive and Facility administration need to evaluate the nurses' clinical workspace and consider making physical plant adjustments to afford larger and safer environments to examine individuals, more space for storage, and more efficient desk and workspace for nurses to work. The Infection Control Program was folded into the Safety/Risk Management/Infection Control Committee which was a combined meeting with RGSC, Mental Health Hospital, and Outpatient Services. Review of the Safety/Risk Management/Infection Control Committee Minutes, for January 12, 2010, February 11, 2010, March 11, 2010, April 22,	

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		2010, and May 13, 2010, minutes reflected little information or discussion regarding infection control issues specific to the ICF/MR component with the exception of reporting on the percentage of infections, nosocomial, reportable disease rates, and number and types of infections; and whether or not Infection Surveillance was completed. The committee was responsible for addressing issues related to three distinct service areas. Within the three service areas numerous topics were addressed, e.g., Safety/Risk Management, Accident Review Board Updates and Follow-up, Risk Management Reports for Review, Environmental Surveillance, Patient Safety Data Reports, Security Management Reports, Hazardous Materials/Waste, Fire Safety Management, Medical Equipment Management, Emergency Management, Utility Systems Management, Construction, Infection/Prevention Prevention, New Business, Educational Literature, and Announcements and Communication. As was evident by the list of topics related to three distinct service there was little time in the meeting available for more than a cursory report on each of the respective topics and little if any time for problem solving discussions on any one single topic. The Facility needs to consider forming an Infection Control Committee specifically for the ICF/MR component where focus can be centered on infection control and problems solving issues unique to the Facility.	
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.	Since the baseline review the Nursing Department had implemented numerous interventions to improve the practice of medication administration. Because most of the interventions were recently implemented there had not been enough time elapsed to yield a finding of compliance with this provision's. As these interventions mature with time and practice this section should steadily progress toward substantial compliance. The State Office had not yet revised the Medication Administration Policy and Procedures. When the State Office revises this policy, as it is integrated into RGSC's Nursing Manual, and nursing staff trained, further improvement should be evident as the Nursing Department continues to progress toward compliance with this Section of the Settlement Agreement and Health Care Guidelines. Since the baseline review, where numerous omissions were identified on the Medication Administration Records (MARs) Records, the Quality Assurance Nurse had begun auditing six MARs per month. The nine critical items on the audit sheet were weighted, e.g., Yes = 100%, Partial = 50% and No = 0%. Audits include summaries of findings, recommendations for corrective action, and due and returned dates for validation that corrective action was completed. Recommendations for corrective action were made each month for audited items failing to meet 100% compliance. Audit results were sent to the Quality Management Office for further review. Then, copies of the final audit findings with recommendations were sent to the Chief Nurse and Unit Nurse Manager to	NC

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		review and take corrective action. Validation that corrective actions were taken was not available for review. Audits began April 2010. Review of the MAR audits, April 2010 through July 2010, revealed the following monthly ratings: • April 60.63% • May 85.14% • June 79.13% • July 72.57% (The decrease in ratings for July might be related to the ninth item added to the audit tool in July.) MAR audit findings failing to consistently meet 100% compliance with the audit criteria included: • Failure for the MAR to match Physician's Orders. • The reason for the medication was not written on the MAR. • Failure of the transcribing nurse to initial and date new Physician Order's on the MAR. • Failure of the nurse verifying the monthly MAR checks to initial that the MARs were verified. • Failure of nurses to initial that medications were given, or circled if not. • Failure of nurse to document reasons medications were not given in the Integrated Progress Notes. • Failure to have current consents in the record for psychotropic medication prescribed. • Failure to list allergies on the MAR. Failures identified of the above items were relatively consistent with the findings at the baseline review. The initiation of the MAR Audit was a good example of self-monitoring. With the progressive improvement in ratings demonstrated so far, it was evident that such an audit was bringing about improvements in the documentation of critical items on the MAR. Review of 10 Medication Administration Observation Sheets completed November, 2009 through July, 2010 revealed 100% correctness. It was difficult to have confidence in the findings considering the rating achieved from the MAR audits. The Nursing Department needs to develop an inter-rater reliably check by the Quality Assurance nurse to ensure the accuracy of the Medication Administration Observations. Having a monitoring system that accurately identifies and corrects inappropriate medication administration practices enables the Nursing Department to resolve undesirable practices. There was no schedule for the Medication Administration Observations available for review to determine to what percentage of the nurses responsible for medication administration	

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		had been observed. The Nursing Department needs to prepare a schedule for Medication Administration Observations to ensure that all nurses are observed quarterly. RGSC Medication Administration Observation Tool, Exhibit B, NR 100-60, Revised 1/11/99, was obsolete and inadequate to evaluate or correctly monitor all potential aspects of safe and current medication administration practices. The tool needs to be revised to include such item as: • The three checks for safe administration: 1. Check medication against the MAR when taken from the individual's drawer. 2. Check medication against MAR when medication is placed, before opening package, in the medication cup. 3. Check the medication against the MAR just before opening the package for administering medication to the individual. • The five rights: 1. Right individual. 2. Right medication. 3. Right dose. 4. Right route. 5. Right time. Plus checking the individual's PNMP for alterations in texture, consistency, special presentation techniques, adaptive equipment, and positioning. • Cleaning medication cart with an antiseptic solution in accordance with acceptable Infection Control Guidelines as opposed to the use of alcohol solution. • Checks for expiration dates of medications. • Checks for all routes of medication administration, enteral, ocular, otic, topical, all forms of injections, intravenous, inhalation, rectal, vaginal. • Proper disposal of waste material. • Proper disposal of wasted medications. • Proper procedure for hand washing and/or use of hand sanitizers. The procedure on the tool for hand washing and/or frequency for proper hand washing was confusing and needs clarifying in accordance with acceptable Infection Control Guidelines. At the time of the review the State Office had not finalized the Medication Administration Policy and Procedures. Once this policy is revised and integrated into the Facility's policies it is expected that the policy will reflect current standards of medication administration practices in accordance with the requirements of the Settlement Agreement and Health Care Guidelines. In the meantime, the Nursing Department needs to, without delay, update and revise the Medication Administration Observation Tool, Exhibit B, NR 100-60 to ensure that all potential aspects of safe medication administration practices are included on to one single monitoring tool. The MARs in El Paisano and La Paloma were reviewed. As was recommended at the baseline review PNMPs were placed in the MARs and Treatment Books. Individuals' PNMPs were present in both the MAR and in the Treatment Book in El Paisano but only present in the Treatment Book in La Paloma. The missing PNMPs in La Paloma's MAR	

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		were discussed with the Chief Nurse Executive Nurse and Nurse Operation Officer, who were present at the time of the discovery. They immediately took corrective action and copies of the PNMPs were placed La Paloma's MAR. Review of the PNMPs revealed that not all individuals had instructions for medication administration and oral care. The names of individuals without instructions for medication administration or oral care could not be determined at review as some individuals may not require such PNMPs. The Nursing Department needs to collaborate with the PNMT to ensure that individuals' who require alternate textures, consistencies, special oral presentations, adaptive equipment, and positioning have the information included on their PNMPs. The nursing staff had identified individuals with seizure disorders who could more safely receive medication mixed with pudding by the use of maroon spoons. The Nursing Department needs to collaborate with the PNMT staff to identify other individuals who might benefit by use of maroon spoons for medication administration. Individuals with the identified need to use maroon spoons must have this information placed on their PNMPs. Review of the MAR revealed missing allergies and diagnoses on some of the records. It was the responsibility of the physicians to make changes for allergies and/or diagnoses on the 90 Physician's Order. The nurses were required to send any changes to the Health Information Management (HIM) system to add to the WORx that ultimately prints the MARs. This issue was discussed with the Chief Nurse Executive and Nurse Manager. They stated that frequently there were communication failures between the HIM and WORx systems. It could not be specifically identified were the breakdown occurred. The Chief Nurse Executive discussed the problem with the HIM staff and nursing staff in an effort to resolve the failure of the MARs that did not have allergies and diagnoses printed. The Nursing Department needs to implement a procedure for the nursing staff who receives MARs from the Pharmacy to check them upon receipt to ensure that all pertinent information was printed and correct, and if not, take immediate action to correct any problems identified. The Facility was piloting, in El Paisano, the use of MediMAR, a web based application designed to enable the nurse to automate the Five Rights of Medication Safety, and use integrated bar-coding, electronic medication administration, nursing alerts and point of care administration and documentation controls to minimize potential medication errors during administration. MediMAR also speeds documentation. Plans were to "go live" in both units when the piloting phase ends. The fact that the medication's barcode must be scanned before opening the package and before administration should help reduce medication errors. The individuals' MARs were loaded into the system and will not allow the nurse to progress to administration until the system identifies that the medication	

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		was for the right individual, right medication, right dose, right time, and right route. An Enteral Administration Observation was completed at the 3:00 p.m. feeding, August 26, 2010, for individual #47. The monitoring team observed two staff nurses set up the enteral feeding formula in preparation for administration. The nurses explained that two nurses were required to administer the feeding in an effort to safely decrease the time it took to administer the feeding due to individual #47's uncooperativeness and resistance to feedings. The method of administrating the feeding consisted of using a large volume syringe, approximately 60 cc, to administer the feeding using very gentle pressure for instillation. The monitoring team member expressed concern regarding the use of any degree of pressure to instill formula since the acceptable practice was to instill feeding formula by gravity flow. The staff nurses stated that individual #47 had tolerated this method of instillation without any adverse reactions. The preparation of the feeding setup was performed correctly. As was observed at the baseline review this individual continued to wear double binders, one fastened from the back and the other one in front to prevent the individual from pulling out the G-tube. Individual #47continued to require 1:2 staff ratio during feedings due the possibility of pulling out the G-tube during feeding and causing self-injury. Because of individual #47's uncooperativeness during feedings the direct care staff were observed setting on either side of individual #47, whose arms were resting on the chair armrest. The staff were observed patting individual #47's arms and/or hands while the nurse instilled the feeding. During the feeding individual #47 did not resist and did not require the use of actual manual restraint to stop movement. It was difficult for this team member to determine if the procedure the staff used was actually considered a medical restraint or other type of restraint because the procedure they used was to prevent individual #47 from pulling out the G-tube and prevent self-injury. The PST and PBST need to critically evaluate the support individual #47 receives during feeding and develop strategies that do not result in restraint use for the numerous daily feeding. Observed two staff nurses administering the enteral feeding. After individual #47 stood up to remove the binders, individual #47 sat down in an arm chair. One nurse checked the stoma site, auscultated the stomach and aspirated for residual stomach content before instilling the enteral feeding. Approximately 50 to 60 cc of formula was slowly instilled with the use of gentle pressure, while the other nurse refilled syringes until the total amount of formula was instilled. The feeding took approximated 10 minutes to administer and it was tolerated well without any adverse reaction observed. Individual #47 remained relatively calm and cooperative throughout the feeding. Staff stated this was the most cooperative individual #47 had never been during the administration of enteral feedings. The PST, PNMT, HST, and PBST should evaluate the risk and benefits of administering individual #47's enteral	

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		feeding using such a procedure; even if it was done to reduce the length of time it takes to administer because of the individual's uncooperativeness. The Chief Nurse Executive should seek the counsel of the State Office Nursing Consultant regarding the matter since it was not an acceptable professional standard of practice. The Nursing Department needs to evaluate the practice of administering enteral feeding by instilling the formula with a large feeding syringe with gentle applied pressure, even with a justifiable reason. The monitoring team member was not comfortable condoning this practice of administering enteral feeding, even if the rationale behind it seems sound and the individual was not observed to experience any adverse reaction during the feeding, because it goes against nursing best practices which requires that enteral feedings delivered by gravity flow. There was too much of a chance for complications, e.g., reflux leading to aspiration, resulting from such a procedure. The safety of the practice of administering enteral feeding by use of a large syringe with the application of gentle pressure needs to be discussed with the PST, PNMT and PBST to explore the risks and benefits associated with this form of delivery. The safety of individual #47 should be the paramount consideration as opposed to the expedient means of delivery due to behavioral reasons. Further, the Chief Nurse Executive needs to discuss with the State Office Nursing Consultant the use of administering enteral feedings by use of a large syringe with the application of gentle pressure. Medication Administration Observations were completed in El Paisano at 4:00 p.m. on August 26, 2010, for individuals #140, #5, #145, and #126. Medications were administered correctly, except privacy was not afforded during administration. As was observed during the baseline review, the medications were passed out by the nurse handing individuals' medication through the double Dutch door with individual standing on the other side of the door. Contrary to the baseline review, individuals were not escorted to the door by the direct care staff while the other residents were not allowed near the door. During the observation other individuals frequently came to the door or walked by while the nurse was administering medications. Not only did this not allow individuals receiving medications privacy but had the potential to serve as a distraction and interfere with the nurse's concentration during the medication administration. Such interference has the potential to cause medication errors. The Facility Administration and Nursing Department needs to afford individuals with privacy during medication administration. The monitoring team attempted to review the last 10 medication errors; however, the Medication Error Reports requested through the document request were incomplete; therefore, it was not possible to accurately evaluate the reports because they also	

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		included reports from the Mental Health Hospital and Outpatient Clinic. The Medication Management Committee Minutes were only available for February 9, 2010, April 8, 2010, and May 27, 2010. The committee was comprised of members from ICF/MR, Mental Health Hospital, and Outpatient Clinic. Medication errors reported in the minutes for ICF/MR included: three medication errors for January, 2010 and one for April, 2010. Since there were no committee minutes available for January, March, June, and July, 2010, it could not be determined if there were no meetings or if the monitoring team was not provided minutes for those meeting in the document request. The Medication Management Committee did not meet unless there was a quorum of members present. The number of members that were necessary to complete a quorum was not identified. This issue will be explored further at the next review. The discussion of medication errors contained in the minutes and during the Medication Management Committees Meeting, August 25, 2010, of which the team member attended, reflected only a few raw numbers of medication errors for RGSC. There was no problem solving regarding medication errors reflected in the minutes or during the meeting discussions. Because the Medication Management Committee was comprised of the three different services, ICF/MR, Mental Health Hospital, and Outpatient Clinic, there was no specific focus addressing medication administration practices and/or medication errors specific to the ICF/MR as related to compliance with the Settlement Agreement and Health Care Guidelines. As was identified in the baseline review, the ICF/MR's medication errors were entered together with the Mental Health Hospital and Outpatient Clinic in the CWS. The Medication Error Reports available for review were represented in graphic format for April, 2009 through April, 2010. The combined medication error data was difficult to interpret and make any determination regarding compliance. The Facility's Nursing Department needs to form a Medication Management Committee solely for the ICF/MR. Additionally, the Nursing Department needs to separate medication error data specifically for ICF/MR and complete trend analyses. Trending and analyzing medication error data is critical for identifying problematic areas of medication administration practices and can serve as a mechanism to assist with developing plans for corrective action.	

Recommendations:

1. Nursing Department needs to consider adding another Nurse Manager so that El Paisano and La Paloma each have a Nurse Manager. Additionally, the Nursing Department needs to consider adopting a Nurse Case Manager System like the other SSLCs. Although RGSC has a census of 72 individuals the health care responsibilities to provide day to day health care to individuals, coupled with administrative responsibilities, ICF/MR Regulations, Joint Commission, and the Settlement Agreement, necessitates adequate nursing leadership at all levels of the Nursing Departments.

2. Given the weight of responsibility and accountability the Chief Nurse Executive has for administering and managing nursing services for the ICF/MR services and compliance with the Settlement Agreement, coupled with the responsibility for Mental Health Hospital and Outpatient Clinic, the Facility needs to consider a full time Chief Nurse Executive solely for ICF/MR services and compliance with the Settlement Agreement. Because of the weight responsibility and accountability inherent in administering and managing nursing services, the Chief Nurse Executive needs to have direct line authority for all nursing staff.
3. As the Facility gains more experience with the use of Settlement Agreement Monitoring Tools, instructions need to be developed and implemented for each tool as well as for establishing inter-rater reliability at 85% or above. Development of such procedures needs to be done in collaboration with the State Office to ensure that all Facilities use the same audit criteria and documentation to evaluate outcomes consistently across the state.
4. The Facility's Nursing Department needs to develop a Nursing Peer Review Committee that reviews and analyzes audit data derived from the peer review in an effort to identify and solve problematic areas of nursing practice as a means to improve the quality of nursing services provided.
5. The Nursing Department's current policy regarding Nursing Peer Review that addresses peer review from an investigative standpoint needs to be revised to reflect peer review from a quality improvement process; as defined by the American Nurses Association.
6. The Facility's Nursing Department needs to assign a dedicated staff member to track purchase orders for medical equipment through to receipt of purchase.
7. The Facility needs to conduct advanced training on Physical and Nutritional Management by a qualified specialist, particularly as relates to dysphagia issues. This training needs to be arranged as soon as possible, included in nursing orientation, and in re-training.
8. The Facility's Nursing Department needs to prepare a schedule for Medication Administration Observations to ensure that all nurses are observed quarterly.
9. The Facility's Nursing Department needs to ensure that all records contain demographic information.
10. The Facility's Nursing Department needs to, without delay, revise the Seizure Management policy and reporting to in accordance with the Health Care Guidelines. All nurses and direct care staff need training in seizure management,
11. The Facility's Nursing Department needs to assess the reason for late entries in the records.
12. The Annual and Quarterly Nursing Assessment Summaries need to include heath status as relates to the effectiveness of the nursing interventions, care plans, and therapeutic response to medications or treatments, particularly antiepileptic and psychoactive medications.
13. The Facility's Nursing Department needs to ensure that Health Care Protocols: for Handbook for Nurses used to develop care plans are individualized to meet the unique needs of individuals. The nursing staff using the protocols needs to be retrained to ensure that they understand that the protocol must be individualized, not simply copied with an individuals name placed on the form and implemented. .
14. The Facility's Nursing Department needs to cease the practice of the direct care supervisors providing training on care plans.
15. The Facility's Nursing Department needs to ensure that nurses on each shift are made responsible for training the direct care staff on care plans, and keep training rosters to validate that the training occurred.
16. The Facility's Nursing Department needs to purge the older versions of the generic care plans so that they will not inadvertently continue to be used.
17. The Facility's Nursing Department needs to collaborate with other disciplines when developing health care plans so that an interdisciplinary team approach is used consistently as required by Settlement Agreement Sections G and F.
18. The Facility's Nursing Department needs to develop an inter-rater reliably check by the Quality Assurance nurse to ensure the accuracy of the Medication Administration Observations.
19. The Facility's Nursing Department needs to ensure that Infection Control Reporting Form IC-1, is completed for all infections and reportable communicable diseases. Reportable communicable diseases must also be immediately called into the Infection Control Program.
20. The Facility's Infection Control Program needs to ensure that when supervisors/managers are notified of infection control surveillance deficiencies

there is verification that the deficiencies were corrected.

21. The Chief Nurse Executive and Facility administration needs to evaluate the nurses' clinical workspace and consider making physical plant adjustments to afford larger and safer environment to examine individuals, more space for storage, and more efficient desk and workspace for nurses to work.
22. The Facility needs to consider forming an Infection Control Committee specifically for the ICF/MR where focus can be centered on infection control and problems solving issues unique to the Facility.
23. The Facility's Nursing Department needs to, without delay, update and revise the Medication Administration Observation Tool, Exhibit B, NR 100-60 to ensure that all potential aspects of safe medication administration practices are included on to one single monitoring tool.
24. The Facility's Nursing Department needs to collaborate with the PNMT to ensure that individuals' who require alternate textures, consistencies, special oral presentations, adaptive equipment, and positioning have the information included on their PNMPs.
25. The Facility's Nursing Department needs to collaborate with the PNMT staff to identify other individuals who might benefit by uses of maroon spoons for medication administration. Individuals with the identified need to use maroon spoons must have this information placed on their PNMPs.
26. The Nursing Department needs to evaluate the practice of administering enteral feeding by instilling the formula with a large feeding syringe with gentle applied pressure, even with a justifiable reason.
27. The Facility's Nursing Department needs to implement a procedure for the nursing staff who receives MARs from the Pharmacy to check them upon receipt to ensure that all pertinent information was printed and correct, and if not, take immediate action to correct any problems identified.
28. The Facility Administration and Nursing Department need to afford individuals with privacy during medication administration.
29. The Facility's Nursing Department needs to form a Medication Management Committee solely for the ICF/MR program. Additionally, the Nursing Department needs to separate out from CWS medication error data specifically for ICF/MR and completed trend analyses. Trending and analyzing medication error data is critical for identifying problematic areas of medication administration practices and can serve as a mechanism to assist with developing plans for corrective action.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. The following documents of individuals #59, #62, #77 and #97 were reviewed: • Physician orders • Quarterly pharmacy reviews • Annual medical review • Problem list • Neurology consults • Polypharmacy committee meeting minutes • Medication list • Laboratory results • Cardiogram reports • Electroencephalogram reports • Pharmacy recommendation form • DISCUS • MOSES • Personal support plan 2. Quarterly Drug Regimen Reviews (QDRRs) reviewed with the Pharmacist **People Interviewed:** **1**. Anne Ikponwomba, Director of Pharmacy
	Facility Self-Assessment: The Facility reported that the pharmacist consults before dispensing medications with the Primary Care Physician (PCP) when there are concerns about orders, that the PCP discusses these cases with the pharmacist, and any disagreements are referred to the Medical Director for resolution. The monitoring team found in all reviewed cases that the physician followed the recommendations of the pharmacist. The Facility reported that the pharmacist documented in QDRRs that abnormal or sub-therapeutic lab results were considered and, as appropriate, addressed. The monitoring found that the pharmacist did consider these at the time of the QDRR, but that did not promote timely response when abnormal labs or sub-therapeutic levels initially occurred; this could and perhaps did lead to serious health concerns for individuals. The Facility reported that the Pharmacy and Therapeutics committee was in compliance with several specified actions. However, these actions related to documentation such as the use of approved

	abbreviations or documentation that PTM reviews were conducted with input from the pharmacist. The Facilty reported and, based on documentation and outcomes noted during this visit, the monitoring team concurs that the Pharmacy and Therapeutics Committee does not yet comply with actions related to clinical review, such as interpreting Drug Utilization Evaluation data.
	Summary of Monitor's Assessment: **Provision N1:** Because there is no meaningful mechanism, such as specific policies and procedures that clearly delineate the important daily activities of the pharmacists, the monitoring team has determined that Facility is not compliant with provision N1. **Provision N2:** Inconsistency among quarterly and annual pharmacy reviews, format issues of annual reviews and lack of an integrated team process for collecting and disseminating information data and other information results in provision N2 from being compliant. **Provision N3:** Based on the review of several individuals, the combined use of typical and atypical neuroleptics, without significant clinical justification for their use results in the Facility being out of compliance for provision N3. **Provision N4:** At the time of this evaluation and based on the review of four cases, the monitor team has determined that the Facility is in compliance with provision N4. **Provision N5:** Although the Facility has adopted the use of the DISCUS and MOSES assessments for drug monitoring and that they are incorporated into the quarterly pharmacy review process, there is no evidence that indicates that potential side effects for medications are being assessed at other times. Side effects for medications must be assessed when ever a medications change (especially when antibiotics are prescribed) and when there is a change in the persons condition. The monitor team has determined that the Facility is not in compliance with provision N5. **Provision N6:** Upon review, it was determined that the Facility is not in compliance with provision N6. A mechanism to promptly and efficaciously identifies adverse drug reactions is not evident. Identification of adverse drug reactions should begin at the level of the individual self reporting of drug reaction and direct care staff, who must be enabled to better identify adverse drug reactions. **Provision N7:** Although there is a committee structure to provide a drug utilization review, the process must be

	significantly enhanced. It is determined that the Facility is not in compliance with provision N7. **Provision N8:** **A** data base analysis of medication variances was not identified at the time of the review. Longitudinal data is critical when assessing medication variances within a health care setting. The Monitor team has determined that the Facility is not in compliance with Provision N8. **Additonal Comment:** The current pharmacy electronic prescribing system is cumbersome and may lead to error. The pharmacist reported that an outcome analysis was done that found the system may have contributed to errors. An example is that a physician enters the medication into the system and there is no mechanism to automatically update the MARS; the newly prescribed medication is not administered by nursing staff because they are not informed about the medication order. It would take the physician a huge amount of time to complete a medication order using this system. The physicians hand write an order, allow the nursing staff to process the order and fax it to pharmacy. The pharmacy technician then enters the scripts and it is verified by the pharmacist. This is a convoluted process that uses lots of human resources and is primed for errors.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing 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.	Pharmacy quarterly reviews were done timely. The pharmacist at the center completed a comprehensive review for all new medications prescribed. The Facility must, however, ensure that there is a robust mechanism in place to ensure continuity of care in the event the current pharmacist becomes unavailable for a prolonged period of time. There are no current policies and procedures in place for many duties that the pharmacist is currently responsible for; hence, in the event of the Pharmacist's absence, the Facility would not be in a position to understand the many complexities of what is actually expected to be performed in routine daily operations.	NC

#	Provision	Assessment of Status	Compliance
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.	Quarterly drug and annual pharmacy reviews are completed timely; however, there is inconsistency between the quarterly and annual reports, including differing recommendations and diagnoses. Abnormal and sub-therapeutic medication values are listed but may not be addressed until the quarterly review, which could cause a delay of up to three months. Most important, information gained for the report is not obtained through the interdisciplinary team process, hence, critical information regarding the individual is not incorporated into review. Annual reviews consist mostly of a list of side effects and there is no mechanism for recommendations to be incorporated into the personal support plan of the individual served. There was also no mechanism for direct care staff to be made aware of important side effects to monitor the individual for. Although the pharmacy did not have a mechanism in place that ensured prompt follow-up on abnormal drug monitoring levels, the monitoring team was informed by Dr. Moron that he, as Clinical Director, reviews all abnormal laboratory values, and ensures that the primary physicians attend to dose changes and clinical monitoring when necessary. The monitoring team concern with this process is that a more formal redundancy process be in-place that ensures that all abnormal drug levels (and all other "panic lab values") are promptly addressed.	NC
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The Facility has several committees designated to ensure compliance with provision N3; however, the functionality of the polypharmacy review committee is questionable. Outcomes from review of psychiatric services (individuals #5, #33, #76 and #139) indicate that unfavorable polypharmacy practices exist at the facility, especially in the area of intraclass psychotropic use. The committee structure consists of the prescribing physicians as the reviewing physicians on the committee; hence, the physicians are reviewing their own prescribing practice. In general, reviews should be provided by non-prescribing physicians, such as the clinical director.	NC

#	Provision	Assessment of Status	Compliance
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.	Of the four individuals reviewed (#59, #62, #77 and #97), all cases indicated that the physician followed the recommendations of the pharmacist.	S
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.	Although the DISCUS and MOSES have been implemented, there is no evidence to suggest that potential medication side effects are monitored other than when the scheduled assessment is to take place, even when clinically indicated due to changes in medication and health status. It is important that a mechanism be developed to ensure all direct care, nursing and physician staff are aware of common and serious side effects of medications prescribed to individuals served and observe for and report potential side effects so that the need for interim assessments can be determined timely. This is especially important when new medications are prescribed and when doses are adjusted.	NC
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.	At the time of the on-site review, there was no functional process to identify, report and follow up remedial action for all significant or unexpected adverse drug reactions in a timely manner. During its review, the monitoring team could not identify a process that enables regular and prompt determination of drug reactions. Identification of adverse drug reactions begins with the individual to self report signs and symptoms of adverse drug reactions and direct care staff ability to identify adverse drug reactions.	NC
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	During the review, a functional utilization process was not in effect at the Facility. The current committee structure enables prescribing physicians to evaluate their own prescribing habits. Reviews must be independent of the prescribing physician and must provide a "critical" review of medication use, including accuracy of diagnosis and drug indication, risk and benefit profile, off labeled use of medications, and data supporting the use of medications.	NC

#	Provision	Assessment of Status	Compliance
	be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.		
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The Facility, under the leadership of Anne Ikponwomba, Director of Pharmacy, is currently enhancing their process of regularly documenting, reporting, analyzing data, and providing remedial action regarding actual and potential medication variances. A database system will need to be developed to monitor variances.	NC

Recommendations:

1. The Facility should enable the addition of an additional full time pharmacist, preferably a Pharm. D. The current pharmacist is significantly over burdened and can not be expected to complete all of the significant responsibilities necessary to ensure the safe and efficient dispensing of medication and provide quality reviews. The current full time pharmacist serves both the DD and MH components of the Facility.
2. The current electronic prescribing system (Avatar) has resulted in significant prescribing errors. A failure analysis study was completed by the Facility and should be carefully reviewed by Central Office. The monitoring team had ample opportunity to observe the use of Avatar and concurs with the Facility's review.
3. Pharmacy reviews, especially the annual, must occur in the context of an IDT process. The IDT/PST will enable professional clinical staff, and others including direct care staff and LARs who know the individual well, to communicate relevant information and enhance the level of care provided and improve outcomes.
4. It is essential to improve the continuity between the personal support plan, annual pharmacy review and quarterly pharmacy review. The annual review must serve as a mechanism to summarize important information and ensure that all side effects and adverse drug reactions experienced, risks, benefits, alternative treatments, appropriateness of the medication for the given diagnosis, and off label use of medications are made aware to the team, which must include the LAR for the individual served.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: **Review of Following Documents**: 1. Record reviews of Individuals #4, #10, #13, #16, #19, #23, #27, #29, #35, #36, #47, #51, #62, #66, #72, #80, #82, #85, #86, #107, #113, #118, #122, #126, #133, #140, #149, #150 2. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), and Physical and Nutritional Management (PNM) team members, including credentials 3. Policies, procedures, and/or other documents related to Physical and Nutritional Management,(Policy #013 dated 1/31/2010 and #012 dated 1/31/2010) 4. Curriculum vitae (CVs) for PNMT members 5. A list of continuing education sessions or activities participated in by PNMT members since 1/2010 6. Minutes, including documentation of attendance, for the following meetings i. PNMT meetings (3/2010 to 6/2010) ii. Health Support Team (HST) meetings (1/2010 to 6/2010) 7. Individual PNMT reports for individuals reviewed above 8. Tools used to screen and identify individuals' PNM health risk level. 9. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order. 10. Tools used to assess PNM status and needs. 11. A list of PNM assessments and updates completed in the last two (2) quarters. 12. PSPs for the individuals on the list above for whom PNM assessments and updates have been completed in the last quarter. 13. Completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs. 14. Tools used to monitor implementation of PNM procedures and plans. 15. A list of individuals for whom PNM monitoring tools were completed in the last quarter. 16. Tools utilized for validation of PNM monitoring. 17. For the past two quarters, any data or trend summaries used by the facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans. 18. Nutritional management plan template and any instructions for use of template. 19. Dining Plan template. 20. Lists of individuals: (a) On modified diets/thickened liquids; (b) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (c) With BMI equal to or greater than 30; (d) With BMI equal to or less than 20;

	(e) Since January 1, 2010, who have had unplanned weight loss of 10% or greater over six (6) months; (f) During the past 12 months, have had a choking incident; (g) During the past 12 months, have had a pneumonia incident; (h) During the past 12 months, have had skin breakdown; (i) During the past 12 months, have had a fall; (j) During the past 12 months, have had a fecal impaction; (k) Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); (l) With poor oral hygiene; and (m) Who receive nutrition through non-oral methods 21. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year. 22. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials. 23. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans. 24. For the prior 12 months, a list of competency-based training sessions addressing foundational skills in PNM. 25. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM. 26. RGSC Plan of Improvement 8/9/10 (POI) 27. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) **Interviews with**: 1. Betty Perez, PNMP tech 2. La Paloma and El Paisano DCPs **Observations of**: 1. PNM meeting (8-24-10) 2. HST meeting (8-25-10) 3. Behavior Management Meeting (8-24-10) 4. La Paloma and El Paisano lunch and dinner 5. La Paloma and El Paisano transition times
	Facility Self-Assessment: The Facility reported it is not in compliance with any of the provisions of this Section but has completed steps leading to compliance.

	Areas of noncompliance included the PNM team not meeting regularly in response to a change in status and/or monitoring results. RGSC noted that they are in compliance with regards to assessing the risk of falling, however, the monitoring team found this area to be not in compliance due to the lack of assessments occurring outside of the scheduled times or in response to falls occurring throughout the year. The Facility reported that dining plans were in place but did not always include current information on positioning, and that individuals were not positioned as called for in the plans. The monitoring team's review indicated that individuals are not consistently provided with plans to minimize regression. The Facility reported that dining plans are in place, can be understood by staff, and are present and used during eating activities. . The monitoring team found that while plans are present, they are not being utilized with any degree of consistency. and staff were not implementing dining plans accurately. RGSC stated that are in compliance with regarding strategies to address oral hygiene and medication administration. The monitoring team found this component to not be in compliance due to lack of comprehensiveness. The Facility reported that all staff are provided with competency based training related to PNM issues. The monitoring team found that several staff members are working on the homes prior to receiving any training. The Facility reported that it is in compliance with regards to monitoring deficiencies being formally shared, however, there was no evidence of review or active discussion regarding monitoring results. RGSC stated that assessments and/or interventions are provided when an individual is determined to be at an increased risk of harm. While there is discussion regarding the occurrence of falls, there is a lack of investigation and/or assessment that takes place to comprehensively mitigate the identified risk.
	Summary of Monitor's Assessment: Other than RGSC hiring a full time speech and language pathologist (SLP), there has been little to no progress made towards compliance in this provision. The hiring of the SLP should assist the center in providing better services regarding swallowing identification and treatment but issues related to safe dining were abundant and occurring without intervention. PNMPs were still not comprehensive as they did not consistently contain comprehensive information needed to minimize the risk of aspiration and/or choking especially during oral care and medication administration.

	Provision O.1: This provision was determined to be not in compliance. Areas of need include increasing the frequency and consistency in which the team meets to respond to changes in status. **Provision O.2:** This provision was determined to be not in compliance. DADS was in the process of developing a new risk process that is planned to address the need to more accurately identify individuals at risk. Additionally, supports regarding the areas of oral care and medication administration are missing from the assessment process and are not comprehensively included in the PNMP. **Provision O.3:** This provision was determined to be not in compliance. PNMPs are not comprehensive due to the plans lacking information regarding oral care and medication administration strategies. Additionally, PNMPs are not developed with clear input from the PST. **Provision O.4:** This provision was determined to be not in compliance. Staff were observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline. Per interview, staff were not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being. **Provision O.5:** This provision was determined to be not in compliance. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. Additionally, new employees were often working at the homes prior to receiving PNM training **Provision O.6:** This provision was determined to be not in compliance. There was no evidence that staff or the individuals were being monitored in all aspects in which the individual was determined to be at increased risk. **Provision O.7:** This provision was determined to be not in compliance. There was not a formal process in place that ensures individuals with increased PNM issues are provided with increased monitoring. At this time, this process is informal and directed by the attending clinician. **Provision O.8:** This provision was determined to be not in compliance. All Individuals did not receive an annual assessment that addressed potential pathways to PO status. Those individuals that did receive assessments did not have clear justification as to why the tube was necessary nor did the assessments list possible pathways to oral intake.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with	RGSC has two teams that cover portions of physical and nutritional management. The HST meets monthly and consists of an occupational therapist (OT), dietitian (RD), QMRP,	NC

#	Provision	Assessment of Status	Compliance
	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 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	nurse, physician, and other members as needed; however, the team focuses primarily as a medication and medical health status review and does not address the individualized physical needs and concerns of the individuals. Additionally, the individuals discussed appear to be based on schedule and not recent health events. The other team is called the Physical and Nutritional Management Team (PNMT). Per state policy 013, this team meets a minimum of monthly and as indicated by a change in status and consists of the OT, RN, QMRP, RD, and various other professionals and staff. As of this review, there remains no SLP involvement, however, a SLP was just recently hired and there are plans to have the SLP involved in the meetings. As with the baseline study, these meetings are based on schedule and did not occur in response to a change in status. Examples of the team failing to meet or issues not being discussed and/or addressed included: • Individual #10 had falls occurring on 5/18/10 and 6/25/10 but there is no discussion of this during the 6/29/10 meeting. • Individual #140 had falls occurring on 5/13/10, 5/14/10, 5/23/10, 6/9/10, 6/22/10, and 6/24/10. The PNM team did not meet to address this issue until the regularly scheduled meeting on 6/29/10. • Individual #29 had a choking incident on 5/31/10. The PNM team did not initiate a meeting to discuss the incident nor was there evidence in the PNM minutes of discussion at the regularly scheduled meeting on 6/2910. • Individual #113 had a speech evaluation on 3/30/10. A swallow study was recommended. The swallow study was not completed until 7/29/10 and there was no indication in the minutes as to why there was such a substantial delay. • Individual #101 was observed during lunch grabbing and consuming sugar packets. There is no evidence that this issue has been discussed or plans developed. These issues are discussed during morning meeting but again, this serves as more of a notification rather than an active discussion of how to address these issues. PNM Team attendance records and meeting minutes from 3/2/10 to 5/11/10 documented 88% of attendance level by PNM Team standing members. Examples of individuals missing from the meetings included the Assistant Residential Coordinator and MD. Review of facility documentation of CV, and copy of current licenses submitted for each	

#	Provision	Assessment of Status	Compliance
	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.	PNM Team standing member did demonstrate the following qualifications for PNM Team standing members: • In six of six licenses reviewed, a copy of the license was current. • In six of six CVs reviewed, experience in respective field was documented. Interview with the PNMP tech revealed that PNM Team members did not complete training and professional development related to physical and nutritional supports. Videos were received from State Office but have not been released for training by Habilitation Services. Based on a review of six of ten individual records, documentation supported that the PNMT did not meet regularly to address change in status, assessment, clinical data and monitoring results. • Individual examples: Please see further above in Provision O.1 and P.2 for examples of where the PNM Team did not meet regularly to address change in status, assessment, clinical data and monitoring results. Therapists did not actively participate in the PSP meetings although the individuals may have identified issues relevant to their field. This was identified through interviews with therapists and observation of Individual #140's PSP. Therapists stated the reason behind not attending was due to not having time. Areas relevant to PNM were read with minimal discussion without the presence of the staff that were most knowledgeable of the subject matter.	
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	A process is not in place that identifies individuals with PNM concerns. Sixteen of 16 records reviewed did not accurately identify individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individual #35 was on a modified diet, has problems chewing and requires cues to avoid overstuffing but was listed as a "low risk" of choking. • Individual #113 was evaluated on 3/30/10. A Swallow Study completed on 7/29/10 showed penetration of thin liquids but was still listed as "low risk" of aspiration. • Individual #29 had a choking incident occur on 5/31/10 but was listed as not being at risk for choking. • Individual #80 had five falls occurring from May 2010 to July 2010 but was listed as not being at risk of injury • Individual #140 had 12 falls occurring from May 2010 to July 2010 but was listed	NC

#	Provision	Assessment of Status	Compliance
	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.	as being at a "low risk" of injury • Individual #107 has a BMI greater than 30 but was listed as being "low risk" for weight. Based on a review of 16 individuals, 16 of 16 Individuals are not provided with a comprehensive assessment by the PNM team that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. Currently the OT components regarding oral care and medication administration are missing from the assessment process. Additionally, the oral motor section of the assessments was vague and did not provide clear objective information regarding swallow status and cannot be considered an assessment. For example: • Individual #126 assessment (7/10) states the individual has poor oral motor skills but does not state or provide information regarding the different components of the oral motor status (i.e., lingual or labial range of motion, and anterior-posterior propulsion). • Individual # 62's assessment (7/10) states the individual has good oral motor skills but does not state or provide information regarding the different components of the oral motor status (i.e., lingual or labial range of motion, and anterior-posterior propulsion). While the rationale of adaptive equipment was included in the assessments, 15 of 16 assessments reviewed did not contain the rationale behind many interventions that were not linked to adaptive equipment listed in the PNMP. For example: • Assessment (7/30/10) for Individual #16 stated that a chin tuck was utilized but did not provide the rationale for this strategy. • Assessment (7/16/10) for Individual #72 stated that the individual must alternate liquids and solids did not provided the rationale behind said technique. Review of 16 records involving individuals revealed: • In 16 of the 16 records reviewed (100%), there was no documentation of PNM review/analysis of the findings, including but not limited to relevant discipline-specific assessment(s), PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. The summary did not address: • Oral care • Medication administration • Mealtime strategies in a method that is clear as to why the strategies are	

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		relevant. • In 16 of the 16 records reviewed, there was no documentation of PNMPs developed with input from the PST for those individuals at highest risk. Currently PNMPs are developed by Habilitation Therapists based on their clinical judgment. • In 16 of the 16 records reviewed, there was lack of congruency between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. Congruency was not noted with regards to Oral Motor/Swallowing as it is unclear as to what the rationale or justification was for multiple dining strategies. See above information regarding lack of justification and reasoning for examples.	
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 persons identified as requiring PNM supports were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans are not comprehensive as they lack detail regarding oral care and medication administration. For example: • Individual #10's PNMP states the position during oral care but does not provide information regarding thickness of liquids or strategies to implement to increase safety. • Individual #118's PNMP states the position during oral care and medication administration but does not provide information regarding thickness of liquids or strategies to implement to increase safety. Based on a review of 16 individuals, individuals were not provided with a comprehensive PNM.P. A breakdown of the PNMP revealed: • In 16 of 16 records reviewed (100 %) positioning instructions for wheelchair and alternate positions instructions were included as indicated. • In 16 of 16 records reviewed (100%) transfer instructions were included as indicated. • In 16 of 16 records reviewed (100 %) the mealtime/dining plan included oral intake strategies for mealtime and snacks. • In 16 of 16 records reviewed (100 %) the mealtime/dining plan included food/fluid textures. • In 16 of 16 records reviewed (100 %) the mealtime/dining plan included behavioral concerns related to intake. • In 0 of 16 records reviewed (0%) strategies for medication administration were included as indicated. • In 0 of 16 records reviewed (0%) strategies for oral hygiene were included. • In 16 of 16 records reviewed (100%) individual adaptive equipment was	NC

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		included as indicated. • In 16 of 16 records reviewed (100%) bathing/showering positioning and instructions were included as indicated. • In 16 of 16 records reviewed (100%) communication strategies were included. Although the PNMPs reviewed contained the needed components, the PNMP components were not comprehensive as the following examples indicate: • Individual #10's PNMP states the position during oral care but does not provide information regarding thickness of liquids or strategies to implement to increase safety • Individual #118's PNMP states the position during oral care and medication administration but does not provide information regarding thickness of liquids or strategies to implement to increase safety. • Individual #126's PNMP does not provide information regarding medication texture (crushed, whole) PNMPs were not formally developed with input from the PST, home staff, medical and nursing staff. In 16 of 16 records reviewed (100%), PNMPs were not clearly developed with input from the PST with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per interview with the PNMP tech, PNMPs are drafted by the PNMP tech and finalized by the OT and PT. Per record review, there is evidence in the PSPs that the PNMPs are included, but there was no evidence of discussion or input from other team members. This was evident during Individual #140's PSP where recommendations were read with no discussion provided by the PST. In 16 of 16 records reviewed (100%), there was documentation that the PNMPs were reviewed annually at the PSP meeting but as mentioned above, there was no indication of active discussion of the plan. In 4 of 8 records reviewed (50%) PNMPs were not reviewed and updated as indicated by a change in the individual's status, transition (change in setting) or as dictated by monitoring results. Examples of when PNMPs were or were not reviewed and updated as indicated by a change in the individual's status, transition (change in setting) or as dictated by monitoring results are found in Provision O1.	
O4	Commencing within six months of	Staff did not consistently implement interventions and recommendations outlined in the	NC

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	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.	PNMP and/or Dining Plan. Two mealtime observations demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to provoke swallowing difficulties and/or increased risk of aspiration. In only eight of sixteen individual observations, staff were following mealtime plans accurately. Nevertheless, there were some examples of accurate implementation: • In three of three observations staff were following transfer instructions, • In two of two observations, nursing staff were following mealtime instructions for medication administration Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: • Individual #149 was not provided cues to slow down or cues to prevent overfilling of the oral cavity. • Individual #36 was not provided cues to eat slowly or take small bites. • Individual #35 was not wearing high top shoes with ½ inch insole or provided with cues to slow pace and prevent overfilling of the oral cavity. • Individual #51was not provided cues to alternate liquids and solids or take small bites. • Individual #140 was not provided with cues to alternate liquids and solids **or** take small bites. • Individual #11 was not provided with cues to slow down or alternate liquids and solids. • Individual #96 was overstuffing and was not cued to decrease size of bite or rate of intake. Staff did not understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. Based on interviews with three DCPS on El Paisano and four DCPs on La Paloma: • In seven of seven interviews with staff, they were able to identify the location of PNMP and/or mealtime plan. • In zero of seven interviews with staff , staff could describe individual-specific PNMP strategies. • In three of seven interviews with staff , staff could describe the schedule for implementation of PNMP strategies. • In four of seven interviews with staff , staff stated they had received individual-	

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		specific training for PNMP strategies.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	Staff were provided initially with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff; however, there was no evidence of these trainings being offered on an annual basis or assurance that these trainings were occurring prior to staff beginning employment. Review of the Facility's training curricula revealed that it did include adequate PNM training in the following areas: • Body mechanics • Handling techniques • Optimal alignment and support in seating systems and alternate positions • Mechanical lift transfers • Manual transfers approved by facility policy • Mealtime positioning • Food and fluid consistency • Safe presentation techniques for food and fluid • PNMPs. Staff were not consistently trained prior to working with individuals and retrained as changes occur with the PNMP. Information provided by the Facility training reports from 4/15/10 to 6/21/10, 14 of 18 new staff were provided foundational training and based on an interview with Habilitation Services, it was stated that not all staff were trained prior to working with individuals. For example: • Five staff began employment on 3/1/10 or 3/16/10 but did not receive PNM training until 4/15/10 • One staff began employment on 4/1/10 and did not receive training until 6/21/10 With regard to changes in plans, it is difficult to determine who has been trained outside of those present when the initial change in made to the plan. Training sheets are passed on to the supervisors but there was no follow up to ensure all staff had been trained and no log or spreadsheet that tabulates total people trained. Provision of person-specific training and training to staff in response to changes to plans of care was not able to be validated due to RGSC's inability to produce training records. Additionally, there was no process in place to provide this additional training should a unit have to utilize floating or pull staff from another area. It is essential that PNM	NC

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		supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual.	
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 policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted does not exist at RGSC. Based on review of the Facility's monitoring practices, a system which included the following components was not in place to monitor staff implementation of PNMPs including mealtime plans: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • Formal schedule for homes to be monitored on a quarterly basis with an identified staff schedule, • Monitors are re-validated on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms are correct and consistent among various individuals conducting the monitor, and • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician. Findings of the current monitoring forms are filed with the Incident Management Coordinator but there was not a clear system in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with physical and nutritional risk. The PNM team does meet monthly to discuss health issues related to PNM but response to indicators identified by monitoring did not appear to be a focus of conversation nor did the development of the pnm system. Monitoring does not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities) Examples of PNM activities that were not being monitored: • Oral care	NC

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		• Medication Administration All members of the PNM team do not conduct monitoring; however this was an area that was changing to include all members. Currently, monitoring is primarily conducted by OT, PNMP technician, and senior direct care staff; however there was not a clear process in place that outlines the frequency in which individuals will be monitored (i.e., high risk vs. low risk) or the response if a deficiency was noted.	
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.	There was not a formal process in place that ensured individuals with increased PNM issues were provided with increased monitoring. At this time, this process is informal and directed by the attending clinician. Per report, DADS is currently in the process of developing a monitoring policy that is intended to address this issue. While the PNM status is scheduled to be regularly reviewed during the HST meetings, there is no clear indicator that status is reviewed by this team or the PNM team in the event of a change in status. See Provision O.1.	NC
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.	RGSC only has one individual who receives enteral nutrition. Based on the review of the record, the individual who received enteral nutrition did not receive an annual assessment that addressed the medical necessity of the tube and potential pathways to PO status. While the assessment identified the need for continued NPO (no intake by mouth) status there was no evidence of discussion or development of a plan that may lead the individual back to po (oral) status. Examples of individuals who received enteral nutrition and did not receive an annual assessment: • Individual #47 received an assessment but there was no identification of potential pathways to regain oral status. One of one individuals with a PNMP (100%) who received enteral nutrition and/or therapeutic/pleasure feedings was provided with a PNMP. This PNMP, however, was missing the same information as listed in Provision O.3. PSP s for the individuals who received enteral nutrition did not clearly document the rationale for the continued need for enteral nutrition.	NC

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		An example of an individual PSP that did not document the rationale for the continued need for enteral nutrition was: • It was mentioned in the PSP that Individual #47 was tolerating tube feedings but did not specify why enteral nutrition was appropriate or possible pathways to PO intake. A policy does not exist that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT) as it relates to the assessment of individuals who are NPO. Per the POI, this policy will be developed and/or revised.	

Recommendations:

1. Dysphagia and the risk of choking and aspiration must be assertively managed at the Facility. Physicians, nurses and direct care professionals must be provided regular competency based training on the many issues associated with dysphagia. Importantly, all individuals should be assessed regularly for dysphagia, aspiration, and choking. When an individual is suspected or diagnosed with dysphagia, aspiration or choking, a comprehensive evaluation should be obtained that includes more than a swallowing study. Evaluations to determine the etiology of the problem must be performed and may require the assistance by various consultants, such as a movement specialist or ENT, additional diagnostics, and comprehensive review by the team process. Issues such as a new neurologic insult, or medication effect. Refer to recommendations in Section O for additional detail. Individuals who receive enteral nourishment should be assessed annually to determine appropriateness of continued enteral status and the possible return to oral intake. Assessments must clearly indicate possible pathways to resume oral intake.
2. Assessments should be reviewed and revised so that all aspects of physical and nutritional management are addressed. This includes assessing oral care, and medication administration.
3. A formal process should be developed that ensures individuals who are at an increased risk receive more intensive monitoring.
4. All staff should be trained in all areas of PNM prior to working at the homes.
5. All individuals who are determined to be at an increased risk should only be provided assistance from staff who have received competency based training specific to that individual.
6. All developed processes should be detailed so that those reviewing an individual's history and care are easily able to ensure the loop of care was closed (onset to resolution).
7. PNMPs should be expanded to include oral care and medication administration. Strategies should not only include positioning for these activities but also strategies and adaptive equipment that will assist in minimizing the individuals' risk. Included in these strategies should be methods to increase safety of intake through modification of texture/consistency and identification of intake strategies.
8. The PNM meeting should be a collaborative meeting in which all parties bring their area of expertise to the table to investigate the etiology of such illness as pneumonia, skin breakdown, and constipation and how to prevent or minimize the reoccurrence. Change of status should result in additional meetings in an effort to provide more comprehensive problem solving.
9. The PST should develop an interdisciplinary plan to address Individual #101's issue with food stealing. A Health Care Plan should be developed to address complications that may arise from the ingestion of sugar packets. Considerations may be to increase the monitoring of bowel sounds and the regularly scheduling of ultrasound in an effort to mitigate the risk of obstruction. Additionally, a PBSP should be developed that focuses on identifying why the behavior occurs and clear methods to decrease the behavior while providing a replacement behavior. This replacement

behavior may be found in the form of a communication program that will allow the individual an increased ability to express his needs surrounding mealtime.

10. Nursing reported that they are having difficulty achieving a smooth mixture of the gel thickener and liquids. It is recommended that RGSC consider buying handheld battery mixers to assist in achieving an adequate mix. These mixers are commonly used for infant formulas and do a successful job with gel based thickeners as well.

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:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. Record reviews of Individuals #3, #4, #5, #10, #13, #16, #19, #23, #27, #29, #35, #36, #47, #51, #62, #66, #72, #80, #82, #85, #86, #107, #113, #118, #122, #126, #133, #140, #149 2. Policies, procedures and/or other documents related to the provision of OT/PT supports and services (policies 012 dated 1/31/2010, 013 dated 1/31/2010and 014 dated 10/7/2009) 3. Current Lists of people: (a) Who use wheelchair as primary mobility; (b) With transport wheelchairs; (c) With other ambulation assistive devices, including the name of the device; (d) With orthotics and/or braces; (e) Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution. and (f) Who have experienced a falling incident during the past three (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury. 4. Habilitation Therapy Adaptive Equipment Spreadsheet 5. OT/PT assessments template. 6. Five (5) most current OT/PT assessments conducted by each therapist and corresponding PSPs. 7. Wheelchair seating, PNM clinic assessment templates and related documentation 8. For the past 12 months, any summary reports or analyses of monitoring results related to OT/PT generated by the facility, including but not limited to quality assurance reports, including action plans 9. List of individuals receiving direct OT and/or PT services and focus of intervention 10. Adaptive Equipment Checklist (3/1/2010 to 5/12010) 11. RGSC Plan of Improvement 8/9/10 (POI) 12. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) **Interviews with**: 1. Betty Perez, PNMP tech 2. La Paloma (three) and El Paisano (four) DCPs **Observations of**: 1. PNM meeting (8-24-10) 2. HST meeting (8-24-10) 3. Behavior Management Meeting (8-24-10) 4. La Paloma and El Paisano lunch and dinner 5. La Paloma and El Paisano transition times
	Facility Self-Assessment:

	The Facility reported it is not in compliance with any of the provisions of this Section but has completed steps leading to compliance. The Facility accurately reported that it was in process of seeking to fill an open PT position. RGSC reported it is in compliance with the comprehensiveness of assessment and rationale for recommendations; however, based on the Monitoring Team's review, the facility is not in compliance with these Action Steps. The Facility accurately reported it is not yet in compliance with all requirements for identifying and assessing individuals at risk. The Facility reported, and the monitoring team confirmed, that OT/PT service plans were developed within 30 days of the date of the assessment/update as indicated by the assessment. However, intervention plans were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies.
	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. RGSC has a position open for a PT which should assist in increasing services to individuals but this position has not been filled as of this review. Assessments are completed in accordance to the schedule set forth by RGSC; however, assessments are not being consistently completed in response to a change in status. **Provision P.2:** This provision was determined to be not in compliance. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. **Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans. **Provision P.4:** This provision was determined to be not in compliance. A system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational	In an effort to improve clinician to individual ratio, the facility has listed an additional PT positions. As of this review, this position remains open. Based on a review of CVs for each clinician (2) and interviews with therapy staff, the	NC

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	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.	Department did document appropriate qualifications for licensed OTs, PTs, and assistants. All individuals have received an OT/PT assessment and/or screening. This was validated via review of eight records for completed OT/PT assessment/screening, including those who were recently admitted within the last 12 months. Assessment/screening indicated whether or not the individual required OT/PT supports and services for eight of eight records reviewed. If receiving services, direct or indirect, eight of eight individuals were provided an OT and/or PT assessment a minimum of every 3 years, with annual interim updates (as applicable). The problem is that the assessment is vague and does not contain objective measurements or in depth assessments of identified issues. Examples of assessments that are not comprehensive included: • Individual #118's mobility assessment only stated that a merry-walker is utilized and did not provide information regarding why there is a need for such device.. • Individual #16's mobility assessment only stated that a gait belt is used and did not provide information regarding why there is a need for such device.. • Individual #86's mobility assessment did not provide detailed information regarding ability to ambulate Additionally, plans are not consistently developed to address issues: For example: • Individual #72 used a gait belt to assist with stability but there was no plan in place to minimize regression or increase stability • Individuals #118, #80, and #10 had unstable gait but there was no plan in place to minimize regression or improve stability. Based on record review of individuals who had experienced a change in health or physical status, seven of ten individuals had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. See O.1 for examples. Eight of eight assessments reviewed (100%) contained probes that identified the need for additional assessment.	

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		Based on review of eight OT/PT assessments, 100% included signatures and date of both OT and PT and included evidence of active collaboration between OT and PT. Based on review of eight OT/PT assessments, zero of eight were comprehensive with content from each discipline as indicated. For example: • Oral Motor section of the report was primarily a summary and does not provide objective measurable data. • Oral Care and Medication Administration is not adequately addressed in the assessment as there was no mention of strategies other than positioning that may be utilized to decrease risk of choking and/or aspiration • Mobility sections were often summarized and did not include objective or measurable data • See Provision O.2 for additional information	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for eight individuals receiving OT/PT services, plans were developed within 30 days of the date of the assessment/update as indicated by the assessment. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. See Provision O.1 regarding assessments in response to a change in status and Provision P.1 for issues with plan development. Intervention plans were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. See Provision O.2 for specifics. Based on reviews of PNMPs and other positioning plans for eight individuals, equipment is specified for eight of eight plans reviewed. Individuals not receiving direct services are not consistently reviewed by OT/PT should there be a change in status. See Provision O.1 for additional information. Of particular concern was the failure to conduct adequate root-cause analysis of falls. This failure places individuals at risk of injury. Successful fall prevention requires a thorough clinical assessment of individuals who fall (or have a history of falls) and their environment. After a fall, clinical staff should evaluate extrinsic factors (e.g., wet floor, loose rug), intrinsic factors (e.g., seizure disorder), and medications. A thorough	NC

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		assessment of gait and balance should be included as part of the assessment. Further, the appropriateness of mobility devices, such as walkers and wheelchairs, and the need for personal assistance should be reviewed regularly and re-evaluated as necessary. Such steps, which will decrease the risk of future falls, are not currently being taken. For example: • Individual #10 had a fall occurring on 5/18/10 but there was no evidence that an assessment took place other than to state it was due to the shoes and an MD referral would be made. • Individual #5 had falls occurring on 5/13/10 and 6/21/10. While there is evidence in the progress notes that this was reported, there is no evidence of an assessment. • Individual #140 had falls occurring on 5/13/10 and 5/14/10 with no evidence of assessment. • See Provision O.1 for additional examples.	
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.	Based on observations of OT/PT interventions all PNMPs or other intervention plans were not implemented as written for five of ten individuals reviewed in the sample. See Provision O.4 for examples Staff do not consistently complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. See Provision O.5 for examples Based on interviews of DCPs, staff did not consistently understand rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs. Based on interviews with seven DCPs: • In seven of seven interviews with staff, they were able to identify the location of the OT/PT plans. • In two of seven interviews with staff, staff could describe individual-specific strategies outlined in the plan. • In two of seven interviews with staff, staff could describe the schedule for implementation of the OT/PT plans. • In three of seven interviews with staff, staff stated they had received individual-specific training for OT/PT intervention/support plans.	NC

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		Examples of direct care professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • PNA on La Paloma was not able to describe rationale for maintaining appropriate elevation. • PNA on La Paloma was not able to describe why individuals used modified dining equipment.	
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.	Per interview with PNMP tech and review of monitoring form, a system does exist to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology. There is evidence in OT/PT documentation that equipment prescribed is available for eight of eight records reviewed. • Based on monitoring forms reviewed from 3/1/2010 to 5/1/2010, monitors documented that appropriate adaptive equipment and assistive technology supports were immediately available to all individuals in the sample. Per POI, all staff are monitored for their continued competence in implementing the OT/PT programs. This is inconsistent due to lack of a formalized process. A policy does not exist that clearly defines the details of the monitoring system including frequency, implementation and acquisition of data. A system does not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff (Refer to Provision O-5). Per POI, there is no formal process to ensure a data collection method is validated by the program's author(s). As of this review, this area is in the process of being developed and outlined. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.	NC

Recommendations:

1. The current assessment format needs to be reviewed to determine if it is sufficiently comprehensive to identify the needs of the individuals at RGSC. Special care should be given to the areas of oral care and medication administration as well to improving overall detail. Information should be measurable to allow for comparative analysis from year to year. If there are strategies listed on the PNMP then there should be an assessment

indicating why the strategies listed were appropriate.

2. After a fall, clinical staff should evaluate extrinsic factors (e.g., wet floor, loose rug); intrinsic factors (e.g., seizure disorder); and medications. A thorough assessment of gait and balance should be included as part of the assessment. Further, the appropriateness of mobility devices, such as walkers and wheelchairs, and the need for personal assistance should be reviewed regularly and re-evaluated as necessary.
3. Programs to address weakness or instability with gait should be expanded as part of the overall plan of care.
4. Habilitation Therapies should participate more actively in the annual PSP process. Individuals who have OT/PT needs are not being represented by those who have the most expertise in the area.
5. See Provision O for recommendations regarding monitoring and training.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. The following records of individuals #15, #33, #47, #58 and #69 were reviewed: • All dental records for the past 12 months • Annual personal support plan and related addendums for dental issues • Dental pre-sedation medication list for past 24 months • All clinical documentation specific to pre sedation for the past 12 months • Current problems list • Annual medical evaluation 2. List of individuals who have received pre-treatment sedation for dental or medical care **Meeting Attended/Observations:** 1. Individual #58 was observed at home.
	Facility Self-Assessment: The Facility reported that it works with two contract dentists to provide services and is currently in process of developing a new contract with a family dentistry company. Although not stated explicitly as part of the Self-Assessment, the Facility made this comment in relation to care and timeliness actions. The monitoring team found that timeliness of assessments and treatments was deficient. Fragmenting dental services among contractors may also have contributed to the lack of involvement with the PST. The monitoring team would hope that any new contract would include provisions for involvement with the PST and for development of a robust oral health program. Regarding programs to minimize future need for restraint and pre-treatment sedation, the Facility reported that the Psychologist is reviewing requirements of the POI and the State Office. The monitoring found little evidence of meaningful desensitization or other programs to reduce this need.
	Summary of Monitor's Assessment: **Provision Q1:** Following review of the provision of dental care the monitor team determined that the Facility is deficient in providing timely dental treatment or dental, meaningful oral hygiene, quality documentation practices, IDT integration and routine monitoring of oral health issues. For these reasons, the monitor team has determined that the Facility is not in compliance with provision Q1. **Provision Q2:** The monitoring team has determined that dental issues and services are significantly lacking as part of the IDT process. It is critical that the PST play a more active role in monitoring oral health concerns at the Facility.

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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.	During the monitor team's review of dental service, it was evident that dental service is not incorporated into the team process. The IDT and the PST were unaware of critical dental issues. Given the extent of periodontal disease at the center, the monitor team has concern over the quality of daily oral hygiene practices offered to individuals served by the Facility. Timeliness of assessments and treatments, as well as continuity of dental care were noted as deficient. The following examples delineate the rational for the Facility not being compliant with provision Q: Review of individual #58, revealed that a complete set of upper and lower replacement denture were recently provided to the individual. Upon observation of the individual at his home and vocational work place, it was noted that the individual had a large chip on the upper denture. Upon review of the dental and medical records, and addendums to the personal support plan, there was no indication that this issue has been addressed. Dental records do not comment on oral health. The personal support plan does not comment on issues related to recurrent breaking of the individual's dentures. The dental and medical records and the personal support plan of individual #47 were reviewed. Dental records indicate the need for comprehensive evaluation since at least May, 2009. There is no indication that dental x-rays were obtained to evaluate for potential periodontal abscess. Five months later, after several subsequent dental visits, the person was admitted to the hospital for evaluation under general anesthesia. Tooth #25 was noted to have periodontal abscess and was removed. The dental records provided and the hospital records did not comment on the condition of the individual's other teeth or other oral health issues. Dental records delineated the need to "increase meds prior to apt." The personal support plan was devoid of any meaningful insight with regards to the individual's significant dental issues. The dental, and medical records and personal support plan and addendums to the personal support plan of individual #69 were reviewed by the monitoring team. Dental records indicated moderate chronic periodontal disease and severe dental caries with a history of restorative care and previous extractions. The individual was provided quarterly treatment by the dental hygienist and there was strong recommendation to enhance oral hygiene at the living area. Documentation provided did not indicate that a robust oral hygiene program was provided to this individual. Importantly, the interdisciplinary team did not effectively address the individual's dental health care issues.	NC

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		Dental care of Individual #33 was reviewed by the monitoring team. Many entries were noted by the PST; however, no effective methodology was developed to address the individual's oral hygiene issues. Importantly, on October 14, 2009, it was recommended by the dentist that the individual undergo a root canal by an endodontist. Documentation provided was without evidence that the individual underwent a root canal and on February 24, 2010, a recommendation was made to return to the office for "fillings" and one month later, on March 24, 2010, the individual was provided a amalgan filling of tooth #20. On August 13, 2010, the individual was again seen by the dentist secondary to continued dental pain and was recommended for dental restoration under general anesthesia. Individual #15 was seen by the dentist on January 28, 2010, and a limited examination determined that there was at least moderate periodontal disease and mild dental caries. At the time of the dental evaluation, the dentist recommended that the individual undergo general anesthesia to complete the assessment and provide additional treatment. The annual medical evaluation completed on August 22, 2010 indicated that the individual did undergo general anesthesia in February, 2010. The medical evaluation also documented that at the time of the medical examination, the individual's teeth were stained and "has lots of thick plaques." No other dental records were provided to indicate a follow-up since the January 28, 2010, dental examination and there were no pre, post or intra-operative records provided. The PSPs and addendums did not adequately address the seriousness of the individual's dental issues and support requirements.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions;	As determined by review of dental and medical records, and the personal support plans of individuals #15, #33, #47, #58 and #69, that provision Q2 is not in compliance. The PST did not play an active role in supporting the needs of individuals with dental issues at the Facility. There was no evidence to suggest that meaningful desensitization programs were offered to individuals reviewed by the monitor team. Sedation and general anesthesia were used extensively for dental evaluations. According to information provided by the Facility in response to a document request, 32 of the 72 individuals residing at the Facility have received pre-treatment sedation for dental or medical services.	NC

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	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.		

Recommendations:

1. The Facility must enhance the interdisciplinary team process with regard to dental services.
2. To enhance oral health care needs it is imperative that a robust dental hygiene program be developed at the Facility.
3. Dental records must be more comprehensive and enable a meaningful understanding of the individual's oral health care needs and history of dental services.
4. The use of sedation and general anesthesia should be reviewed by the Facility and practices employed by special need dentist be developed for individuals served by the Facility.
5. Efficacious desensitization and/or other procedures to reduce and minimize the need for sedation and anesthesia are required by the SA and must be developed.
6. Delay in treatment must be minimized.

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:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. Record reviews for Individuals #11, #13, #29, #39, #51, #54, #62, #74, #75, #79, #97, #98, #101, #113, #143, #149 4. Policies, procedures and/or other documents addressing the provision of speech and/or communication services and supports (state policy 016 dated 10/7/2009 and RGSC policy dated Jan 2010) 5. A list of people with Alternative and Augmentative Communication (AAC) devices 6. AAC evaluation and Speech Language assessment template. 7. Five most current AAC and SLP assessments conducted by each therapist, and corresponding PSPs. 8. List of individuals receiving direct speech services, and focus of intervention **Interviews with**: 1. Betty Perez PNMP tech 2. La Paloma (three) and El Paisano (four) DCPs **Observations of**: 1. PNM meeting (8-24-10) 2. HST meeting (8-25-10) 3. La Paloma and El Paisano lunch and dinner 4. La Paloma and El Paisano transition times 5. Behavior Management Meeting 8-24-10 6. HST Meeting 8-24-10 7. PNMP meeting 8-24-10
	Facility Self-Assessment: The Facility reported it is not in compliance with any of the provisions of this Section but has completed steps leading to compliance. The Facility accurately reported that it is not in compliance with having an adequate number of speech pathologists but that it is seeking to fill an open SLP position. RGSC stated that they are in compliance with regards to PSP integration; however, the monitoring team is not in agreement with this finding. Communication was absent or inadequately integrated into PSPs. Rationales and descriptions of interventions regarding use and benefit from AAC devices are not clearly integrated into the PSP.

	The Facility accurately reported that some action steps not in compliance included policy and procedures, speech and behavior integration ofAAC, meaningfulness of AAC, staff training, and comprehensiveness of assessment.
	Summary of Monitor's Assessment: **Provision R.1:** This provision was determined to be not in compliance. RGSC has just hired a new full time SLP. **Provision R.2:** This provision was determined to be not in compliance. The Communication Assessment did not consistently address expansion of current abilities and development of new skills **Provision R.3:** This provision was determined to be not in compliance. AAC devices are not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs **Provision R.4:** This provision was determined to be not in compliance. There was no monitoring of the presence and working condition of the AAC devices or was there monitoring of whether or not the device was effective and or meaningful to the individual. As stated in Provisions O and P, there has been very little progress in this area since the baseline visit. Assessments continue to be sporadic in completion and as well as comprehensiveness. Individuals who are nonverbal or have severe expressive and receptive language disorders were not provided with services to enhance or develop communication.

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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	Sixteen out of 16 records reviewed (100 %) indicated individuals with identified language difficulties were not receiving active Communication Treatment or participating in a Communication program of any kind. Examples of Individuals with identified Speech or language difficulties not receiving services: • Individual #51 has limited speech and gestures yet there is no plan to address expansion of current skills • Individuals #8, #79, #54, #98, #39, and #29 are all diagnosed with a severe speech disorder yet none had received services or programs designed to enhance current skills or develop new modes of communication Based on a review of the CV for each therapy clinician (1) and interviews with therapy	NC

#	Provision	Assessment of Status	Compliance
	training, and monitor the implementation of programs.	staff, the Department did document appropriate qualifications for licensed SLPs and assistants. Based on a review of 16 records involving individuals who were identified with severe expressive or receptive language, 14 individuals were not receiving supports designed to improve or augment existing language. Based on a review of 16 records, Speech Language Pathologist(s) were not actively involved in the care of individuals with identified speech/language and behavioral difficulties. • Individuals #11, #51,and #101 are individuals with dual difficulties (behavior and communication) not receiving active SLP collaboration:	
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.	Thirteen of 16 records reviewed indicated individuals identified with severe expressive/receptive language did not have the potential for AAC investigated and assessed. For example: • Individuals #98, #54, and #113 are diagnosed with severe language difficulties but AAC was not assessed or investigated. Out of the 16 records reviewed, the Communication Assessment did not address all necessary components. For example, • In zero of 16 records reviewed the assessment addressed verbal and Nonverbal Skills • In zero of 16 records reviewed the assessment addressed expansion of current abilities • In zero of 16 records reviewed the assessment addressed development of new skills Communication programs are not integrated into the PBSP as indicated. Thirteen of the 13 records for those individuals who have dual issues reviewed (100 %), indicated lack of integration of the communication program and the PBSP. Examples of individuals with identified communication difficulties whose plans were not integrated in the PBSP: • Record Review of Individuals #51, #62, and #98 did not show integration or collaboration between communication and behavioral issues. There was no integration or evidence of collaboration that identified the link between behaviors and lack of communication.	NC
R3	Commencing within six months of	Rationales and descriptions of interventions regarding use and benefit from AAC devices	NC

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	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.	are not clearly integrated into the PSP.
		
		Zero of the 16 records reviewed (0 %) had a clear rationale and description of communication interventions integrated into the PSP.
		• Examples of PSPs in which communication was absent or not adequately integrated:
		  • Individuals #79, #98, #51, #8, #62 did not have communication present in the PSP.
		  • Individual #75 has a communication folder but this is not listed in the PSP nor integrated in other programs.
		
		The PSP did not contain information regarding how the person communicates and strategies staff may utilize to enhance communication.
		• Zero of the 16 records reviewed (0%) clearly identified how the individual communicates with others and interacts with his surroundings. The examples above demonstrate that PSPs do not contain information on communication nor include strategies to enhance communication as information about communication is absent.
		
		Communication information is not integrated into the daily schedule
		• 16 of the 16 records reviewed did not have communication interventions and methods to improve communication integrated into the daily schedule; therefore, opportunities to promote generalization were minimal to none.
		
		How AAC devices are individualized and meaningful to the individual was not consistent across assessments.
		
		The records of three individuals who have AAC devices, out of the 16 records reviewed, showed that one of the three records clearly indicated how the individual communication programs were functional and meaningful to the individual and how it improved his/her daily living.
		
		Examples of communication programs that were not functional and meaningful to an individual in their daily life:
		  • Individual #75 has a communication folder but there is no indication in the record as to how this augmentative speech device is beneficial or as there is no clear indication as to what need or preference is being addressed. To ensure interdisciplinary understanding and the appropriateness of integrated plans, it is essential to clarify for other team members the purpose of interventions.	

#	Provision	Assessment of Status	Compliance
		Per interview, staff were not trained in the use of the AAC devices. Questions asked of staff were mostly general but did include a few questions regarding individual strategies. The reasoning for this is that all staff are responsible for implementing plans and there is a possibility that staff will work with various individuals throughout the day, week or month. Because staff at RGSC may be required to work with any individuals at a home where up to 41 individuals may live, it is both difficult and important that they have at least a general knowledge of the programs and devices to be used. Zero of five DCPs (two on El Paisano and three on La Paloma) interviewed (0%) were knowledgeable of the communication programs as evidenced by: • In zero of five interviews, the importance of AAC and how the assigned programs lent themselves to the development of language was not expressed. • In zero of five interviews, DCPs were able to locate adaptive equipment. • In zero of five interviews, staff could describe individual-specific communication strategies. • In zero of five interviews, staff could describe the schedule for implementation of communication strategies. • In zero of five interviews, staff stated they had received individual-specific training for communication strategies. Instances in which staff were not knowledgeable of individuals' communication plans: • Staff on La Paloma were not able to locate AAC devices. • Staff on El Paisano and La Paloma were unable to state who had AAC programs or devices. General AAC devices were not available in common areas. • Zero of the two homes had general AAC devices present in the Common areas.	
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	RGSC did not have a Monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC devices; the implementation of the device; and effectiveness of the device. Because of this, a proper assessment cannot be made at this time.	NC

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	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.		

Recommendations:

1. An increased presence and utilization of communication devices is needed at RGSC. Individuals who are verbal as well as nonverbal should be provided with comprehensive speech assessments. Communication dictionaries should be developed for all individuals to improve communicative interactions and understanding between staff and the person. Even an individual who has some verbalizations may benefit from AAC devices. AAC can be very effective in supplementing and enhancing existing language.
2. Communication and AAC Assessments should focus on functional communication and address clear areas of need that have been identified through an integrated assessment process including all relevant disciplines (e.g., Psychology assessment that may identify a communication need).
3. Communication assessments should be comprehensive and provide measurable data regarding the individuals' communication capabilities. Assessments should include information on verbal skills, nonverbal skills, expressive and receptive language, AAC investigation, methods to improve existing language as well as methods to develop new language. Clear direction and detail should be included in all sections.
4. Communication devices should be present in common areas for use by multiple individuals, and staff should be provided with frequent training regarding the benefits of AAC as well as its implementation.
5. SLPs should participate more actively in the annual PSP process. Individuals who have communication needs are not being represented by those who have the most expertise in the area.
6. All goals written for individuals regarding communication should be developed by the person with the most experience. In the case of communication, this person is often the SLP. All written goals should be followed by the SLP or individual determined by the team to be most closely related to the determined goal. Frequency of goal review should be monthly if receiving direct services and quarterly for all others.
7. A monitoring system should be developed that ensures availability of equipment as well as the equipment's use.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1.RGSC Plan of Improvement 8/9/10 (POI) 2.RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3.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 for the following individuals: #1, #2, #3, #5, #10, #15, #27, #31, #35, #36, #47, #59, #62, #63, #66, #69, #76, #77, #80, #82, #84, #88, #91, #96, #98, #107, #133, #140, #145, #149 4.Counseling/psychotherapy plans for individuals #69 and #107 **People Interviewed:** 1. Megan Gianotti, M.Ed. – Behavioral Services Director 2. Cheryl Fielding, Ph.D. – BCBA consultant 3. Myrna Wolfe – Incident Management Coordinator 4. David Moron, MD – Clinical Services Director 5. Babu Draksharam, MD – Contract Psychiatrist 6. James Arnold – RGSC Patient Rights Officer 7. Direct Care Professionals: Approximately 15 staff members in both residences. **Meetings Attended/Observations:** 1. Behavior Management Committee meeting 2. Psychotropic Medication Review 3. PSP for Individual #140 4. Observations of meals, transition activities, and programming activities in both residences.
	Facility Self-Assessment: The Facility reported that it is not yet in compliance with any provision of this Section. The Facility reported that a plan was in place for regular community activities but monitoring for compliance was not yet occurring. The monitoring team confirmed that a plan for activity was in place and that numerous community leisure activities are available. The use of these activities for formal training opportunities was not yet explored by the monitoring team. The Facility accurately reported that other actions have not yet been completed.
	Summary of Monitor's Assessment: **For Provision S.1:** This provision was determined to be not in compliance. The Facility reported that

	minimal changes had been implemented in regard to this Provision. Observations and recorded reviews reflected substantial limitations in formal assessment and skill acquisition plans. **For Provision S.2:** This provision was determined to be not in compliance. An annual assessment process did typically take place, but the process lacked rigorous and meaningful assessment. **For Provision S.3:** This provision was determined to be not in compliance. The Facility had made progress in providing community access and opportunities, but this process had not been sufficiently standardized or monitored to allow for a determination of substantial compliance.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the site visit, RGSC reported that no skill assessment instruments or procedures had changed since the baseline visit as, "State Office (was) looking into an assessment to measure individual skills to establish a more functional program." It was also reported by Myrna Wolfe that State Office had been revising the policy for integrated services and would be conducting training this fall for the State Centers. Facilities had been asked not to make any changes until this training was completed. A review of assessment and skill acquisition training records during the baseline visit revealed that for 18 of 18 individuals it was not possible to unequivocally demonstrate that the assessments upon which training programs were based were accurate or had identified real and meaningful needs. During the most recent compliance visit, the assessment and training records for five individuals were reviewed to establish the accuracy of the statements about assessment and skill acquisition programs made by the Facility. This review revealed that five of five individuals lacked assessments that could be shown to be accurate or that had identified real and meaningful needs. • Actions plans for Individual #96 included objectives reflecting completion of complex tasks, such as to put toothpaste on a toothbrush or to wipe appropriately after using the toilet. Service objectives for these skill areas suggest that Individual #96 possesses only minimal skills in these areas. No assessment results were reported that indicate the individual possessed the prerequisite skills for the action plans in question, nor were action plans established to increase prerequisite skills or to identify other skills that would increase the individual's ability to complete a functional activity of living and for which the individual demonstrated prerequisite skills or some of the skills involved in the activity.. • A Positive Assessment of Living Skills completed for Individual #133 indicated that the individual could brush all surfaces of teeth and use mouthwash and	NC

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		dental floss independently without assistance or prompting. A note at the end of this section of the PALS indicated that the individual required verbal prompts to complete tooth brushing, which conflicts with the ratings in the assessment. Substantial weaknesses in psychological and psychiatric assessments are documented in Provision K. In addition to valid assessment procedures, the successful introduction and strengthening of skills requires that the training program includes specific components. Based upon the lack of progress reported by the Facility and substantiated by record reviews and interviews, it was unlikely that current skill acquisitions programs at RGSC included the necessary components. A probe involving five records was conducted to test this hypothesis. The findings of that probe, presented below, supported the hypothesis and negated the need for the review of additional records. The findings of that review are presented below. • Zero of five records contained training plans that reflected development based upon a task analysis. • Zero of five records contained training plans that included behavioral objective(s). • Zero of five records contained training plans that included operational definitions of target behavior(s). • Zero of five records contained training plans that included a description of teaching conditions. • Zero of five records contained training plans that included a schedule of implementation comprised of sufficient trials for learning to occur. • Zero of five records contained training plans that included relevant discriminative stimuli. Discriminative stimuli are environmental cues or markers that help the individual to focus upon the activity, recognize the expectations of the situation and understand that reinforcement is available. For example, the presentation of various coins and the prompt to place the pennies in the open container could be discriminative stimuli for the individual to sort coins by denomination. • Zero of five records contained training plans that included specific instructions. • Zero of five records contained training plans that included opportunities for the behavior to occur. For learning to take place, it is essential that a sufficient number of displays of the desired behavior be possible in order for reinforcement to occur. A training program that indicates that reinforcement	

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		should be offered at any time throughout the day when the desired behavior is displayed could result in very few opportunities for the behavior to be reinforced. A training program that includes 20 formal trials within a specific interval makes it more likely that ample opportunities for the presentation of the behavior and thus reinforcement will occur. Although this could be done in an artificial way, the Facility can also be creative in use of opportunities inserted into normal daily activities and the planning of teachable moments, such as pouring a small amount of a preferred drink rather than a whole glass when the individual makes a sign requesting drink so that the person will need to make the sign more often. • Zero of five records contained training plans that included specific consequences for correct responses. • Zero of five records contained training plans that included specific consequences for incorrect responses. • Zero of five records contained training plans that included a plan for maintenance and generalization (i.e. assessment and measurement methodology) An example of weaknesses in skill acquisition programs is presented below (Individual #133). • Action Plan #2 for Individual #133 stated an objective to "complete a waling (sic) routine independently" following verbal cue. A Specific Program Objective (SPO) for physical fitness had the same objective; the assessment had a completion step of 20 minutes of walking, but the Evaluative Criteria section of the SPO did not state the criterion for the data. Data on the Training Data/Progress Note sheet for this SPO stated only the date, prompt level, and place walked. From this information, it is not possible to determine how many minutes the individual walked independently or to track whether this is increasing. Due to the limitations noted in the assessments of skills, and given the lack of task analysis, the inadequate description of behavioral objectives, the limited number of learning opportunities, the lack of specific instructions to guide staff in implementation of training, and the lack of specification of consequences that might serve as reinforcers, the monitoring team could not determine that these programs were effectively enhancing the skills and independence of the people living at Rio Grande State Center. The Facility reported that there was no plan in place to address, monitor and maintain	

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		reasonable levels of engagement across settings at the Facility. Although this indicates the Facility is not in compliance with this Provision, observations did reflect that the Facility was making improvements in engagement and training opportunities. • A nutrition program had been implemented that involves supporting individuals in preparing snacks in a kitchen environment. • In residence 501, a leisure room had been developed that provides an opportunity for socialization in a home-like environment. During the site visit, the individuals living at the residence hosted an open house for the new room. • In residence 501, staff were observed engaging individuals in conversation about personal interests and assisting with leisure activities such as sewing.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	The Facility indicated that at the time of the site visit there were no data to support annual habilitation assessments for 100% of individuals living at the Facility. A review of records reflected that an assessment process did take place on an annual basis. This assessment process conducted as part of the PSP lacked the rigor and sophistication necessary to be considered valid. Attempts by the Facility to assess individual strengths, limitations, barriers, etc. typically involved anecdotal statements, narrative reports, and generic rating scales. While these approaches could produce correct findings, research has indicated that such strategies are often inaccurate and misleading. To ensure that findings are valid, it is necessary to conduct objective assessments that can corroborate the subjective or informal attempts at assessment. For example, staff may report that an individual does not like to use the treadmill for exercise because she cries while she is on the treadmill. More formal and objective assessment may reveal that the individual is more likely to choose the treadmill over three other exercise modalities, contrary to staff reports, but that she cries when using the treadmill because it is next to a window where she can observe peers eating ice cream that she cannot have. Record reviews at RGSC did not reveal formal and objective attempts to corroborate informal and subjective assessments.	NC
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each	This provision was found not in compliance as indicated in the findings below.	NC

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	individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	Observations were conducted in both residences, as well as vocational and training settings during the site visit. These observations revealed the following issues involving skill acquisition program implementation. • Staff often indicated a lack of familiarity with the written training programs and that a variety of environmental limitations, such as staffing ratios, often resulted in modified program implementation. • Training programs for individuals living at the Facility often lacked structure, being presented without clear steps or trials. • It was frequently observed that no consequences that might have served as reinforcement were offered following successful attempts during training. When such consequences were offered, they typically involved verbal praise. Verbal praise can serve as reinforcement, but it was not clear from observation that verbal praise was limited only to those individuals for whom it was reinforcing. As noted in Section K, there were few examples of functional assessment. Furthermore, there were no examples of assessments of preferences to identify consequences that might serve as reinforcement. • Although staff would often offer general prompts in order to elicit cooperation in non-training circumstances, no examples of formal and consistent prompting or opportunity for practice was observed. • Data for skill acquisition programs were not routinely graphed. • It was not clear from available progress notes that individuals were strengthening existing behaviors or developing new skills because of skill acquisition programs.	NC
	(b) Include to the degree practicable training opportunities in community settings.	The Facility indicated that a process was pending for providing individualized training in the community. It was also reported by the Facility that a plan existed for regular community activities. A review of records and interviews with both staff and individuals reflected the following. • The Facility provided a list of 23 recent events in the community attended by people living at RGSC, four parks that were routinely visited as a part of community activities and seven restaurants at which individuals often chose to dine. • Individuals living at RGSC often indicated that they had visited the community and had favorite places or activities.	NC

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		• Contracts with Goodwill were in development to establish community employment opportunities for individuals living at RGSC. The Facility indicated that substantial compliance had been achieved regarding the establishment of a plan for regular community activities. As indicated above, progress had been made by RGSC at the time of the site visit but more was in development. Furthermore, the process to ensure that these community activities were used to provide individualized opportunities for training was also in development. The Facility indicated formal monitoring of such a plan had not been implemented, so it could not be established that the Facility was in substantial compliance with this provision.	

Recommendations:
Although decisions are pending in State Office, there exist skills that staff will be required to possess regardless of the remediation eventually approved. For example, the implementation of skill acquisition programs requires that the staff implementing those programs possess knowledge regarding positive reinforcement, the skills to deliver reinforcement, the ability to document displays of skills with objectivity and reliability, and the ability to select functional tasks and activities and to break tasks into steps that can be taught. It is therefore recommended that RGSC aggressively implement a competency-based training program for staff that emphasizes the basic concepts and skills for teaching individuals to acquire new behaviors and increase desired behaviors and assists staff to carry out such teaching in vocational, activity, and residential settings.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. DADS Policy 018.1 Most Integrated Setting Practices 3/31/10 4. DADS Information Letter No. 10-62 to Home and Community-Based Services Program Providers, dated May 25, 2010, with subject State Supported Living Centers Post-Move Monitoring Visits 5. RGSC Standard Operating Procedure (SOP) MR 300 20 Most Integrated Setting, dated January, 2010, and all Exhibits 6. RGSC SOP MR 600 01 Person Directed Planning dated July, 2003 7. RGSC SOP MR 600 02 Development and Monitoring of Individual Program Plans, Person Directed Approach, dated September, 1992 8. Document Request information, including: a. List of individuals referred for placement b. List of individuals who have requested but not been referred for community placement (Facility response: None) c. List of individuals who have transferred to community settings. d. List of individuals who have been assessed for placement (Facility response: all individuals are assessed through the Living Options Discussion that is part of the PSP) 9. Active Record for Individuals #15 and #133 10. PSPs for Individuals #80, #82, and #140 11. For Individual #116: a. Community Living Discharge Plan (CLDP) b. PSP dated 6/9/09 c. Post-Move Monitoring (PMM) Checklists for visits 5/28/10 and 6/29/10 d. Letter from physician reporting lab results **People Interviewed:** 1. Joint interview 8/23/10, with: a. Alma Ortiz , Admission/Placement Coordinator (APC) b. Alondra Machado, Data Analyst) c. Rebecca Oliveros, Qualified Mental Retardation Professional (QMRP) d. Blanca Torres, QMRP 2. Isai Rodriguez, staff of MRA Tropical Texas, 8/25/10 **Meeting Attended/Observations:** 1. PSP Annual Meeting for Individual #140 8/25/10

	Facility Self-Assessment: RGSC reported that it complied with most requirements of planning for movement, transition, and discharge. The Facility reported it takes action to encourage and assist people to move to the most integrated setting, including developing policies and procedures to implement the requirements of the Most Integrated Environment section of the SA and noted staff adhere to these policies. The Facility also indicated it was in compliance with the completion of record reviews to ensure that community placement decisions are consistent with the settlement agreement. The monitoring team determined that RGSC had taken many steps to encourage individuals to move to community living, but had identified only two people in six months for referral to community living, and only one person had moved during the prior six months. The Facility had not yet developed a process to address obstacles to movement effectively. The Facility accurately reported it had not addressed the identification of protections, supports and services in the PSP that were needed to ensure safety and adequate habilitation in the most integrated setting, the identification of obstacles in the PSP to movement to the most integrated setting, the provision of adequate education about community living and the completion of assessments of individuals for community placement. The Facility reported many actions have taken place in each of these areas. The Facility reported compliance in the development and implementation of policies and procedures regarding the current comprehensive assessment that must be completed for individuals within 45 days prior to the individual moving to the community. The Facility reported that not all assessments had been reviewed to ensure compliance. The Facility accurately reported it had not yet developed quality assurance policies and procedures to ensure the timely and appropriate development of the CLDP. The Facility reported implementing and having appropriate record of the PMM process, and adequately identifying that the essential and non essential supports prescribed by the CLDPs were in place at the time of the PMM visits. The monitoring team determined that PMM visits were timely but that the presence of planned supports was not completely verified. The Facility did not address alleged offenders and no Action Steps were described.
	Summary of Monitor's Assessment: RGSC was not yet in compliance with this provision. **Provision T1:** This provision was determined to be not in compliance. Although RGSC had taken many steps to encourage individuals to move to community living, the Facility had identified only two people in six months for referral to community living, and only one person had moved during the prior six months.

	The Facility had not yet developed a process to address obstacles to movement effectively. **Provision T2:** This provision was determined to be not in compliance. Post Move Monitoring was completed timely. Identification of supports in the Community Living Discharge Plan was not documented so that all needed supports were clearly listed; as a result, the Post-Move Monitoring visit did not review and verify presence of all needed supports. **Provision T3:** This provision was determined to be in substantial compliance. **Provision T4:** This provision was determined to be not in compliance. RGSC SOP 300 20 includes language that matches the language in the SA for this provision. The Facility reported that no individuals have been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. The Facility did not currently have a policy and procedure in place describing how it would comply with the requirements of this provision if such a circumstance arose.

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T1	**Planning for Movement, Transition, and Discharge**	This provision is not in compliance. Although RGSC had taken many steps to encourage individuals to move to community living, the Facility had identified only two people in six months for referral to community living; only one of those had moved. The Facility had not yet developed a process to address obstacles to movement effectively; Facility staff reported that the major barrier to movement is the unwillingness of LARs to consent to referral. Furthermore, a number of individuals served by RGSC are ineligible to receive Medicaid funding HCS services due to citizenship status.	NC
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,	DADS Policy 108.1 Most Integrated Setting Practices prescribes "procedures for encouraging and assisting individuals to move to the most integrated setting"; this policy describes the role of the APC and MRA, requirements for informing individuals about community living and for training staff, requires and establishes responsibilities for the Community Living Options Information Process (CLOIP), requires the PST to identify protections, supports, and services that need to be provided to each individual and to identify obstacles to the individual's movement (and requires an annual report of obstacles to be sent to the DADS State Office), and establishes a process to follow if the PST cannot reach consensus regarding a referral for movement to community living. The policy requires the State Center to "encourage and assist individuals to be served in the most integrated setting appropriate to their needs." This policy does state that no move will occur if an individual or LAR "has indicated a preference to remain at the State Center." The policy requires that the opportunity to participate in community exposure opportunities should continue, and that the	NC

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	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.	individual's and LAR's choice be documented as "an obstacle to placement which will require identification and implementation of strategies to attempt to overcome." Only one individual had moved since January 1, 2010, and only two people had been referred for movement during this time. Although policy is in place, the monitoring team will continue to review the effectiveness of State actions to encourage and assist individuals to move.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	RGSC SOP MR 300 20 Most Integrated Setting, dated January, 2010 implements DADS Policy 108.1. The Facility policy essentially restates the DADS policy but does not provide information on procedures to operationalize that policy. For example, Procedure II.C states, "Active treatment programming to address the identified supports and services should be initiated immediately." The policy does not provide information that may differ across state centers, such as which staff are responsible for the tasks required to initiate the specific active treatment programs for the individual.	NC
	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	Five of five PSPs reviewed included in the Living Options Discussion a listing of supports needed to ensure safety and habilitation; however, there was not a clear connection between the supports needed and the specific program objectives (SPO) established in the PSPs. This indicated that important supports were not identified in the Living Options Discussion, and that important supports that were identified did not lead to interventions that might reduce future need for those supports. For example, for individual #80: • A support identified for safety related to the individual's wandering from home environment. No SPO or other intervention was identified to address this issue. • A Learning Objective for the Desired Outcome "To increase skills that will be used in a less restrictive environment" was to "blow nose into tissue." Another was to "shave all areas of face." Neither was identified as supports needed for success in community living. Not all PST members yet have a full understanding of the role of the PST in encouraging movement to a more integrated setting. For example, for Individual #76, as reported in Section J, in the psychiatric evaluation, under the heading of "chief complaint," the psychiatric evaluation states that the individual had resided at the facility for almost 17 years and that "I do not foresee any changes as far as residency is concerned. "	NC

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	obstacles.	The PSP meeting for Individual #140 began with the Living Options Discussion and continued to focus throughout on the supports needed for movement to a more integrated environment. Although the PSP document that was prepared based on the discussion was not comprehensive (refer to example below and to Provision V4 for additional information) the discussion during the meeting provided a list of supports needed and made clear the actions that would be done by the Facility, MRA, and LAR. The instructions for Form POR-MR-80.3 Living Options Discussion Record state "an action plan is not required if the individual and/or their LAR is aware of community living options and prefers that the individual remain at the current facility." If the preference to remain is defined as an obstacle to movement, strategies intended to overcome this obstacle must be put in place; Action Plans define the strategies and interventions established in the PSP. Therefore, the PSP should establish individualized strategies to overcome this obstacle. Indeed, when an individual (or LAR) states a preference to move or does not object to a move to a more integrated environment, an Action Plan should be developed to establish steps to reach that outcome. In some cases, that might involve skills to be learned or medical care to be provided. When there are no obstacles to movement, an Action Plan should be developed that involves steps to identify possible providers and to ensure a transition plan is developed. • The PST and LAR determined that Individual #140 should be referred for move to community living. Although there was discussion documented in the PSP that the MRA and "Placement Specialist" would arrange tours of possible homes for the LRA, there was no Action Plan to document and track this. Although RGSC SOP 300 20 requires the Facility to identify obstacles to each individual's move to the most integrated setting consistent with the individual's preferences and needs and to provide to DADS by September 1 of each year an assessment of identified obstacles, the Facility reported it did not have such a facility-wide assessment at the time of the compliance visit. For two of five PSP Living Option Discussions reviewed, obstacles to movement were identified. • For Individual #140, no obstacles were identified, and this person is being referred for movement.	

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		• For Individual #133, no obstacles were identified, nor is referral in process; the MRA recommended "continued placement at RGSC." The PST recommended the same but "believes that [Individual #133] would benefit from some overnight visits to some group homes and will make this available to her." No Action Plan identifies this plan or a person responsible to implement the plan. Of the obstacles that were identified, one related to funding as a result of being undocumented and ineligible for Medicaid; for the other two, obstacles related primarily to the individual's behavior rather than whether a provider and other necessary clinical resources could be found to provide behavioral supports that could be effective in making success likely, so it was unclear whether these were truly obstacles.	
	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.	The MRA staff participating in the PSP meeting for Individual #140 reported that a CLOIP had not been done due to change of staff at the agency. Nevertheless, the LAR agreed to visit group homes to select a provider. The individual stated a desire to move to a group home. The Facility did not report any additional education activities since the baseline visit.	NC
	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.	The Facility reported that individuals are assessed for placement through the Living Options Discussion at annual PSP review meetings. Because only two people had been referred for community placement since January 1, 2010, it is unclear how comprehensive this review is. For example, no obstacles were identified for Individual #133, but this individual was not referred for movement to community living. Per interview, seven people are in process of exploring residences for possible referral; review at the next compliance visit will determine whether exploration leads to referral.	NC
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the	The Monitoring Panel will discuss the expected criteria further, and would like to discuss this with the State and DOJ in further detail. However, briefly, ensuring adequate transition planning will require looking at the entire transition process from start to	NC

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	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:	finish. Part of the problem at this time is that teams are only beginning to define important and critical supports and services (called essential and nonessential supports in the CLDP process) at the time the CLDP is developed. If this process started earlier, specifically when the PSP is developed (especially for those individuals who are referred during the annual PSP), then the CLDP would flow from the essential and non-essential supports that already had been identified. Although some Living Options Discussion Records have included a reiteration of supports needed by individuals once they move, these have not been comprehensive and often consist of a listing of the supports being provided at the SSLC. PSTs should be discussing the configuration of supports and services that the individual needs no matter where those services and supports are provided. The Living Option Discussion records could identify if there are additional things that need to be in place for community living, or specific items that are "givens" at the Facility, such as a fenced in yard, but teams should only reiterate supports and services that are already identified in an individuals' PSPs when these will affect success in community living. Generally, individuals' needs do not change drastically, and the supports and services that are provided at the Facility also need to be provided in the community. However, there needs to be time to figure out how such supports and services will be provided when the individual moves and who will be responsible.. This is what the CLDP should lay out, in addition to specific transition activities to ensure the individual is comfortable with moving, staff are trained, etc. Currently, because the teams are starting over with a blank slate, two weeks is clearly inadequate. Even if the PSPs provided better direction, two weeks would be inadequate. The CLDP identification of supports to be provided should be seen as an outgrowth of PSP planning with additional attention to the transition process at the point when the PST determines a person could move and the individual and LAR do not object. This would allow for transition activities such as visits to providers and the supports needed with that process to be defined, and the individualization with regard to numbers of visits to potential providers, training to be required for provider staff (regardless of who the provider is), opportunities for provider staff to observe the individual while still at RGSC and to speak with staff who provide supports to the individual, and other processes that may increase the likelihood of a successful move to be defined and implemented. Finally, starting over in the CLDP process in terms of defining needed supports also means that supports and services that individuals need are being missed or not adequately defined.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to	Per interview, there is currently no individual in residence at RGSC for whom a CLDP has been developed. For Individual #116, who had moved, there was no list of the steps that the Facility	NC

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	implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	would take to ensure a smooth and safe transition. Furthermore, the CLDP table of support needs did not mention the need for medical follow-up for a health condition (although it was listed as a diagnosis in the medical information on the CLDP, and the need for monitoring on a periodic basis was identified in the Medication History and under Special Medical Needs). As a result, the Post-Move Monitor (PMM) did not review to ensure this. Although not checked during the monitoring, the community provider did arrange the medical follow-up, which was verified by a report from a physician; this could have been available to the Post-Move Monitor at the time of the monitoring visit Other support needs identified in the CLDP narrative but not included in the table of support needs included calorie controlled diet for weight control (although the texture modification was listed) and monitoring of side effects of several medications.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Responsibilities for actions to provide supports were all listed at "Texas HCS." This meant: • No individual had responsibility, nor was there an individual contact person identified. • RGSC had no responsibilities assigned to ensure any activities were carried out.	NC
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDP for Individual #116 was reviewed. The individual did not have an LAR. There was no documentation to show the individual had reviewed the CLDP and no place for a signature by the individual (or LAR, if there had been one). There was documentation in the individual had been given the opportunity to visit providers but had declined. The individual selected a home at which a friend lived. Per staff interview, the individual then notified his mother of his interest in moving, and his mother (who had not supported a move in the past) agreed. The Facility should identify a process to document that the CLDP is reviewed with the individual and, as appropriate, the LAR. Because there was no LAR and it was impossible to determine whether the CLDP had been reviewed with the individual, the monitoring team did not rate this item.	NC
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.	The CLDP included assessments from several disciplines that included support recommendations and resulted in a listing of supports to be provided. The listing did not include all supports mentioned in the narrative. The date identified as "Date (of CP referral or CL/DP) was more than 45 days before date identified as the Date of Move.	NC
T1e	Each Facility shall verify, through	DADS Information Letter No. 10-62 provided HCS Program Providers with information	NC

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	the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	on the Post-Move Monitoring Visit process; the requirement for the provider to make available to the PMM access to records and to the individual, the residence, and the day habilitation site; and steps to be taken if a support is not being provided. This clarification demonstrated the commitment of DADS to ensuring supports are provided as identified in the CLDP as well as giving the PMM a checklist of elements to review. As identified in Provision T2a, the PMM did not verify that all essential supports were in place. The establishment of an important health care assessment and the required staff training were essential supports that were not verified at the time of the move.	
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.	DADS State Supported Living Center Policy Number 018.1: Most Integrated Setting Practices requires that "an assessment will be conducted to identify the effectiveness of the living option process. A ten percent (10%) random sample will be conducted monthly to evaluate policies, procedures and practices related to the transition/discharge process." This policy does not provide further detail as to how this evaluation will be conducted. The Facility reported that an audit process began in June, 2010, but was not yet in compliance. RGSC Policy MR 300 20 Most Integrated Setting establishes procedures for the CDLP and has, as an attachment, a post-move monitoring checklist, but it does not identify a process for quality assurance. Because this policy is dated January, 2010, and there had been only one move since then, quality assurance for CDLP was not reviewed. The Facility reported that a quality assurance process had not yet been developed.	NC
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	Although RGSC SOP 300 20 requires the Facility to identify obstacles to each individual's move to the most integrated setting consistent with the individual's preferences and needs and to provide to DADS by September 1 of each year an assessment of identified obstacles, the Facility reported it did not have such a facility-wide assessment at the time of the compliance visit. The Facility reported that an audit process began in June, 2010. As identified in Provision T.	NC

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	annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	As reported in Provision T1b1, obstacles to movement were identified in some but not all PSPs reviewed.	
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 Facility provided information on individuals who have been referred for movement to a more integrated setting and those people who have moved. The Facility did not provide a listing of individuals for whom PSTS have determined they can appropriately receive community services and for whom such movement is being explored. Overall, the Facility would appear to be in substantial compliance with this component, as it collects the information necessary to meet the intent of the requirement. In the future, the Facility should ensure that the data are compiled and issued as the Community Placement Report as required.	S

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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**		NC
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	Individual #116 moved from the Facility. Post Move Monitoring was completed timely by the APC, whose responsibilities included serving as PMM. One important health care support was not checked because it was not listed in the CLDP table of supports to be provided. The PMM confirmed the individual was working and receiving pay (a support identified in the CLDP) by observing the individual at work and reviewing pay records. The PMM relied on report by the provider agency to verify staff at the agency received training; no training records were available. The PMM also relied on report by the provider agency that the ground diet was being provided and did not observe a meal or check equipment or instructions to staff to ensure this occurred.	NC

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	deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.		
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.	Because no PMM was scheduled during this compliance review, the Monitor did not participate in such a visit.	Not Rated
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	RGSC SOP 300 20 includes language that matches the language in the SA for this provision. The Facility serves one individual who is an alleged offender. There are no current plans for this individual to move.	S
T4	**Alternate Discharges -**		NC

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	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	RGSC SOP 300 20 includes language that matches the language in the SA for this provision. The Facility reported that no individuals have been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. The Facility did not currently have a policy and procedure in place describing how it would comply with the requirements of this provision if such a circumstance arose. As it is possible that such an alternative discharge could occur at any time, a Facility policy and procedure should be in place to identify how the Facility will identify alternate discharges and implement discharge procedures consistent with CMS-required discharge planning procedures.	NC

Recommendations:

1. When there are no obstacles to movement, an Action Plan should involve steps to identify possible providers and to ensure a transition plan is developed.
2. A process should be developed to ensure that all supports identified in the narrative of the CLDP are transferred to the table of community living supports to be provided.

3. A Facility policy and procedure should be developed to identify how the Facility will identify alternate discharges and implement discharge procedures consistent with CMS-required discharge planning procedures.
4. Ensure that the required data are compiled and issued for the Community Placement Report.
5. Identify a process to document that the CLDP is reviewed with the individual and, as appropriate, the LAR.

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. Texas Administrative Code Title 40, Part 1, Chapter 4, Rights and Protection of Individuals Receiving Mental Retardation Services 4. Texas Probate Code Chapter XIII, Guardianship 5. DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship) 6. RGSC SOP MR 200 04 Process for Reviewing the Need for Guardianship, dated March, 1999, reviewed February, 2010 7. Need for Guardianship List 07/27/2010 8. Training for Ranking Need for Guardian cover sheet (Assessments Completed dated 7/27/10) and Training/Course Sign-In Sheet dated 7/29/10 9. List of New Guardians Obtained since 1/1/2010 10. Log of contacts seeking guardianship for nine individuals, each identified by a number 11. List of individuals for whom consents are signed by RGSC Superintendent 12. Human Rights Committee Minutes of August 19, 2010 and August 26, 2010 (with attached PBSPs for the August 26, 2010 meeting) 13. PSPs for Individuals #80, #82, #133, and #140 **People Interviewed:** 1. James Arnold, Rights Officer 8/25/10 **Meeting Attended/Observations:** 1. PSP Annual Meeting for Individual #140 8/25/10
	Facility Self-Assessment: RGSC reported that it did not comply with either provision of Section U. The Monitoring team reviewed the RGSC POI and Supplemental POI. The POI indicates that the DADS State Office Policy Unit will be responsible for the development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA. A draft policy, Policy Number: 019 Rights and Protection (including Consent & Guardianship), has been promulgated and was under review at the time of the monitoring site visit. The POI stated that Facility policies, procedures and practices in this area would be developed following the final issuance of the statewide policy. The Facility reported that a priority ranking was made for individuals prior to the baseline review and will be completed every six months. The Facility reported it is waiting for policy to be developed by DADS State Office before revising the Facility policy to meet all requirements. A process for corrective action plans has

	not yet been developed. The Facility reported that it was in compliance with none of the 14 Action Steps, most of which focused on outreach to recruit guardians.
	Summary of Monitor's Assessment: RGSC had developed a list of individuals who do not have guardians and had prioritized the list. Criteria for prioritization were stated neither in policy nor in documentation of training of staff who identified the levels of priority for individuals. Although actions had been taken to recruit guardians, these had limited effect. The Facility Director provides consents for a large percentage of the people served by the Facility.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	This provision is not yet in substantial compliance. RGSC did maintain a prioritized list of individuals needing guardianship. The list was prioritized into levels of Critical (with eight individuals), High (with seven individuals), Medium (with 14 individuals), Low (with 18 individuals), and N/A (with 22 individuals). Two individuals, #14 and #62, were not on the list. A third individual had been admitted during the prior week and was not on the list. Although the Rights Officer could describe criteria for levels of need, SOP MR 200 04 did not describe those, nor did documentation on training. The SOP should provide guidelines for levels of need. The list included names of individuals, level of need, and comments related to the decision on level of need. The inclusion of comments can be valuable. If comments are included, they should address the criteria for selecting level of need. Comments address criteria for people at N/A level (mostly notation of "Has Guardian") and Low (mostly related to family involvement and advocacy) but are less clearly identified at the other levels. Information on training for ranking need for guardianship was minimal. No curriculum was provided. Per interview, training consisted primarily of mentoring trainees through ranking of individuals. Although this is an important component of competency-based training, it would be useful at a minimum to have the criteria for levels presented; ranking of individuals independently by trainees could serve to verify competence.	NC

#	Provision	Assessment of Status	Compliance
		Review of PSPs for three individuals showed consistency between information in the comments on the prioritized list and in the PSP on availability of guardian, family contact and restrictive programs with information in the Comments on the prioritized need for guardianship list. Facility action plans to develop a quality assurance process are appropriate and should help to ensure the provision, once in compliance, remains in compliance.	
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.	For 30 of the 72 individuals residing at RGSC, the Facility Superintendent signs consents. The contact log included several examples of a stream of communications with individuals who had indicated the possibility of serving as guardians or renewing guardianship. It also noted that "75 letters were sent out 03/30/2010 to encourage individuals to become Guardians." The Facility is making active efforts to recruit guardians but has had limited success to date. Guardianship was established for one individual since 1/1/10. One way to reduce the need for guardianship is to provide habilitation that assists people to make decisions and possibly to maintain competence to make decisions in some or all areas of life. PSTs did not routinely develop PSP action plans to assist individuals to maintain or improve decision-making capacity. In four of the four PSPs reviewed, there were no specific action plans to address the individuals' capacity to make informed decisions. The Rights Officer will become the Facility Ombudsman. The Facility reported plans to fill the Rights Officer position when that occurs.	NC

Recommendations:

1. When listing comments on the Need for Guardianship list, clearly address criteria for ranking level of guardianship need.
2. When updating SOP MR 200 04 to meet requirements of the upcoming DADS policy, ensure guidelines for ranking level of guardianship need are clearly stated.
3. Training on ranking levels of guardianship need should include presenting the criteria for levels; ranking of individuals independently by trainees could serve to verify competence.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement 8/9/10 (POI) 2. RGSC Supplemental Plan of Improvement 8/9/10 (SPOI) 3. DADS draft policy 020.1 Recordkeeping Practices, dated 03/05/10 4. RGSC SOP HIM 400-03 Retention/Destruction of Health Records established October, 2004, last reviewed July 2, 2010 5. RGSC SOP 400-04 Storage of Medical Records established August 5, 1992, last reviewed July 2, 2010 6. RGSC SOP HIM 400-14 Filing and Purging of Information (MR Medical Records) established January 5, 1996, last reviewed July 2, 2010 7. RGSC SOP HIM 400-18 Coding Diagnosis, dated January 1, 2007 8. RGSC SOP HIM 400-20 Monthly Reiew and Reporting Percentage of Delinquent Medical Records (ICF-MR Services) revised August 3, 2010 9. Active Record Order & Maintenance Guidelines, dated 06/11/10 10. Active Record Audit-Chart1 form 11. Active Record Audit-Chart2 form 12. RGSC DOJ Plan of Improvement Corrective Action Plan Reporting Document, July, 2010 audit 13. ICF Monthly Delinquent Assessment Report for 7/1/10-7/31/10 14. Email from Leticia Gonzalez of July 1, 2010, Subject: Back-Dated Documentation 15. Client Work Station (CWS) Screen Shots (printed versions of screens) 16. Hard copy of Power Point slides used for training staff on Unified Record 17. Unified Record Training/Course Sign-In Sheets for 6/17/10 and 6.18/10 18. Active records for Individuals #3, #10, #15, #47, #80, #86, #133, and #150 19. PSP for Individual #140 20. Numerous progress notes on CWS for several individuals **People Interviewed:** 1. Interview with Leticia Gonzalez, RHIT, Health Information Management Director, and Melissa Canales, RHIT, Unified Records Coordinator, **Meeting Attended/Observations:** N/A
	Facility Self-Assessment: The Facility reported it is not in compliance with any of the provisions of this Section but has completed steps leading to compliance. The Facility reported, and the monitoring team confirmed, that it has established a unified record with the required components. The monitoring team agrees with the Facility's report that not all components in

	each record are yet consistent with Appendix D of the SA or that the audit process on the new format has yet documented compliance. The Facility reported that a quality assurance audit process is in place. The monitoring team confirmed that this has begun. The monitoring team agrees with the Facility's report that records are not yet routinely used to make care, medical treatment, and training decisions. A very serious issue facing the Facility is the integration of the CWS as part of the Active Record in a way that makes information easier to access and supports rather than hinders integrated planning. The CWS format does not match all requirements of the Facility and the SA. The State should review the CWS to determine what needs to be added or changed to permit development of an effective EHR that meets those needs.
	Summary of Monitor's Assessment: The Facility has made progress on implementation of an improved unified record. At the same time, there are significant difficulties in using a record that includes both the hard copy record and and electronic record. RGSC had established a unified record that includes an Active Record, Individual Notebooks, and Overflow/Master Record. The new format established by DADS had been rolled out. Records were consistent with requirements of Appendix D. Quality Assurance procedures had begun but were not yet fully effective in ensuring content of records included all required information. Furthermore, none of the records reviewed was completely legible, accurate, and complete.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	RGSC had established a unified record that includes an Active Record, Individual Notebooks, and Overflow/Master Record. The new format established by DADS had been rolled out. Records were consistent with requirements of Appendix D. Training on the new record format had been provided to home supervisors, dept heads, nursing staff, psychiatric nurse assistants (PNAs). Sign in sheets did not identify the job classes of the participants, so it was not possible to determine whether all people who needed the training received it yet.	NC

#	Provision	Assessment of Status	Compliance
		It was much easier to find information in the current records than in the records at the baseline visit. None of the eight records was legible, accurate, and complete. Most assessments were missing from the Assessments tab. Some other assessments that were to be in other sections were not complete or were not current. For example, for Individuals #10 and #133, not all required quarterly DISCUS scales were in the chart. During the review, every medical component of the active record reviewed was noted to be in excellent condition and order. Importantly, the record department was efficient and promptly able to retrieve requested clinical documents. In five of the eight records, entries were dated as required. In the other three, some entries did not include all dates. For Individual #10, handwritten changes to an HRC referral were not dated. For Individual #47, changes to a Water Safety Assessment were not dated. For Individual #80, a progress note from 5/3/10 had a change which was not dated. Four of eight records were missing at least one required signature. For Individual #10, physician progress notes for 5/20/10 and 8/12/10 were not signed. Six of eight records had no gaps. For Individual #3, some physician order sheets had gaps at the bottom without strikethrough. A progress note of 5/3/10 is blank at the bottom; however, that progress note had originated at Denton SSLC. Although records generally followed the Table of Contents, there were numerous errors in placing items, or not all items identified in the instructions were found. For example, for Individual #15, the Table of Contents calls for PSP Addendums since the most current PSP, but several older Addendums were in the record. A very serious issue facing the Facility is the integration of the CWS as part of the Active Record in a way that makes information easier to access and supports rather than hinders integrated planning. The CWS format does not match all requirements of the Facility and the SA. While RGSC's use of an electronic system was commendable it was difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of individuals' clinical picture. Some of the clinical data was entered into the Clinical Work Station (CWS), while other clinical data was contained on	

#	Provision	Assessment of Status	Compliance
		hard copies in a record binder. This posed a barrier when integrating clinical data into a useful manner. For example, while completing record reviews for the Integrated Progress Notes for the last six months related to nursing care, each and every single entry had to be accessed, aggregated together, and printed. It was not functionally practical to access chronologically notes for other disciplines to evaluate nursing's integration of services with other disciplines. . The State should review the CWS to determine what needs to be added or changed to permit development of an effective EHR that meets those needs.	
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.	Following the baseline visit, the Facility added last revision date to the information on each policy when reviewed. This will enable the Facility to track revisions as well as reviews and to ensure they remain compliant with State policy. The Facility Self-Assessment identified numerous policies throughout the SA provisions that are in process of development or revision. One area of policy revision is the policy on at-risk individuals. Both DADS and the Facility had policies. The DADS policy is currently in process of review and revision. There were two main issues with the DADS At Risk policy. One is that the Facility incorrectly followed the policy as RGSC individuals at low risk when they should have been placed at medium risk according to policy. Second, the policy as written is flawed in its ability to identify those who are at a high risk of physical and nutritional decline, injuries due to behavior problems, or other areas of risk. Compliance with policies was not monitored in all cases. RGSC had a comprehensive policy on the use of restraint. It was last revised in April, 2010. Provision C3 provides examples of noncompliance with policy.	NC
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	Quality Assurance procedures had begun but were not yet fully effective in ensuring content of records included all required information. The procedures currently focused on inclusion of all required components but not yet on the content of those components. The audits completed to date were on records in the former format. Evidence of the beginning of an effective audit process could be found. • The monthly delinquent audit assessment for July, 2010, found missing assessments. This information was provided to Dr. Moron. The audit of seven records provided information on the individuals whose assessments were reviewed and the number and percent of assessments compliant and	NC

#	Provision	Assessment of Status	Compliance
	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.	noncompliant for each individual and total. No evidence of follow-up to ensure completion was provided to the monitoring team. • The email from Leticia Gonzalez of records reviewed for May, 2010, indicated that follow-up review was done and found that corrected records were backdated to the date due. The email reminded staff that backdating records is an unacceptable practice. Ms. Gonzalez stated during interview that she had not found reoccurrence during further auditing. • Per interview, records will be audited in the month the PSP is held. Because of the small population of the facility, there are not five PSPs each month, so PSPs were being rescheduled to ensure there will be at least five each month. This practice could be acceptable if it does not affect timeliness of service planning for individuals (that is, so long as reviews and revisions of PSPs occur as needed). Another option acceptable to the monitoring team would be to provide documentation of the reason why fewer than five audits were completed in a specific month while maintaining an average of five audits per month. Content of records did not include all required information.—As noted in Provision C1: In reviewing the records of six individuals (#29, #55, #61, #80, #122, and #149) who were restrained, among them, a total of thirteen times since 3/1/10 there was nothing in the red restraint tab section of the record even though in the Order of the Record there was a clear requirement that anything missing from a tab should include a note describing where the information could be found. Staff using the record for assessment and planning could assume the individual was not subject to restraint when in fact they were. Progress notes from nurses, direct care staff (psychiatric nurse assistants/PNAs) and dietitians were found in the CWS. Some progress notes from physicians were also found in the CWS; per interview, entry of physician notes into the CWS remained inconsistent. The process of checking progress notes against other information was cumbersome, which is to be expected during rollout of an electronic health record (EHR). The Facility needs to ensure that all information is readily available to staff who need it. Per interview and the observation for Provision C1, the CWS format does not match all requirements of the Facility and the SA. The State should review the CWS to determine what needs to be added or changed to permit development of an effective EHR that meets those needs.	
V4	Commencing within six months of	PSPs were accessible in the active record. They did not always clearly specify the services	NC

#	Provision	Assessment of Status	Compliance
	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.	and supports to be provided and who was responsible. Services were found in various sections of the active record. For example, skill acquisition/ habilitation goals were separate from PBSP goals, which limit the holistic understanding of how these relate to each other. Many recommendations and Action Plans in PSPs were vague or not comprehensive. For example, the PST and LAR determined that Individual #140 should be referred for move to community living. Although there was discussion documented in the PSP that the MRA and "Placement Specialist" would arrange tours of possible homes for the LRA, there was no Action Plan to document and track this. Also, one Learning Objective was established to "manage own money with minimal supervision" without defining what is meant by "manage own money" or "minimal supervision." This information would not be useful in ensuring these records are used to provide care and treatment. In reviewing the records of six individuals (#29, #55, #61, #80, #122, and #149) who were restrained thirteen times since 3/1/10 there was nothing in the red restraint tab section of the record even though in the Order of the Record there was a clear requirement that anything missing from a tab should include a note describing where the information could be found. Staff using the record for assessment and planning could assume the individuals were not subject to restraint when in fact they were.	

Recommendations:

1. The State should review the CWS to determine what needs to be added or changed to permit development of an effective EHR that is not cumbersome to use, provides information that meets the requirements of the SA and is easily accessible, and ties clinical information together in a way that supports integrated planning and review.
2. Ensure that all staff who require training on the Unified Record receive it, including PNAs.
3. As part of the Quality Assurance process, identify issues for which compliance with policy needs to be monitored and implement monitoring and review.
4. Establish within the PSP monitoring process a review of whether information from the records is provided accurately and is discussed and used in making decisions.

List of Acronyms
Rio Grande State Center
August, 2010 Baseline Tour

Acronym	Meaning
ACP	Acute Care Plan
AIMS	Abnormal Involuntary Movement Scale
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
BCBA	Board Certified Behavior Analyst
B/P	Blood Pressure
BSP	Behavior Support Plan
CAP	Corrective Action Plan
CLDP	Community Living Discharge Plan
CWS	Clinical Work Station
CLOIP	Community Living Options Information Process
CEN	Certified Executive Nurse
CPR	Cardiopulmonary Resuscitation
DADS	Texas Department of Aging and Disability Services
PNA	Direct Care Professional/Psychiatric Nurse Assistant/direct care staff
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	United States Department of Justice
DSM	Diagnostic and Statistical Manual of the American Psychiatric Association
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
ELMO	Employee Health Program, Employee Health Medical Records Policy and Procedure
EPS	Extrapyramidal Syndrome
FA	Functional Analysis of behavior or Functional Assessment

HCG	Health Care Guidelines
HIM	Health Information Management
HMP	Health Maintenance Plan
HRC	Human rights committee
HST	Health Status Team
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDT	Interdisciplinary Team
IMC	Incident Management Coordinator
ISP	Individual Support Plan
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MD/M.D.	Medical Doctor
MI	Mental Illness
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation
MRA	Mental Retardation Authority
NCP	Nursing Care Plan
MDRO	Multi-Drug Resistance Organism
MRSA	Multi-drug Resistant Staphylococcus Aureus
NP	Nurse Practitioner
OIG	Office of the Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PNA	Psychiatric Nurse Assistant/direct care staff
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSP	Personal Support Plan

PT	Physical Therapy/Physical Therapist
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietitian
RGSC	Rio Grande State Center
RN	Registered Nurse
r/o	Rule out
SA	Settlement Agreement
SAM	Self-Administration of Medication
SIB	Self-injurious Behavior
SO	State Office
SLP	Speech and Language Pathologist
SOP	Standard Operating Procedure
SPO	Specific Program Objective
SSLC	State Supported Living Center
STD	Sexually Transmitted Disease
STHCS	South Texas Health Care System
TB	Tuberculosis