# United States v. State of Texas

## Monitoring Team Report

## Rio Grande State Center
## February 28-March 4, 2011

**Date of Report: April 27, 2011**

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## Introduction

### Background

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

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

Initial reviews conducted between January and May 2010 are considered baseline reviews. 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 ofRio 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. However, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. Several sections of this report include information provided by multiple team members.

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

### Methodology

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

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

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

**Organization of Report**

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

The report 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, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;

b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report. It should be noted that the Action Steps listed by RGSC are a plan of improvement and may not be fully in congruence with, or may not at a given time address all, components of the SA that are being reviewed. The Assessment of Status by the Monitoring Team, therefore, reports on the findings of the monitoring team in relation to the provisions of the SA and may differ from the self-assessment by the Facility;

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 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") is stated; and

f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. 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. The recommendations for some provisions include a subsection of additional suggestions for the facility. These are presented in an effort to assist the facility in prioritizing activities as the facility staff work towards achieving substantial compliance with the provision.

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

**Executive Summary**

First, the Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators of the Facility for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The Facility made available to the Monitoring Team and number of staff members in order to facilitate the many activities required, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The Monitoring greatly appreciated the assistance of all Facility staff.The Facility made staff readily available to meet with members of the Monitoring Team and to provide documents and other information. The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Mary Ramos.

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

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations conducted, and interviews held. Specific information regarding many individuals is included in this report, providing a broad sampling from all homes and across a variety of individual needs and supports. It is the hope of the Monitoring Team that the information and recommendations contained in this report are credible and helpful to the facility.

As the findings in this report illustrate, there are areas of the SA in which RGSC has made significant progress. In a number of areas in which improvement is still needed, the Facility had plans in place to make needed changes. This following provides brief highlights of areas in which the Facility is doing well or had made significant improvements and other areas in which improvements were needed.

**Improvements and Positive Practices:** Following is a brief summary of some of the improvements and positive practices noted during this visit.

<u>Restraints</u>

- RGSC had significantly reduced the use of crisis intervention and medical restraints since the last compliance review. In the last compliance review one individual accounted for nearly 1100 crisis intervention restraints in the previous 7 months. This individual did not experience any crisis intervention restraint in the most recent 6-month period. Psychology staff developed very specific procedures for staff to follow to address the situations that had previously resulted in restraint. Psychology staff worked “hands on” with staff to ensure the procedures that were proving to be successful were implemented consistently.
- The facility initiated several improvements that have significantly decreased the use of medical restraint. Several new medical/dental providers had established relationships with the RGSC. These providers are more willing to work with RGSC individuals without pretreatment sedation. Additionally, RGSC was using a portable dental operatory stationed on its campus to prepare individuals for the experience of a visit to the dentist. The RGSC dental hygienist who also goes with the individual to the community dentist staffed this. The Facility had recently initiated a process for the development of a plan of individualized support plans for individuals going to medical appointments who in the past required pretreatment sedation.

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

- The Facility's policies and procedures included a commitment that abuse and neglect of individuals will not be tolerated and required that staff report abuse and/or neglect of individuals.

Quality Assurance

- The Facility has taken steps forward from what the monitoring team observed during the first compliance review. Data reports are better organized and labeled. Examples of contradictory data on different reports that were identified in the first compliance review appear to have been corrected.
- A system for corrective action plans and the tracking of their implementation is in place although it does not as yet include a focus on systemic trends requiring organizational change response.

Integrated Protections, Services, Treatments and Supports

- The PSP annual meeting observed by the Monitoring Team demonstrated improvement in interdisciplinary discussion, as did two Quarterly Reviews.
- A PSP was developed for each individual. Individualized programs and services were established.

Integrated Clinical Services

- The Facility had revised the process for review of PSPs to increase opportunity for integrated planning. The Quarterly PSP reviews brought together several disciplines.

Psychiatric Care and Services

- The Monitoring Team was exceptionally pleased with the efforts set forth by the Facility to enhance Psychiatric Services. Subsequent to the Monitoring Team's past review, the Facility has reassigned a board certified psychiatrist to assume at least 20 hours of direct care service to Individuals served by the center.
- Psychiatric diagnoses were in process of review and updating to ensure that psychiatric diagnoses are justifiable and that there is clear and concise rational for the use of psychotropic medications.

Psychological services

- The Psychology Director had continued to progress toward the BCBA credential. The Facility had hired an additional Associate Psychologist who was also enrolled in coursework required to obtain BCBA certification.

Medical Care

- Specific to medical staffing, the Facility had a robust after hour coverage plan that utilizes staffing from the Mental Health component of the Facility. The covering physician was available 24/7 and will triage routine and urgent clinical issues. At present, one full time physician provided routine care to persons served during normal business hours; however, the Facility was making arrangements with an additional physician, to assume more responsibility of routine health care.
- The Facility has developed, and continues to enhance, a trends analysis report that enables close monitoring of immunization status and some important clinical indicators, including diabetes, hypertension, GERD, Hepatitis, UTI's, Cardiac issues and infections. This process is exceptionally promising and should be considered for other Facilities within the Texas system.

- The Facility had developed a flow sheet for managing diabetes, which will help better manage individuals with diabetes mellitus. The Monitoring Team has reviewed the flow sheet and has found its utility valid.

Nursing Care

- A RN had been hired for the 10 to 6 shift to ensure that there was an RN present on all shifts at all times. The Nursing Department had consistently maintained the required nursing ratios for each shift and had continued to minimize the use of agency nurses.
- The Nursing Department had significantly improved communication with the local hospital. The Hospital Liaison Nurse consistently visited and/or communicated by telephone with hospital personnel when individuals were hospitalized. There was documentation in the Integrated Progress Notes regarding the nursing staffs' communication with hospital personnel when individuals were being sent to the emergency room or hospital and prior to discharge.
- The Unit Nurse Manager and Nurse Operating Officer began selecting three cases from each home on a monthly basis to audit current Physician's Orders. Review of Physician's Orders for February 2011 indicated 32% compliance with the criteria on the audit tool. The completed audit tools for Scheduled Medical/Dental Appointments for February 2011 indicated 83% compliance.
- The Nursing Department had developed and implemented an excellent database to track all required training. All required trainings on policies, procedures and protocols were tracked by percentages of nurses trained on each topic along with a projected date for completion for nurses who failed to complete specific topics by 100%.

Physical and Nutritional Management

- The full time Speech Language Pathologist (SLP) had been focusing on swallowing disorder identification through the administration of tableside swallow evaluations and the use of the mobile modified Barium Swallow Study Suite. As a result of the assessments, people were provided with more appropriate textures than in previous visits.

Dental Services

- The Facility had developed a new, computerized dental appointment log that is comprehensive in nature.

Communication

- A full-time Speech and Language Pathologist (SLP) had been hired.

Most Integrated Environment

- The Post-Move Monitor carried out the required activities comprehensively and verified supports were in place in both home and work settings.

Consent

- RGSC had revised criteria used for rating need and priority for guardianship. The Facility had reviewed all individuals served and developed rankings of need for guardianship based on the criteria that had been revised.

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. Records were consistent with requirements of Appendix D.

- RGSC had developed a process to audit at least five records per month. The sample consisted of all the individuals whose PSP annual meetings occurred during the prior month.
- PSPs were accessible, and records were well organized.

**Areas in Need of Improvement:** Following is a summary of improvements that continue to be needed.

Restraints

- Although there is no indication that restraints are used for convenience of staff, the Monitoring Team is concerned with the apparent ineffectiveness of some behavior support programs, which can lead to restraint use. If a Positive Behavior Support Plan (PBSP) has not been effective and needed changes are not being addressed, inappropriate use of restraint may result.

Abuse, Neglect and Incident Management

- The systems of abuse/neglect reporting and the incident management system at RGSC have improved since the first compliance review but significant improvements are still needed. There are too many incidents of late reporting or lack of reporting.
- Timeliness of DFPS investigations is a significant problem. Too often too much time elapses between the report of an incident and the initiation of substantive investigatory activity.

Quality Assurance

- The Facility tracks much data but improvements are needed in data organization and presentation to make it useful for analysis and process improvement decision-making.
- RGSC did not have, as yet, a written Quality Assurance Policy or Plan.

Integrated Protections, Services, Treatments and Supports

- Although the discussion at the annual PSP planning meeting and Quarterly Review involved participation by several disciplines, it still relied on reports by the disciplines of their impressions without presentation of data and other information that would encourage more informed interdisciplinary decision-making. Although data and information from assessments were available before and at planning meetings, they frequently were not used in PSP discussion.
- Numerous cases were identified in which medical assessment was inadequate, there was delayed or no follow up to lab results and consultations, and the PST was not informed of or did not discuss the results of assessments.
- Programs were not well integrated in the PSP. Many of the programs did not provide detail adequate to ensure consistent implementation.

Integrated Clinical Services

- Facility clinicians routinely indicate review of consultation documents from non-Facility clinicians by initialing and dating the consult forms, but there was no documentation that the Facility clinician accepted or rejected the recommendation or referred it to the PST.

Minimum Common Elements of Clinical Care

- Plans were still established discipline by discipline, and decision making around supports and services for individuals was not integrated across disciplines.
- The Facility policy on Medical Care did not reference the PST or PSP process. It also does not require that clinical indicators of health be established to determine efficacy of treatment or to monitor the health care of individuals,

At-Risk Individuals

- RGSC has not as yet implemented the new risk screening policy required by DADS. The facility is scheduled for additional training on March 9, 2011. As a result efforts directed at assessing risk and developing individual plans to mitigate risk are observably inadequate.

Psychiatric Care and Services

- Although plans were in place to enhance psychiatrist involvement in the polypharmacy committee, there had been a less then robust physician involvement in the current reviews of Individuals who receive polypharmacy.
- The Monitoring Team did not observe any instance of all clinical records reviewed for Provision J and L ordering or documenting additional or more enhanced monitoring for potential side effects, especially when new medications were added, dose changed or when an individual was noted to have functional changes.
- Although consents and approvals were routinely obtained for PBSPs, restrictive procedures and the use of psychotropic medication, weaknesses in the assessment process made it likely that limited understanding of the individual's treatment targets is gained and only minimal support for intervention strategies can be provided, making the consent unlikely to be fully informed.

Psychological services

- PBSPs often were not implemented. In addition, the Facility routinely allowed staff who had not been assessed for competence or who had failed to demonstrate competence in behavior interventions to serve in direct contact positions.
- RGSC also failed to ensure that all individuals living at the facility receive timely and comprehensive Psychological Assessments.
- Data collection continued to lack demonstrable reliability and validity. It was also unclear that existing data were used to make data-based treatment decisions.

Medical Care

- The Monitoring Team identified, and raised significant concerns with the delivery of clinical care to individuals served by the Facility.

Nursing Care

- The Pharmacy sends medications that required the nurses to split the tablets for the correct dosage. This was not an acceptable practice due the potential for an inaccurate dose since tablets may not always split equally and the desired therapeutic may not be achieved. The Pharmacy needs to evaluate this practice.
- The MediMAR electronic system as used at RGSC slowed the process of administering medications, caused duplicate documentation with the potential for documentation errors, and caused situations in which the likelihood of medication errors increased.
- There was no database for tracking plans of corrective action through to resolution. Therefore, it was not possible to determine if the plans of corrective action were completed.
- The nursing staff did not consistently follow the Settlement Agreement and Health Care Guidelines for Urinary Tract Infections and Acute Illnesses.

Pharmacy Services and Safe Medication Practices

- Pharmacy services is not making sufficient progress toward compliance with the settlement agreement. Pharmacy services must immediately review requirements of the Settlement Agreements, consult with pharmacy services who are making advances towards compliance with the Settlement Agreement, and review the current literatures on practice standards for pharmacy services.

- Most important, pharmacy services must immediately enhance its own documentation practices and ensure appropriate filing of clinical documents.
- The quality of annual and quarterly pharmacy reviews must be immediately enhanced.
- Medication variances and drug utilization reviews must be immediate enhanced per the Monitoring Teams recommendations.
- The polypharmacy committee must be improved and include active participation by pharmacy, nursing and physician services in reviewing and addressing issues.

Physical and Nutritional Management

- While there is a team called the PNMT, the team failed to meet on a monthly basis as per state policy 013 and did not meet when there was a change in status. Failure to meet to discuss the root cause of problems and develop plans to address the identified issue resulted in their reoccurrence.
- A new risk process that is intended to more accurately identify individuals at risk had been developed but had not been implemented as of this review. Additionally, supports regarding the areas of oral care and medication administration were missing from the assessment process and were not comprehensively included in the PNMP.
- 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. The primary focus of monitoring remained mealtime. Failure to provide monitoring in all aspects of PNM results in the individual being exposed to unnecessary risk.

Physical and Occupational Therapy

- A major obstacle facing RGSC is lack of therapists to address the needs of the individuals. Individuals were not provided with direct services at a frequency to prevent decline or sustain progress.
- Assessments were completed in accordance to the schedule set forth by RGSC; however, assessments were not being consistently completed in response to a change in status. Medical issues and health risk indicators were not included in the assessment process with appropriate analysis to establish rationale for recommendations /therapeutic interventions.
- 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.

Dental Services

- The Facility did have efficient and functional emergency dental services available to persons served; however, there was no formal policy or procedure in place that outlines the process.
- Policies and procedures for pre and post anesthesia monitoring had not been developed or updated.
- The Facility remained significantly backlogged on dental cases. Because the database was not fully implement for tracking cases, an actual accounting of those deficient with dental services could not be provided.

Communication

- Assessments lack the comprehensiveness needed to identify strengths, needs and to develop appropriate plans of action to improve communication. Individuals who are nonverbal or have severe expressive and receptive language disorders were not provided with services to enhance or develop communication.
- Even though a full time SLP had been hired, the workload for the speech language pathologist was excessive thus not allowing the therapist to be an active member of individuals' Personal Support Team, nor to provide adequate functional communication supports to the individuals.

- The Communication Assessment did not consistently address expansion of current abilities and development of new skills either through the use of AAC or other methods of communication. AAC devices were essentially nonexistent. DCPs interviewed were not knowledgeable of communication strategies to utilize with individuals residing at their homes. 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

- Observations and recorded reviews reflected 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.
- RGSC routinely failed to provide formal and informal training to the individuals living at the facility, either on campus or in the community.

Most Integrated Environment

- Only one person and only one additional person wasreferred at the time of the compliance visit. This outcome may have resulted from the Facility's approach of waiting for an individual or LAR to express interest in moving. PSPs stated RGSC was the most integrated setting when an individual did not express an interest in moving, even when few barriers to movement were stated.
- Obstacles to movement were not identified and addressed.
- There was no standardized approach to assessing people for appropriateness of community living.

Consent

- DADS had drafted a policy on guardianship but had not completed or implemented it.
- The Facility used no specific assessments or processes to aid in classifying an individual as low or high functioning, which are terms used on the criteria for rating need for guardianship. Furthermore, the Facility did not use any standardized assessment instrument or process to assist the PST to make the determination of whether an individual could advocate for him or herself.

Recordkeeping and General Plan Implementation

- The Facility did not have a process in place to monitor and evaluate use of information from the record in making decisions on care, medical treatment, and training.
- There was a separate electronic system, the Clinical Work Station that contained progress notes, medical progress notes, and other information. Not all information could be accessed chronologically, which made this system more difficult to use when tracking the actions and results related to a health care condition.

## Status of Compliance with the Settlement Agreement

| **SECTION C: Protection from Harm-Restraints** | |
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| 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:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. Crisis intervention restraint records for individuals #11, #35, #77, #82, #122, and #145<br>3. Medical restraint records for individuals #3, #15, #23, #47, #55, #61, #79, #97, and #140<br>4. Individual Supports for Medical/Dental Appointment plans for Individuals # 61, #62, and #77<br>5. 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<br>6. Training material used by Psychologist labeled"PNA/Rehab Tech Competency Check," "Restraint Monitor Competency Check," "Clinically Competent Nurse Competency Check," and "Personal Support Team Competency Check"<br>7. Restraint Log 1/25/11<br>8. List of the last 10 medical restraints with Personal Support Plan Addendums (PSPA) documenting Personal Support Team (PST) review<br>9. List of the last 10 crisis intervention restraints PSPAs documenting PST review<br>10. Behavior Support Committee meeting minutes 10/12/10, 12/29/10, and 1/6/11<br>11. Restraint & Seclusion Reduction Core Workgroup Committee meeting minutes 12/7/10 and 2/8/11<br>12. Procedures to Assist with Feeding 9/10, updated 3/1/11<br>13. Restraint Trend Analysis through February, 2011<br>14. Core Minimum Training Requirements by Position Type – Paraprofessional Direct Contact (MR) dated 8/3/10<br>15. Training transcripts for selected staff<br>16. Personal Support Plan for individuals #11, #35, #77, #82, #122, and #145<br>17. Behavior Support Plan for individuals #11, #35, #77, #82, #122, and #145<br>18. DADS Policy 001-Use of Restraint 8/31/09<br>19. RGSC SOP MR 500-07 Use of Mechanical Devices to Prevent Involuntary Self Injury and to Provide Postural Support 2/10<br>20. RGSC SOP MR 700-13 Levels of Supervision last revised 2/10<br>21. RGSC SOP MR 700-14 The Use of Restraint last revised 2/11<br>**People Interviewed:**<br>1. Sonia Hernandez-Keeble, Superintendent<br>2. Blas Ortiz, Jr., Assistant Superintendent<br>3. Jamie Flores, Interim ICF-MR Program Director<br>4. Mary Ramos, Quality Management Director<br>5. Rosie Sanchez, QE Coordinator<br>6. Alondra Machado, Data Analyst |

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| | 7. Megan Gionotti, Psychology Manager<br>8. Myrna Wolfe, Incident Management Coordinator<br>9. Janie Villa, QMRP Manager<br>**Meetings Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 2/28/11<br>*2.* Settlement Agreement Performance Improvement Council (SA-PIC) 3/2/11<br>*3.* Personal Support Plan (PSP) annual meeting for Individual #113, 3/3/11<br>*4.* Behavior Management Committee 3/3/11<br>**5.** Quarterly PSP Review meeting for Individuals #63 and #140 |
| | **Facility Self-Assessment:** The RGSC POI reported that the Facility is not in substantial compliance with 7 of the 8 provisions of this section of the Settlement Agreement (SA). The monitoring team review validates this self-assessment in six provisions, including the one provision RGSC self-assessed as being in substantial compliance. This was provision C.8, which addresses post restraint review activity. In addition the Monitoring Team determined that provision C.2 is in substantial compliance. The Monitoring Team could not rate Provision C7, as no individual met the criterion that would trigger the requirements of the provision.<br><br>RGSC has initiated significant improvements in the oversight of restraint use and as a result has self-identified problem areas needing continued improvement in order to achieve substantial compliance. The monitoring team did not identify any substantive problems in its review that the staff at RGSC had not already identified and was working to correct. |
| | **Summary of Monitor's Assessment:**<br>RGSC had significantly reduced the use of crisis intervention and medical restraints since the last compliance review. In the last compliance review one individual accounted for nearly 1100 crisis intervention restraints in the previous 7 months. This individual did not experience any crisis intervention restraint in the most recent 6-month period. Psychology staff developed very specific procedures for staff to follow to address the situations that had previously resulted in restraint. Psychology staff worked "hands on" with staff to ensure the procedures that were proving to be successful were implemented consistently. The number of other crisis intervention restraints over the six month period September, 2010 through February, 2011 totaled 9 compared to 19 (not included the one individual who had 1100) the previous 6 months. RGSC is to be commended for figuring out ways in which to support the one individual without use of restraint, and for its 53% decrease in restraint use among the other individuals.<br><br>The use of medical restraint had also decreased significantly. In the last compliance review the monitoring team noted the use of 150+ medical restraints a month. In the 6-month period of this review, medical restraint was used 47 times, 35 of which were in September and October, 2010. In the most recent four months medical restraint had only been used 6 times. The facility initiated several improvements that have significantly decreased the need for medical restraint. Several new medical/dental providers had established relationships with the RGSC. These providers are more willing to work with RGSC individuals |

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| | without pretreatment sedation. Additionally, RGSC was using a portable dental operatory stationed on its campus to prepare individuals for the experience of a visit to the dentist. The RGSC dental hygienist who also goes with the individual to the community dentist staffed this. The Facility had recently initiated a process for the development of a plan of individualized support plans for individuals going to medical appointments who in the past required pretreatment sedation. These plans identify the best time of day for an appointment, preferred staff, whether the presence of family members might be helpful, what type of activities staff should engage in while waiting at the medical providers office, and what type of post visit activity should be planned so the individual has something to look forward to immediately after the medical/dental visit. The early results of this new process are promising.<br><br>The facility was now using forms and processes required by State policy and had updated its restraint policy to reflect the requirements of the State policy, which are intended to address all elements and provisions of the SA. |

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| C1 | Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used. | The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). This was primarily because RGSC's internal monitoring of restraint practices and documentation identified numerous issues with policy compliance. The monitoring team concurs with this self-assessment.<br><br>RGSC SOP ICFMR 700-14, The Use of Restraint, revised 2/11, guides facility practices with respect to restraint use. This policy addresses the requirements mandated by the State policy, is comprehensive, and directed to the practices necessary to achieve compliance with the Settlement Agreement.<br><br>RGSC used restraint for crisis intervention only nine times since the last compliance review. Rather than take a sample of the nine (involving six individuals) the monitoring chose to review all nine restraint episodes. This will be referred to as sample C.1 throughout this report.<br><br>None of the individuals had Safety Plans for Crisis Intervention (SPCI).<br><br><u>Prone Restraint</u><br>Based on Facility policy review, prone restraint is prohibited.<br><br>Based on review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Review Team (IMRT), no use of prone restraint was identified or the subject of any discussion in meeting minutes. | Noncompliance |

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| | | The monitoring team interviewed ten Psychiatric Nursing Assistants (PNAs). PNA is the job title at the RGSC for Direct Care Professionals (DCP). All were aware of the prohibition on use prone restraint. Only four of the 10 (40%) answered the question posed by the monitoring team without hesitation. The other six (60%) required additional prompting by the monitoring team explaining what prone restraint was. After provided the explanation all six responded that we don't do that here. Only two staff (20%) of thoseinterviewed were sufficiently knowledgeable in policies and procedures governing the use of restraint to instill confidence in the Monitoring Team that training was effective and staff knowledge was sufficient to ensure correct policy implementation. For example, eight staff provided vague or unclear responses to questions such as "Can you tell me about some of the major policy requirements associated with restraint use?"or, "If an individual is in restraint what type of staff supervision is expected?" As use of restraint continues to be reduced, it will be essential to ensure staff remain aware of the policies and procedures required so that they carry out the requirements of policy and of the SA.<br><br><u>Other Restraint Requirements</u><br>Based on document review, the Facility policy states that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment.<br><br>Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, debriefing forms, and Personal Support Plan Addendums (PSPAs). The following are the results of this review:<br>• In eight of nine restraint records reviewed (89%), there was documentation showing that the individual posed an immediate and serious threat to self or others. This information was provided on the Restraint Checklist in the section labeled "Describe Events Leading to Behavior That Resulted in Restraint" and on the face-to-face assessment/debriefing form in section 3, "Determine if restraint was necessary." It does not appear that the chemical restraint of Individual #11 was in response to an immediate and serious risk of harm. When the Incident Management Review Team (IMRT) reviewed this restraint the minutes reflect the following: "the psychologist noted concerns with this restraint. Our own policy was not followed with this chemical restraint; nursing did not contact the psychologist before administering the medication. This is a concern as the psychiatrist noted that the individual was no longer agitated; however, he still prescribed the medication."<br>• In all nine of the restraint records reviewed (100%), a review of the descriptions | |

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| | | of the events leading to the behavior that resulted in restraint contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. While restraint documentation supports this conclusion, the Monitoring Team is concerned with the apparent ineffectiveness of some behavior support programs, which can lead to restraint use. For example, on 12/9/10, DADS Regulatory cited the facility for a regulatory deficiency for lack of appropriate interventions and services being implemented in accord with an individual's Behavior Support Plan. If there is a pattern of Positive Behavior Support Plans (PBSPs) being ineffective and needed changes are not being addressed,or if PBSPs have not been implemented accurately and have been ineffective, inappropriate use of restraint may result.<br><br>Eight of the nine restraint records reviewed (89%) contained documentation that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Examples where this was the case included: Several restraint checklists indicated use of a large number of pre-restraint interventions. For example, for Individual #35, interventions noted included verbal prompt, redirection, removed dangerous object, moved others away, and changed environment. For Individual #82 interventions noted included interventions in PBSP, verbal prompt, redirection, changed environment, moved others away, and traded out staff. Two (22%) restraint checklists only indicated verbal prompt and redirection as interventions attempted pre restraint. This was the case with Individuals #77 and #122. One checklist (11%) did not have any interventions checked on the checklist but did contain a note "redirection but unsuccessful." This was for Individual #11. This individual received chemical restraint. When the Incident Management Review Team (IMRT) reviewed this restraint the minutes reflect the following: "the psychologist noted concerns with this restraint. Our own policy was not followed with this chemical restraint; nursing did not contact the psychologist before administering the medication. This is a concern as the psychiatrist noted that the individual was no longer agitated; however, he still prescribed the medication."The Monitoring Team is concerned that staff are not always following policy and may not be sufficiently trained and knowledgeable with policy and the full range of interventions that may be appropriate for each specific individual.<br><br>The Settlement Agreement (SA) also requires that restraint be used in a clinically justifiable manner. Restraint may on occasion have been used without good clinical justification. For example, in reviewing the PSPAs associated with each use of restraint the documented discussion typically describes what happened and what led up to the behavior that created the need for restraint but does not discuss the PBSP, its implementation, its effectiveness, and any recommended changes. Most typically, as is the case with Individual #122, the | |

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| | | team recommends "staff to follow behavior support plan" when the plan had not worked well enough to avoid the use of restraint (or wasn't followed) in this particular instance resulting in the need for restraint, thus prompting a need for review of the PBSP and its implementation.<br><br>Facility policies identify a list of approved restraints.Based on the review of nine restraints all (100%) were restraints approved in policy. | |
| C2 | Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others. | The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). This was because RGSC internal monitoring reported six incidents of reported medical restraint with one individual whose behavior, upon review by the psychology department, did not pose a danger to self or others. Restraint for this individual is no longer used. The monitoring team has determined this provision of the SA is in substantial compliance having reviewed 100% of crisis intervention restraints since the last review.<br><br>Three of the nine instances of restraint were chemical restraints. The other six restraints consisted of:<br>1. Basket Hold 7 minutes<br>2. Basket Hold 1minute<br>3. Basket Hold/horizontal side-lying 4 minutes<br>4. Horizontal side-lying 2 minutes<br>5. Horizontal side-lying 5 minutes<br>6. Basket Hold 4 minutes<br><br>In each instance the release code used on the Restraint Checklist was "P" (released immediately because no longer an immediate and serious risk of harm to self/others) or "L" (released immediately when longer immediate and serious risk of harm to self or others). The additional documentation reviewed by the monitoring team including the face to face assessment/debriefing and PSPA minutes further substantiated compliance.<br><br>Note: release code "P" and "L" are virtually identical. Code "P" is on the most current version of the Restraint Checklist (6/10). Code "L" is on an earlier version of the Restraint Checklist (12/08). RGSC used the outdated form for four of the nine restraint checklists reviewed (44%). While the two versions of the form are very similar there are important differences. RGSC should purge its supply of the old forms and only ensure use of the current form in the future. | Substantial Compliance |
| C3 | Commencing within six months of the Effective Date hereof and with | The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). This was because RGSC internal monitoring identified the use of chemical restraint | Noncompliance |

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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. | without the required consultation of the psychology department (two of three instances) and one instance of use of chemical restraint rather than less restrictive interventions. The monitoring team concurs with this self-assessment.<br><br>RGSC SOP ICFMR 700-14, The Use of Restraint, revised 2/11, guides facility practices with respect to restraint use. The policy is comprehensive and directed to the practices necessary to achieve compliance with the Settlement Agreement and include the necessary components called for in this provision of the SA.<br><br>Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas:<br>1. Policies governing the use of restraint;<br>2. Approved verbal and redirection techniques;<br>3. Approved restraint techniques; and<br>4. Adequate supervision of any individual in restraint.<br><br>RGSC SOP ICFMR 700-14, The Use of Restraint policy does not include specific classes, by reference number, required of staff. The Psychology Manager reported the restraint related required classes to achieve competency include:<br><br>1. PBS0100 Positive Behavior Support (pre-service)<br>2. PMA0100 PMAB1 (pre-service)<br>3. PMA0200 PMAB2 (pre-service)<br>4. PMA0310 PMAB3.1(pre-service)<br>5. PMA0320 PMAB3.2(pre-service)<br>6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities (pre-skill)<br><br>These classes were also included on a comprehensive listing of Core Minimum Training Requirements by Position Type – Paraprofessional Direct Contact (MR) dated 8/3/10. This list included those referenced by the Psychology Manager and additional restraint related training requirements (pre-skill) as follows:<br><br>1. PMA0330 PMAB 3.3<br>2. PMA0400 PMAB 4.0<br>3. PMA0600 PMAB 6<br>4. PMA0700 PMAB 7<br><br>The Monitoring Team chose a sample of 22 employees for review. This included 21 PNAs and one person identified as a restraint monitor who was in an administrative position. This will be referred to as sample C-2 throughout the report. Staff training transcripts for | |

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| | | these 22 employees were reviewed with the following results:<br><br>1. PBS0100 Positive Behavior Support (pre-service) - 20 of 22 (91%) had completed this training.<br>2. PMA0100 PMAB 1 (pre-service) - 0 of 22 (0%) had completed this training.<br>3. PMA0200 PMAB 2 (pre-service) - 0 of 22 (0%) had completed this training.<br>4. PMA0310 PMAB 3.1 (pre-service) - 0 of 22 (0%) had completed this training.<br>5. PMA0320 PMAB 3.2 (pre-service) - 21 of 22 (95%) had completed this training.<br>6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities (pre-skill) - 20 of 22 (91%) had completed this training.<br>7. PMA0330 PMAB 3.3- 21 of 22 (95%) had completed this training.<br>8. PMA0400 PMAB 4.0- 21 of 22 (95%) had completed this training.<br>9. PMA0600 PMAB 6- 22 of 22 (95%) had completed this training.<br>10. PMA0700 PMAB 7- 22 of 22 (95%) had completed this training.<br><br>PMA0100, 0200, and 0310 had zero compliance and there may be an acceptable explanation for this: however, none of the documentation presented to the monitoring team provided any insight in this regard.<br><br>Based on interviews with 10 direct care professionals, in which they were asked to tell the interviewer about the policies covering restraint and were prompted, if necessary, to add information about restraint techniques,<br><br>1. Five were able to describepolicies governing the use of restraint (50%);<br>2. All ten were able to describeapproved verbal and redirection techniques (100%);<br>3. Six were able to describeapproved restraint techniques (60%); and<br>4. Seven were able to describeadequate supervision of any individual in restraint (70%).<br><br>Four of the 10 DCP's interviewed had been directly involved in using restraints. Interviews included staff from all three shifts.<br><br>As noted in Section C.1 89% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. | |
| C4 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the | The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). This was because RGSC internal monitoring identified the use of chemical restraint without the required consultation of the psychology department (two of three instances) and one instance of use of chemical restraint rather than less restrictive interventions. The | Noncompliance |

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| | 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. | monitoring team concurs with this self-assessment.<br><br>Based on a review of ninecrisis intervention restraint records (Sample #C.1), seven (78%) included evidence documenting that restraint was used as a crisis intervention.<br><br>Individual #11 received a chemical restraint. When the Incident Management Review Team (IMRT) reviewed this restraint the minutes reflect the following: "the psychologist noted concerns with this restraint. Our own policy was not followed with this chemical restraint; nursing did not contact the psychologist before administering the medication. This is a concern as the psychiatrist noted that the individual was no longer agitated; however, he still prescribed the medication." The facility concluded, and the monitoring team concurs, that this chemical restraint was not administered in response to crisis intervention.<br><br>Individual #82 received a chemical restraint. When the Incident Management Review Team (IMRT) reviewed this restraint the minutes reflect the following: "psychologist was not called before or after the restraint order was written. DADS policy specifically requires this process. Psychologist mentioned that the Dr's order to administer was not carried out immediately since it required consent. However #82 does not have a guardian so it should not have been delayed because our Superintendent signs off on the consents." In addition the Restraint Checklist for this restraint did not contain an entry in the "type of restraint" section. This is the section where "crisis intervention" would typically be checked. The Restraint Checklist is considered by the Monitoring Team to be a primary source of restraint documentation. It is imperative it be complete and accurate. The monitoring team does not believe the facility provided sufficient documentation to validate this chemical restraint as in response to crisis intervention. In addition, the RGSC SOP ICFMR 700-14 The Use of Restraint is explicit in limiting the use of restraints: "Restraints may only be used if an individual poses an immediate and serious risk of harm to him/herself or others…" and thus did notallow for the use of non-medical restraint for reasons other than crisis intervention.<br><br>Documentation provided by the Facility for the nine non-medical restraint records reviewed did not contain information about whether a physician had provided a medical order stating whether the individual could or could not be restrained, or if there were limitations on the type of restraint that could be used. Therefore, the Monitoring Team could not determine whether any restraints used were prohibited by medical orders.<br><br>The facility had recently initiated several improvements that have significantly decreased the need for pretreatment sedation. Several new medical/dental providers had established relationships with the RGSC. These providers are more willing to work with RGSC individuals without pretreatment sedation. RGSC was using a portable dental operatory | |

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| | | stationed on its campus to prepare individuals for the experience of a visit to the dentist. This was staffed by the RGSC dental hygienist, who also goes with the individual to the community dentist. The facility had recently initiated a process for the development of a plan of individualized support plans for individuals going to medical appointments who in the past required pretreatment sedation. These plans identify the best time of day for an appointment, preferred staff, whether the presence of family members might be helpful, what type of activities staff should engage in while waiting at the medical providers office, and what type of post visit activity should be planned so the individual has something to look forward to immediately after the medical/dental visit.<br><br>Plans had been put in place for Individuals #61, #62, and #77 and have proved effective in eliminating the need for pretreatment sedation. | |
| 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 | The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). This was because RGSC internal monitoring identified the use of chemical restraint without the required consultation of the psychology department (two of three instances) and one instance of use of chemical restraint rather than less restrictive interventions. The monitoring team concurs with this self-assessment.<br><br>Review of Facility training documentation showed that there were adequate training curricula on the application and assessment of restraint. This training curriculum for persons who conduct face to face assessments, otherthan the competency based training described in Provision C.3, was not reviewed in enough detail by the Monitoring Team to determine if it was competency based. The face-to-face assessments (FFAs) reviewed by the Monitoring Team were generally complete, descriptive, and described the restraint episode in a manner consistent with other documentation such as the Restraint Checklist and PSPAs. There were some exceptions. For example:<br><br>1. For Individuals #35 and #77 the FFA indicated 1:1 supervision while in restraint but the Restraint Checklist had no entry.<br>2. For Individual #35 a series of questions on the FFA were answered N/A when a yes or no would be more appropriate. Examples: “Issues with protection of person’s privacy? Issues with protection of person’s clothing and personal property?”<br>3. On the FFA there is space for a nurse to check what checks were done (injury, vital signs, and/or mental status). For Individuals #82, #145, #35, and # 77 there were no entries on the FFA. For Individuals #82 and #145 the nursing section of the Restraint Checklist was also incomplete.<br><br>In the review of restraint documentation six staff were identified as restraint monitors. | Noncompliance |

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| | 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. | RGSC restraint policy requires that restraint monitors complete the following training:<br><br>1. PMAB Curriculum<br>2. CPR<br>3. Rights of an Individual<br>4. Abuse/Neglect<br>5. Use of Restraint<br>6. Conducting and documenting the face-to-face assessment and debriefing<br><br>The first five requirements are met by completing staff development classes. The last requirement consists of training conducted by the psychology department. With regard to the first five requirements,five of six (83%) of the restraint monitors had completed all five courses. One restraint monitor had not completed PMAB classes or CPR. With regard to the training conducted by the psychology department there does not appear to be a formal curriculum and a formal class. Rather, the Psychology Manager trains/retrains restraint monitors as she reviews completed FFAs with them.<br><br>Based on the review of nine crisis intervention restraint records (Sample #C.1), a face-to-face assessment was conducted in six of nine incidents of restraint (67%) by an adequately trained staff member. The restraint documentation for Individuals #11 and #77 did not include a FFA, and the FFA done for Individual #145 was done by a restraint monitor who had not completed all required training.<br><br>Seven of nine (78%) of crisis intervention restraint records in the sample included an FFA and, as mentioned above, the FFAs were for the most part complete and descriptive.<br><br>In seven instances (100%), the documentation on the FFA showed that an assessment was completed of the application of the restraint.<br><br>In zero instances (0%), the documentation on the FFA showed that an assessment was completed of the circumstances of the restraint. There were brief entries in section 3 of the FFA. At best these described circumstances immediately preceding the use of restraint. A discussion of circumstances associated with restraint use should be more substantive and include relevant variables from the individual's PBSP, PSP, and daily schedule. Some of this is contained in the PSPA and IMRT meetings that review the restraint episode, but direct care staff who know the person best, and typically are responsible for implementation of skill acquisition programs, positive behavior support plans, and individual activity schedules are not always part of these important discussions.<br><br>None of the ninecrisis intervention restraint records in the sample indicated an alternative | |

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| | | physician-ordered monitoring schedule.<br><br>Based on a review of nine restraint records for restraints that occurred at the Facility (Sample #C.1), there was documentation that a licensed health care professional:<br>▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in three (33%) of the instances of restraint. Records that did not contain documentation of this included:<br>o Individual #11 – 12/16/10<br>o Individual #122 – 8/30/10<br>o Individual #82 – 1/19/11<br>o Individual #82 – 1/10/11<br>o Individual #82 – 9/17/10<br>o Individual #145 – 12/28/10<br>▪ Monitored and documented vital signs in four (44%). Records that did not contain documentation of this included:<br>o Individual #11- 12-16-10 (refused vital signs)<br>o Individual #82 -1/10/11<br>o Individual #145 – 12/28/10<br>o Individual #35 – 1/5/11 (refused vital signs)<br>o Individual #82 – 12/9/10 (refused vital signs)<br>▪ Monitored and documented mental status in seven (78%). Records that did not contain documentation of this included:<br>o Individual #82 – 1/10/11<br>o Individual #145 – 12/28/10<br><br>Based on documentation provided by the Facility, one restraint had occurred off the grounds of the Facility in the last six months. A review of this restraint determined that a licensed health care professional:<br>▪ Conducted monitoring within 30 minutes of individual #35's return to the Facility.<br>▪ Monitored and documented vital signs.<br>▪ Monitored and documented mental status.<br><br>Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 20% of the individuals for whom medical restraint was used. It included the following nine individuals: Individuals #47 (9/4/10), #97 (9/15/10), #55 (9/7/10), #140 (12/14/10), #15 (1/12/11), #61 (11/2/10), #3 (11/12/10), #79 (10/25/10), and #23 (10/20/10). For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. In none of the nine (100%) medical restraints reviewed did the physician specify the schedule and type of monitoring required. None of the nine (100%) medical restraints in the sample indicated an alternative | |

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| | | monitoring schedule or type ordered by the physician. In seven of nine (78%) incidents of medical restraint, chemical restraints were used. The physician did write orders to discontinue activities until the sedation wore off for each medical restraint where chemical sedation was used. Two of nine (22%) incidents of medical restraint were for personal holds.<br><br>In eight of nine (89%) incidents of medical restraint, documentation was summarized from the nurses' Integrated Progress Notes and Physician's Orders and was entered into the Client Work Station (CWS) by the Psychology Department. Nurses completed the Restraint Checklist, number 4012008R, in three of nine (33%) instances of medical restraint. The revised Restraint Checklist, number 06032010R should have been used. None of the seven (100%) incidents of chemical medical restraint followed the monitoring schedule by nurses as required for pre-treatment and post-sedation monitoring, e.g., monitoring vital signs, including oxygen saturation levels (02sats) , and mental status pre-treatment sedation and at 15 minute intervals post sedation until recovered from the effects of sedation and every 30 minutes for two hours after sedation. RGSC had not established and implemented the Standard Operating Procedure NR200-55, Pre-Treatment and Post-Sedation Monitoring Policy until February 2011. This Policy was not congruent with the DADS Pre-Treatment and Post-Sedation Policy and needs to be revised accordingly.<br><br>RGSCs management of medical restraints does not meet the requirement of the Settlement Agreement which specifies "in each instance of medical restraint the physician shall specify the schedule and type of monitoring required." Nor did RGSC nursing staff comply with the frequency of monitoring required for medical restraints. Because RGSC's present system for monitoring medical restraints does not meet the requirements of the Settlement Agreement, the Monitoring Team felt it useful to review and comment on examples of medical restraint monitoring.<br><br>Individual #97's Integrated Progress Notes on 9/15/10 documented that vital signs and O2Sats were taken at 8:00 a.m. prior to the administration of pre-treatment sedation and after sedation at 10:45 a.m. upon return from dental appointment. The nurse documented that individual #97 was cooperative and did not show signs of distress upon return home. No further monitoring was documented. The documentation contained in the CWS note summarized individual #97's medical restraint stating that individual #97 was "somewhat sedated upon return. Will be kept in dorm for the day." This statement conflicts what the nurse documented in the Integrated Progress Note. It was of concern to the monitoring team that the two statements were in conflict, particularly since the nurse failed to continue to monitor individual 97's post-treatment status until the individual was cleared to return to usual activity. | |

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| | | Individual #55's Integrated Progress Notes on 9/7/10 documented that vital signs and O2Sats were taken at 1300 prior to the administration of pre-treatment sedation and post sedation at 4:04 p.m. a.m. upon return from dental appointment. The nurse documented upon return to home that individual #55 was "alert to drowsy but is stable and with steady gait." No further monitoring was documented. It was of concern to the monitoring team that the nurse did not continue to monitor individual #55, particularly since the nurse reported that individual #55 was drowsy post-treatment. Individual #55 should have been monitored until the individual was cleared to return to usual activity.<br><br>Individual #140's Integrated Progress Notes on 12/14/10 documented that vital signs including O2Sats and mental status were assessed at 9:30 a.m., prior to the administration of pre-treatment sedation of Chloral Hydrate 2 grams orally, then every 15 minutes at 9:45 a.m. and 10:00 a.m. post sedation when transported via van, accompanied by two staff for an appointment for a Magnetic Resonance Imaging (MRI). Upon return home vital signs and mental status was assessed post sedation at 1:00 p.m. The nurse documented that individual #140 returned in a wheelchair, awake, alert and was not in any form of distress. No further monitoring was documented. On 12/14/10 at 4:45 p.m. the Integrated Progress Notes documented that individual #140 fell in the dining room on to the right side. Individual #140's vital signs were taken and individual #140 was assessed for injury. No injury was documented and no treatment was need. Individual #140 should have continued to be monitored until the individual was cleared to return to usual activity.<br><br>Individual #15's Integrated Progress Notes on 1/12/11 documented that vital signs including O2Sats and mental status were assessed at 11:00 a.m., prior to the administration of pre-treatment sedation of Ativan 1 milligram orally and Chloral Hydrate 1 gram orally, then every 15 minutes from 11:15 a.m. to 12:15 p.m. post sedation until transported at 12:30 p.m. via van accompanied by staff for a cardiac appointment. Upon return home vital signs and mental status was assessed post sedation at 4:00 p.m. The nurse documented that individual #15 returned ambulating and was in no distress. No further monitoring was documented. Individual #15 should have continued to be monitored until the individual was cleared to return to usual activity.<br><br>Individual #61's Integrated Progress Notes on 11/2/10 documented that vital signs including O2Sats and mental status were assessed at 7:55 a.m., prior to the administration of pre-treatment sedation of Ativan 2 milligrams orally, then every 15 minutes from 8:10 a.m. to 9:25 a.m. post sedation until transported at 9:30 a.m. to a dental appointment accompanied by staff. Upon return home vital signs and mental status was assessed every 15 minutes post sedation from 10:55 a.m. to 1:00 p.m. The nurse documented that individual #61 returned "sleepy" at 10:55 a.m. At 1:18 p.m. the nurse documented vital signs and mental status and stated that individual #61 was alert and wanting to go to | |

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| | | Vocational Services. It was positive to find that Individual #61 was monitored until the individual was cleared to return to usual activity.<br><br>Individual #23's Integrated Progress Notes on 10/20/10 documented that vital signs including O2Sats and mental status were assessed at 10:00 a.m., prior to the administration of pre-treatment sedation of Chloral Hydrate 2 grams orally, then every 15 minutes from 10:15 a.m. and 10:30 a.m. post sedation until transported at 10:40 a.m. for a dental appointment. Upon return home refused vital signs and mental status assessments post sedation at 11:40 a.m. and at 1:00 p.m. The nurse documented that individual #23 was alert, ambulating, in no distress, resumed regular program, but stayed in the dorm for the rest of the day. No further monitoring was documented. The nurse should have continued to attempt taking vital signs and monitoring mental status until it was confirmed that individual #23 had returned to baselinethe individual was cleared to return to usual activity.<br><br>Individual #79 was ordered Benadryl 25 milligrams (route of administration not noted) one hour prior to dental appoint on 10/25/10. There was no documentation available to review regarding the administration of Benadryl, or whether individual kept the dental appointment.<br><br>Individual #47's Integrated Progress Notes on 10/14/10 indicated that medical restraints were for personal holds during administration of Enteral Nourishment from 7:00 a.m. to 7:08 a.m. and again from11:20 a.m. to 11:27 a.m. The nurses documented that individual #47 remained calm throughout the medical restraints and did not sustain injury. No vital signs were taken nor did they appear indicated.<br><br>Individual #3's Integrated Progress Notes on 11/12/10 indicated that medical restraint was for personal hold to perform a blood draw from 4:30 to 4:31 a.m. Individual #3 was reported as uncooperative and struggled against staff holding the arms. No injuries were sustained during the personal hold of which was less than one minute. No vital signs were taken nor did they appear indicated. | |
| 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 | The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). This was because RGSC internal monitoring identified that injury checks were not being completed for each instance of pretreatment sedation and level of supervision for individuals receiving chemical restraint for pretreatment sedation was not being specified. The monitoring team concurs with this self- assessment.<br><br>A sample (Sample #C.1) of nine Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each | Noncompliance |

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| | medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A. | of the required elements:<br><br>1. In one (11%), continuous one-to-one supervision was documented;<br>2. In nine (100%), the date and time restraint was begun was documented;<br>3. In nine (100%), the location of the restraint was documented;<br>4. In nine (100%), information about what happened before, including the change in the behavior that led to the use of restraint was documented;<br>5. In eight (89%), the interventions taken by staff prior to the use of restraint were documented and are adequate for post restraint review.<br>6. In nine(100%), the specific reasons for the use of the restraint were documented. The monitoring team found that when taken together the information provided on the restraint checklist, the FFA, and the debriefing the specific reason for the use of restraint was apparent.<br>7. In eight (89%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated on the restraint checklist.<br>8. In nine (100%), the names of staff involved in the restraint episode were indicated on the restraint checklist.<br>9. The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint, including:<br>o In nine(100%), the observations documented at least every 15 minutes and at release. All restraints in the sample were of short duration. None exceeded 15 minutes;<br>o In nine(100%), the specific behaviors of the individual that required continuing restraint were noted; and<br>o Because of the short duration of all restraint episodes reviewed there was no obvious need for staff to provide, during the restraint, opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan.<br>o In one (11%), the level of supervision provided during the restraint episode was recorded on the restraint checklist.<br>10. In nine (100%), the date and time the individual was released from restraint was recorded on the restraint checklist although in one case (Individual #145) the time released was recorded incorrectly (at 9:50 am which was the time the restraint was initiated). Other data on the checklist indicated the restraint release time as 9:54am.<br><br>In seven (78%), the results of assessment by a licensed health care professional were documented as to whether there were any restraint-related injuries or other negative health effects. For Individual #77 there was no indication of a post restraint assessment. For Individual #122 there was no indication of a post restraint assessment even though the | |

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| | | restraint documentation provided to the monitoring team indicated two injuries to the individual.<br><br>In the sample of nine records (Sample #C.1), restraint debriefing forms had been completed for eight (89%). Restraint documentation for Individual #11 did not include the debriefing form.<br><br>Sample #C.4 was selected using the list the Facility provided of individuals who had chemical restraint since the last on-site review. This included the following individuals: Individual #11 and Individual #82 (2x).<br><br>In two of the three restraints (67%) there was not documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, to assess whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. | |
| 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: | The RGSC POI reported a compliance rating for this provision of the SA of not applicable because RGSC did not have any restraint use that met these criteria during this review period.<br><br>RGSC SOP ICFMR 700 14 - The Use of Restraint, addresses this provision of the SA. The Monitoring Team was not able to assess whether the Facility would have met the requirements of this provision because noindividual met the criterion of restraint use more than three times in any rolling thirty day period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision in such a circumstance.<br><br>Because the Facility had no opportunity to demonstrate whether it would be able to meet the requirements of this provision, the Monitoring Team has chosen not to rate this provision. Nevertheless, the Monitoring Team commends the Facility for having no individuals placed in restraint, other than medical restraint, more than three times in any rolling thirty day period. | Not Rated |
| | (a) review the individual's adaptive skills and biological, medical, psychosocial factors; | RGSC did not have any restraint use that met these criteria during this review period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision.. | Not Rated |
| | (b) review possibly contributing environmental conditions; | RGSC did not have any restraint use that met these criteria during this review period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision. | Not Rated |

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| | (c) review or perform structural assessments of the behavior provoking restraints; | RGSC did not have any restraint use that met these criteria during this review period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision. | Not Rated |
| | (d) review or perform functional assessments of the behavior provoking restraints; | RGSC did not have any restraint use that met these criteria during this review period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision. | Not Rated |
| | (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; | RGSC did not have any restraint use that met these criteria during this review period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision. | Not Rated |
| | (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 | RGSC did not have any restraint use that met these criteria during this review period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision. | Not Rated |

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| | targeted behavior; and | | |
| | (g) as necessary, assess and revise the PBSP. | RGSC did not have any restraint use that met these criteria during this review period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision. | Not Rated |
| C8 | Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate. | The RGSC POI reported substantial compliance with this provision of the SA and the monitoring team concurs.<br><br>The RGSC process for reviewing each episode of restraint, as reported by staff,begins with a FFA done by the restraint monitor immediately after the restraint episode. The restraint episode is reviewed in the unit morning meeting the next business day with whatever information has been prepared by the time of the meeting. This often consists of verbal reports from staff. It is reviewed that same day by the IMRT, again often based on verbal reports from staff, either the Unit Director, Psychology Manager, or both. The restraint episode is kept on the agenda of both meetings until the restraint checklist, FFA, and debriefing have been completed and each review level has the necessary information to conduct a final review and determine a follow-up course of action which may include a referral to the PST for PSP revisions. Corrective Action Plans initiated at the IMRT meeting are put in place and tracked by the Incident Management Coordinator until closed.<br><br>Documentation of these reviews is expected to be in IMRT meeting minutes but it was sometimes quite general, often just noting date and time and that a review occurred. There is also space on the FFA to document that both a unit and IMRT review took place and the date. If a restraint related issue is referred to the Personal Support Team (PST) the results are ordinarily documented in a Personal Support Plan Addendum (PSPA) that becomes part of the permanent record.<br><br>A sample of documentation related to nine instances of crisis intervention restraint was reviewed (Sample #C.1). The Facility was asked to prepare a file for each of these restraint episodes that included all documentation associated with the restraint episode including review activity. In each case, documentation validated review by the IMRT and review by the PST that generated a PSPA addressing the circumstances of the restraint use and follow-up actions to be taken by the team. | Substantial Compliance |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:
1. Purge old forms, especially the Restraint Checklist, to ensure the most updated form is always used.
2. Continue implementing the positive practices put in place the last six months.
3. Address the issue of staff training documentation to ensure transcripts and required training classes are clearly presented.
4.

| **SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management** | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2/17/10.<br>2. RGSC SOP MR 200-02 Restrictive Practices last revised 2/10<br>3. RGSC SOP ICFMR 200-03 Incident Management last revised 1/11<br>4. RGSC SOP ICFMR 200-07 Protection From Harm – Abuse, Neglect, and Exploitation last revised 1/11<br>5. RGSC SOP MR 400-01 Injuries to Consumers last revised 2/10<br>6. RGSC SOP MR 700-13 Levels of Supervision last revised 2/10<br>7. DADS Policy 2.1 Protection From Harm - Abuse, Neglect, and Exploitation last revised 6/18/10<br>8. DADS Policy 2.2 Incident Management last revised 6/18/10<br>9. Abuse, Neglect, Exploitation training material dated 10/07 and training material developed by Incident Management Coordinator titled "Experiential Activities"<br>10. Poster used to inform staff, individuals, LARs, and visitors of A/N reporting responsibilities<br>11. Sample of MR Tracer Forms<br>12. List of current staff 1/5/11<br>12. Criminal Background Check due diligence report matrix 1/1/11<br>13. Personal Support Plan for Individuals #11, #27, #35, #77, #82, #101, #122, #145, and #149,<br>14. Behavior Support Plan for Individuals #11, #35, #77, #82, #122, and #145<br>15. Training transcripts of Facility and DFPS investigators<br>16. Sample of Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation forms<br>17. Guidelines for Securing Evidence<br>18. Unusual Incident Log 9/1/10 to 1/26/11<br>19. List of Peer caused injuries 9/1/10 to 1/26/11<br>20. Injury Log 9/1/10 to 3/2/11<br>21. Department of Family and Protective Services Investigative Reports 37816281, 38506660, 38505213, 38496661, 38467198, 38349929, 38464025, 38436120, 38393515, 37893360, and 38317541<br>22. Facility investigations for discovered injuries for Individuals #35 and #140<br>23. Facility investigations for serious injuries for Individuals #10 (UIR 11-011 and 11-007), #47, #61 (UIR 11-015), #79 (UIR 11-016), #80 (UIR 11-010 and 11-017), #94 (UIR 11-002), #118 (UIR 11-003), and #139 (UIR 11-013),<br>24. TDMHMR Community Relations Program Manual (undated)<br>25. List of volunteers used by RGSC<br>26. Friends and Family Survey FY2010<br>27. Employee Satisfaction Survey FY11<br>28. Sample documentation of employee discipline taken post investigation<br>29. Incident Management Review (IMRT) minutes for22 meetings from 8/30/10 to 2/27/10. |

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| | 30. Self-Advocates meeting minutes 2/8/11<br>31. Under Reporting Record Review 12/17/10, 1/5/11, and 2/17/11<br>32. Training transcripts of sample of employeesand Core Minimum Training Requirements by Position Type – Paraprofessional Direct Contact (MR) dated 8/3/10.<br>33. UIR Audit Tool (2/24/11)<br>34. UIR Audits 1/8/11 and 1/22/11<br>35. FY10 Allegations Trend Report,<br>**People Interviewed:**<br>1. Sonia Hernandez-Keeble, Superintendent<br>2. Blas Ortiz, Jr., Assistant Superintendent<br>3. Jamie Flores, Interim Program Director<br>4. Mary Ramos, Quality Management Director<br>5. Rosie Sanchez, QE Coordinator<br>6. Alondra Machado, Data Analyst<br>7. Megan Gionotti, Psychology Manager<br>8. Myrna Wolfe, Incident Management Coordinator<br>9. Janie Villa, QMRP Manager<br>**Meetings Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 2/28/11<br>*2.* Settlement Agreement Performance Improvement Council (SA-PIC)3/2/11<br>*3.* Personal Support Plan (PSP) annual meeting for Individual #113, 3/3/11<br>*4.* Behavior Management Committee 3/3/11<br>5. Quarterly PSP Review meeting for Individuals #63 and #140 |
| | **Facility Self-Assessment:** The RGSC POI reported that it was in substantial compliance with two of the five (40%) provisions in section D. These included policy commitments to zero tolerance of abuse, and background checks of employees and volunteers. The Monitoring Team review substantiated compliance with these two provisions.<br><br>The RGSC POI reported substantial compliance with seven components of the other three provisions of the SA. The Monitoring Team found substantial compliance with six components within these three provisions. There was not necessarily overlap. Some components that RGSC deemed noncompliant the monitoring team determined were in substantial compliance, for example, the requirement that reporters of abuse not be subject to retaliation. Some components that RGSC deemed compliant the monitoring team determined were not, for example the requirement that informative posters be posted throughout the facility.<br><br>The POI reported several initiatives that have begun since the last compliance review and work products associated with these initiatives were evident to the Monitoring Team. Most notable in this regard is the system of tracking actions needing to be taken following IMRT review of investigations. |
| | **Summary of Monitor's Assessment:** |

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| | The systems of abuse/neglect reporting and the incident management system at RGSC have improved since the first compliance review but significant improvements are still needed. There are too many incidents of late reporting or lack of reporting. To its credit, the internal management and monitoring systems in place at RGSC are self-identifying most of these. Late reporting, or not reporting, suggests staff knowledge needs to improve and the facility is encouraged to aggressively pursue a method to conduct frequent competency checks of staff knowledge. The IMRT process appears to be functioning well, although as described in the report, access to some information may be necessary to improve the quality of their review of abuse/neglect investigation. Timeliness of DFPS investigations is a significant problem. Too often too much time elapses between the report of an incident and the initiation of substantive investigatory activity. Data on trend reports needs improvement, most notably in the separate categorization of incidents investigated by DFPS.<br><br>The Facility's policies and procedures included a commitment that abuse and neglect of individuals will not be tolerated and required that staff report abuse and/or neglect of individuals. |

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| D1 | Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals. | The RGSC POI reported substantial compliance with this provision of the SA and the monitoring team concurs.<br><br>The Facility's policies and procedures included a commitment that abuse and neglect of individuals will not be tolerated and required that staff report abuse and/or neglect of individuals. According to the RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11), staff were required to report abuse, neglect, and exploitation to the Department of Family Protective Services (DFPS) within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement. | Substantial Compliance |
| D2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require: | The RGSC POI reported substantial lack of compliance with this provision of the SA and the Monitoring Team concurs. Several components of this provision are in substantial compliance with the SA but all must be for the provision to be considered in substantial compliance. For example, subsections D2a, b, c, e, f, g, and I were determined by the Monitoring Team to not be in compliance with the SA.<br><br>The Facility's policies and procedures included a commitment that abuse and neglect of individuals will not be tolerated and required that staff report abuse and/or neglect of individuals. According to the RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11), staff were required to report abuse, neglect, and exploitation to the Department of Family Protective Services (DFPS) within one hour by calling the DFPS 1-800 number. This was consistent with the | Noncompliance |

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| | | requirements of the Settlement Agreement. | |
| | (a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting. | The RGSC POI reported substantial lack of compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>According to the RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11), staff were required to report abuse, neglect, and exploitation to the Department of Family Protective Services (DFPS) within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement.<br><br>With regard to serious incidents, the RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11), does not provide instruction specific to the reporting of serious incidents and the monitoring team was not provided any other policy which included such instructions.<br><br>The Trend Report entitled FY10 Allegations Trend Report did not separately identify types of DFPS allegations (i.e. abuse, neglect, exploitation). As a result the monitoring team had to compile data from the Unusual Incident Log and a separate log prepared in response to a document request. The following represents the numbers of allegations that occurred at the Facility for the 5-month period from 9/1/10 through 1/31/11.<br><br>Total abuse allegations – 40<br><br>The disposition of these 40 cases included 3 confirmed,11 were determined inconclusive, 19 were unconfirmed, 3 were unfounded, and 4 were merged with other cases.<br><br>Total neglect allegations – 20<br><br>The disposition of these 20 cases included, 3 confirmed cases, 4 found to be inconclusive, 11 unconfirmed cases, and 2merged with other cases.<br><br>Total exploitation allegations – 3<br><br>All 3 resulted in an administrative referral back to the facility by DFPS.<br><br>It should be noted that an administrative referral by DFPS back to the facility occurs when an allegation is reviewed and, in the opinion of DFPS, the allegation, if proven to be true, would not meet the statutory requirements to be considered abuse, neglect, or exploitation. Such allegations are referred back to the facility for administrative review | Noncompliance |

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| | | and follow-up by the facility.<br><br>Based on an interview of 10 staff responsible for the provision of supports to individuals, 7 (70%) were able to correctly describe the complete reporting procedures for abuse, neglect, and/or exploitation. The others indicated they would talk to their supervisor and did not mention they would call the DFPS 800 number. Two of those who responded correctly also indicated they had the DFPS 800 number programmed in their personal cellphone.<br><br>Based on an interview of 10 staff responsible for the provision of supports to individuals, nine (90%) were able to describe the reporting procedures for other serious incidents.<br><br>RGSC's Unusual Incident Log also provided data on serious injuries. From this report the monitoring team was able to determine the RGSC had 22 serious injuries between 8/1/10 and 1/31/10. From this six were selected for sample D.2.<br><br>Two samples of investigations were selected for review. These included:<br>• Sample #D.1 included a sample of six DFPS investigations of abuse, neglect, and/or exploitation between 9/1/10 and 1/31/10. This sample included the following DFPS investigation reports: 37816281, 38349929, 38464025, 38496661, 38505213, and 38506660.<br>• Sample #D.2 included a sample of six Facility investigations between 9/1/10 and 1/31/11. This sample included the following investigations: 11-007, 11-011, 11-013, 11-015, 11-016, and 11-017.<br><br>Based on a review of the 12 investigation reports included in both Sample #D.1 and Sample #D.2, six (50%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Facility policy required that unusual incidents (which include serious injuries) be reported immediately, no later than one hour from identification, to the Superintendent/designee and that allegations of abuse/neglect are reported to DFPS within one hour of identification. The six that did not meet this policy requirement include:<br>1. DFPS 38506660: The DFPS report stated the date and time of the incident was 12/30/10 at 6:50pm. And that it was reported to DFPS on 12/31 at 5:20pm. The RGSC UIR indicated the incident occurred on 12/30/10 but was not reported until 12/31/10. Based on review of the report, it appears that the person who observed the incident on 12/30/10 did not report it to DFPS until the next day that the first RGSC administration learned of it was when DFPS notified the facility of the report. | |

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| | | 2. DFPS 38505213: the RGSC UIR indicated this incident (unconfirmed physical abuse) was reported to the RGSC designee at 6:03 pm on 12/30/10. It was not reported to DFPS until 9:37pm, which was confirmed in the DFPS report.<br>3. DFPS 38464025: the RGSC UIR indicated this incident (confirmed physical abuse) was reported at 5:56am 12/1/10, but the Monitoring Team could not determine from the UIR to whom it was reported on. It was not reported to DFPS until 11:58 am. However, the DFPS report stated the alleged abuse occurred on 12/1 at 4:56am and 5:08am and their initial report from the facility came at 11:58am.The UIR reported DFPS notified RG of the allegation at 12:15pm.<br>4. DFPS 38349929: DFPS concluded the incident (confirmed physical abuse) occurred at 7:30 am from information developed in the course of the investigationbut was not reported to DFPS until 5:37pm.The Monitoring Team could not find any clear statement in the UIR that abuse was suspected at a specific time and therefore could not correlate that time to a report time. An injury was noted at 11:50am yet the report to DFPS did not occur until much later.<br>5. UIR 11-007: this serious injury was witnessed at 8:50 am and was not reported to the Superintendent/designee until 10:00am.<br>6. UIR 11-013: this serious injury was witnessed at 1:48pm and was not reported to the Superintendent/designee until 4:45pm.<br><br>The Facility hada standardized reporting format that meets generallyaccepted standards with sufficient information necessary for adequate follow-up, as well as tracking and trending of incidents.<br><br>Based on a review of 14 investigation reports included in Sample #D.1 and Sample #D.2, 14 (100%) contained a copy of the report utilizing the required standardized format. | |
| | (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 | The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) and RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) govern all aspects of abuse/neglect/exploitation reporting and follow-up. In reviewing these policies the Monitoring Team did not find explicit language that directed staff to take the necessary action to stop the abuse, neglect, or exploitation. Nor was language found that required the removal of alleged perpetrators from contact with individuals (it should be noted that from its review of UIRs it was clearly the practice at RGSC to remove alleged perpetrators from contact with individuals). The policies did contain language addressing other safety concerns, including initiating first aid and | Noncompliance |

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| | least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation. | notifying a nurse. The policy addressing these issues needs to contain additional requirements and be organized more efficiently so that all the steps expected to be taken to protect individuals are in one section.<br><br>Based on a review of 12 investigation reports included in Sample D.1 and Sample D.2, in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status.<br><br>Review of 12 investigation files included in Sample #D.1 and Sample #D.2, showed there were no instances where staff that had been removed from direct contact and subsequently reinstated after a well-supported preliminary assessment posed a risk to individuals or the integrity of the investigation.<br><br>Based on a review of the 12 investigation files, it was documented that adequate additional action was taken to protect individuals in each case. For example: nursing assessments were done and treatment rendered as appropriate, alleged perpetrators were removed from client contact, retraining, and environmental conditions that could have created a safety hazard for other individuals were corrected. | |
| | (c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training. | The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) requires that all staff complete class ABU0100 Abuse and Neglect pre-service and at least yearly.RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) requires that all staff complete class UNU0100 Unusual Incidents pre-service and at least yearly. These two classes are sufficient to demonstrate compliance with the SA.<br><br>A review of the training curricula related to abuse and neglect was carried out for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows:<br><br>In relation to the requirement that training is competency-based, the material reviewed includes provisions for trainees to demonstrate their understanding of what constitutes abuse, neglect, and exploitation and how to report observations or suspicion of abuse, neglect, or exploitation. The material also includes adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation.<br><br>Review of 22 staff records (Sample C.2), showed that 19 (86%) of these staff had | Noncompliance |

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| | | completed competency-based training on abuse and neglect (ABU0100) within the previous 12 months. Sixteen (73%) had completed competency-based training on unusual incidents (UNU0100) within the previous 12 months.<br><br>Based on interviews with 10 staff:<br><br>▪ Four (40%) were able to list signs and symptoms of abuse, neglect, and/or exploitation with sufficient depth to demonstrate competency of understanding; and<br>▪ Seven (70%) was able to describe the complete reporting procedures for abuse, neglect, and/or exploitation. | |
| | (d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect. | The RGSC POI reported substantial compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) and RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) do not include specific requirements associated with this component of the SA and the monitoring team was not provided any other policy which included such information. These requirements should be included in future policy revisions.<br><br>Copies were requested of the forms for staff hired during the two full months prior to the on-site review. Based on a review of those forms, 11 of 11 (100%) of staff hired during this time period had signed the DADS required acknowledgement form 1020. This is the form required by DADS policy to document compliance with this component of the SA.<br><br>Form 1020 was requested for the 22 employees in Sample C.2. Properly signed forms for all 22 staff were provided to the monitoring team.<br><br>The facility had self-identified seven instances where staff witnessed, or were aware of, an incident that should have been reported and was not.The Monitoring Team was provided documentation to validate the administrative personnel action that was taken which, in most cases, was counseling and retraining the staff with a record of this placed in their personnel file. | Substantial Compliance |
| | (e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has | The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>RGSC engages in very limited activity directed at this component of the SA. The facility | Noncompliance |

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| | 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. | reported that materials are provided to LARs prior to each individuals PSP meeting. Monitoring Team members attended the one PSP meeting held the week of the review and there was not any discussion of abuse, neglect or other reportable incidents. The Monitoring Team reviewed the PSPs for Individuals #27, #35, #101, and #149 and there was no evidence to suggest discussion of this topic.<br><br>In interviewing a sample of two individuals, they were able to describe what they would do if someone hurt them, or they had a problem with which they needed help.<br><br>No serious incidents had been identified as being reported by an individual, their LAR, or others who were significantly involved in their lives. | |
| | (f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights. | The RGSC POI reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) and RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) do not include specific requirements associated with this component of the SA and the Monitoring Team was not provided any other policy that included such information.<br><br>In observations made by the monitoring team on 3/1/10 a poster directed at individuals informing them of rights and exercising those rights was found posted in one of two (50%) residential buildings. These are large buildings and more than one poster should be displayed. Posters directed at staff, and their abuse/neglect reporting responsibilities, were posted in both buildings although not very conspicuously. RGSC had many posters posted throughout the campus. Most are colorful and laminated or framed. The rights poster and abuse/neglect were not and while they contained good content they were not eye catching nor did they stand out in any way.. Neither poster was displayed in the ICFMR conference room, the location of many staff meetings and PSP meetings. | Noncompliance |
| | (g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement. | The RGSC POI reported substantial compliance with this component of this provision of the SA. The monitoring team does not concur.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) and RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) included specific requirements associated with this component of the SA.<br><br>Based on a review of six allegation investigations completed by DFPS (Sample #D.1) | Noncompliance |

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| | | DFPS had made law enforcement referrals inthree (50%) cases. The three cases that did not include law enforcement referrals were 38506660 (unconfirmed neglect), 38496661 (unfounded verbal abuse), and 38464025 (confirmed physical abuse). Based on a review of this last case it appears to the Monitoring Team it should have been referred to law enforcement. This was an allegation that a staff person used inappropriate force in redirecting an individual. There would ordinarily be an expectation that allegations involving physical interaction between a staff person and an individual be referred to law enforcement to determine if the facts warrant investigation as battery, aggregated battery, or any similar violation of criminal codes. The Monitoring Team did not find a pattern of lack of reporting. DFPS has notified the Monitoring Team that it will follow up with the supervisor for this case. The Monitoring Team recommends that the Facility, DADS, and DFPS review current criteria and consider whether to revise criteria to ensure that physical abuse or allegations of physical abuse are reported to law enforcement.<br><br>Based on a review of six investigations completed by the Facility (Sample #D.2), law enforcement referral was not necessary or appropriate given the nature of the incident being investigated and the facts discovered during the course of the RGSC investigation. | |
| | (h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner. | The RGSC POI reported lack of compliance with this component of this provision of the SA. The monitor team finds this component to be in substantial compliance.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) included specific requirements in section IX associated with this component of the SA.<br><br>Based on interviews with the Facility Director and Assistant Facility Director it was clear retaliation would not be tolerated and this was reinforced in training and during the course of individual investigations.<br><br>Based on interviews with two individuals served by the Facility, both reported they thought they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. In interviewing 10 direct care staff, eight (80%) reported retaliation would not be tolerated by administration and they were unaware of any retaliation. The other two staff reported they had heard of rumors in the past but were personally unaware of anything specific that had happened.<br><br>Based on a review of investigation records (Sample #D.1 and Sample #D.2), there were noconcerns noted related to potential retaliation.<br><br>The Facility was asked for a list of staff since the last review against whom disciplinary | Substantial Compliance |

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| | | action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation. There were no instances of reported retaliation. | |
| | (i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation. | The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>RGSC initiated a process in December, 2010 of reviewing two records a month to detect whether the record reflects any incidents that occurred and weren't reported. The data collection form used by the Health Information Management department calls for the reviewer to look at the last 30 days of injury reports, progress notes, care flow sheets and the nursing quarterly report and biophysical assessment. At the time of the monitoring review six records had been reviewed and no instance of under-reporting was identified.<br><br>The new process is a significant step toward compliance. This audit reviewed only a 30-day period, which provides only a small sample of possible underreporting for an individual. To achieve substantial compliance with this component of this provision the monitoring team would expect to see a longer look back period, at least 90 days, to ensure there is an adequate opportunity to determine whether underreporting has occurred. | Noncompliance |
| 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 RGSC POI reported lack of compliance with this provision of the SA and the monitoring team concurs.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) and RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) included specific requirements associated with this component of the SA. As described in subsections a, b, e, g, h, and j, these policies were not always implemented correctly. | Noncompliance |
| | (a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, | The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) include specific requirements associated with this component of the SA.<br><br>The monitoring team review of this policy found it described in a comprehensive fashion | Noncompliance |

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| | including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator. | the conduct of all such investigations; required that investigators be qualified andidentified specific requirements/training classes that would cause an investigator to be deemed qualified; required that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and required that investigators be outside of the direct line of supervision of the alleged perpetrator.<br><br>The Monitoring Team did not review curricula used by DFPS in training its investigators and cannot comment on its content and whether or not it is competency based. Because DFPS case investigations reviewed by the monitoring team are generally thorough and comprehensive and case reports are generally well written the Monitoring Team believes, at least for now, the training DFPS investigators receives is achieving the desired results.<br><br>RGSC policy required that Facility Investigator training is to consist of the following classes:<br><br>ABU0100 Abuse and Neglect, UNU0100 Unusual Incidents, CIT0100 Comprehensive Investigator Training, and MEN0300 People with Mental Retardation. Staff designated as principal investigators also are required to complete the LRA training Conducting Serious Investigations (CSI0100) and Root Cause Analysis. The Monitoring Team believes this training, if completed as described, should be adequate for the conduct of investigations at RGSC.<br><br>DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire. While not required it appears many investigators also take a class titled "MH&MR Overview – APS Investigator Role". Completion of this class would demonstrate training in working with people with developmental disabilities.<br><br>DFPS had five investigators assigned to work RGSC cases.The training records for these investigators were reviewed. Four of the five (80%) completed the requirements for investigations training. For the other investigator DFPS reported that person had completed the training but his current training transcript does not contain credit for the training. DFPS reported that if they are unable to locate proof of completion of the training he may be scheduled toretake the training. Three investigators also completed the MH/MR overview. DFPS investigations reviewed by the monitoring team were conducted by one of these five investigators.<br><br>RGSC hadthree staff designated as principal investigators, which includes the Incident Management Coordinator. The training records for these investigators were reviewed. | |

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| | | None had completed training in Root Cause Analysis. One had not completed the LRA Conducting Serious Investigations course.<br><br>RGSC had an additional three staff identified as investigators. Two are campus coordinators and one works in QA and is available as backup. The Monitoring Team reviewed their training records. One of the three (33%) had completed root cause analysis training. Two of the three (67%) had completed CIT0100 Comprehensive Investigator Training.<br><br>None of the staff designated as investigators had supervisory responsibilities and therefore are not in the direct line of supervision of anyone subject to investigation.<br><br>Due to the deficiencies in completing training on root cause analysis, which is required by Facility policy, the Facility does not yet comply with this provision. | |
| | (b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation. | The RGSC POI reported substantial compliance with this component of this provision of the SA. The monitoring team does not concur.<br><br>RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) includes requirements associated with the conduct of investigations. This policy did not contain a requirement that facility staff cooperate with outside entities that are conducting investigations of abuse, neglect, and exploitation. It is necessary that this requirement be included in policy to ensure the facility has a policy-based rationale for the discipline of staff who may fail to cooperate with investigations.<br><br>As described above in Section D.2.a of this compliance report, two samples of investigation files were selected for review. These included Sample #D.1 and Sample #D.2, which consisted of DFPS investigations, and Facility investigations, respectively. Review of the investigation files in Sample #D.1 showed that in six out of six investigations (100%), Facility staff cooperated with DFPS investigators. This notwithstanding, to achieve compliance with this component of this provision of the SA policy must include the requirement for staff cooperation. | Noncompliance |
| | (c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations. | The RGSC POI reported substantial compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each | Substantial Compliance |

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| | | other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency."<br><br>Based on a review of the investigations completed by DFPS and the Facility, the following was found:<br><br>▪ Six of the six (100%) investigation records from DFPS (Sample #D.1) identified no evidence of interference by one agency or the other in any of these 6 case files.<br>▪ Of the six investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies. All were serious injuries where there was no suspicion of abuse or neglect, and therefore would not be reported to DFPS or law enforcement. | |
| | (d) Provide for the safeguarding of evidence. | The RGSC POI reported substantial compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) included specific requirements associated with this component of the SA.<br><br>While on site, the monitoring team observed the area the Facility uses for safeguarding evidence. Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2) any evidence that needed to be safeguarded was. | Substantial Compliance |
| | (e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services | The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) and RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) included specific requirements associated with this component of the SA.<br><br>The Monitoring Team was not provided with any policies directed at this element of the SA beyond RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) and RGSC SOP ICFMR 200-03 titled Incident | Noncompliance |

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| | Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. | Management (revision date 1/11). The Monitoring Team was provided with a list of approved RGSC policies which did not include any policies directed at serious incidents in general.<br><br>The above referenced policies did not require that investigations commence within 24 hours or sooner, if necessary and be completed within 10 calendar days of the incident. The policies did not require a written extension request from the Facility Superintendent or Adult Protective Services Supervisor to be completed outside of the 10-day period. The policiesdid not reference that time extensions are only to be considered when due to circumstances that constitute "extraordinary circumstances" as required by this provision.The policiesdid notspecifically require that an investigation is to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. Many elements of this component of the SA were reflected in actual practice at RGSC; however, a policy foundation is needed in order to achieve substantial compliance.<br><br>To measure compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br><br>Two ofsix (33%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation, if any, that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following were the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner:<br>• Investigation 3850660 is an allegation of neglect reported on 12/31/10 at 5:20pm. The initial face-to-face interview did not occur until 1/3/11 at 5:45pm and it was of the alleged victim who is non-verbal. The first staff interview did not occur until 1/5/11. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided.<br>• Investigation 38496661 is an allegation of emotional and verbal abuse and was reported to DFPS at 3:37pm on 12/23/10. The initial face-to-face interview did not occur until 12/26/10 at 10:44am. This was an attempted interview of the | |

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| | | alleged victim who was unwilling to talk to the investigator. The first face-to-face interview of staff was on 12/29/10 although there was phone contact with a staff person on 12/27/10. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided.<br>• Investigation 38464025 is an allegation of physical abuse and was reported to DFPS at 11:58am on 12/1/10. The initial face-to-face with the alleged victim was on 12/3/10. The alleged victim is nonverbal. Staff interviews did not begin until 12/8/10. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided.<br>• Investigation 37816281 is an allegation of physical abuse and was reported to DFPS at 5:25pm on 9/7/10. The initial face-to-face with the alleged victim was on 9/9/10 at 10:00am. Staff interviews did not begin until 9/14/10. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided.<br><br>Four of six (67%) investigations were completed within 10 calendar days of the incident. For the two that were not completed within 10 days (38505213 and 38349929), the Monitoring Team was not provided during the visit with documentation of approval of an extension by the Adult Protective Services Supervisor, and there was no documentation these extensions were due to circumstances that constitute "extraordinary circumstances." It is possible that such approval existed but the Monitoring Team could not confirm that.<br><br>Six (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement.<br><br>In three of the investigations reviewed, recommendations for corrective action were included. In all three the recommendations were adequate to address the findings of the investigation.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br><br>Two of six (100%) commenced within 24 hours or sooner, if necessary (11-016 and 11-017). It is difficult ascertaining when an investigation actually started because of the manner information is presented on the UIR. The first information presented on the UIR is a summary of progress notes preceding or immediately following the incident. It is not possible to tell when the investigator gathered these data. This is also the case with the | |

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| | | collection of staff statements noted in the UIR. The UIR noted dates of staff interviews and the Monitoring Team used these data to determine when the investigation began. The Monitoring Team believes investigatory activity commenced well before the date of the first staff interview but cannot determine with confidence when this activity started because of the manner information is presented in the UIR.<br><br>Six of six (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor.<br><br>Six of six (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement.<br><br>In all six of the investigations reviewed, recommendations for corrective action are included. In all six of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation.<br><br>Through the course of reviewing investigations the Monitoring Team noted that the video surveillance cameras that have been in operation since 11/1/10 have been helpful in ascertaining the facts associated with some allegations. The Monitoring Team is concerned with interruptions that were observed of the surveillance camera monitoring room. The door to the room was often left open and the staff who were observing the video screens were almost always distracted by staff walking down the hall or staff that dropped in who appeared to be visiting with the camera monitoring staff. These distractions could result in reportable incidents not being detected. | |
| | (f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all | The RGSC POI reported lack of compliance with this component of this provision of the SA. The Monitoring Team determined this component of this provision to be in substantial compliance.<br><br>RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) included specific requirements associated with this component of the SA.<br><br>The contents of the investigation reports reviewed were sufficient to provide a clear basis for its conclusion and the reports utilized a standardized format that sets forth explicitly and separately:<br>o Each serious incident or allegations of wrongdoing;<br>o The name(s) of all witnesses;<br>o The name(s) of all alleged victims and perpetrators; | Substantial Compliance |

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| | 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. | o The names of all persons interviewed during the investigation;<br>o 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;<br>o All documents reviewed during the investigation;<br>o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;<br>o The investigator's findings; and<br>o The investigator's reasons for his/her conclusions.<br><br>To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>▪ In six of six investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.<br>▪ The report utilized a standardized format that set forth explicitly and separately<br>o In six (100%), each serious incident or allegations of wrongdoing;<br>o In six (100%), the name(s) of all witnesses;<br>o In six (100%), the name(s) of all alleged victims and perpetrators;<br>o In six (100%), the names of all persons interviewed during the investigation;<br>o In six (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;<br>o In six (100%), all documents reviewed during the investigation;<br>o In six (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;<br>o In six (100%), the investigator's findings; and<br>o In six (100%), the investigator's reasons for his/her conclusions.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations: | |

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| | | In six of six investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.<br><br>The report utilized a standardized format that set forth explicitly and separately<br>o In six (100%), each serious incident or allegations of wrongdoing;<br>o In six (100%), the name(s) of all witnesses;<br>o In six (100%), the name(s) of all alleged victims and perpetrators;<br>o In six (100%), the names of all persons interviewed during the investigation;<br>o In six (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;<br>o In six (100%), all documents reviewed during the investigation;<br>o In six (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency<br>o In six (100%), the investigator's findings; and<br>o In six (100%), the investigator's reasons for his/her conclusions. | |
| | (g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. | The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) includes specific requirements associated with this component of the SA. Based on review of this policy it does require that staff supervising the investigations review each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete and coherent. The policy does not require that any further inquiries or deficiencies be addressed promptly.<br><br>To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>▪ Three of the six(50%) DFPS reports reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. No supervisory review was noted in cases 38464025, 38349929, and 37816281. Case | Noncompliance |

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| | | 37816281 was completed prior to the implementation of a revised policy and form that no has a copy of the supervisor approval form included in the report packet. Following the compliance visit, the supervisor approval for Case 38349929 was found. With both of these, the compliance would increase to four of five (80%).<br>▪ In all six case files, there was evidence that the RGSC Incident Manager Coordinator had conducted a review of the investigation report and that any concerns had been reported back to DFPS to correct deficiencies or complete further inquiry.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>▪ In all six investigation files reviewed there was evidence that the supervisor had conducted a review of the investigation report.<br>▪ In all six, there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. | |
| | (h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident. | The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>RGSC used the IMRT process to review DFPS reports and used the minutes of that group to represent compliance with this component of this provision of the SA. This process is intended to ensure senior management of the facility is involved in the review of each case and the written report pursuant to this component includes their input. A concern of the Monitoring Team is that the members of the IMRT do not have access to the actual DFPS report when conducting this review. Rather, they are relying on the verbal representations of report content presented by the Incident Management Coordinator. It was reported this practice existed because of concerns over confidentiality. The Monitoring Team is of the opinion that at least some members of senior management, along with the IMC, should be part of a review team that assesses the adequacy of each DFPS report to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent and that deficiencies or areas of further inquiry in the investigation and/or report are addressed promptly.A process similar to this is in place at most other facilities this Monitoring Team has reviewed. | Noncompliance |
| | (i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent | The RGSC POI reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) included | Substantial Compliance |

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| | recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes. | specific requirements associated with this component of the SA.<br><br>The Monitoring Team reviewed the tracking system used by the RGSC to assign responsibility for follow-up disciplinary and programmatic action and monitor the intended actions through completion. The data base system is well organized and used by the IMC and the IMRT to ensure follow-up is occurring, and to administratively remind those responsible for any delays in follow-up. The Monitoring Team review included review of a sample of source documents (such as disciplinary documentation) to assess the integrity of the tracking system and found the tracking system to accurately reflect intended administrative activity. | |
| | (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 RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs.<br><br>RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) did not include specific requirements associated with this component of the SA. This should be corrected the next time RGSC updates this policy.<br><br>Upon inspection by the monitoring team, maintenance of investigation files was found to be easily accessible. A data base was in place to enable an investigator to quickly identify individuals and staff who have been the subject of prior investigations. A database is maintained to facilitate this process.File storage at RGSC is organized and up-to-date.<br><br>The monitoring team did not probe whether DFPS has a similar process by which it can quickly access prior history of alleged perpetrators and alleged victims and will need to do so in the next review. | Noncompliance |
| 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 | The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs.<br><br>RGSC produced a monthly Allegations Trend Report and a monthly Unusual Incidents Trend Report. Neither report provided DFPS reportable incidents by type, e.g. physical abuse, verbal abuse, or neglect. In the Allegations Trend Report all DFPS allegations were included as one category. The Unusual Incident Trend Report didnot include separately identified DFPS reportable incidents. Since DFPS reportable allegations and incidentstend to represent the more serious incidents that occur at a facility it is imperative that data associated with these incidents be sufficiently detailed to facilitate trending and tracking that may be useful for facility analysis and process improvement decision-making. | Noncompliance |

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| | incident; and outcome of investigation. | Current month data on these reports included identification of type of incident (with some deficiencies as noted above); 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 investigations. This provided a snapshot of the current month; however, these data were not trended over time, such as a rolling 12-month period. The Monitoring Team believes they must be in order to achieve compliance with this provision of the SA.<br><br>The RGSC had established a Settlement Agreement Program Improvement Council (SA-PIC). The monitoring team observed a meeting of this group during the review. The Trend Reportsand other data were presented but there was little substantive discussion of unusual incidents and investigation outcomes that could stimulate change in policy or practice. This was despite the fact some significant data from internal monitoring was presented, including: documentation associated with peer to peer aggression was only present in 50% of the incidents reviewed, the monitoring of PBSP implementation indicated implementation was done correctly in only 51% of the observations, and, in a three month period 29 (of 70, 42%) of the individuals living at RGSC had been involved in DFPS allegations. The Monitoring Team suggests that trend reports be reviewed by SA-PIC members before the meeting (rather than have them essentially read at the meeting) so that meeting time can be devoted to more substantive discussion. | |
| 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 RGSC POI reported substantial compliance with this provision of the SA and the Monitoring Team concurs.<br><br>By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks.<br><br>In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 25 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed | Substantial Compliance |

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| | 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. | with the Facility Director.<br><br>Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of October, 2010. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry.<br><br>Similar checks were done for a sample of volunteer records reviewed by the monitoring team. | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. Improvements in policy content are needed as noted in the report.
2. DFPS needs to improve the timeliness of initiating its investigations and to document all activities that may demonstrate investigations begin within required timelines.
3. Data elements included in trend reports need improvement minimally to further delineate type of DFPS case and to display rolling 12 month trend data..
4. Staff training and competency checks need more emphasis to improve staff knowledge in reporting responsibilities
5. Staff who are deficient in one or more required training classes need to be made current.
6. UIR content needs to clearly include information that describes when an investigation started.
7. If the IMRT is going to be the primary review panel for DFPS reports members should be provided with DFPS reports prior to the meeting in which they are reviewed.
8. The Monitoring Team recommends that the Facility, DADS, and DFPS review current criteria and consider whether to revise criteria to ensure that physical abuse or allegations of physical abuse are reported to law enforcement.

The following are offered as additional suggestions to the facility:

1. SA-PIC should if possible receive reports for review prior to their meeting.
2. There should be a senior management review panel to review DFPS cases.

| **SECTION E: Quality Assurance** | |
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| 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 | **Steps Taken to Assess Compliance:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11.<br>2. SA -PIC meeting minutes 10/28/10, 11/18/10, 12/13/10, and 1/20/11<br>3. Sample MR Tracer Forms<br>4. RGSC Monitoring Tools and Summary Report (undated)<br>5. RGSC Trend Analysis Report 1st Quarter FY 2011 |

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| 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: | 6. RGSC Allegations Trend Report 1/31/11<br>7. RGSC Unusual Incidents Trend Report 1/31/11<br>8. RGSC Injury Trend Report 1/31/11<br>9. Corrective Action Plan (CAP) Report for SA-PIC December 2010<br>10. CAP Reporting Log 2/23/11<br>11. Sample of completed SA monitoring tools<br>12. Friends and Family Survey FY2010<br>13. Employee Satisfaction Survey FY11<br>14. Incident Management Review (IMRT) minutes for22 meetings from 8/30/10 to 2/27/10.<br>15. Self-Advocates meeting minutes 2/8/11<br>**People Interviewed:**<br>1. Sonia Hernandez-Keeble, Superintendent<br>2. Blas Ortiz, Jr., Assistant Superintendent<br>3. Jamie Flores, Interim Program Director<br>4. Mary Ramos, Quality Management Director<br>5. Rosie Sanchez, QE Coordinator<br>6. Alondra Machado, Data Analyst<br>7. Megan Gionotti, Psychology Manager<br>8. Myrna Wolfe, Incident Management Coordinator<br>9. Janie Villa, QMRP Manager<br>**Meetings Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 2/28/11<br>*2.* Settlement Agreement Performance Improvement Council (SA-PIC) 3/2/11<br>*3.* Personal Support Plan (PSP) annual meeting for Individual #113, 3/3/11<br>*4.* Behavior Management Committee 3/3/11<br>5. Quarterly PSP Review meeting for Individuals #63 and #140 |
| | **Facility Self-Assessment:** The RGSC POI reported it was not in compliance with the five provisions of this section of the SA. The monitoring team is in agreement with this assessment.<br><br>The facility has taken steps forward from what the monitoring team observed during the first compliance review. This was most notable in the system that is now in place to establish corrective action plans and track their implementation.<br><br>The Facility tracked much data but improvements are needed in data organization and presentation to make it useful for analysis and process improvement decision-making.<br><br>A process for data analysis was reported as in a developmental stage. The monitoring team observed evidence of this in the SA–PIC presentation by the QA Director. The SA-PIC was beginning to establish selection of process improvement initiatives based on trend information. One example of a process improvement initiative was being implemented. Data on injuries identified falls as the highest cause of |

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| | injuries. An improvement plan was initiated through SA-PIC. This plan began with appointment of an ad-hoc committee and includes actions involving several disciplines and departments that contribute to efforts to reduce falls. Improvements were being planned or implemented at the time of the visit.<br><br>A process for the development and implementation of Corrective Action Plans has been developed and is in place. In its present form it sets forth plans that address sentinel events. The process of using these data to identify systemic patterns and problems will need to be the next big step in quality assurance. |
| | **Summary of Monitor's Assessment:**<br>The Facility has taken steps forward from what the monitoring team observed during the first compliance review. Data reports are better organized and labeled. Examples of contradictory data on different reports that were identified in the first compliance review appear to have been corrected. A system for corrective action plans and the tracking of their implementation is in place although it does not as yet include a focus on systemic trends requiring organizational change response.<br><br>The Facility tracks much data but improvements are needed in data organization and presentation to make it useful for analysis and process improvement decision-making.<br><br>A process for the development and implementation of Corrective Action Plans has been developed and is in place. In its present form it sets forth plans that address sentinel events. The process of using these data to identify systemic patterns and problems will be the next big step forward for the QA department.<br><br>The SA-PIC was beginning to establish selection of process improvement initiatives based on trend information. One example of a process improvement initiative was being implemented. Data on injuries identified falls as the highest cause of injuries. An improvement plan was initiated through SA-PIC. This plan began with appointment of an ad-hoc committee and includes actions involving several disciplines and departments that contribute to efforts to reduce falls. Improvements were being planned or implemented at the time of the visit. RGSC reported it intended to use this same approach to initiating other process improvements it identifies through the SA-PIC trend analysis.<br><br>RGSC did not have, as yet, a written Quality Assurance Policy or Plan. Facility staff reported these are a "work in progress." |

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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; | The RGSC POI reported lack of compliance with this provision of the SA and the monitoring team concurs.<br><br>Data being tracked met the minimal requirements of the SA in most respects but were deficient in some important areas. For example, RGSC produced a monthly Allegations Trend Report and a monthly Unusual Incidents Trend Report. Neither report provided | Noncompliance |

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| | individual staff; and/or individuals receiving services and supports. | DFPS reportable incidents by type, e.g. physical abuse, verbal abuse, or neglect. In the Allegations Trend Report all DFPS allegations were included as one category. The Unusual Incident Trend Report did not include separately identified DFPS reportable incidents. Since DFPS reportable allegations and incidentstend to represent the more serious incidents that occur at a facility it is imperative that data associated with these incidents be sufficiently detailed to facilitate trending and tracking that may be useful for facility analysis and process improvement decision-making.<br><br>Current month data on these reports included identification of type of incident (with some deficiencies as noted above); 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 investigations. This provides a snapshot of the current month; however, these data are not trended over time, such as a rolling 12-month period. The Monitoring Team believes they must be in order to achieve compliance with this provision of the SA.<br><br>The RGSC had established a Settlement Agreement Program Improvement Council (SA-PIC). The Monitoring Team observed a meeting of this group during the review. The Trend Reportsand other data were presented but there was little substantive discussion directed at interpreting the data in a meaningful manner that may stimulate change in policy or practice. This was despite the fact some significant data from internal monitoring was presented, including: documentation associated with peer to peer aggression was only present in 50% of the incidents reviewed, the monitoring of PBSP implementation indicated implementation was done correctly in only 51% of the observations, and, in a three month period 29 (of 70, 42%) of the individuals living at RGSC had been involved in DFPS allegations. The monitoring team suggests that trend and other reports be reviewed by SA-PIC members before the meeting (rather than have them essentially read at the meeting) so that meeting time can be devoted to more substantive discussion. | |
| E2 | Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) | The RGSC POI reported lack of compliance with this provision of the SA and the monitoring team concurs.<br><br>The RGSC had established a Settlement Agreement Program Improvement Council (SA-PIC). The monitoring team observed a meeting of this group during the review. The Trend Reportsand other data were presented but there was little substantive discussion directed at interpreting the data in a meaningful manner that may stimulate change in policy or practice. This was despite the fact some significant data from internal monitoring was presented, including: documentation associated with peer to peer aggression was only present in 50% of the incidents reviewed, the monitoring of PBSP implementation indicated implementation was done correctly in only 51% of the | Noncompliance |

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| | responsible; and the time frame in which each action step must occur. | observations, and, in a three month period 29 (of 70, 42%) of the individuals living at RGSC had been involved in DFPS allegations. The monitoring team suggests that trend and other reports be reviewed by SA-PIC members before the meeting (rather than have them essentially read at the meeting) so that meeting time can be devoted to more substantive discussion.<br><br>The Facility had, though, initiated one process improvement initiative through the SA-PIC. The Facility had, at an ICF-MR survey, received a citation for having many falls. Review of trends in injury data for January, 2011, identified that the category with the highest number of injuries was slips/trips/falls. Per report at the SA-PIC meeting of 3/2/11, the Facility had established an ad-hoc committee to identify means to reduce falls. The ad-hoc committee included members from several departments and disciplines, and improvement actions reported at the SA-PIC meeting covered several of these areas. For example, review of the environment and information from direct care staff identified some floors that needed leveling; habilitation services found a need for review of gait belts and installation of hand rails; medical services found a physiatrist who could see patients quickly; psychiatry requested that each report of a fall include information on psychotropic medications the individual is prescribed; and a system to keep wheelchairs in repair and available and to train staff on wheelchair use was designed. Some actions had already been taken, and others were being planned. Furthermore, the definition of "falls" had been revised to provide better information on whether people are falling or are sitting down. This was an excellent example of evaluation of data, selection of an important issue to address, and use of an interdisciplinary review and improvement process.<br><br>A process for the development and implementation of Corrective Action Plans was in place. In its present form it sets forth plans that address sentinel events. Plans reviewed by the Monitoring Team addressed an action to correct the specific problem that was identified for correction but did not include remedies that would prevent the recurrence of problems. The Monitoring Team developed the impression from this review that nearly all problems are determined to be the result of single error of one type or another and did not see evidence that this process was attempting to identify issues as systemic and in need of a broader organizational response. The process of using these data to identify systemic patterns and problems will need to be the next big step in quality assurance. | |
| E3 | Disseminate corrective action plans to all entities responsible for their implementation. | The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs.<br><br>The corrective action plan process went into effect in November, 2010. This represents a | Noncompliance |

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| | | significant improvement in quality improvement planning than observed during the last compliance review. Individual CAPs, while addressing for the most part single error issues, are discussed at IMRT meetings to ensure all entities responsible for their implementation are made aware of their responsibility and that necessary effort to implement each plan is occurring. CAPs are disseminated but the process to review completion at SA-PIC was established too recently to demonstrate effective tracking and follow up of completion and effectiveness of CAPs.Although the process improvement plan addressing falls did involve a wide range of departments, there were not other CAPs for which evaluation of outcome could confirm that all entities responsible for implementation had been identified and had received the plans. Furthermore, there was not yet effective tracking to validate that this had occurred; The QA Director reported the dissemination/tracking system is still evolving. Therefore, it is not possible to ensure that all entities responsible for implementation received corrective action plans. The procedures in place provided a good beginning; with further examples and an effective tracking system, the Facility may be able to come into compliance with this provision in the near future. | |
| 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. | The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs.<br><br>The corrective action plan process went into effect in November, 2010. This represents a significant improvement in quality improvement planning than observed during the last compliance review. Individual CAPS, while addressing for the most part single error issues, are discussed at IMRT meetings to ensure all entities responsible for their implementation are made aware of their responsibility and that necessary effort to implement each plan is occurring. CAPs are disseminated but the process to review completion at SA-PIC was established too recently to demonstrate effective tracking and follow up of completion and effectiveness of CAPs.Only the process improvement plan addressing falls included monitoring of implementation and outcomes, and that plan had not been fully implemented yet and could not yet demonstrate the outcomes at which the plan was aimed, although there were preliminary data showing the possibility the plan might be effective. The Monitoring Team will review to determine whether this process becomes routine, whether problems needing to be addressed are selected, and whether corrective actions are implemented fully. | Noncompliance |
| E5 | Modify corrective action plans, as necessary, to ensure their effectiveness. | The RGSC POI reported lack of compliance with this provision of the SA and the monitoring team concurs.<br><br>The corrective action plan process went into effect in November, 2010. This represents a | Noncompliance |

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| | | significant improvement in quality improvement planning than observed during the last compliance review. Individual CAPS, while addressing for the most part single error issues, are discussed at IMRT meetings to ensure all entities responsible for their implementation are made aware of their responsibility and that necessary effort to implement each plan is occurring. CAPs are disseminated but the process to review completion at SA-PIC was established too recently to demonstrate effective tracking and follow up of completion and effectiveness of CAPs.The process improvement plan had been implemented in part but had not been completely implemented, nor had monitoring been in place long enough to determine whether the plan would be effective or would need revision. The Monitoring Team will review corrective action plans at future compliance visits to determine whether they are monitored and then are revised if monitoring shows they are not effective. | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. Continue the development of a written Quality Assurance Policy and Plan.
2. Refine the trend reports to provide more data and array the data in a more useful manner for analysis.
3. Continue to improve on the corrective action plan process, including ensuring there is a process to identify that CAPs are completed and to track effectiveness when appropriate.
4. As appropriate based on trend data, select and implement additional process improvement initiatives.

The following are offered as additional suggestions to the facility:

1. SA-PIC should if possible receive reports for review prior to their meeting so that meeting time can be devoted to substantive discussion and selection and tracking of process improvement initiatives.

| **SECTION F: Integrated Protections, Services, Treatments, and Supports** | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated2-17-11<br>2. DADS Policy 004 Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports) dated 7/30/10<br>3. RGSC SOP MR 600 01 Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports) last revised 10/10<br>4. RGSC SOP MR 600 02 Development and Monitoring of Individual Program Plans Personal Support Team Approach last revised 2/10<br>5. Supporting Visions Training Outline 7/10<br>6. Rio Grande State Center ICF-MR Personal Support Plan Meeting/Documentation Monitoring Checklist 9/01/10<br>7. Personal Support Plans (PSPs) for Individuals #10, #11, #35, #55, and #87<br>8. Personal Support Plan Addendum for Individual #140 dated 2/28/11, "Quarterly Review"<br>9. Personal Focus Assessment (PFA) for Individuals #35, #55, and #87<br>10. Behavior Support Plan for individuals #61, #80, #122, and #145<br>11. Active record for Individuals #10, #11, #15, #19, #27, #31, #33, #35, #47, #48, #63, #77, #80, #87, #94, #96, #126, #140, #143, and #149<br>**People Interviewed:**<br>1. Group interview of Janie Villa, QMRP Manager; Jaime Flores, ICF-MR Director; Rebecca Olivarez, QMRP, and Hector Sanchez, Program Improvement Specialist<br>2. Mary Ramos, Quality Management Director<br>3. Megan Gionotti, Psychology Manager<br>**Meetings Attended/Observations:**<br>1. PSP Annual Planning Meeting for Individual #113 3/3/11<br>2. PSP Quarterly Review for Individual #63 and #140 2/28/11<br>*3.* Behavior Management Committee 3/3/11<br>4. Incident Management Review Team (IMRT) 2/28/11<br>5. Settlement Agreement Performance Improvement Council (SA-PIC) 3/2/11 |
| | **Facility Self-Assessment:** The RGSC POI reported lack of compliance with all provisions, and all components within provisions, of this section of the SA. The Monitoring Team concurs but would like to acknowledge that improvements in the PSP process since the first compliance review were noted and were observable to the Monitoring Team. This was especially noticeable at the one PSP meeting and the two Quarterly review meetings observed by the Monitoring Team. The level of interdisciplinary discussion, including direct care professionals, at these meetings was noticeably improved from the first compliance |

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| | review.<br><br>The POI noted that beginning in November, 2010, "PSP action plans developed during the annual review identify methods for implementation, time frames and integrates all services." The Monitoring Team does not concur in this finding but noted many cases in which services were not integrated or were not established as actions in the PSP.<br><br>The POI noted that beginning in November, 2010, "Programming is currently being reviewed monthly by the QMRP and quarterly by the PST. Changes and /or modifications are made when necessary." The Monitoring Team did not concur that changes were made when necessary. |
| | **Summary of Monitor's Assessment:**<br>RGSC implemented the new PSP process established by the state. As the process had begun recently, it had not yet matured, and improvement is needed. The PSP annual meeting observed by the Monitoring Team demonstrated improvement in interdisciplinary discussion, as did two Quarterly Reviews. Although the discussion involved participation by several disciplines, it still relied on reports by the disciplines of their impressions without presentation of data and other information that would encourage more informed interdisciplinary decision-making.Although data and information from assessments were available before and at planning meetings, they frequently were not used in PSP discussion. An improvement from the last compliance visit was that other members of the PST, for some issues, asked questions and added information, and discussed the summaries and impressions of the clinicians.<br><br>Direct care staff actively participated in the PSP meetings. When asked about participation in development of Physical and Nutritional Management Plans (PNMPs), they reported they were not involved.<br><br>There was variability in the quality and comprehensiveness of assessments. New psychiatric evaluations were well within expected standard of care practice. At the time of the site visit, approximately 81% of the individuals living at RGSC had not received a psychological assessment or update in the past year; psychological assessments did not include intellectual or adaptive assessments completed or reviewed according to current standards of practice. Numerous cases were identified in which medical assessment was inadequate, there was delayed or no follow up to lab results and consultations, and the PST was not informed of or did not discuss the results of assessments.<br><br>Assessment when there was a change in status for an individual also was variable. Several individuals were identified who had numerous falls without assessment of the health and behavioral conditions contributing to those falls. Individuals with severe language disorders did not routinely receive assessments for communication programs or devices. At the previous site visit, the Facility indicated that a new process and format for structural and functional 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 the formulation of specific hypotheses regarding the function of undesired behavior. Although establishing the process is a good step |

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| | in developing adequate assessment, there were still numerous deficiencies in implementation that will take time to resolve.<br><br>The Facility did not address obstacles to movement to a more integrated environment. Although visits to community settings were provided once an individual indicated an interest in moving,only one of four (25%) PSPs reviewed also included plans relevant to movement to a more integrated environment. For the other three PSPs reviewed, one of three (33%) identified actions to encourage movement to a more integrated environment. Two of three specifically mentioned either that the individual did not express interest in moving, or that it was difficult to ascertain whether the individual would wish to move; the requirement, however, is that the PST members provide their professional determination of whether community placement is appropriate, rather than wait for an expression of interest from the person.<br><br>A PSP was developed for each individual. Individualized programs and services were established. They were not well integrated in the PSP. Many of the programs did not provide detail adequate to ensure consistent implementation. Some programs and services needed by individuals were not planned or provided. |

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| **F1** | **Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall: | The RGSC POI reported lack of compliance with this provision of the SA and the monitoring team concurs.<br><br>Although the structure of an interdisciplinary team process was in place, most involvement was multidisciplinary. Observation at the one PSP planning meeting held during the week of the review demonstrated significant improvement in interdisciplinary discussion. Still, discussion at these meetings relied on reports by disciplines of their impressions without providing data and other information that would encourage more informed interdisciplinary decision-making.<br><br>The PSPs themselves did not yet demonstrate interdisciplinary process. Action Plans did not show evidence of integrated planning. The Facility had made progress in the process for meetings, which is an important step.<br><br>The Monitoring Team observed the one annual PSP planning meeting and the two PSP Quarterly Reviews being held during the visit. In addition, four PSPs were reviewed in detail. | Noncompliance |
| F1a | Be facilitated by one person from the team who shall ensure that members of the team participate in | The RGSC POI reported lack of compliance with this provision of the SA and the monitoring team concurs. | Noncompliance |

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| | assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. | The PSP process observed by the Monitoring Team was led by a QMRP, and each PSP reviewed by the Monitoring Team documented QMRP responsibility.<br><br>The QMRP led discussion during the observed PSP annual meeting in a manner that facilitated input and discussion from team members. Participation by clinicians and direct care staff was active. Individual disciplines provided summaries of their information but, for the most part, provided impressions rather than data or direct information from the active record. Although it is appropriate that the meeting focuses on decisions to be made about supports and services that address the individual's preferences, strengths, and needs rather than consisting of presentations of reports, it is also important that essential information be included when describing an individual's status. Clinicians were observed during the PSP annual planning and Quarterly Review meetings referring to the information in records, but they did not describe the information when giving impressions; the information might help other PST members provide more valuable insights and make better decisions.<br><br>The same patterns were observed during PSP Quarterly Reviews of two individuals. In both, there was discussion in which several participants asked questions and provided relevant information across several topics. For example, during the PSP Quarterly Review for Individual #140, there was good participation by the PST members. During a discussion of lack of progress on a self-care activity of putting on lotion, the psychiatrist, Dr. Moron, asked what reinforcer was being used and pointed out it might not be working. The Associate Psychologist asked whether the individual would allow nurses to put on the lotion. A management observer stated that attention from nurses and medical providers is the strongest reinforcer. Unfortunately, although the discussion provided useful information and the PST agreed with this conclusion, there were no changes made to the program nor was there discussion of a short-term test of using nursing attention as a reinforcer.<br><br>Clinicians looked at and appeared to review documents and then report impressions but did not provide data. For example, discussion was held about one individual's sleep patterns. Dr. Moron asked about sleep patterns. The QMRP reported that a sleep study had been done but provided no data; it should be noted that the PSP Addendum of 10/15/10 documented a 1:1 Level of Supervision in order to take 5-minute sleep observations; a data sheet was attached. At this Quarterly Review, no updated data were mentioned, although Dr. Moron reported he had looked at the sleep study. Attached to the PSP Addendum for 2/28/11 was the QMRP Quarterly Review for the quarter reviewed ("November, December 2010, January 2011"). This report described activities that had taken place including medical, dental, pharmacy, and nursing evaluations and orders; listed all PSP Action Plans, vocational, and money management training | |

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| | | objectives; and described behavioral and psychiatric issues. The only data provided were on number of injuries, occurrences of aggression and restraint, number of shopping requests initiated, and weight.<br><br>The Facility provided a monitoring checklist for PSP meetings; the checklist covered the requirements of this Section of the SA but also included other questions such as whether PST members spoke directly to the individual. For the PSP annual planning meeting for Individual #113, the Monitoring Team completed the checklist. Some of the items rated included:<br>• PST members actively participated in the meeting.<br>• Preferences were identified as a priority addressed in action plans. The actual PSP was not available at the time of this report, but the QMRP summarized what would be in the plan and who would be responsible for developing supports.<br>• The PST discussed the need for communication devices.<br>• The person's legal status was reviewed.<br>• At least five training objectives were established.<br>• The team did not incorporate any PBSP in the action plan with replacement training identified.<br>• There was no clear statement that the person would be scheduled to be away from home at least five hours a day.<br>• Although there was discussion of scheduling the individual to attend at least one community activity per week, this was not confirmed, and one clinician suggested training be on campus rather than in the community.<br>• There was no discussion of rights and abuse/neglect policies with the individual including reporting. It was noted that a letter regarding this subject would be sent to the individual's brother.<br><br>As described in the finding for Provision component F1c, there were numerous issues in which a lack of timely assessment meant that information for PST consideration in planning and revising treatments and services was not available. | |
| 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 | The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>PSP annual planning and quarterly review meetings had begun to include the participants required.<br><br>Two of four (50%) PSPs provided in response to document requests included sign-in sheets. The Monitoring Team therefore could not confirm that all required participants | Noncompliance |

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| | persons who participate in IDT meetings shall be dictated by the individual's preferences and needs. | attended PSP meetings. However, for the two PSPs that included sign-in sheets and for the observed PSP annual meeting and PSP Quarterly Review for Individual #140, the QMRP, individual, Psychiatric Nurse Assistant direct care professional (PNA), and other persons apparently relevant to the individuals' preferences and needs were present.<br><br>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 from different work shifts are present at least at every annual PSP planning meeting to facilitate input into the planning process.<br><br>For one of two (50%) PSP annual planning meetings for which a sign-in sheet was available, and for the observed meeting, habilitation therapies clinicians—physical therapist (PT) and speech and language pathologist (SLP)--attended.<br><br>PST member involvement in development of supports and treatments was not always evident. There was some evidence that participation of Direct Care Professionals in development of programs and services had not expanded beyond participation in the meetings. When interviewing various discipline staff, the Monitoring Team was unable to confirm that DCPs were routinely engaged in conversation and consultation that may have been germane to the development of the relevant treatment plan. For example, the Assessment of Status for Provision P.3 reports that DCPs did not know the rationales for services provided; without knowing what needs to be accomplished for an individual, it would be difficult for a DCP to provide meaningful recommendations to improve those services.<br><br>PNMPs were not formally developed with input from the PST, home staff, medical and nursing staff.In zero of 12 records reviewed (0%), PNMPs were clearly developed with input from the PST with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per interview with Habilitation Services, PNMPs are developed by Habilitation Services. However, there was evidence in the PSP attended by the monitoring team of discussion of the PNMP.<br><br>Per interview with Nine DCPs, zero of nine (0%) DCPs stated they had input into the development of the PNMPs. DCPs stated that the plans are often passed down with no opportunity for discussion with team members regarding the development. Input from DCPs in the development of PNMPs and other programs and services is absolutely essential. | |

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| 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. | The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs. There was variability in the quality and comprehensiveness of assessments.<br><br>The Monitoring Team reviewed three psychiatric evaluations (Individuals #66, #3, #54). The Monitoring Team determined that the psychiatric evaluations reflected the Facility's procedure and were well within expected standard of care practice.<br><br>At the time of the site visit, approximately 81% of the individuals living at RGSC had not received a psychological assessment or update in the past year. In August 2010, only 40% had not received a psychological assessment or update in the previous 12 months. Furthermore, since the previous site visit, only nine individuals had received a psychological assessment. In addition to the inability to provide annual psychological assessments and updates, RGSC had achieved no progress in regard to the assessment of intellectual and adaptive abilities. For 100% of individuals living at the Facility, psychological assessments did not include intellectual or adaptive assessments completed or reviewed according to current standards of practice. At the previous site visit, the Facility indicated that a new process and format for structural and functional 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 the formulation of specific hypotheses regarding the function of undesired behavior. Although establishing the process is a good step in developing adequate assessment, there were still numerous deficiencies in implementation that will take time to resolve.<br><br>Numerous cases were identified in which medical assessment was inadequate, there was delayed or no follow up to lab results and consultations, and the PST was not informed of or did not discuss the results of assessments. Medical conditions that could be relevant to the function of behavior were not discussed as part of development of PBSPs. Individuals, in some cases, did not receive appropriate medical care, so that conditions were not resolved.<br><br>Not all people identified with therapy needs received a comprehensive OT and PT assessment within 30 days of identification.Per review of OT/PT consult logs for the months of October 2010 to February 2011, eight of 11 issues occurring that required additional assessment by OT or PT were not addressed within the 30-day period. Therefore, these assessments were not available for timely discussion by the PST.<br><br>There were two individuals listed as receiving enteral nutrition and hydration. While | Noncompliance |

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| | | the assessment identified the need for continued NPO (no intake by mouth) status there was no evidence of identification, discussion or development of a plan that may lead the individual back to full PO (oral) status other than the administration of a Video fluoroscopy (VFS) (swallow study). The VFS identifies what the person can tolerate at that moment but does not provide details regarding how to improve the swallow function to mitigate the risk of a declined swallow.<br><br>Several individuals were identified who had numerous falls without assessment of the health and behavioral conditions contributing to those falls. PST discussion was not documented. Physical therapists had recently begun to attend PST meetings; the Facility had identified falls as an area for improvement. Per review of the PNM minutes, the team met during the months of November 2010, December 2010, January 2011, and February 2011. During the months of November 2010 and December 2010 there was limited to no discussion of individuals who experienced multiple falls. For example:<br>• Individual #77 had four falls occurring during the month of November and three falls during the month of December with no discussion by the PNMT or assessment by PT.<br>• Individual #94 had four falls occurring during the month of November and three falls during January with no discussion by the PNMT or assessment by PT.<br>• Individual #35 had two falls occurring during the month of November and eight falls during December with no discussion by the PNMT or assessment by PT.<br>• Individual #63 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT.<br><br>Failure to respond and implement changes to an individual's plan resulted in the continuation of falls into the months of December and January and increased the risk of injury.<br><br>The same can be said for individuals who were listed as having BMIs in excess of 35, and diet downgrades. For example:<br>• Individual #33 had a BMI of 41.41 but there was no evidence of discussion by the PNMT.<br>• Individuals #15, #48 #31, and #149 had diet downgrades but there was no evidence of discussion by the PNMT.<br><br>Issues related to falls are discussed during morning meeting but upon review of the meeting minutes, this serves as more of a notification rather than an active discussion of how to address these issues or the root cause of the issue. For example:<br>• Individual #35 had a fall on 1/26/11. The morning meeting minutes simply | |

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| | | stated "encourage to slow pace."<br><br>Additionally, there was a lack of follow up by OT and PT in response to consults or in response to their own recommendations. For example:<br>• Individual #19 had a skin tear and a consult was made to OT. Per review of the record, there was no evidence that this consult was addressed to by OT.<br>• Individual #35 had a PT consult completed on 1/21/11. The PT stated that multiple types of adaptive equipment would be trialed to improve safety. There was no evidence in the record that this was completed.<br>• Individual #77 had a Physiatrist consult completed on 2/7/11. Recommendation was for aggressive PT. There was no evidence that this was initiated.<br>• Individual #19 was reviewed by PT on 2/9/11. The recommendation was for a neurology consult to determine if a cervical brace would be beneficial. Per neurology consult on 2/21/11, this issue was not addressed. There was no evidence of follow up by the PT.<br><br>Additionally, plans are not consistently developed to address issues, for example:<br>• Individuals #80 and #10 used a gait belt to assist with stability but there was no plan in place to minimize regression or increase stability<br><br>Individuals with severe language disorders did not routinely receive assessments for communication programs or devices. There were no active communication programs; therefore there was no opportunity for integration into the PBSP.One out of 14 records reviewed (7 %) indicated individuals with identified language difficulties were receiving active speech treatment or participating in a speech program of any kind.<br><br>Examples of individuals with identified speech or language difficulties not receiving services were:<br>• Individuals #27, #35, #47, #96, #126 and #143 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 | |
| F1d | Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. | The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>Although data and information from assessments were available before and at planning meetings, they frequently were not used in PSP discussion; instead, they were reported or summarized. An improvement from the last compliance visit was that other members | Noncompliance |

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| | | of the PST, for some issues, asked questions and added information, and discussed the summaries and impressions of the clinicians.<br><br>The Monitoring Team reviewed Individual #11's Personal Support Plan (PSP) and PSP Addendums from 4/30/10 through 1/21/11. Individual #11's PSP, 4/27/11, Nursing Assessment stated there was no medical diagnosis for individual #11's urinary incontinence. There was no recommendation for medical follow-up to determine the cause of the urinary incontinence. The PSP Addendums addressing urinary incontinence primarily focused on the problem being one of the individuals' behaviors. On 5/5/10 the Personal Support Team (PST) met and discussed allowing individual #11 to wear Crocs shoes due to *"wetting"*(urinating) his shoes. The PST determined that Crocs would not be appropriate due to lack of an arch support or side supports. On 7/6/10 the PST met and discussed a purchase request for shoes because individual #11 continues to urinate on them and he runs out of shoes (sic) even though he had nine pairs. The Team agreed to purchase shoes. On 7/12/10 the PST met and discussed the effectiveness of individual #11's toileting schedule as he continued to urinate on his shoes (sic). The Qualified Mental Retardation Professional (QMRP) had compiled data on the frequency of urination on himself and in the toilet. It was noted that individual #11 urinated on himself at least once a day. It was reported that staff were not documenting all toileting successes and attempts. New shoes were requested because he urinated on them and it took a couple of days for the shoes to dry. The Team recommended continuing with the toileting program and schedule. On 1/20/11 the PST met for a Quarterly Review. The PST discussed individual #11's continued incontinence of urine, "*Bathroom issues discussed. He (sic) had tendency of urinating on his self.Goal in future Possible Bladder Scan, if toileting schedules is not successful".* On 1/21/11 The PST met and did not recommend a Bladder Scan, rather they decided to continue the toileting schedule, prompting individual #11 to use the toilet every hour on the hour. Never once in all of the PST meetings did the Team discuss the possibility that individual #11 might have an underlying medical problem causing the incontinence of urine; although the meeting on 1/20/11 casually considered a Bladder Scan but did not state why they considered it. The Teams focus continued on the toileting program and schedule. The physician did order a Bladder Scan on 1/20/11 that was never performed. It was only after the Monitoring Team observed individual #11 briskly pacing the hall, slapping his face throughout the day on 3/1/11, and changing clothes at least five times that it was discovered that the reason he was changing clothes so often was due to incontinence as opposed to a behavioral reason. According to the PST meeting Sign-in Sheets, professional staff, including RNs and physicians, was always present at the meetings where individual #11's urinary incontinence was discussed. It was appalling to discover that none of the professional staff were astute enough to consider the possibility of an underlying medical condition that might be causing the urinary incontinence. As a result | |

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| | | of the Monitoring Team's persistence in prevailing upon the nursing and medical staff to evaluate individual #11 to rule out an underlying problem for the urinary incontinence, the Bladder Scan reordered and performed. The Bladder Scan indicated that individual #11 had urinary retention. The incontinence was most likely due to the overflow of the bladder. After review of individual #11's record it was apparent the problem of incontinence had been going on since at least 5/1/10. While a toileting program may have been appropriate, it would not be effective in resolving the urinary retention. In the Integrated Progress Notes there were numerous entries documenting that individual #11 was taken to the toilet and prompted to urinate and "refused" but would urinate on himself shortly after leaving the toilet. The reason he could not urinate was most likely not due to refusal but because of the involuntary retention of urine. Then, and after the bladder overflowed, individual #11 would have urinary incontinence. It was most regrettable that individual #11's urinary incontinence was not evaluated for an underlying medical condition for at least 10 months. | |
| 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 RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>The PSP annual planning meeting for Individual #140 began with a discussion of the potential for referral to move to a more integrated environment; this remained the focus of the meeting. Supports needed included tours of group homes and discussion of supports the individual would need both for visits and for successful living.<br><br>One of four (25%) PSPs reviewed also included plans relevant to movement to a more integrated environment. As an outcome of PSP planning, Individual #140 was referred for a move. The individual made two three-day visits and one ten-day visit to a specific home; at the end of the ten-day visit, the individual stated she wanted to continue to live at RGSC.<br><br>For the other three PSPs reviewed, one of three (33%) identified actions to encourage movement to a more integrated environment. Two of three specifically mentioned either that the individual did not express interest in moving, or that it was difficult to ascertain whether the individual would wish to move. For example:<br>• The PSP for Individual #35 stated under "Obstacles identified by the PST" that the individual "did not show interest in any living options" but did not address this through documented plans to provide opportunities to learn about or experience more integrated settings or to initiate referral for movement. The PSP did not document any other obstacles.<br>• The PFA for Individual #55 documented a preference to have personal space and | Noncompliance |

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| | | avoid noisy or crowded places. The PSP did not address this preference in relation to the possibility of movement from the large home on campus where the individual lives to a smaller community setting where there would be less crowding and noise.<br>• The PSP for Individual #87 did not identify obstacles to the individual's movement to more integrated living. The PSP, under "Obstacles identified by the PST," stated the individual "was not able to give a definite answer to wanting to live at a group home." Under "Preferences of [Individual #87] and/or LAR for a specific living option" documented that the individual "stated he would like to live in a group home but later changed his mined [sic] and stated that he wants to live at RGSC." Although there were no obstacles to movement and the individual did not object to movement, the PSP stated, "The PST determined that the most integrated setting at the current time is: Rio Grande State Center." The PSP included a statement that some tours should be arranged; the attached MRA Service Coordinator Community Living Options Information Process (CLOIP) Worksheet stated, "will schedule tours of providers for the individual to see and visit."<br><br>The professional members of the PST have a responsibility under the requirements of the Olmstead decision to make a determination as to whether community placement is appropriate without requiring the individual to express interest. This provision is discussed in detail later in this report with respect to the Facility'sprogress in implementing the provisions included in Section T of the SettlementAgreement. | |
| **F2** | **Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below: | The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs.<br><br>The revised Supporting Visions PSP policy was trained and implemented, and RGSC SOP MR 600 01 Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports) had been approved and implemented. Nevertheless, implementation did not yet fully comply with policy. | Noncompliance |
| 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: | A PSP had been developed for each individual. Per Monitoring Team review of a sample of four PSPs, the PSPs did not yet meet the requirements of this provision.<br><br>According to the RGSC POI, beginning in November, 2010, PSPs addressed the individuals preferences and strengths in identifying needs, and supports; as noted below, the Monitoring Team did not concur that this was occurring yet. | Noncompliance |

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| | | Also according to the RGSC POI, beginning in November, 2010, PSP action plans developed during the annual review identify methods for implementation, time frames and integrates all services. The Monitoring Team did not concur that this was occurring yet. | |
| | 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; | For each PSP reviewed, a PFA had been conducted. Documents provided showed separate PFAs were completed by different individuals but did not provide a single aggregated assessment. The PSPs listed only a limited number of preferences and did not describe strengths or provide explanations for needs or barriers not addressed.<br>• One of four (25%) PSPs addressed and built on the individual's preferences as identified in the PFA.<br>• Two of four (50%) PSPs identified the prioritized needs of the individual.<br>• Two of four (50%) PSPs identified needed supports relevant to the preferences and prioritized needs<br><br>For example, the PFA for Individual #55 documented a preference to have personal space and avoid noisy or crowded places. The PSP did not address this preference in any way; there were no relevant Action Plans, no documentation of supports to enable occurrence of this preference, and no documentation that availability of more integrated environments that could provide smaller and less crowded environments would be explored. | Noncompliance |
| | 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; | Documents provided in response to a request for PSPs and "all associated skill acquisition/teaching programs" included such programs for one of four (25%) PSPs. No programs were provided for the other three PSPs, so they could not be evaluated.<br><br>Programs were provided for Individual #87. These were provided as Specific Program Objectives (SPOs).<br>• For four of four (100%) SPOs, definitions of the target behaviors were not clear enough to provide an expectation of reliable measurement. For example, for one SPO to "participate in walking routine…for 30 minutes" with a task analysis step that states "will start walking," it was unclear whether the individual must walk 30 minutes to be marked as doing the behavior or only has to start walking. For an SPO to "dry feet (focusing on toes)" the criterion for a correct response was not specified.<br>• For four of four (100%) SPOs, task analyses were included. Although the use of task analyses is valuable and should be encouraged, all four task analyses included a mix of the task steps and actions to be done by staff.<br>• For four of four SPOs (100%), teaching/prompting procedures were provided. | Noncompliance |

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| | | For two of these four (50%), the procedures were stated in detail that might permit consistent implementation. Two of the four (50%) did not have adequate detail. For example, for the SPO instruction that staff will model how to dry feet, there was no detail about the modeling to be provided, including whether staff needed to remove their shoes and socks. For the SPO to select items to purchase, there were instructions to give a cue, to give verbal and gestural prompts simultaneously by pointing at the budget worksheet, and to assist in listing items to purchase on the worksheet. However, the assistance to be provided was not specified.<br>• For four of four SPOs (100%), the reinforcement to be given was described as "social praise" or "give social praise." There were no instructions on when to give praise, except in the SPO for drying feet, which stated in the teaching/prompting procedures to give verbal praise when the task was completed.<br><br>There were examples of additional services and supports identified in the PSP but not provided, such as those identified in the finding for Provision R1. For example:<br>• Individual #75 had a communication goal; however, documentation regarding progress was only completed once weekly. This level of frequency is not sufficient to develop an accurate picture of how well the person is performing.<br>• Individual #88's PST stated that a communication book would be beneficial, but there was no evidence that this was implemented by the SLP. | |
| | 3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual; | The Facility had not yet integrated all protections, services, supports, and plans provided for individuals, as the following examples demonstrate.<br><br>In four of four (100%) PSPs reviewed by the Monitoring Team for this purpose, the Action Plans involved separate services or goals with no indication of integration of interventions. For example:<br>• For Individual #140, an Action Plan for Time Telling-Learning Schedule only involved indicating on a clock the time the van leaves to the vocational program. There could be many other opportunities to use a similar skill during the day. For example, the individual also had a learning objective to remain at the worksite for a specified time; a learning objective to identify when it is time to leave the vocational program might be used both for Time Telling-Learning Schedule and as a means to address leaving the worksite early.<br><br>As documented in the findings for Provision R1, there were no active communication programs; therefore there was no opportunity for integration into the PBSP.One out of | Noncompliance |

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| | | 14 records reviewed (7 %) indicated individuals with identified language difficulties were receiving active speech treatment or participating in a speech program of any kind.One of the 14 records reviewed (7%) had a clear rationale and description of communication interventions integrated into the PSP. One individual had a communication goal to utilize a communication folder during interactions but use of the communication folder was not integrated into other training programs.<br><br>As described in the finding for Provision R3, PSPs contained reference or a brief statement of an individual's communication skills but did not provide integration of the utilized devices or strategies into existing action plans resulting in a decreased opportunity for generalization and/or acquisition of skills.<br><br>Although the newly assigned Psychiatrist was providing exceptional clinical reviews to determine the need for psychotropic medications and ensuring that psychotropic medications are well justified, the PSP process was not fully involved, nor had all individuals been assessed. Following review of the most recent PSP's for Individuals #66, #94, #31, #55, #27, #19, #31, #93, #54, #133, 143#55, #36, #88, # 69, #140, #80, #5 and #27, the Monitoring Team determined that the PSP process of reviewing and monitoring the use of psychotropic medications was not adequate and requires enhancement. There was no indication that the PST and resulting PSP explore or question the appropriateness of medications, explore the rationale for the use of medications, nor explore or questions the validity of psychiatric diagnosis.<br><br>PNMPs were not comprehensive and did not show integration of all relevant clinical disciplines due to the plans lacking information regarding oral care and medication administration strategies. While the plans did contain positioning for these activities, strategies intended to mitigate risk were lacking in detail thus resulting in an increased risk of variance when implementing the activity among multiple staff. | |
| | 4. Identifies the methods for implementation, time frames for completion, and the staff responsible; | As noted for Provision component F2a2, methods for implementation were not clearly specified.<br><br>For four of four (100%) PSPs, Action Plans specified Responsible Person as "PNA" for all supports and services except for one specified as "Nurse" and one as "QMRP." None specified a particular person assigned responsibility for ensuring implementation. | Noncompliance |
| | 5. Provides interventions, strategies, and supports that effectively address the | Interventions, strategies, and supports for behavioral and habilitation services were, as indicated throughout the report, often written with general instructions or were not implemented accurately. | Noncompliance |

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| | individual's needs for services and supports and are practical and functional at the Facility and in community settings; and | Based upon the lack of progress reported by the Facility and substantiated by record reviews and interviews, it was unlikely that current skill acquisition programs at RGSC included the necessary components. There was no indication that formal or informal training was provided in the community. Furthermore, it was not evident that people living at the facility had been provided with assessments necessary for the development of skill acquisition programming within the community.<br><br>PNMPs for some individuals require a high degree of specificity and competency based training and monitoring of staff who implement them. The Facility had not yet developed, implemented, and monitored PNMPs at a level of consistency that would allow evaluation of ways to make them practical and functional in community settings. | |
| | 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. | Observations and documentation reviewed during the site visit revealed the use of a diverse and robust assortment of forms and strategies to collect behavior data. Not only were there a variety of data collection strategies, but in each instance in which a strategy was used there were clear indications on the data forms that the strategy had been tailored to the specific nature of the individual's behavior.<br><br>However, the Monitoring Team identified issues that make data collection difficult and that inhibit the objective analysis of an individual's progress.<br>• For example, programs were provided for Individual #87. These were provided as Specific Program Objectives (SPOs). For four of four (100%) SPOs, definitions of the target behaviors were not clear enough to provide an expectation of reliable measurement and therefore reliable data. For example, for one SPO to "participate in walking routine…for 30 minutes" with a task analysis step that states "will start walking," it was unclear whether the individual must walk 30 minutes to be marked as doing the behavior or only has to start walking. For an SPO to "dry feet (focusing on toes)" the criterion for a correct response was not specified which would presumably result in inconsistent data.<br>• The lack of interrater agreement measures did not allow confirmation that data were gathered correctly according to definitions or that the definitions were clear enough to allow different raters to agree on the measures. | Noncompliance |
| 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 | There was no single place in which all goals, treatments, and strategies are presented in the PSP. Action Plans contain some information, but they do not include PBSP goals, for example. 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 | Noncompliance |

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| | outcomes, services, supports, and treatments are coordinated in the ISP. | facilitate team discussion focusing on integrated planning in the PSP meeting. Action Plans for four of four (100%) PSPs reviewed did not include all areas of planning or intervention. For example:<br>• For Individual #87, there was a decision that the MRA would schedule tours of community facilities. This was not listed in the PSP.<br>• For Individual #35, there was a recommendation for a hearing assessment. There were statements that the individual had a PNMP and used adaptive equipment. None of these were included in Action Plans, and there was no documentation in the PSP that any of these supports were or would be implemented. | |
| F2c | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it. | 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. 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. For example, skill acquisition/ habilitation goals were separate from PBSP goals, which limit the holistic understanding of how these relate to each other.<br><br>Better organization of information in the PSP document would facilitate team discussion focusing on integrated planning in the PSP meeting. Action Plans for four of four (100%) PSPs reviewed did not include all areas of planning or intervention. For example:<br>• For Individual #87, there was a decision that the MRA would schedule tours of community facilities. This was not listed in the PSP.<br>• For Individual #35, there was a recommendation for a hearing assessment. There were statements that the individual had a PNMP and used adaptive equipment. None of these were included in Action Plans, and there was no documentation in the PSP that any of these supports were or would be implemented. | Noncompliance |
| 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 | Observations and documentation reviewed during the site visit revealed the use of a diverse and robust assortment of forms and strategies to collect behavior data. Not only were there a variety of data collection strategies, but in each instance in which a strategy was used there were clear indications on the data forms that the strategy had been tailored to the specific nature of the individual's behavior. However, many progress notes reflected treatment decisions that were not supported by the presented data. For example:<br>• For Individual #12, the behavior intervention was revised in September 2010. | Noncompliance |

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| | 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. | Target behaviors either remained unchanged in frequency or increased following the intervention change. No further assessments or treatment revisions were done.<br>• For Individual #36, aggression increased for two months without a recommendation for additional assessment or a change in intervention.<br>• For Individual #94, target behaviors increased for five months before a new assessment was initiated. | |
| F2e | No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised. | Per Report from the QMRP Manager and ICF-MR Director, all staff had participated in the training developed by DADS entitled Supporting Visions. Although this training provides much of the philosophy and description of the revised PSP process and includes participatory activities to practice the required procedures, it does not yet meet all requirements for comprehensive competency-based training. Additional training on how to facilitate planning sessions was to be scheduled for QMRPs. Competency measures for the skills trained and practiced during Supporting Visions training had not yet been developed, so there was no evaluation of each individual participant's learning. The observed PSP annual planning meeting and Quarterly Reviews, while they did involve participation from numerous staff and the individual, did not use assessment information in making decisions. DADS and the Facility should continue to identify ways to enhance staff skills and knowledge of the PSP development process and to monitor to ensure those skills are used during planning sessions.<br><br>Provision of competency-based training on the implementation of individuals' plans was not routine. For example:<br>• 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 to work with individuals. Review of the Facility's training curricula revealed that it did not include adequate PNM training in a timely manner in a number of areas. PNMP was not part of the new employee orientation (NEO) schedule. Therefore, staff worked in homes without having received training related to physical and nutritional management.<br>• At the time of the site visit, RGSC had recently initiated attempts to assess staff competence in relation to PBSPs. Although the opportunity for demonstrated competence was included in the assessment process, Psychology Department | Noncompliance |

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| | | personnel reported that the competency assessments typically required only that staff verbally state how to conduct components of a PBSP. A review of the Competency Assessment forms reflected that the assessments target very general concepts or elements of a PBSP, such as stating the function of a target behavior or demonstrating a response to a challenging behavior, rather than demonstration of the ability to implement the actions specified in the PBSP. An additional concern regarding competency assessments was that competence regarding PBSPs was not a prerequisite for working in direct contact with individuals living at the facility. As a result, staff for whom competence had not been assessed, as well as staff who had failed to demonstrate competence, were routinely placed in positions where they were required to implement behavior interventions targeting potentially dangerous behavior.<br>• Many Acute Care Plans (ACPs) failed to document training of direct care professionals on how to implement the plans. The initiation of ACPs and direct care staff training needs to be documented on the ACPs and in the Integrated Progress Notes. Nursing staff needs to document in the Integrated Progress Notes that interventions specified in the ACPs are carried out.<br>• Staff were not trained in the use of the AAC or knowledgeable of the communication strategies of individuals on their homes. | |
| 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. | No individuals had been admitted to the Facility since the prior compliance visit.<br><br>In response to a request for a listing of all individuals residing at the Facility and the date of the current PSP, the Facility did not provide the date of PSP. Therefore, the Monitoring Team was unable to check all PSPs to determine that they were revised within the past year. The list provided to the monitoring team reported the PSP date for each individual for 2008, 2009, and scheduled date for 2010. This list showed that PSPs were always held (or in the case of 2010 scheduled) within 365 days of the prior PSP. Four of four (100%)PSPs reviewed were prepared within the past year.<br><br>No individuals had been admitted, so preparation of PSPs within 30 days of admission could not be reviewed. The Monitoring Team did not review implementation of PSPs within 30 days of preparation following annual review. This will be reviewed at the next compliance visit. | Noncompliance |
| F2g | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and | The Facility reported that it had begun to use the monitoring checklist for PSP meetings provided by DADS. During the PSP observed by the Monitoring Team, the monitoring tool was not used. The POI stated that review of PSPs would begin in March, 2011. The Facility had not begun to identify and trend findings from monitoring. | Noncompliance |

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| | implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section. | | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should monitor PSP annual and quarterly meetings to ensure participation of multiple disciplines in integrated discussion continues to occur, the focus on movement to a more integrated living environment and the individual's preferences drive planning, and that disciplines provide information needed for informed decision-making. The Facility should remind staff of their responsibility to identify the most integrated appropriate environment for individuals so they will not wait for the individuals to express interest before planning movement.
2. Participants in PSP meetings should present the data that inform their impressions of progress, while at the same time guarding against a return to reading reports.
3. Participation by multiple disciplines should extend beyond the meeting into providing input and assistance in the development of programs and service on an ongoing basis.
4. The Facility should develop a process to track completion of assessments and ensure they are done timely. The Facility should develop a process to ensure the assessments include all necessary components.
5. The Structural and Functional Assessment process should be implemented routinely. At the same time, the Facility should continue to improve this assessment process.
6. The process of establishing the PFA and using it to guide the development of the PSP needs to be more integrated and robust.
7. The Facility needs to ensure clinicians use the data that is being gathered to make decisions on treatment.
8. The Facility should ensure that staff demonstrate competence in providing supports and services before working with individuals, particularly when there is a need to implement a PBSP, PNMP, or ACP.
9. The Facility needs to establish a process for ensuring the reliability of data being gathered, including measurement of interrater agreement.

| SECTION G: Integrated Clinical Services | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI), updated 2-17-11<br>2. RGSC SOP ICF-MR 400=14 Medical Care established December 9, 2010<br>3. PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in other sections of this report.<br>4. Active Record for Individuals #11, #87, and #140<br>5. Consultation reports for Individuals #4, #19, #33, #48, #55, #62, #140, and #143<br>**People Interviewed:**<br>1. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report.<br>**Meeting Attended/Observations:**<br>1. PSP annual planning meeting for Individual #113 3/3/11<br>2. PSP Quarterly Review for Individual #63 and #140 2/28/11 |
| | **Facility Self-Assessment:**<br>RGSC reported that it does not yet comply with either provision of this Section. The Monitoring Team concurs.<br><br>The Facility has taken steps to move toward compliance. Supporting Visions training was provided to improve the PSP process.<br><br>The Medical Care policy was established to operationalize DADS policy. However, the Monitoring Team noted that this policy does not reference the need for integrated planning or interdisciplinary involvement. |
| | **Summary of Monitor's Assessment:**<br>The Facility had revised the process for review of PSPs to increase opportunity for integrated planning. The Quarterly PSP reviews brought together several disciplines. Nevertheless, plans were still established discipline by discipline, and decision making around supports and services for individuals was not integrated across disciplines.<br><br>In addition to the Quarterly PSP process, there were other improvements in interdisciplinary communication. The Hospital Liaison Nurse, as well as other nursing staff, communicated routinely with hospital personnel prior to admission, during hospitalization, and prior to discharge and kept other team members apprised of individuals' health status.<br><br>Facility clinicians routinely indicate review of consultation documents from non-Facility clinicians by initialing and dating the consult forms, but there was no documentation that the Facility clinician accepted or rejected the recommendation or referred it to the PST. |

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| G1 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need. | The Facility had revised the process for review of PSPs to increase opportunity for integrated planning. The Quarterly PSP reviewsbrought together several disciplines along with the individual served. The Quarterly reviews observed by the Monitoring Team demonstrated active participation of several disciplines in discussing the supports and services for individuals.<br><br>Nevertheless, planning of services and supports and review of individual needs remained multidisciplinary. That is, several disciplines were involved in planning for each PSP, but the decisions and plans were still established discipline by discipline, as demonstrated by Individual #11.<br><br>The Monitoring Team reviewed Individual #11's Personal Support Plan (PSP) and PSP Addendums from 4/30/10 through 1/21/11. Individual #11's PSP, 4/27/10, Nursing Assessment stated there was no medical diagnosis for individual #11's urinary incontinence. There was no recommendation for medical follow-up to determine the cause of the urinary incontinence. The PSP Addendums addressing urinary incontinence primarily focused on the problem being one of the individuals' behaviors. On 1/20/11 the PST met for a Quarterly Review. The PST discussed individual #11's continued incontinence of urine, "*Bathroom issues discussed. He (sic) had tendency of urinating on his self.Goal in future Possible Bladder Scan, if toileting schedules is not successful".* On 1/21/11 the PST met and did not recommend a Bladder Scan, rather they decided to continue the toileting schedule, prompting individual #11 to use the toilet every hour on the hour. Never once in all of the PST meetings did the Team discuss the possibility that individual #11 might have an underlying medical problem causing the incontinence of urine; although the meeting on 1/20/11 casually considered a Bladder Scan but did not state why they considered it. The Teams focus continued on the toileting program and schedule. According to the PST meeting Sign-in Sheets, professional staff, including RNs and physicians, was always present at the meetings where individual #11's urinary incontinence was discussed. In the Integrated Progress Notes there were numerous entries documenting that individual #11 was taken to the toilet and prompted to urinate and "refused" but would urinate on himself shortly after leaving the toilet. The reason he could not urinate was most likely not due to refusal but because of the involuntary retention of urine. Then, and after the bladder overflowed, individual #11 would have urinary incontinence. It was most regrettable that individual #11's urinary incontinence was not evaluated for an underlying medical condition for at least 10 months. In this case, the PST met, but there was not integrated discussion of why the individual might be urinating other than the assumption that it was a behavior problem. | Noncompliance |

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| | | There were improvements in interdisciplinary communication. Review of individuals' records who had recent emergency room visits and/or hospitalizations demonstrated that the Hospital Liaison Nurse, as well as other nursing staff, communicated routinely with hospital personnel prior to admission, during hospitalization, and prior to discharge. There was evidence that the Hospital Liaison Nurse made frequent visits to individuals hospitalized, documented visit findings in the Integrated Progress Notes contained in CWS, and kept other team members apprised of individuals' health status. The enhanced communication identified in these records between the RGSC nursing staff and hospital nursing staff demonstrated significant improvement in coordinating care for individuals seen in the emergency room and those admitted to the hospital.<br><br>Physicians stated that they had received training in the new PSP process, including role-playing of participation in planning. They reported that Physicians attend PSP annuals and quarterly reviews and try to stay for whole meeting so medical issues aren't marginalized. Because many individuals are not very verbal, the issues of participation in activities such as vocational services provide important information. This was supported by Monitoring Team observation of an annual PSP planning meeting and a quarterly PSP review, in which active participation by physicians was observed.<br><br>RGSC SOP ICF-MR 400=14 Medical Care was established December 9, 2010 to guide medical services. The policy does not reference the need for integrated planning or interdisciplinary involvement. Except for the requirement to send recommendations from consulting physicians to the QMRP for review by the PST and inclusion of definitions of the PSP and PST, the policy does not mention the PSP process or involvement of the clinician with the PST. The Facility should ensure that policy reflects the requirement of involvement of all disciplines in integrated planning through the PST. | |
| 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 | Facility clinicians routinely indicate review of consultation documents from non-Facility clinicians by initialing and dating the consult forms. Of 14 consults reviewed by the Monitoring Team to determine whether decisions about adoption of recommendations were documented, all 14 (100%) documented review by the Facility clinician. For four of 14 consults (29%), documentation was found that the Facility clinician agreed with the recommendations; that included three of three consultations for a modified barium swallow study (MBSS). For all the other 10 consults (71%), there was no documentation that the Facility clinician accepted or rejected the recommendation or referred it to the PST.<br><br>Additionally, there was a lack of follow up by OT and PT in response to consults or in | Noncompliance |

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| | supports and services. | response to their own recommendations. For example:<br>• Individual #19 had a skin tear and a consult was made to OT. Per review of the record, there was no evidence that this consult was addressed to by OT.<br>• Individual #35 had a PT consult completed on 1/21/11. The PT stated that multiple types of adaptive equipment would be trialed to improve safety. There was no evidence in the record that this was completed.<br>• Individual #77 had a Physiatrist consult completed on 2/7/11. Recommendation was for aggressive PT. There was no evidence that this was initiated.<br>• Individual #19 was reviewed by PT on 2/9/11. The recommendation was for a neurology consult to determine if a cervical brace would be beneficial. Per neurology consult on 2/21/11, this issue was not addressed. There was no evidence of follow up by the PT. | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should monitor to ensure Facility clinicians review recommendations from non-Facility clinicians and document whether they accept or reject them, or whether they refer them to the PST.
2. The Facility should ensure that policy reflects the requirement of involvement of all disciplines in integrated planning through the PST.

| SECTION H: Minimum Common Elements of Clinical Care | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI), updated 2-17-11<br>2. RGSC SOP ICF-MR 400=14 Medical Care established December 9, 2010<br>3. PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in other sections of this report.<br>4. Psychiatric evaluations of Individuals #66, #94, #31, #55, and #27<br>**People Interviewed:**<br>1. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report.<br>**Meeting Attended/Observations:**<br>1. PSP annual planning meeting for Individual #113 3/3/11<br>2. PSP Quarterly Review for Individual #63 and #140 2/28/11 |
| | **Facility Self-Assessment:**<br>RGSC reported that it does not yet comply with any provision of this Section. The Monitoring Team concurs.<br><br>The Medical Care policy was established to operationalize DADS policy. This policy includes procedures for carrying out medical assessments.<br><br>The Facility reported that psychiatric evaluations have been brought back into the "active chart" and that a psychiatrist and psychologist are reviewing diagnoses.<br><br>Supporting Visions training had been provided and the new PSP policy implemented with a new Facility policy pending approval.<br><br>The Facility is seeking technical assistance on development of clinical indicators for the population served. |
| | **Summary of Monitor's Assessment:**<br>The Facility is not in compliance with any of the provisions of this Section. Assessments and evaluations were not always completed timely and were not always comprehensive. Assessments were not always completed when an individual's status changed.<br><br>Psychiatric evaluations had improved. The clinical justification of the individuals' documented diagnoses clearly meet exceptionally high standards of psychiatric care. However, in other areas, assessment was not comprehensive and documentation of diagnoses was problematic. |

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| | Although the Facility gathered a great deal of data on health indicators for its quality assurance reviews, it had not identified use of those data as clinical indicators of efficacy of treatments and interventions. Raw data were reported but not always analyzed to determine whether treatments and interventions are effective.<br><br>The Facility policy on Medical Care did not reference the PST or PSP process. It also does not require that clinical indicators of health be established to determine efficacy of treatment or to monitor the health care of individuals. |

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| H1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs. | Assessments and evaluations were not always completed on a timely basis and were not always comprehensive. Furthermore, there were many examples in which assessments were not completed when an individual's status changed.<br><br>Examples in which additional assessment and evaluations should have been carried out for medical conditions include the following:<br>• Individual #118 was noted to have chronic anemia, per labs, and documentation by the Facility's Physician. The individual was prescribed and administered ferritin and iron supplements; however, the clinical record was devoid the necessary diagnostic work-up; hence, the etiology of the chronic anemia may not be known. There are many serious conditions that manifest with anemia, such as serious disorders of the blood and malignancy. A more thorough assessment was warranted.to determine etiology so as to ensure appropriate treatment can be provided. Furthermore, chronic hyponatremia was noted on multiple labs and documented in the clinical record. As with anemia, there was no documentation of a formal evaluation or documented differential diagnosis as to the cause of hyponatremia.<br>• For Individual #19, during examination of the upper extremities, the physician noted "full range of motion although can not lift up her arms completely. " Based on this documentation the Monitoring Team was confused as to how the individual was assessed as having full range of motion, although she could not lift her arms above her head. On examining the lower extremities, the physician noted "limb edema but no edema on her feet. " Edema of the extremities requires an evaluation to determine the etiology and if treatment is necessary, which was not documented in the records provided for review.<br><br>There was evidence that assessments were not completed when there were changes in an individual's status. The Physical and Nutritional Management Team met during the months of November 2010, December 2010, January 2011, and February 2011. During | Noncompliance |

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| | | the months of November 2010 and December 2010 there was limited to no discussion of individuals who experienced multiple falls, and assessments were not documented. For example:<br>• Individual #77 had four falls occurring during the month of November and three falls during the month of December with no discussion by the PNMT or assessment by PT.<br>• Individual #94 had four falls occurring during the month of November and three falls during January with no discussion by the PNMT or assessment by PT.<br>• Individual #35 had two falls occurring during the month of November and eight falls during December with no discussion by the PNMT or assessment by PT.<br>• Individual #63 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT.<br><br>Routine assessments were not always completed. For example:<br>• At the time of the site visit, approximately 81% of the individuals living at RGSC had not received a psychological assessment or update in the past year. In August 2010, only 40% had not received a psychological assessment or update in the previous 12 months. Furthermore, since the previous site visit, only nine individuals had received a psychological assessment. In addition to the inability to provide annual psychological assessments and updates, RGSC had achieved no progress in regard to the assessment of intellectual and adaptive abilities. For 100% of individuals living at the Facility, psychological assessments did not include intellectual or adaptive assessments completed or reviewed according to current standards of practice.<br><br>Furthermore, routine assessments were not always comprehensive. For example:<br>• Based on a review of 19 individuals' OT/PT and SLP assessments, zero of 19 Individuals are 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.<br>• Most nursing assessments were completed according to the timelines in policy. The nursing assessment contained in the PSPs failed to adequately and accurately summarize individuals' health status.<br>• Communication assessments lack the comprehensiveness needed to identify strengths, needs and to develop appropriate plans of action to improve communication.<br>• It was not possible to unequivocally demonstrate that the assessments upon which training programs were based were accurate or had identified real and | |

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| | | meaningful needs. | |
| H2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. | In the area of psychiatric diagnosis, psychiatric evaluations had improved. The newly assigned psychiatrist initiated a review of all individuals at the Facility who have a psychiatric diagnosis, and/or who are on psychotropic medications. At the time of the review, 20 of the 45 identified individuals had been re-evaluated. The Monitoring Team reviewed five of the 20 individuals (Individuals #66, #94, #31, #55, and #27). The clinical justification of the individuals' documented diagnoses clearly meet exceptionally high standards of psychiatric care.<br><br>However, in other areas, lack of thorough assessment and of documentation of diagnoses was problematic.<br>• A neurology consultation dated November 8, 2010 for Individual #118 noted a diagnosis of spastic paraparesis. The Monitoring Team observed the individual and concurred with the noted diagnosis per the neurologist. The diagnosis listed in the clinical record is devoid of such diagnosis.<br>• For Individual #35, there were several indications of possible congestive heart failure. There was no diagnosis or other documentation addressing this possibility.<br><br>RGSC SOP ICF-MR 400=14 Medical Care does not specifically require that diagnoses shall be consistent with the current versions of the Diagnostic and Statistical Manual or the International Statistical Classification of Diseases. The Facility should consider revising the policy to include that requirement. | Noncompliance |
| 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. | Due to the lack of assessments when there are changes in health status, treatments and interventions may not be timely. Lack of thorough and comprehensive assessments may result in lack of accurate diagnosis and treatment that is not appropriate. It is impossible for the Monitoring Team to assure treatment is clinically appropriate when assessments that may be clinically indicated are not ordered, so that there are no clear indications of whether diagnoses are accurate.<br><br>Individual #11, as described in detail in Provision M1, provides an example of that. Urination and self-injury were being treated as behavior problems until the Monitoring Team prompted additional evaluation that resulted in a diagnosis of urinary retention. Without that diagnosis, there was not appropriate treatment.<br><br>The example of lack of assessment following falls, as identified in Provision H1, also could result in lack of timely diagnosis and treatment. There was no assessment to | Noncompliance |

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| | | identify whether an emergent medical condition contributed to the falls, so no treatment for such a condition was provided.<br><br>The findings for Provision L1 list several cases in which laboratory, x-ray, and consultation reports were indicative of a need for additional assessments to address possible health conditions, but for which these assessments were not ordered or completed and, therefore, differential diagnosis that could lead to appropriate treatment was not done.<br><br>One out of 14 records reviewed (7 %) indicated individuals with identified language difficulties were receiving active Speech Treatment or participating in a Speech program of any kind. | |
| 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. | The Facility reported a need for technical assistance to identify clinical indicators of efficacy of treatments and interventions. At the same time, the Facility gathered a great deal of information on health indicators for its quality assurance reviews. The Facility had data on hospitalizations, incidence of pneumonia, numbers of people whose weights were outside accepted weight ranges, and more. Based on data on falls, the Facility had initiated an improvement process that included reviews of psychotropic medication that could influence falling and physical assessment of people who fall. Data on falls can provide one clinical indicator of the efficacy of treatments and interventions.<br><br>Gathering clinical data is only a first step. Clinicians must review and analyze the data to identify whether treatments are effective or need to be reviewed. Section XI of the Nursing Assessments (Nursing Summary) primarily consisted of raw clinical data, statements to continue Health Maintenance Plans, and lists of recommendations and goals as opposed to stating whether individuals' health status were progressing, maintaining, or regressing in relation to their established goals. Section XI (Nursing Summary) of the nursing assessment should provide a clinical analysis of the raw data from the previous sections.<br><br>Findings for Provision K4 included identification of cases in which behavioral programs were not modified even though data (that is, indicators of efficacy) did not show progress.<br><br>There was not a system in place that clearly monitored the effectiveness of the plan by tracking the occurrence or absence of triggers associated with physical and nutritional decline.<br><br>The Facility should continue to seek technical assistance for better use of clinical | Noncompliance |

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| | | indicators of efficacy of treatments and interventions for individuals as well as for assessment in order to monitor and improve the Facility's services in the aggregate. | |
| H5 | Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals. | The Facility had not yet identified clinical indicators that could be analyzed and used in a system to monitor health status. As guidelines for clinical care are developed, they should include information on appropriate and useful clinical indicators that the Facility could use to monitor health status of individuals.<br><br>Where monitoring did occur, it did not include all necessary components. For example, while the monitoring system for nutrition management was designed to address mealtime and have multiple professionals involved, a policy or process was not fully developed that included:<br>• Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk,<br>• Identification of monitors and their roles and responsibilities,<br>• 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<br>• Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician. | Noncompliance |
| H6 | Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators. | As indicated through many examples in Sections K, L, and M, treatments and interventions often continue even as conditions appear to worsen or do not show progress. The Facility should establish an expectation that emerging health and behavioral assessments and changes in individuals' status will lead to assessments and evaluation, that clear indicators of efficacy of treatment will be identified and monitored, and that treatments and interventions will be modified in response to clinical indicators. | Noncompliance |
| 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. | RGSC SOP ICF-MR 400-14 Medical Care was established December 9, 2010 to guide medical services. The policy does not reference the need for integrated planning or interdisciplinary involvement. It does not mention the PSP process or involvement of the clinician with the PST. It does not require that clinical indicators of health be established to determine efficacy of treatment or to monitor the health care of individuals, although it does state that a medical quality improvement program will collect data relating to the quality of medical services. | Noncompliance |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:
1. The Facility should ensure that assessments and evaluations are done routinely as required.

2. The Facility should develop a system to monitor whether changes in health status of individuals trigger assessments as appropriate.
3. RGSC SOP ICF-MR 400=14 Medical Care does not specifically require that diagnoses shall be consistent with the current versions of the Diagnostic and Statistical Manual or the International Statistical Classification of Diseases. The Facility should consider revising the policy to include that requirement.
4. As guidelines for clinical care are developed, they should include information on appropriate and useful clinical indicators that the Facility could use to monitor health status of individuals.

| SECTION I: At-Risk Individuals | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11.<br>2. RGSC SOP MR 400-02 At Risk Individuals last revised 2/11<br>3. DADS At Risk Policy 6.2 updated 2/18/11<br>2. Active Records for Individuals #15, #27, #31, #33, #35, #48, #63, #77, #85, #94, #118, #129, and #149<br>**People Interviewed:**<br>1. Jamie Flores, Interim Program Director<br>2. Mary Ramos, Quality Management Director<br>3. Megan Gionotti, Psychology Manager<br>4. Myrna Wolfe, Incident Management Coordinator<br>5. Janie Villa, QMRP Manager<br>**Meeting Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 2/28/11<br>2. Settlement Agreement Performance Improvement Council (SA-PIC) 3/2/11<br>3. Personal Support Plan (PSP) annual meeting for Individual #113, 3/3/11<br>4. Behavior Management Committee 3/3/11<br>5. PSP Quarterly Review meeting for Individuals #63 and #140 |
| | **Facility Self-Assessment:** The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs. RGSC is awaiting additional training on the new policy for assessing individuals, identifying risk, and developing individual plans to mitigate risk. |
| | **Summary of Monitor's Assessment:** RGSC has not as yet implemented the new risk screening policy required by DADS. The facility is scheduled for additional training on March 9, 2011. As a result efforts directed at assessing risk and developing individual plans to mitigate risk are observably inadequate. |

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| I1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk. | The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs.<br><br>RGSC has not as yet implemented the new risk screening policy required by DADS. The facility is scheduled for additional training on March 9, 2011. As a result efforts directed at assessing risk and developing individual plans to mitigate risk are observably inadequate. For example, 10 of 13 (77%) 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: | Noncompliance |

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| | | • Individual #48 was on a modified diet, had problems chewing, required cues to avoid overstuffing and was identified on 12/4/10 via a swallow study to be "High Risk" of aspiration but was listed as a "low risk" of aspiration.<br>• Individual#85 was on a modified diet, has poor oral hygiene, requires cues to prevent from eating fast, and must swallow twice to ensure clearance was listed as a "low risk" of choking or aspiration.<br>• Individual #126 had pneumonia within the past 12 months and received enteral nutrition but was listed as a "low risk" of choking or aspiration.<br>• Individual #77 had ten falls occurring from November 2010 to January 2011 but was listed as being at low risk of injury.<br>• Individual #94 had eight falls occurring from November 2010 to January 2011 but was listed as not being at low risk of injury.<br>• Individuals#27 and #88 had a BMI greater than 35 but were listed as being "low risk" for weight.<br>• Individual #35 was determined to be at low risk for constipation; however, the individual is known to have an atonic bowel, and has a diagnosis of chronic constipation. The individual had also undergone abdominal surgeries in the past for bowel perforation. Staff were not adequately monitoring this serious issues.<br>• Individual #118 was noted on a consultation report to have paraparesis. The risk assessment for falls for this individual, who also had a history of fractured hip, history of fractured ribs, and underlying diagnosis of ataxia, was inadequate, as it determined the individual to be at low risk for falls.<br><br>In reviewing the risk status list provided in response to a document request only one individual was identified as high risk with the identified risk being "weight." Eight other individuals were identified as overall medium risk, and 61 individuals were identified low risk. It is apparent from the examples presented above that whatever methodology RGSC has been using to identify risk has been ineffective.<br><br>RGSC conducted a trial of the new risk screening process and the monitoring team reviewed the results of this trial:<br>• Individuals #48 and #85 would be listed as "medium risk of choking."<br>• Individual #126 would be listed as "high risk of aspiration."<br>• Individuals #77 and #94 would be at a "high risk of falls."<br><br>This discrepancy in risk identification demonstrated how inadequately people were being identified as having PNM risks. Failure to accurately identify the level of risk results in lack of awareness among staff regarding the severity of risk and the intensity of interventions and supports needed to mitigate risk. | |

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| I2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk. | The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs.<br><br>Per review of the PNM minutes, the team met during the months of November 2010, December 2010, January 2011, and February 2011. During the months of November 2010 and December 2010 there was limited to no discussion of individuals who experienced multiple falls. For example:<br>• Individual #77 had four falls occurring during the month of November and three falls during the month of December with no discussion by the PNMT or assessment by PT.<br>• Individual #94 had four falls occurring during the month of November and three falls during January with no discussion by the PNMT or assessment by PT.<br>• Individual #35 had two falls occurring during the month of November and eight falls during December with no discussion by the PNMT or assessment by PT.<br>• Individual #63 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT.<br><br>Failure to respond and implement changes to an individual's plan resulted in the continuation of falls into the months of December and January and thus increased the risk of injury.<br><br>A similar conclusion can be deduced for individuals who are listed as having BMIs in excess of 35, and diet downgrades. For example:<br>• Individual #33 has a BMI of 41.41 but there was no evidence of discussion of this by the PNMT.<br>• Individuals #15, #48 #31, and #149 had diet downgrades but there was no evidence of discussion of this by the PNMT.<br><br>Issues related to falls are discussed during morning meeting but upon review of the meeting minutes, this serves as more of a notification rather than an active discussion of how to address these issues or the root cause of the issue. For example:<br>• Individual #35 had a fall on 1/26/11. The morning meeting minutes simply stated "encourage to slow pace." | Noncompliance |
| I3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and | The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs. The Facility had not yet fully implemented the new risk assessment process and therefore had not yet accurately identified the risk levels of individuals nor specified appropriate responses to various levels of risk. | Noncompliance |

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| | implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring. | As described in Provisions I1 and I2 the PNMPs have not adequately identified risk and therefore plans to mitigate risk have not been developed.<br><br>As described in Provision M1, assessment of the health care condition and target behaviors for Individual #11 did not include interdisciplinary, integrated planning and therefore did not result in an integrated PSP that included preventive interventions. | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. Fully and expeditiously implement the DADS policy on At-Risk Individuals

| **SECTION J: Psychiatric Care and Services** | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. Standard Operating Procedure ICF-MR 300-01<br>3. Standard Operating Procedure ICF-MR 400-13, dated December 3, 2010<br>4. Diagnostic review and justification for individuals: #66, #94, #31, #55, #27<br>5. Psychiatric Evaluations for Individuals #66, #3, #54<br>6. PSPs for Individuals: : #66, #94, #31, #55, #27, #19, #31, #93, #54, #133, #143, #55, #36, #88, #69, #140, #80, #5 and #27.<br>7. Nursing health care plans and medical evaluations for Individuals: #66, #94, #31, #55, #27, #19, #31, #93, #54, #133, #143, #55, #36, #88, #69, #140, #80, #5 and #27<br>8. Reiss Screen on Individuals: #3 and #150<br>9. Discus, Moses, Annual Psychiatric Assessment, Psychiatry Notes, Medication List for Individuals: #27, #139, #140, #15, #35, 35, #3, #12, and #82.<br>10. Standard Operating Procedure NR200-08, dated January 1993<br>**People Interviewed:**<br>1. David Moron, M.D, Clinical Director, Psychiatrist<br>**Meeting Attended/Observations:**<br>1. Observations of Individuals served were made at all living areas on February March 1, 2011 and March 3, 2011 |
| | **Facility Self-Assessment:**<br>The RGSC POI reported not being in compliance with any provision of this Section. Steps had been taken to make progress. The Monitoring Team determined that some provisions of this Section are in compliance, as noted below.<br><br>For Provision J.1, the Facility stated it is not in compliance with this provision.Effective 02/01/2011, Dr. David Moron, Clinical Director, who is board certified, has been assigned to the ICF-MR population 100%.The Monitoring Team has reviewed recent efforts by Dr. Moron, and has determined that he is clearly enhancing practice standards and providing currently accepted standard of care practice, and therefore found the Facility to be in compliance with this provision. |

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| | For Provision J.2, the Facility stated it is not in compliance with this provision. The Facility reported the Clinical Director is evaluating all psychiatric evaluations completed by the contract Psychiatrist. Effective 02/01/11, Dr. Moron began providing psychiatric services to the ICF-MR population on a full-time basis.<br><br>For Provision J.3 the Facility stated it is not in compliance with this provision. The Facility reported the Clinical Director is evaluating all psychiatric evaluations and psychiatric diagnosis completed by the contract Psychiatrist. Effective 02/01/11, Dr. Moron began providing psychiatric services to the ICF-MR population on a full-time basis.<br><br>For Provision J.4, the Facility stated it is not in compliance with this provision. A new process to "special staff" all individuals was implemented with the February 2011, dental and medical appointments. The PST will determine the supports needed for each individual prior to their scheduled appointments. The appointment calendar has been placed in the shared drive and access has been provided to the ICF-MR staff who need to know this information.<br><br>For Provision J.5, the Facility stated it is not in compliance with this provision.Effective 02/01/11, Dr. Moron will provide psychiatric services to the ICF-MR population on a full-time basis. In addition, Dr. William Race is providing clinical oversight of psychiatric services in the ICF-MR program, one week per month. The Monitoring Team has reviewed recent efforts by Dr. Moron, and has determined the Facility employs or contracts 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.<br><br>For Provision J.6, the Facility stated it is not in compliance with this provision.The Facility reported it is using the revised psychiatric evaluation made mandatory by DADS Medical Director.<br><br>For Provision J.7, the Facility stated it is not in compliance with this provision. A new process, to complete a Reiss Screen for all new admissions, has been implemented by the Psychology Department as of 8/2010.<br><br>For Provision J.8, the Facility stated it is not in compliance with this provision.ICF-MR staff have been trained in the new PSP process, which was implemented starting with the 11/2010 meetings. Per policy, joint assessments are encouraged when appropriate. RGSC stated it will develop and implement an integrated PSP for each individual that ensures individualized protections, services, supports and treatments. Assessments will be completed and placed in the facility computer shared drive for the PST to review no later than ten working days prior to the annual PSP meeting. This will require 12 months to complete. The psychiatrist and psychologist meet regularly. All medication changes are relayed to the psychologist. The psychiatrist covers targeted symptoms with the psychologist prior to medication changes. The psychiatrist is a participant in the PSP process.<br><br>For Provision J.9, the Facility stated it is not in compliance with this provision.In keeping with the new PSP Process Policy ICF-ID staff have been trained in the new process, which was implemented starting with the |

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| | 11/2010 meetings. Per policy, joint assessments are encouraged when appropriate. RGSC will develop and implement an integrated PSP for each individual that ensures individualized protections, services, supports and treatments are provided. Assessments will be completed and placed in the facility computer shared drive for the PST to review no later than ten working days prior to the annual PSP meeting at all times that medications are discussed, a review will occur. This will require 12 months to complete.<br><br>For Provision J.10, the Facility stated it is not in compliance with this provision.The Facility reported it adheres to the new PSP process, which was implemented 11/2010<br><br>For Provision J.11, the Facility stated it is not in compliance with this provision.Polypharmacy reviews are held monthly.<br><br>For Provision J.12, the Facility stated it is not in compliance with this provision.Nursing staff has completed the Moses and Discus assessment on all individuals and will be updating as required. The psychiatrist reviews all such assessments.<br><br>For Provision J.13, the Facility stated it is not in compliance with this provision.Effective 02/01/11, Dr. Moron began providing psychiatric services to the ICF-MR population on a full-time basis. In addition, Dr. William Race is providing clinical oversight of psychiatric services in the ICF-MR program, one week per month. The psychiatrist will document symptoms that meet criteria for diagnoses in the latest DSM edition, as well as specify target symptoms for the medications being used. A review of all charts has already begun.<br><br>For Provision J.14, the Facility stated it is not in compliance with this provision.The medical staff is now documenting these efforts.<br><br>For Provision J.15, the Facility stated it is not in compliance with this provision.The psychiatrist is reviewing all neurology consults. When a change in a medication is made, the neurologist will be made aware. The Facility reported it is encouraging the neurologist to do the same. When the psychiatrist notices a change, he will contact the neurologist. |
| | **Summary of Monitor's Assessment:**<br>The Monitoring Team was exceptionally pleased with the efforts set forth by the Facility to enhance Psychiatric Services. Subsequent to the Monitoring Teams past review, the Facility has reassigned a board certified psychiatrist to assume at least 20 hours of direct care service to Individuals served by the center. The Monitoring Team has reviewed recent efforts by Dr. Moron, and has determined that he is clearly enhancing practice standards and providing currently accepted standard of care practice.<br><br>Numerous enhancements have been noted, including the review and updating of psychiatric diagnosis, to ensure that psychiatric diagnoses are justifiable and that there is clear and concise rational for the use of psychotropic medications. |

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| | The Monitoring Team has concluded that the Facility is in substantial compliance with Provisions J1, J5 and J6, and complements the dedicated staff and professionals, who have dedicated themselves to improving services for Individuals at the Facility.<br><br>The Monitoring Team concurs with the Facilities self assessment in findings Provisions, J2, J3, J4, J7-J15 as remaining out of compliances, at the time of this review. The Monitoring Team would, however, like it known that much effort is being made in brining the remaining Provisions into substantial compliance, and concurs with its direction.<br><br>Specific to monitoring for side effects, the Monitoring Team highly recommends that enhanced efforts be made to better assess for adverse effects of medications. |

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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, the Facility had made significant enhancements relevant to Provision J1, of the Settlement Agreement. A Physician, Dr. David Moron, who is board certified in general and forensic psychiatry, had begun providing at least 20 hours of direct care, while serving the remainder of the time as the Facility's Clinical Director. During an extensive meeting with the Monitoring Team, Dr. Moron shared his diagnostic and treatment philosophy, examples of prior experience, and five copies of recently completed diagnostic reviews of Individuals served by the Facility (Individual: #66, #94, #31, #55, #27).<br><br>TheMonitoring Team has determined that the Facility is currently in substantial compliance with Provision J1 of the Settlement Agreement. | Substantial Compliance |
| J2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist. | The newly assigned psychiatrist initiated a review of all individuals at the Facility who have a psychiatric diagnosis, and/or who are on psychotropic medications. At the time of the review, 20 of the 45 identified individuals had been re-evaluated. The Monitoring Team reviewed five of the 20 individuals (Individuals #66, #94, #31, #55, and #27). The clinical justification of the individuals' documented diagnoses clearly meet exceptionally high standards of psychiatric care.<br><br>The Monitoring Team is most satisfied with the current direction of the Facility for Provision J2, and is confident that if the quality of the updates remains at this level, the Facility will be in substantial compliance with J2 in the near future. | Noncompliance |
| J3 | Commencing within six months of the Effective Date hereof and with | As per Provision's J1 and J2 above, the Facility had assigned a board certified psychiatrist to begin a comprehensive review of individuals who are administered psychotropic | Noncompliance |

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| | 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. | medications, update their diagnosis and ensure that all psychotropic medications are well justified. At the timeof the review, 20 of the 45 known individuals have been reviewed. The Monitoring Team reviewed five of the 20 updated cases (Individuals #66, #94, #31, #55, and #27).The Monitoring Team found these cases to be in compliance with Provision J3 of the Settlement Agreement.<br><br>The Monitoring Team reviewed the policy for the use of "emergency medications"(Standard Operating Procedure MR700 – 14). Because of the low utilization of "emergency medications" there were no recent cases for the Monitor to evaluate at the time of this review.<br><br>The Monitoring Team discussed with the treating psychiatrist the Facility's policy and procedure for prescribing psychotropic medications for routine use. There was no policy at this time that delineates the Facility's comprehensive practice standards for the use of psychotropic medications.<br><br>Following review of the most recent PSP's for Individuals #66, #94, #31, #55, #27, #19, #31, #93, #54, #133, 143#55, #36, #88, # 69, #140, #80, #5 and #27, the Monitoring Team determined that the PSP process of reviewing and monitoring the use of psychotropic medications was not adequate and requires enhancement. There was no indication that the PST and resulting PSP explore or question the appropriateness of medications, explore the rationale for the use of medications, nor explore or questions the validity of psychiatric diagnosis.<br><br>The Monitoring Team has determined that the Facility is not in compliance with Provision J3, of the Settlement Agreement. | |
| 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 | The Monitor reviewed the practice of pre-treatment sedation with Dr. Moron. The Facility has determined that it remains non-compliant with Provision J4 but is making significant headway. The Facility has implemented a new process to assign specific staff to closely monitor persons receiving pre-treatment sedation. The Facility, under the leadership of psychology services, is developing and implementing a new desensitization program to help mitigate the need for pre-treatment sedation. Enhancements will be initiated to ensure that the PST is more assertive in the evaluation and monitoring of the use of pre-treatment sedation.<br><br>At the time of this review, the Facility was unable to provide rates or trends analysis of persons receiving pre-treatment sedation.<br><br>The Facility does not provide i.v sedation or enable the use of TIVA;instead, the Facility | Noncompliance |

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| | including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects. | refers individuals who require full anesthesia to the local hospital. Rates and trends analysis for the use of pre-treatment sedation were not available for review. | |
| J5 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement. | Per Provision J1 above, the Facility had reassigned Dr. Moron, to provide 20 hours of direct care services. Dr. Moron is board certified in psychiatry. At the time of the review, about 40 people at the Facility were receiving behavioral and psychiatric services.<br><br>The Monitoring Team concludes that the Facility is in substantial compliance with Provision J5 of the Settlement Agreement. | Substantial Compliance |
| J6 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B. | The Facility had implemented a standard operating procedure for psychiatric services (Standard Operating Procedure ICF-MR 400-13), on December 13, 2010. The Monitoring Team reviewed the new procedure and determined its clinical efficacy. To assess implementation of the procedure, the Monitoring Team reviewed three psychiatric evaluations (Individuals #66, #3, #54). The Monitoring Team determined that the psychiatric evaluations reflected the Facility's procedure and were well within expected standard of care practice.<br><br>The Monitoring Team has determined that the Facility is in substantial compliance with Provision J6, of the Settlement Agreement. | Substantial Compliance |
| 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 | At the time of this review, the Facility had determined that they were not in compliance with Provision J7, of the Settlement Agreement. The Facility was in the process of developing an updated policy to address the use of functional screening and enhanced implementation of the Reiss Screen for Maladaptive Behavior. The Facility currently screened all new admissions by the Reiss Screen; however, there wasa discrepancy with regards to who requires and who does not require the Reiss Screen for those already admitted. Dr. Moronwas addressing this issue and has indicated to the Monitoring Team that all individuals will have been screened by the Reiss Screen within the subsequent six months.<br><br>The Monitoring Team has determined that the Facility remainednon-compliant with Provision J7 of the Settlement Agreement but is confident that the Facility is moving in the correct direction. | Noncompliance |

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| | need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner. | | |
| 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. | Per the Facility's self-assessment and per discussion with Dr. Moron, the Facility remains non-compliant with Provision J8, of the Settlement Agreement. The Facility continues to evaluate the Provision, has trained staff in the new PSP process, is enabling a collaborative approach with relevant disciplines, including pharmacy, and conducts regularly scheduled meetings to review the use and integration of psychotropic medications through combined assessment and case formulation. The Facility reports that it will continue improvements with this provision and expects to be in compliance in 12 Months, effective from the date of this review. | Noncompliance |
| J9 | Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non- | At the time of this review, the Facility had begun to enhance the PST process and determined that the Facility remains non-compliant with Provision J9. The Monitoring Team reviewed the PSPs of Individuals #66, #3, #54, #94, #31, #55, #27, #19, #31, #93, #54, #133, 143#55, #36, #88, # 69, #140, #80, #5 and #27, and has determined that the PST process remains deficient and must better address behavioral conditions and treatments.<br><br>Furthermore, PBSPs at RGSC typically did not reflect acceptable practices in applied behavior analysis. The lack of comprehensive and thorough assessment reduced the ability of the PST to determine the least intrusive and most positive intervention that might be effective, and whether behavioral, pharmacological, or combination interventions should be selected. The assessments leading to PBSPs, as documented in detail in the finding for Provision K9, included:<br>• A general history of prior intervention strategies and outcomes, butno objective, measurable evidence was provided for the efficacy of previous interventions.<br>• A narrative description of medical, psychiatric or healthcare issues, but the information included in the narrative was not used to identify treatment targets or formulate intervention strategies. This was true even when the individual was diagnosed with a mental illness or developmental disorder likely to present with | Noncompliance |

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| | pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible. | related undesired behavior, such as autism, schizophrenia, and Prader-Willi syndrome.<br>• A description of potential function(s) of the target behavior, although in several instances the validity of the proposed function was unclear.<br><br>Consents and approvals were 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.<br><br>At the time of this review, the Monitoring Team has determined that the Facility is not in compliance with Provision J9, of the Settlement Agreement. | |
| J10 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications. | In review for compliance of Provision J10, the Monitor recognizes that the Facility had enhanced efforts of the PST to better incorporate psychiatric treatments in their review process; however, following review of the PSPs, nursing health care plans, and medical evaluations for Individuals #66, #94, #31, #55, #27, #19, #31, #93, #54, #133, 143#55, #36, #88, # 69, #140, #80, #5 and #27, the Monitoring Team found that a comprehensive assessment, and review of psychiatric conditions and treatment was not substantially completed by the PST. It is essential that when considering a psychiatric diagnosis, behavior intervention and pharmacologic treatment, the PST must ensure that the potential harm of treatment is outweighed by the potential benefits of treatment. Injurious behavior to self and others and behaviors that significantly impair one's ability to live up to his or her potential. These are issues that must be reviewed, when considering treatment options.<br><br>The Monitoring Team concurs with the Facility's self assessment and has determined that the Facility remains out of compliance with Provision J10, of the Settlement Agreement. | Noncompliance |
| J11 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two | At the time of the review, Dr. Moron informed the Monitor that there had been a less then robust physician involvement in the current reviews of Individuals who receive polypharmacy. The use of polypharmacy was reviewed at this time through the polypharmacy committee and presented to the P&T committee. Per discussion with Dr. Moron, and following the Monitoring Teams review of the Facility's process, it has been determined that a meaningful review is not completed. The Facility must ensure that all relevant professionals are not only present at the time of the Facility's review of these issues, but fully participate in the review process. Importantly, relevant utilization data must be collected and analyzed longitudinally, which was not being done at the time of | Noncompliance |

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| | antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated. | the Monitoring Teams review.<br><br>Since assuming his new position, Dr. Moron will be attending the polypharmacy meetings, and as outlined in Provisions J1 and J3, had begun reviewing and updating all diagnoses to ensure that there are appropriate and justifiable clinical rationale for the use of polypharmacy. The Facility has determined that it will take an additional 12 Months to address this issue.<br><br>The Monitoring Team is satisfied with Dr. Moron's approach to Provision J11 and will further evaluate the Facility for compliance at subsequent reviews. | |
| J12 | Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly. | The Monitoring Team has significant concerns over the monitoring of the side effects of medications at the Facility.<br><br>The DISCUS for Individual #15, indicated a score of 3 on 11/7/10, and the physician assessed a conclusion of "probable TD" and instruction to "continue to monitor" was noted. The dose of Thorazine was increased from 75 mg/day to 250 mg/day. On re-screening with the DISCUS on January 7, 2011 the DISCUS score decreased to 1 and the conclusion of "no TD" was assessed. A comment was made noting that "no TD at this time but since he is on polypharmacy" and "on and off symptoms, will be monitored closely. Takes Cogentin already. " Given the individual's symptoms and probable diagnosis of TD, that most likely are masked by the increased dose of Thorazine, the PSP must reflect this issue, which it does not. Importantly enhanced monitoring must be completed by the Facility. No enhanced monitoring was noted. There is no health care plan for the diagnosis or suspected diagnosis of TD in the record.<br><br>The DISCUS assessment dated June 3, 2010, was noted to have a total score of 1 and the Physician assessed a conclusion of no TD. A comment by the nurse indicated that she was unable to complete the assessment because, "client did not stay longer for psychotropic med review. " There was no further effort to assess this individual sooner then the subsequent review.<br><br>Individual #5, who has been on long-term Haldol was noted to have positive findings on the DISCUS assessments dated 12/28/10 and 2/16/11. The Physician's conclusion was that there was no TD.<br><br>Individual #3, who has been on long-term neuroleptics had a DISCUS score of 4, with noted lip smacking and lateral tongue movements. No TD was assessed per the DISCUS assessment and there is no clinical rationale for the individual's abnormal movements located in the clinical record. | Noncompliance |

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| | | Upon review of DISCUS and MOSES assessments for Individuals#27, #139, #140, #15, #35, 35, #3, #12, and #82 along with their nursing health care plans, and medical evaluations, there were numerous omissions on the part of the physician in completing the physician's reviews and comments.<br>#27: MOSES 8/28/10<br>#130: MOSES 2/10/11 and DISCUS 2/27/10<br>#15: MOSES 8/26/10<br>#5: MOSES 2/16/11, 12/28/10<br>#3: MOSES 8/28/10, 5/25/10 AND DISCUS 11/10/10<br>#82: MOSES 8/26/10, 1/31/11<br>#12: MOSES 11/17/10, 2/28/10 AND DISCUS 7/16/10<br>#180: MOSES 8/23/10<br><br>Although DISCUS and MOSES assessments are noted to be timely in the clinical record, the Monitoring Team did not observe any instance of all clinical records reviewed for Provision J and L ordering or documenting additional or more enhanced monitoring for potential side effects, especially when new medications were added, dose changed or when anindividual was noted to have functional changes.<br><br>The Monitoring Team has determined that the Facility is significantly deficient with Provision J12, of the Settlement Agreement. | |
| 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 | Per Provision's J1 and J3, the newly assigned Psychiatrist is providing exceptional clinical reviews to determine the need for psychotropic medications and ensuring that psychotropic medications are well justified. At the time of this review, the PSP process was not fully involved, nor had all individuals been assessed. The Facility is moving forward to better involve the PST in psychotropic management.<br><br>At the time of this review, the Monitoring Team has determined that the Facility is making significant improvements to meet expectations of Provision J13; however, the Monitoring Team concurs with the Facility's self assessment and determines the Facility to remain out of compliance. | Noncompliance |

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| | 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. | | |
| J14 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks. | The Standard Operating Procedure NR200-08, "Consent to Treatment with Psychoactive Medication", dated January 1993 was reviewed, as was a blank consent form. It was noted that consent for psychotropic medications was obtained for the use of psychotropic medications for Individuals #27, #139, #140, #15, #35, 35, #3, #12, and #82.<br><br>The Monitoring Team has concerns over the comprehensiveness of the consent and informing the PST, and LAR of the use of psychotropic medications. Current practice standards must ensure that the following is included in the consent process:<br>1. Name of medication<br>2. Indication for use<br>3. Rationale of use, if not FDA approved<br>4. Dose and route<br>5. Treating physician<br>6. Known and expected common and serious adverse reactions<br>7. Alternate treatments, including no treatment<br>8. Expected outcomes (qualitative and quantitative)<br><br>Based on review, the Monitoring Team has determined that the PST and LAR, are not fully informed to make informed decisions for the use of psychotropic medications. Although information that is necessary to provide informed consent was generally found in progress notes, PSPs, and addendums to PSPS, not all was found in the consent document. The main issues of concern where additional information was needed were notification that drugs were prescribed for off-label non-FDA approved use; and availability of alternative treatment, including no-treatment.Furthermore, although | Noncompliance |

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| | | consents and approvals were routinely obtained for PBSPs, restrictive procedures and the use of psychotropic medication, weaknesses in the assessment process made it likely that limited understanding of the individual's treatment targets is gained and only minimal support for intervention strategies can be provided, making the consent unlikely to be fully informed. | |
| J15 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder. | The Facility has informed the Monitor that at the time of the review, the Facility remains out of compliance with Provision J15 and is making significant enhancements to ensure that the treating psychiatrist and neurologist are working in collaboration with medication changes, when a medication is used for comorbid conditions.<br>At the time of this review, the treating psychiatrist was reviewing neurology consults when there was a medication change; however, the neurologist had yet to be fully included in the process. | Noncompliance |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. Ensure that the PST process provides comprehensive and meaningful evaluation, and continued monitoring of Individuals receiving emergency and routine psychotropic medications. The team, inclusive of the LAR, must be fully aware of the clinical rationale for the use of psychotropic medications, all common and serious known or expected adverse outcomes, alternate treatments including no treatment, expected qualitative and quantitative outcomes, and whether the medication is approved by the Federal Drug Administration, and if not, what is the clinical rationale for it's use

2. Develop a policy and procedure that more clearly delineates the use of psychotropic medications at the Facility

3. Develop a policy and procedure that outlines the PST and PSP process, specific to psychiatric services. The PST and PSP must an integral part in the decision making of the routine use of psychotropic medications and review of the use of emergency psychotropic medications. With this in mind, the process, including that of a rights and ethics review, must not impact the timing of prescribing a psychotropic medication, once the need has been established.

4. Establish new policies and procedures for the use of pre-treatment sedation that clearly delineates the Facility's practice standards. Ensure that all relevant staff, including nursing, physician, pharmacy and direct care services are involved in the process.

5. Ensure that the PST and PSP clearly reflect their involvement in pre-treatment sedation process. The PST, including the LAR must be aware of the clinical rationale for treatment, alternatives to providing treatment including no treatment, known and expected risks and measurable outcomes for the use of pre-treatment sedation.

6. Standardized forms should be used by staff for pre and post monitoring of pre-treatment sedation.

7. To remain in substantial compliance for Provision J6, ensure that all psychiatric evaluations continue to reflect the Facility's policy on Psychiatric Services (Standard Operating Procedure ICF-MR 400-13).

8. Ensure that all individuals who do not have a current psychiatric assessment have been screened by the Reiss Screen within six months.

9. Ensure that the Facility has specific policies and procedures in place for Provisions J10 and J11 and that relevant staff have been trained on all new procedures. Ensure that Polypharmacy Committee minutes reflect the new practice standards and delineate rates and detailed clinical information rationalizing the clinical use of polypharmacy.

10. It is essential that effective immediately the Facility review its practice for medication monitoring of adverse effects and develop and initiate a process that will ensure all persons who are prescribed medications are monitored for adverse effects. This process must include robust involvement of the PST, and involvement of nursing, physician, pharmacy, and direct care staff. Individuals must be assessed regularly when there is a noted change in functional ability, sudden illness, change in medications and dose changes.

11. When informing the LAR for the need of psychotropic medication, ensure that the team explains the following:

    a. Name of medication

    b. Indication for use

    c. Rationale of use, if not FDA approved

    d. Dose and route

    e. Treating physician

    f. Known and expected common and serious adverse reactions

    g. Alternate treatments, including not treatments

    h. Expected outcomes (qualitative and quantitative)

12. Ensure that there is a specific policy and procedure to address Provision J15 and that psychiatric and neurology services are collaboratively addressing comorbid psychiatric and neurological conditions at the Facility.

| SECTION K: Psychological Care and Services | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #2, #11, #12, #27, #35, #36, #55, #58, #61, #62, #77, #82, #84, #94, #98, #101, #122, #139, #149<br><br>**People Interviewed:**<br>3. Megan Gianotti, M.Ed. – Behavioral Services Director<br>4. Samantha Salinas, MSW – Associate Psychologist<br>5. Cheryl Fielding, Ph.D. – BCBA consultant<br>6. Janie Villa, QMRP Coordinator<br>7. Rebecca Olivarez, QMRP<br>8. Direct Care Professionals: Approximately 12 staff members in residences, classrooms and vocational settings.<br><br>**Meeting Attended/Observations:**<br>9. Observed lunch at La Paloma (3/7/2011)<br>10. Observed dinner at El Paisano (3/7/2011)<br>11. Observed active treatment, staff performance and environmental characteristics in La Paloma, El Paisano, classrooms and vocational settings. |
| | **Facility Self-Assessment:**<br><br>RGSC indicated that compliance had been achieved for no provisions in Section K of SA. The facility did indicate that progress had been achieved in relation to the completion of Structural and Functional Behavior Assessments, peer review, data collection forms and non-PBSP behavior interventions. The Monitoring Team found that progress had been achieved in those areas, but that other areas such as PBSP implementation, staff competence in behavior intervention, and the completion of Psychological Assessments had declined. |
| | **Summary of Monitor's Assessment:**<br>Based upon observation conducted during the site visit, as well as documents reviewed during and |

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| | following that visit, it was apparent that RGSC continued to experience difficulty in achieving compliance with the SA. Some areas, such as peer review, data graphing, data collection tools and Structural and Functional Assessments, reflected improvement. Other areas, including PBSP implementation, data collection, staff competence and Psychological Assessments were notable for the lack of progress.<br><br>Of greatest concern to the Monitoring Team was the failure of RGSC to ensure individuals living at the facility received adequate behavior intervention. The site visit revealed that PBSPs often were not implemented. In addition, the Facility routinely allowed staff who had not been assessed for competence or who had failed to demonstrate competence in behavior interventions to serve in direct contact positions. Numerous individuals living at RGSC had been identified as engaging in dangerous behaviors such as self-injury and physical aggression. By failing to ensure that PBSPs were implemented or that staff responsible for those PBSPs were demonstrably competent, the Facility exposed the individuals living at the facility to unnecessary risk of personal harm.<br><br>RGSC also failed to ensure that all individuals living at the facility receive timely and comprehensive Psychological Assessments. In August 2010, 80% of individuals living at the facility had a Psychological Assessment completed in the previous 12 months. By the time of the current site visit, only 41% of individuals had a Psychological Assessment or annual adaptive behavior assessment update completed within the previous 12 months. In addition, the facility had not begun administering intellectual or adaptive behavior assessments as part of the Psychological Assessment process.<br><br>Based upon the information obtained during the current site visit, it was not evident that RGSC had acted as prudently or aggressively as necessary to substantially progress toward compliance with the SA.<br><br>**For Provision K.1:**This provision was determined to be not in compliance. ThePsychology Director is not a licensed psychologist buthadcontinued to progress toward the BCBA credential. The Facility had hired an additional Associate Psychologist who was also enrolled in coursework required to obtain BCBA certification. As no BCBA was employed by RGSC, it was not possible to demonstrate that PBSPs were developed by qualified staff.<br><br>**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 was enrolled in BCBA courses while participating in supervision, but did not yet meet all requirements stipulated in the SA. Nevertheless, she demonstrated broad knowledge of applied behavior analysis. Additional time will be needed to determine if this Provision is in compliance.<br><br>**For Provision K.3:**This provision was determined to be not in compliance. A peer review process was in place, but it was not evident that the process provided comprehensive review of behavior assessments and interventions.<br><br>**For Provision K.4:**This provision was determined to be not in compliance. Data collection continued to |

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| | lack demonstrable reliability and validity. It was also unclear that existing data were used to make data-based treatment decisions.<br><br>**For Provision K.5:**This provision was determined to be not in compliance. Intellectual and adaptive assessments are not completed at RGSC, and an increasing percentage of individuals had not had a psychological assessment completed in over a year. Some improvement had been made in functional assessment.<br><br>**For Provision K.6:**This provision was determined to be not in compliance. Issues discussed in Provision K5 indicated that RGSC did not provide psychological assessments that were current, accurate and based upon complete clinical and behavioral data.<br><br>**For Provision K.7:**This provision was determined to be not in compliance. Psychological evaluations completed at the time of admission reflected the same substantial limitations as those evaluations completed for other individuals living at the Facility.<br><br>**For Provision K.8:**This provision was determined to be not in compliance. Although the current counseling approach was more formal and structured than in the past, the treatment process did not reflect an evidence-based approach to treatment and lacked clear, objective and measurable goals.<br><br>**For Provision K.9:**This provision was determined to be not in compliance. Although the Facility typically provided 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.<br><br>**For Provision K.10:**This provision was determined to be not in compliance. Efforts to improve data collection had not been effectively implemented. Data continued to lack demonstrable reliability and validity. It was also unclear that existing data were used to make data-based treatment decisions.<br><br>**For Provision K.11:**This provision was determined to be not in compliance. At the time of the site visit, it was reported that staff frequently failed to implement PBSPs.<br><br>**For Provision K.12:**This provision was determined to be not in compliance. Although competency assessments have been initiated, those assessments lack sufficient specificity. Furthermore, there was no requirement that staff demonstrate competence prior to serving in direct contact positions.<br><br>**For Provision K.13:**This provision was determined to be not in compliance. Progress had been made toward increasing the number of staff with the BCBA credential, but the numbers did not currently meet the criterion 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 previous site visit, Megan Gianotti, the Psychology Director, was the sole employee of the Psychology Department with graduate training in a behavioral science. She is not a licensed psychologist. At that time, she had been enrolled in course work required to be credentialed as a BCBA and was participating in the supervision necessary for board certification.<br><br>During the current site visit, documentation reflected that Ms. Gianotti had completed two of the four BCBA courses. It was anticipated that she would complete the necessary supervision for board certification in May of 2011, with coursework for board certification to be completed by August of 2011.<br><br>The current site visit also revealed that RGSC had hired Samantha Salinas, MSW, to fill an Associate Psychologist vacancy at the facility. Ms. Salinas had no prior experience in applied behavior analysis or intellectual and developmental disabilities. Since being hired, Ms. Salinas had enrolled in classes required to obtain BCBA credentialing.<br><br>Based upon information obtained during the current site visit, RGSC had made progress toward the goal of employing staff with demonstrable competence in applied behavior analysis. Various obstacles existed, however, in relation to the requirement that behavior interventions be developed by demonstrably competent staff.<br><br>At the time of the site visit, RGSC employed two psychology staff with Master's degrees (Ms. Gianotti and Ms. Salinas) and two Psychology Assistants. Ms. Gianotti, as department administrator, was frequently tasked with administrative duties that limited her participation in the development of behavior interventions. As a result, the staff most readily available were those with the least experience and training. Therefore, the Facility was unable to provide sufficient staff who were competent to complete the task of developing and implementing adequate behavior interventions. Until Ms. Salinas completes training and earns BCBA certification, the ability of RGSC to ensure that behavior interventions are developed by demonstrably competent staff will remain substantially limited. | Noncompliance |
| 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 employed Megan Gianotti, M.Ed. as Psychology Director 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.<br><br>During the current site visit, Ms. Gianotti demonstrated broad knowledge of applied behavior analysis. She was familiar with the published research and demonstrated well- | Noncompliance |

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| | | developed skills in relation to behavior assessment and intervention. In addition, she displayed enthusiasm for her job and the task of achieving compliance with the SA. Conversations with other facility employees reflected respect for Ms. Gianotti and the role she serves at RGSC.<br><br>At the time of the site visit, Ms. Gianotti had not completed the requirements for board certification in applied behavior analysis. Until board certification is obtained, Ms. Gianotti will not fully meet the requirements of this provision. | |
| 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. | During the previous site visit, the facility reported that an internal peer review process was in place and functioning under the auspices of the Behavior Review Committee. Observations by the monitoring team during that visit reflected several substantial weaknesses in the peer review process. Those weaknesses included a committee lacking expertise in applied behavior analysis, the failure to make use of clinical indicators in formulating treatment decisions, and a lack of integration between psychology and medical services.<br><br>Since the previous site visit, RGSC had made substantial changes in the peer review process. The Behavior Review Committee, although still functioning, no longer had the responsibility of peer review. Instead, a modified form of peer review was in place that combined an internal and external review process. Specifically, Cheryl Fielding, Ph.D., the BCBA consultant for the Facility, was serving as the provider of peer review. In this capacity, Dr. Fielding reviewed all behavior interventions, assisted in the review of data and clinical indicators, provided guided discussion and training to all Psychology Department personnel, and provided assistance in formulating and monitoring treatment implementation.<br><br>The combination of internal and external peer review would not be desirable for a larger facility. Given the small size of RGSC and the low number of psychology personnel, such an arrangement was practical for RGSC.<br><br>Although the peer review process examined during the current site visit reflected a substantial improvement over the previous peer review practices, limitations were noted. Specifically, plans that had been approved for implementation included weaknesses in design and assessment that had a high probability of adversely affecting treatment outcome.<br>• In a behavior intervention plan for Individual #61 that was approved by the Peer Review process on 3/7/2011, the Monitoring Team noted the following issues.<br>o Frequency data were to be used to measure the selection of alternative | Noncompliance |

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| | | activities by the individual even though only a single opportunity for choice was likely. Based upon the content of the intervention plan, durational data would have been the appropriate measurement strategy. Although the Psychology Department has a diversity of data collection tools, in this example the appropriate tool was not selected.<br>o No specific treatment expectations or outcome measures were specified in the intervention plan. Although the plan discussed lack of progress and regression, there was no indication of what degree of change in clinical indicators was expected for success or within what time frame treatment effects were anticipated.<br>o There was no indication in the intervention plan or associated assessments that an effort had been made to differentiate learned behaviors from the biological signs and symptoms of the diagnosed impulse control disorder.<br>o The plan lacked true baseline data. Instead, historical data from the past several years were included as "baseline."<br>• In a behavior intervention plan for Individual #98 that was approved by the Peer Review process on 3/7/2011, the Monitoring Team noted the following issues.<br>o No specific treatment expectations or outcome measures were specified in the intervention plan. Although the plan discussed lack of progress and regression, there was no indication of what degree of change in clinical indicators was expected for success or within what time frame treatment effects were anticipated.<br>o The plan lacked true baseline data. Instead, historical data from the past several years were included as "baseline."<br>o Although assessments reflected the role of seizure activity as a setting event, the intervention plan did not involve components that recognized this relationship.<br>o Although the individual possessed the ability to vocally indicate the need to escape (which was assessed as the function maintaining the target behavior), the intervention plan did not include a formal teaching strategy to increase or strengthen this skill.<br>• In a behavior intervention plan for Individual #5 that was approved by the Peer Review process on 3/7/2011, the Monitoring Team noted the following issues.<br>o No specific treatment expectations or outcome measures were specified in the intervention plan. Although the plan discussed lack of progress and regression, there was no indication of what degree of change in clinical indicators was expected for success or within what time frame treatment effects were anticipated. | |

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| | | o The plan lacked true baseline data. Instead, historical data from the past several years were included as "baseline."A pre-treatment measure is essential in determining whether an intervention is successful. This can certainly consist of data collected from existing conditions. However, there needs to be a clear description of what those conditions have been so the difference from baseline to treatment can be clearly described. Using the data from the previous intervention as baseline is acceptable, so long as there exists a clear delineation between the previous and current interventions. Simply a listing of monthly data for the prior year or two does not constitute a current baseline.<br>o Although the individual was diagnosed with Prader-Willi Syndrome and "Mood Disorder NOS with a History of Psychosis" and was prescribed several psychotropic drugs, the intervention plan included no strategies for addressing any biologically-based signs or symptoms.<br>o A general strategy for reinforcing participation in structured activities was included in the plan, but no formal procedure or specific instructions were provided. As a result, staff would have no reference for how to implement the plan.<br><br>In many of the other facilities, the Peer Review Committee functions as the Behavior Support Committee with the objective being to approve only clinically sound interventions. At RGSC, the two processes are separate. The Behavior Support Review Committee (BSRC) did not provide clinical peer review of PBSPs. This is counter-productive in that the committee with the expertise to determine if an intervention is clinically sound is relegated to an advisory role while the committee lacking behavioral expertise determines what interventions will be implemented. The BSRC hadapproved interventions that were not clinically sound.<br><br>The sample of problems listed above were of particular concern given that the Peer Review process is tasked with guiding the development of behavior intervention into compliance with practices accepted within applied behavior analysis. The failure of the process to offer acceptable instructions and promote the use of behavior analytic practices was likely to undermine the intended goals of the 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 | Observations and documentation reviewed during the site visit revealed the use of a diverse and robust assortment of forms and strategies to collect behavior data. These strategies included scatterplots, whole and partial interval measures, durational measures and frequency counts. Not only were there a variety of data collection strategies, but in each instance in which a strategy was used there were clear indications on the data forms that the strategy had been tailored to the specific nature of the | Noncompliance |

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| | 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. | individual's behavior. The combination of formal strategies and individualization suggested an approach to behavior intervention that was based upon behavior analytic principles.<br><br>The most recent PBSP progress notes at the time of the March site visit were reviewed for 18 individuals. This review yielded the following information.<br>• 18 of 18 (100%) progress notes utilized graphs to display treatment data.<br>• Seven of 18 (39%) progress notes reflected treatment decisions that were not supported by the presented data. Examples of this issue included the following.<br>o For Individual #2, no displays of treatment targets were documented for six months. No attempt was made to reduce psychotropic medications, nor were there any revisions in programs or services to increase expectations for independence or to determine whether additional community involvement opportunities could be provided.<br>o For Individual #12, the behavior intervention was revised in September 2010. Target behaviors either remained unchanged in frequency or increased following the intervention change. No further assessments or treatment revisions were done.<br>o For Individual #36, aggression increased for two months without a recommendation for additional assessment or a change in intervention.<br>o For Individual #94, target behaviors increased for five months before a new assessment was initiated.<br><br>During the previous site visit it was noted that 100% of progress notes utilized graphs to display treatment data and that 93% of reviewed progress notes reflected a lack of evidence to support treatment decisions. The increased correlation between data and treatment decisions reflected substantial improvement over the past six months. Nevertheless, that lack of supporting evidence for 39% of those who were targeted with behavioral and/or psychotropic interventions was too high and further effort will be required before compliance with the SA can be achieved.<br><br>It was also noted by the Monitoring Team that for all progress notes reviewed, data graphs reflected only psychotropic drug treatments despite each of the individuals involved also receiving behavior interventions. Data graphs did not reflect changes in PBSPs, counseling, or interventions other than pharmacotherapy. Neither did the data graphs include references to environmental conditions or other changes in personal circumstances likely to have influenced displays of behavior. As a result, even though additional factors were likely to have contributed to changes in behavior, the data graphs did not reflect those factors or allow for the consideration of any intervention other than | |

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| | | psychotropic medication.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 or both, is psychotropic medication. | |
| K5 | Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention. | At the time of the site visit, approximately 81% of the individuals living at RGSC had not received a psychological assessment or update in the past year. In August 2010, only 40% had not received a psychological assessment or update in the previous 12 months. Furthermore, since the previous site visit, only nine individuals had received a psychological assessment. These data indicated that, rather than progressing, RGSC had regressed in terms of compliance with this provision of the SA.<br><br>In addition to the inability to provide annual psychological assessments and updates, RGSC had achieved no progress in regard to the assessment of intellectual and adaptive abilities. For 100% of individuals living at the Facility, psychological assessments did not include intellectual or adaptive assessments completed or reviewed according to current standards of practice. The facility had indicated in August 2010 the intent to obtain the services of a psychological consultant in order to meet the requirements of Provision K5. While a consultant did provide training to the psychology staff in October 2010 on adaptive behavior assessment, no adaptive behavior assessments had been completed at the time of the current site visit.<br><br>At the previous site visit, the Facility indicated that a new process and format for structural and functional 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 the formulation of specific hypotheses regarding the function of undesired behavior. A review of the new assessments that had been completed revealed the following issues.<br>• 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.<br>• 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 identify behavior correlates for the symptoms upon which the diagnoses were based or to ascertain how the diagnosed mental illness related to the function of the undesired behavior or to possible behavioral interventions.<br>• The investigation of health conditions in the SFA would benefit from a more rigorous strategy. Many of the SFAs only indicated the date of the last | Noncompliance |

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| | | examination. The example of Individual #11 described in detail in the finding for Provision M1 documents the lack of integrated review and consideration of medical conditions relevant to self-injury and toileting. The individual was noted to have refused to urinate in the bathroom but had a medical condition of urinary retention. In addition, self-injury may have been affected by the pain and discomfort of both urinary retention and sinusitis (the latter of which was treated symptomatically), but neither was documented as considered to be a possible function of the behavior.<br>• The concepts of motivating operations, setting events, antecedents and precursor behaviors were at times used interchangeably even though each is a distinct concept.<br><br>During the current site visit, a sample of nine most recent Structural and Functional Behavior Assessments was selected for review. The assessment process, although including at least nominally the necessary components, lacked the empirical rigor necessary to the development of an effective PBSP.The results of the review are presented below.<br>• Three of nine (33%) assessments included clear and specific identification of target behaviors. Target behaviors were typically presented in a narrative that included discussion of the targets, historical factors, and potential causes of the behavior.<br>• Zero of nine (0%)of assessments included integration of known medical conditions or mental illness. As was the case during the previous site visit, 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.<br>• Three of nine (33%) assessments reflected a clear understanding of the basic concepts of behavioral contingencies such as setting event, antecedent and consequence.<br>• Four assessments resulted in ambiguous findings of function of the behavior. Of those, four (100%)assessments included attempts to further explore or resolve ambiguous findings of functional screening tools. That demonstrates that the Facility paid attention to the results of the assessment and attempted to better identify the function as a step in developing an effective PBSP.<br>• Zero of nine (0%) assessments reflected an empirical process of investigating behavior and developing a behavior intervention strategy. The development of a behavior intervention should, as much as practically possible, reflect the | |

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| | | development of a single-case study investigation of behavior. This requires that the psychologist adhere to a specific protocol for investigating a behavior, developing an hypothesis and formulating a behavior change strategy based upon that hypothesis. Such a strategy was not evident at RGSC.<br>• Two of nine (22%) assessments provided a clearly identified replacement behavior that was related to the identified function of the target behavior.<br>• Zero of nine (0%) assessments included a hypothesis of the conditions under which the target behavior was displayed and a prediction of the response to an intervention.<br>• Four of nine (44%) assessments provided a clear indication of whether multiple targets were maintained by the same or different functions.<br><br>Based upon the information gathered during the site visit, it was evident that improvement had been achieved in regard to behavior assessment. The noted limitations, however, indicate that further work will be required in order to achieve compliance with the SA. | |
| 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 reflected assessment findings that cannot be demonstrated to be current, accurate or complete. | Noncompliance |
| 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 reflected that individuals newly admitted to the facility had a psychological assessment completed within 30 days of admission. Records did not reflect that individuals admitted to the facility routinely received 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. | Noncompliance |
| K8 | By six weeks of the assessment required in Section K.7, above, those individuals needing | During the previous site visit, two individuals (Individuals #69 and #107) were receiving counseling or psychotherapy in the community. Very little documentation was available from the therapist regarding assessment, measurable goals, or formal intervention | Noncompliance |

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| | psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment. | practices. The information provided by staff indicated that evidence-based practices were not in use in regard to counseling.<br><br>At the time of the current site visit, two individuals living at RGSC (Individuals #122 and #149) were involved in counseling or psychotherapy. Rather than using a therapist in the community, a member of the RGSC Psychology Department (Samantha Salinas, LCSW) functioned as the therapist.<br><br>Based upon interviews with staff and a review of records, the current counseling interventions were more formal and structured than the interventions provided by the community therapist. Despite this achievement, however, substantial limitations were noted in the counseling plans.<br>• Although both counseling plans included general goal statements, there were no operationally-defined targets, specific intervention strategies or treatment expectations included in the plans.<br>• Documentation of performance during counseling was maintained in narrative format. Progress notes were written on a monthly basis, but it was not evident that statements of progress were based upon objective, measurable targets.<br>• As the goals of the counseling plans and PBSPs for both individuals overlapped, it was unclear how the efficacy of either intervention could be isolated or how counseling and other behavioral interventions could be integrated to build on each other for greater efficacy.<br>• Ms. Salinas had not received specialized training, certification, or supervised practice in Dialectical Behavior Therapy, one of the treatment modalities described in the counseling plans but had received some guidance on use of those procedures; at the time of the visit, she was seeking additional guidance on adapting these techniques to this specialized population. Furthermore, individuals who assisted as staff participants or who supervised homework or milieu activities had not received training and monitoring from qualified therapists. It would be valuable to have therapists experienced in this evidence-based approach provide consultation or guidance in its implementation to improve likelihood of effective implementation. | |
| 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 | The Facility had 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. | Noncompliance |

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| | 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. | • Zero of nine PBSPs (0%) provided a rationale for the proposed intervention that was based upon an empirical process reflecting the basic principles of applied behavior analysis.<br>• Nine of nine PBSPs (100%) included a general history of prior intervention strategies and outcomes. No objective, measurable evidence was provided for the efficacy of previous interventions<br>• Zero of nine PBSPs (0%) integrated medical, psychiatric and healthcare issues into the assessment or intervention. All PBSPs included a narrative description of medical, psychiatric or healthcare issues, but the information included in the narrative was not used to identify treatment targets or formulate intervention strategies. This was true even when the individual was diagnosed with a mental illness or developmental disorder likely to present with related undesired behavior, such as autism, schizophrenia, and Prader-Willi syndrome.<br>• Three of nine PBSPs (33%) included formal operational definitions of target behaviors.<br>• Zero of nine PBSPs (0%) included operational definitions of replacement behaviors.<br>• Nineof nine PBSPs (100%) included a description of potential function(s) of the target behavior, although in several instances the validity of the proposed function was unclear.<br>• Zero of nine PBSPs (0%) included the specific and formal use of positive reinforcement sufficient for strengthening desired behavior.<br>• Two of nine PBSPs (22%) included specific strategies for teaching desired replacement behaviors.<br>• Zero of nine PBSPs (0%) included specific, detailed instructions for data collection procedures.<br>• Zero of nine PBSPs (0%) included data collected under true baseline or non-treatment conditions.<br>• Zero of nine PBSPs (0%) included treatment expectations and timeframes written in objective, observable, and measureable terms.<br>• Nine of nine PBSPs (100%) included clear, simple, precise interventions for responding to the behavior when it occurred.<br><br>Consents and approvals were 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.<br>• Zero of nine records reviewed (0%) included results obtained from an empirically-based process or instrument recognized as being able to identify or | |

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| | | assist in identification of potential functions of a behavior.<br>• In nine of nine records reviewed (100%), intervention targets were presented and monitored as a group regardless of topography, the lack of determining whether they had the same function, or other characteristics.<br><br>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. | |
| 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. | As presented in Provision K4, RGSC had continued to expand and diversify the available procedures and forms for data collection. This was a very positive step by the Facility. Unfortunately, a number of factors were extant at the facility that substantially limited the utility of enhanced data collection.<br><br>• Psychology staff and QMRPs reported that direct service staff routinely failed to document displays of targeted behaviors, documented behavior in the wrong location, or failed to submit documentation in a timely manner.<br>• Zero of nine records (0%) indicated that inter-observer agreement checks had been implemented.<br>• Zero of nine records (0%) revealed that data integrity checks had been conducted.<br>• Zero of nine records (0%) revealed a process to ensure the validity of intervention targets or the appropriateness of specific data collection procedures such as ensuring that datameasuring psychiatric treatment efficacy are relevant to symptoms identified for the person, that target behaviors address those issues that facilitate movement to community living, and that that intervention targets are well-defined and based on meaningful assessment.<br><br>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.<br><br>RGSC continued to demonstrate progress in the graphing of data. All individuals | Noncompliance |

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| | | receiving behavior or psychotropic interventions had data graphed on a monthly basis. In addition, these graphs typically included data available from the previous 10 to 12 months. Furthermore, in a substantial improvement over graphs reviewed at the previous site visit, all graphs included indications of when treatments were revised or new assessments were conducted. Despite this progress, observations and record reviews revealed several problems with the graphs and the graphing process.<br>• Eight of nine graphs (89%) included data regarding symptoms of mental illness. It was unclear, however, if the numbers reported reflected a score from a rating scale, a frequency count or some other measure. Without such information, it was not possible to interpret the data reported on the graph.<br>• Zero of nine graphs (0%) included inter-observer agreement or information regarding data integrity. | |
| 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. | A Flesch-Kincaid Grade Level was obtained for the direct service staff instructions in the nine most recently written PBSPs. Microsoft Word 2010 was used to obtain readability statistics. The measures revealed that direct service staff instructions consistently fell within the 9th to 10th grade reading level. Interviews with direct service staff, as well as residence administrators, indicated that staff infrequently experienced problems understanding PBSPs.<br><br>It was unlikely that all active PBSPs reflected the same level of readability as in the nine most recent PBSPs. The nine most recent PBSPs reflected the model for future intervention plans. Therefore, during future site visits the Monitoring Team will have an opportunity to review a broader sample of new and revised PBSPs to determine readability. .<br><br>Despite readable PBSPs and acknowledgement by direct service staff that PBSPs were not difficult to understand, Psychology staff and QMRPs reported numerous incidents of PBSPs not being implemented. Various reasons were described for the failure to implement PBSPs.<br>• There were reports that direct service staff were concerned about being reported for abuse as a result of surveillance cameras and were therefore very cautious about their interactions with individuals and their implementation of any services. This could not be confirmed through interview with direct service staff, but the perception and the possibility that it is accurate may lead to less assertive requirement to implement services.<br>• Direct service staff indicated that PBSPs were not implemented as supervisory staff had stated or implied that behavior interventions were not essential or high priority | Noncompliance |

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| | | The failure to consistently and effectively implement behavior interventions was of substantial concern to the monitoring team. When interventions are not implemented, individuals are unlikely to develop greater independence and may present an increased risk of harm to self or others. It is the obligation of the facility to diligently act to ensure that all individuals receive necessary services and are protected from unnecessary risks. Failure of the facility to act accordingly could be construed as negligence. | |
| K12 | Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans. | At the time of the site visit, RGSC had recently initiated attempts to assess staff competence in relation to PBSPs. Although the opportunity for demonstrated competence was included in the assessment process, Psychology Department personnel reported that the competency assessments typically required only that staff verbally state how to conduct components of a PBSP.<br><br>A review of the Competency Assessment forms reflected that the assessments target very general concepts or elements of a PBSP, such as stating the function of a target behavior or demonstrating a response to a challenging behavior. In order to accurately assess staff competence, it is essential that specific knowledge be targeted, i.e. demonstrate the process for delivering the reinforcer or demonstrate the method for recording displays of the target behavior. In addition, a competence assessment must assess all essential elements of a PBSP.<br><br>An additional concern regarding competency assessments was that competence regarding PBSPs was not a prerequisite for working in direct contact with individuals living at the facility. As a result, staff for whom competence had not been assessed, as well as staff who had failed to demonstrate competence, were routinely placed in positions where they were required to implement behavior interventions targeting potentially dangerous behavior.<br>• Individual #31 was observed for several minutes attempting to elude staff in a facility parking lot near moving vehicles. Staff were able to block his access to traffic. Interviews with three staff following the incident revealed that none of the three were aware of whether the individual had a PBSP.<br>• Individual #35 was observed during dinner. The individual demanded change for her currency, cursed staff who did not provide change, repeatedly slapped the table and rubbed her face, and attempted to strike staff. Staff did not implement the PBSP, which included steps to protect persons targeted by the individual's aggression, and attempted to bargain and negotiate with the individual for calm behavior. | Noncompliance |

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| | | The combination of staff who refused to implement PBSPs and the placement of staff who lacked competence in behavior interventions in direct service positions was of considerable concern to the Monitoring Team. These two conditions created an environment in which effective teaching of skills and alternative behaviors was unlikely and where the risk of injury was unnecessarily high. It is essential that the facility aggressively pursue a strategy to ensure all clients are adequately protected from harm and receive the necessary training identified by the PST. | |
| 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, RGSC employed no staff who were board certified in applied behavior analysis. Two staff were enrolled in classes required for board certification. When those two staff have obtained board certification, the facility will still fail to meet the requirement of one BCBA for every 30 individuals living at the facility, based upon the current facility census.<br><br>RGSC employed two Psychology Assistants. Based upon a presumption of board certification for all eligible staff, the number of Psychology Assistants would meet the requirement of the SA. | Noncompliance |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. RGSC needs to aggressively act to ensure that PBSPs are implemented and treatment data are consistently and accurately collected.
2. RGSC needs to aggressively act to ensure that staff assigned to direct contact positions are demonstrably competent regarding assigned PBSPs.
3. Efforts should be made to ensure that the peer review process encompasses all relevant components of behavior assessment and intervention. The use of a rubric or checklist could assist in achieving this goal.
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 and should make rigorous use of functional assessment to differentiate between learned behaviors and internally driven symptoms of mental illness and situations in which these overlap and affect each other, 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-behavioral intervention procedures, such as counseling and psychotherapy, should be conducted with the goal of establishing clear guidelines for evidence-based practice.
7. 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.
8. The use of specific treatment expectations and additional clinical indicators must be integrated into the intervention review process. Current practices have resulted in decisions lacking a clinical basis or justification.
9. The investigation of health conditions in the SFA would benefit from a more rigorous strategy. Many of the SFAs only indicated the date of the last examination. Because of communication and cognitive limitations, as well as a predisposition toward some health conditions in certain individuals, a more in-depth investigation is often warranted and beneficial.

10. The PBSPs often fail to reflect or address the basic assumptions of applied behavior analysis, such as motivating operations, setting events, formal strategies to weaken undesired behavior and the use of replacement behaviors. A review of the existing format and required components would be helpful to identify and correct the weaknesses in the plans.
11. The Facility should seek to have therapists experienced in the evidence-based approach of Dialectical Behavior Therapy provide consultation or guidance so that it can be implemented effectively.

The following is offered as an additional suggestion to the facility:

1. The Facility should consider reviewing the roles of peer review and BSRC to establish an effective and efficient review process.

| SECTION L: Medical Care | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. RGSC Standard Operating Procedure ICF-MR 100 18, Medical Emergency Response, Date Established: September 23, 2010<br>3. RGSC Standard Operating Procedure EC 100-08, Code Gray, Date Established: April 2009, Revised: September 2010, Attachment: RGSC Emergency Event Debriefing Form Instructions, Revised: October 2010, Approved/Reviewed by the Medical Record Committee: November 2010<br>4. RGSC Standard Operating Procedure EC 100-09, Medical Emergency Response, Initiating a "Code Blue", Date Established: April 2009, Revised: September 2010<br>5. The complete active clinical records of Individuals #19, #31, #93, #54, #133, #143, #55, #36, #88, # 69, #140, #80, #5 and #27.<br>6. Diabetic Monitoring Record – blank form<br>7. Trend Analysis Report Summary dated March 3, 2011.<br>8. Trend Analysis Report and Database for SSLC Services.<br>9. Medical Staff Peer Review Form – no date<br>10. Fall injury data report, March 1, 2011<br>11. Physical Therapy Assessments on Individuals #143, #140, #80, #5, and #27<br>12. RGSC Completed Mock Medical Emergency Drill Sheets, 8/25/10 through 3/2/11<br>13. RGSC Safety/Risk Management/Infection Control Committee Minutes, August 13, 2010, September 9, 2010, October 14, 2010, November 10, 2010, and December 14, 2010<br>14. RGSC Training Due/Delinquent – Employees for Cardiopulmonary Resuscitation (CPR) Basic, March 2011<br>15. RGSC Emergency Medical Equipment Checklist, February 2011<br>16. RGSC Automatic External Defibrillator Daily Checklist, February 2011<br>17. RGSC Safety/Risk Management/Infection Control Committee Minutes, August 13, 2010, September 9, |

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| | 2010, October 14, 2010, November 10, 2010, and December 14, 2010<br>**People Interviewed:**<br>1. Yolanda Gonzalez, RN Chief Nurse Executive (CNE)<br>2. Mary Doris Matabalan, RN, Nurse Operation Officer/Hospital Liaison<br>3. Jessica Juarez, RN, Quality Assurance Nurse<br>4. Marcy Valdez, RN, Nurse Manager<br>5. David Moron, M.D., Clinical Medical Director<br>6. Maria Dill, M.D., Medical Director<br>7. Merle Kraft, Vocational Services Manager<br>8. Lorraine Hinrichs, ICF-MR Program Consultant<br>9. Herlinda. DeVera, M.D.<br>**Meetings Attended/Observations:**<br>1. Mock Medical Emergency Drill conducted in the Vocational Education Building 510, Room 18, at 1:00 p.m., 2/28/11 |
| | Self Assessment:<br>The RGSC POI reported not being in compliance with any of the four provisions of this Section. Steps had been taken to make progress. The Monitoring Team determined that some provisions of this Section are in compliance, as noted below.<br><br>For Provision L1, the Facility stated it is not in compliance. The State office medical care policy was operationalized at RGSC and includes procedure for routine, preventative, and emergency medical care.<br><br>For Provision L2, the Facility stated it is not in compliance. The Facility reported that non-SSLC physicians are currently reviewing medical diagnoses and treatment for each individual. Once all have been reviewed, these physicians will continue to audit a rotating sample of 10% each month.<br><br>For Provision L3, the Facility stated it is not in compliance. The Facility reported an audit tool is being developed to review the requirements of Provision L2.<br><br>For Provision L4, the Facility stated it is not in compliance. Pending receipt of policies and standards from SO, the Facility has chosen to follow the standards put forth in Conn's Current Therapy 2011 and The Care of the Geriatric Patient, 3rd Edition.<br><br>The Facility also reported that it had implemented mock medical drills monthly, per shift at each home and vocational services. The Monitoring Team determined that nurses and physicians did not routinely participate at a level that ensured an effective response. |
| | **Summary of Monitor's Assessment:**<br>On March 1, 2011, the Monitoring Team conducted an interview with Drs. Moron and DeVera, During the interview, the Monitoring Team was informed of significant systems improvements in the area of medical services at the Facility. |

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| | Specific to staffing, the Facility had a robust after hour coverage plan that utilizes staffing from the Mental Health component of the Facility. The covering physician was available 24/7 and will triage routine and urgent clinical issues. At present, one full time physician provided routine care to persons served during normal business hours; however, the Facility was making arrangements with an additional physician, to assume more responsibility of routine health care. As a result of adding the additional physician to the medical staff, it is anticipated that quality indicators of health care will improve in the near future.<br><br>At present, two outside physicians have been contracted to provide a comprehensive review of persons served at the Facility. Their efforts had just begun and the sample size was too small to assess efficacy at the time of this review.<br><br>Medical staff at the Facility had recently begun participating in weekly telephone conferences with the DADS Clinical Coordinator. During these meetings relevant system issues are discussed, such as the development of new health care policies, and health care standards.<br><br>The Facility had developed a flow sheet for managing diabetes, which will help better manage individuals with diabetes mellitus. The Monitoring Team has reviewed the flow sheet and has found its utility valid.<br><br>To better diagnose and treat individuals with seizure disorder, the Facility's physician has recently established efforts to collaborate directly with the consulting neurologist.<br><br>The Facility had recently adopted into practice a new annual medical review form, which was provided by State Office. The new form is much more comprehensive and clinically sound.<br><br>Importantly, the Facility will be implementing dictation for all primary care documentation. The Facility's physician will have the ability to dictate all clinical contacts. The physician will adhere to specific prompts, enabling more comprehensive and standardized approach to documentation practice at the Facility.<br><br>The Facility has developed, and continues to enhance, a trends analysis report that enables close monitoring of immunization status and some important clinical indicators, including diabetes, hypertension, GERD, Hepatitis, UTI's, Cardiac issues and infections. This process is exceptionally promising and should be considered for other Facilities within the Texas system.<br><br>Specific to emergency drills, it was positive to find that since the last RGSC tour the Facility had begun conducting Mock Medical Emergency Drills as defined in the Medical Emergency Response Policy. A drill was performed during the visit. Results of the drill did not indicate that the drills to date had been effective. There was no documented evidence on the completed Mock Medical Emergency Drill forms reviewed that the physicians participated in any of the drills or that the Medical Director and/or CNE actively participated in the Facility's Medical Emergency Response system. |

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| | According to the Course Due/Delinquent list 100% of the staff were current in Basic CPR training. Review of the completed Mock Medical Emergency Drills indicated when staff failed to perform satisfactorily that staff were retrained on the spot and/or when indicated the drill was repeated. The Facility had not begun performing trend analysis on Mock Medical Emergency Drills. According to the POI the completion date for the task was for 8/11. This delay is not acceptable in identifying issues and trends that could need immediate corrective action. The number of drills were reported in the monthly Safety/Risk Management/Infection Control Committee Minutes but failed to include any further information.<br><br>The Nursing Department continued to enter and track appointments in an Appointment Database. While most if not all of the recommendations made on the last tour had been carried out the Facility continues to need improvement as described below.<br><br>Despite enhanced system processes, based on it's review of clinical documentation the Monitoring Team identified, and raised significant concerns with the delivery of clinical care to individuals served by the Facility andstrongly recommends that the Facility conduct an immediate and comprehensive evaluation of the delivery of clinical care to Individuals served by the Facility.<br><br>Following review of the Facility, discussions with clinical leadership and review of the Facilities POI, the Monitoring Team concurs with the Facility's Self Assessment of non-compliance with provisions L1, L2, L3, and L4, of the Settlement Agreement. |

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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. | Based on clinical records provided for review, there were pervasive examples that indicate a need for a comprehensive systems review of care of Individuals served by the Facility, such as indicated by the following cases:<br><br>Individual: #118<br>A neurology consultation dated November 8, 2010 noted a diagnosis of spastic paraparesis. The Monitoring Team observed the individual and concurred with the noted diagnosis per the neurologist. The diagnosis listed in the clinical record is devoid of such diagnosis and clinical services to address spastic paraparesiswere not provided to the individual.<br><br>The individual was noted to have chronic anemia, per labs, and documentation by the Facility's Physician. The individual was prescribed and administered ferritin and iron supplements; however, the clinical record was devoid the necessary diagnostic work-up; hence, the etiology of the chronic anemia may not be known. There are many serious conditions that manifest with anemia, such as serious disorders of the blood and malignancy. A more thorough assessment was warranted to determine etiology so as to | Noncompliance |

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| | | ensure appropriate treatment can be provided.<br><br>Chronic hyponatremia was noted on multiple labs and documented in the clinical record.As with anemia, there was no documentation of a formal evaluation or documented differential diagnosis as to the cause of hyponatremia. This condition can be the result of a serious neurological condition, endocrine condition or related to medication; hence, understanding the etiology of chronic hyponatremia is imperative.<br><br>A consulting urologist diagnosed a renal calculi on January 11, 2011. The urologist requested that a repeat ultrasound be completed in six months. The consult form was signed and dated by the Facility's Physician; however, there was no comment by the physician on the report, nor in the progress notes as to the physician's follow-up plan. Importantly, per records provided for review, the requested follow-up ultrasound was not ordered and there was no accompanying documented clinical rationale for not following the consultant's recommendation.<br><br>The clinical problem list and official diagnosis were found to be incomplete. Spastic paraparesis, chronic anemia, and chronic hyponatremia were not included in the diagnosis.<br><br>Given the individual's diagnosis of spastic paraparesis, history of fractured hip, history of fractured ribs and underlying diagnosis of ataxia, the individual's risk assessment for falls was inadequate, as it determined the individual to be at low risk for falls.<br><br>The individual underwent two surgeries related to gastrointestinal issues, intestinal volvulus and cholycystectomy. A recent history of bowel surgery and known history of intestinal volvulus places this individual at additional risk for constipation, bowel obstruction and bowel perforation. Nursing assessments and the health care plan did not adequately reflect these issues.<br><br>Through review of the most current PSP at the time of this review, and related addendums to the PSP, the Monitoring Team has determined that insufficient information is presented to and reviewed by the PST, and consequently, the PST does not provide the necessary level of review of clinical issues.<br><br>Individual: #35<br>On January 1, 2010, the Facility's Physician assessed the individual for a new cough. The physician diagnosed the individual with "viral syndrome" and obtained a chest x-ray. The chest x-ray was read on January 4, 2010 as "congestive heart failure". The physician noted that the individual does not have a family history of congestive heart failure and | |

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| | | that the individual does not have a diagnosis of hypertension and that there is no evidence of congestive heart failure on historic EKG reports. The physician continued with the diagnosis of "viral syndrome and ordered a specific test for congestive heart failure known as a BNP. Result of the BNP were above normal limits, also the chest x-ray report demonstrated classic signs of congestive heart failure and a previous x-ray reported cardiomegaly – all of which suggesting congestive heart failure. Unfortunately, these issues remain unaddressed by the physician. The PST and the PSP reports did not adequately reflect the important potential issue. This individual is at serious risk for an adverse cardiac outcome, and is without appropriate level of clinical care.<br><br>The individual was seen, diagnosed and empirically treated for recurrent conjunctivitis on at least three previous occasions during 2010, without consultation with an ophthalmologist. The individual was recently referred to an ophthalmologist who diagnosed the individual with blephoritis and corneal scarring. Corneal scarring maybe a consequence of recurrent and ineffective treatment of frequent ophthalmological infections. The Monitoring Team has determined that there was insufficient assessment, follow-up and treatment for the individual's recurrent ophthalmological condition.<br><br>The individual had a PAP smear completed on January 27, 2011 that reported negative for malignancy, but "positive for coccobacilli suggesting bacterial vaginosis ". The Facility's Physician did not comment on the positive result, nor provide further evaluation or treatment for vaginosis. Bacterial vaginosis may, in some cases, be very uncomfortable, and manifest in behavioral issues, which the individual is known to have. The Monitoring Team has determined that follow-up and treatment was inadequate for this condition.<br><br>The individual is known to have severe issues with gait; however, this serious condition had not been appropriately evaluated. The physician's only comment related to the individual's gait issue is, "I still feel that this gait abnormality is secondary to long standing effect of psychotropics over years. " The physician had completed no formal assessment. Physical therapy had not provided a comprehensive review or assessment of the person's condition. The Monitoring Team has determined that a comprehensive assessment of the individual's gait abnormality should have been completedand the underlying etiology of the condition known to the physician and physical therapist.<br><br>During the physical examination, the physician documented "negative hemoccult" and when the Monitor asked the physician specifically how many hemoccults are completed as part of colon cancer screening, the physician replied "one. " The physician verified that only one hemoccult is completed on individuals at the Facility for colon cancer screening. Three hemoccults from different stool samples are considered standard of | |

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| | | care practice.<br><br>The individual was determined to be at low risk for constipation; however, the individual is known to have an atonic bowel, and has a diagnosis of chronic constipation. The individual had also undergone abdominal surgeries in the past for bowel perforation. Staff were not adequately monitoring this serious issues.<br><br>Individual: #19<br>This individual was observed at day program as wearing a protective helmet while sitting in a chair. The individual's left shoe was observed to be untied and her head was maximally flexed to her chest. The individual required two staff assist to ambulate and was without a gait belt, which was ordered to be used for ambulation.<br><br>The HST reviewed the individual and determined that the individual's health status risk level was "low risk" and having "no major issues." Review of the clinical record indicated that the individual's ability to ambulate had significantly worsened over the past six months, and the individual had two hospitalizations for recurrent pneumonia on July 10 and September 10 respectively, and one hospitalization for hyponatremia.<br><br>Physical therapy had recommended that a lift be used for all transfers "to prevent injury." Review of this issue has determined that a mechanical lift is not being used as recommended. The Monitoring Teamfound the physical therapy recommendation that a lift should be used to be appropriate, and recommends that a prompt and comprehensive medical evaluation be obtained to determine the underlying etiology of her gait issue and inability to hold her head in a neutral position.<br><br>The physical assessment during the annual medical evaluation dated September 18, 2010 was noted to be of concern to the Monitoring Team. The individual was noted to have "pellets of hard stools which are upper, but rectal port is empty" and that "I could feel some hard stools during the abdominal examination." In this case, no further evaluation was documented for possible worsening constipation, nor did the PSP comment on this issue.<br><br>During examination of the upper extremities, the physician noted "full range of motion although can not lift up her arms completely." Based on this documentation the Monitoring Team was confused as to how the individual was assessed as having full range of motion, although she could not lift her arms above her head. On examining the lower extremities, the physician noted "limb edema but no edema on her feet." Edema of the extremities requires an evaluation to determine the etiology and if treatment is necessary, which was not documented in the records provided for review. During the | |

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| | | physician's evaluation of coordination and gait, the physician noted "ataxic gait, " and "fine coordination is impaired but gross is intact. " Observation of the individual and discussion with staff regarding coordination corroborates the physician diagnosis of ataxia and indicates marked gross motor coordination impairment. The physician's review of reflexes as being hyperactive and with clonus indicate a possible upper motor neuron disorder, which had not been documented nor was there evidence in the clinical records indicating evaluation of this condition.<br><br>An x-ray of the cervical spine was obtained on January 28, 2011 secondary to worsening flexion of the individual's neck. The x-ray was "non-diagnostic" because of "body habitués. " No further evaluation has been entertained since then and the issue remains undiagnosed. Documentation as to follow-up was not noted in the clinical record.<br><br>An x-ray of the left hand was diagnosed for an avulsion fracture of the left ring fingersecondary to a fall injury. Osteopenia and osteoarthritis was diagnostic of the finger, hence, suggestive of a diagnosis of osteoporosis and arthritis. The Facility's physician did not address this issue in the clinical record.<br><br>An x-ray of the chest was obtained on November 11, 2010 and was diagnostic for minimal cardiomegaly, possible infiltrate, bullae or lung cyst and underlying chronic obstructive lung disease (COPD), and osteopenia. Again, osteopenia or osteoporosis was not evaluated or considered by the treating physician. The individual was referred to a cardiologist and pulmonologist for further evaluation. The pulmonologist consult report dated November 10, 2010 requested follow-up in three months. Review of the clinical record indicated that the Facility Physician did not sign off the consult report, nor had a follow-up appointment with the pulmonologist been obtained. The Cardiology consult report, which indicated possible coronary artery disease, was reviewed by the Facility Physician; however, the recommendation for an echocardiogram was not completed and there was no documented clinical rationale for why the recommendation was not followed.<br><br>A CT of the chest was completed on February 24, 2011, and was diagnostic for "cardiomegaly; cavitary lesions of the lung; linier densities of the lung bases, extensive ground glass opacities in both upper and lower lungs" and "generalized osteoporosis. " Cavity lesions of the lungs can indicate serious underlying pathology including Wegener's granulomatosis; septic emboli, rheumatoid nodules and possible malignancy, among other issues. Ground glass opacities of the lung can be medication induced, pneumonia, rheumatoid arthritis, lupus, lymphoma, chronic infection, sarchoidosis or malignancy, among other diagnosis, among other conditions. This issue had not been addressed in the clinical record at the time of the Monitor's review. | |

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| | | Clinical notes provided indicated that the individual is known to be more sedate then usual. An ammonia level was obtained on October 14, 2010 that demonstrated an elevated ammonia level. Elevated ammonia levels may result or contribute to sedation. This issue was not documented in the clinical records provided for review.<br><br>The individual is reported to have frequent urinary tract infections and there was no evidence of an evaluation being completed to determine the etiology of the recurrent infections, or to determine appropriate treatment..<br><br>The Annual Physical Therapy Evaluation dated August 31, 2010 and the prior "Three Year Evaluation", dated September 22, 2009, did not provide a neuromotor assessment. There was no physical therapy impression as to the condition being evaluated or treated by the physical therapist. There was no evidence provided that indicates the physical therapist was aware of the underlying condition prior to recommending the use of a gait belt. On January 31, 2011, per the records provided, Physical Therapy did not comment on a cause for the individual's neck flexion but recommended referral to a neurologist for an order for a "cervical brace or support, if it would be beneficial. " Physical Therapy also recommended to "encourage to look up at objects to assist with placing her head in a more neutral position. " The Monitoring Team has concerns that the underlying etiology of the person's condition should be well known to the team and well documented, prior to providing recommendations.<br><br>The individual is known to have a diagnosis of dysphagia, however, the etiology of the dysphagia has not been documented. It is critical that efforts be made to establish a definitive etiology of all chronic medical conditions.<br><br>Individual: #143<br>Individual #143 was observed at the on-campus work place. During the observation the individual was observed to have a severe ataxic gait, which was broad based, and the individual was wearing a protective helmet. Upon review of the individual's clinical records that were provided, it was noted that the ataxic, broad based gait was not previously assessed. Of significant concern was the individuals severely protruding tongue and lip smacking behavior that suggests an underlying dystonia and perhaps tardive dyskinesia. Within the psychiatric record, a psychiatrist had commented on this condition in the past; however, no further mention or evaluation had been attempted while at the Facility. The Monitoring Team reviewed all available historic records and noted that the individual apparently was not exposed previously to neuroleptics or other dopaminergic agents that could account for the dystonia. The Monitor did identify a historic diagnosis of Cerebral Palsy (CP), which was not identified in the current records. | |

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| | | CP could account for this condition, as well as the individual's ataxic gait. If the individual does have a diagnosis of CP, routine follow-up and monitoring of this condition is necessary, at least annually and in the event of any decline in functional abilities.<br><br>The individual is known to have under gone a small bowel resection secondary to peritoneal abscess from appendicitis. The individual is also known to have a diagnosis of chronic constipation and is on anticonstipation medication. His health risk screening, dated December 1, 2010 had not been updated; it rated the individual as a low risk for constipation. This individual requires additional monitoring for possible worsening constipation, bowel obstruction and perforation. The individual was assessed as having a low risk for aspiration, despite his protruding and dyskinetic movements of his tongue. Despite a history of bowel resection, the individual remains a low risk for GI concerns and a low risk for osteoporosis when the individual has been on chronic antiepileptic medications and lives a sedentary life style, both of which are high indicators of osteoporosis in this population. Importantly, despite the individual broad based gait and ataxia, he is determined to be at a low risk for injury.<br><br>Individual: #11<br>The annual physical examination dated April 27, 2010 indicated a diagnosis of a positive PPD, however the Nursing annual evaluation of 2010 was not part of the nursing diagnosis and there was no health care plan to support a positive PPD responder.<br><br>Individual: #133<br>The annual medical evaluation indicated a positive PPD responder and there was no special instruction in the health care plan to address this issue. An annual chest x-ray was obtained on July 15, 2010 that demonstrated no active infiltrates; however, mild cardiomegaly was noted. There was no documentation provided that indicates that the physician followed-up on the reported cardiomegaly. All positive PPD responders must be closely monitored at the living area for signs and symptoms of tuberculosis (such as chronic cough and night sweats) .The Facility does not specifically monitor people who are known PPD responders at the living area.<br><br>Individual: #54<br>The PSP of Individual #54 was noted to comment on the diagnosis of cervical cancer; however, there were no additional monitoring or recommendations for monitoring within the PSP document.<br><br>A chest x-ray dated October 27, 2008 indicated mile COPD, mild cardiac enlargement, | |

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| | | and pulmonary congestion. There was no documentation provided to indicate that there had been follow-up on these reported findings to date. Also, an echocardiogram dated September 11, 2009, indicated a "low normal left ventricular function" of the heart, and an ejection fraction "between 50-55%," along with "trace mitral value regurgitation. " No further cardiac evaluation or monitoring had been recommended by the Facility.. These findings indicate possible underlying cardiopulmonary disease that should be further evaluated, or at least monitored for worsening. There was no indication that such further evaluation or monitoring had been done.<br><br>A Colonoscopy completed on January 9, 2009, diagnosed internal hemorrhoids at the internal anal verge and recommended fiber rich diet and stool softeners. Internal hemorrhoids can exacerbate over time and must be routinely monitored. If unchecked, they can lead to infections, severe pain and discomfort, constipation and bleeding. There was no health care plan in place to address this issue.<br><br>On February 16, 2010, the Facility Physician was asked to evaluate the individual because of worsening gait issues. The physician noted "no involuntary movement of the mouth or lips or abnormal movement of the extremities. " The "objective" component of the assessment was mostly focused on "subjective" information and there was no physical assessment documented, except with the observation of the individuals gait. The physician's assessment reported "probably an EPS secondary her psychotropic medications" and the physician's plan was to "monitor" the individual and obtain a "sodium level" (which was normal). The individual was not seen again until February 11, 2011 On February 11, 2009, an MRI of the brain was obtained to evaluate "facial drooping" and reported diffuse cerebral atrophy, chronic bilateral maxillary sinusitis and no acute infarction. There was no documentation provided that indicated that The findings of sinusitis had been addressed, nor had diffuse cerebral atrophy been commented on. Cerebral atrophy can be the result of small vessel disease and manifest with dementia. Also, the issue of facial droop and sudden onset of gait problems that remit may indicate an underlying cerebrovascular condition, such at transient ischemia,which can be a precursor to stroke. Documentation of further assessment wasnot noted in the records provided for review.<br><br>Individual: #93<br>Individual #93 has a history of a colon polyp and cancer of the prostate.Upon physical examination on July 13, 2010, of this person who is post prostatectomy and bilateral orchiectomy, and history of a colon polyp resection, the exam yielded only one hemoccult for the annual colon cancer screening. When questioned, the treating physician indicated to the Monitoring Team that three hemoccult screenings should be completed. | |

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| | | A nodular opacity of the right lung was reported on a chest x-ray report dated July 9, 2010 and recommended comparing the x-ray with previous chest x-rays or to follow-up in three months with a repeat x-ray to evaluate for stability of the lesion. Neither of these important recommendations were noted to have been completed, following review of the records provided. The Monitoring Team reviewed prior chest x-ray reports and determined that on previous x-rays dated February 2, 2004 and January 30, 2008, such lesions were not described; hence, the findings of the recent x-ray are new lesions that had not been further assessed. Such lesions maybe benign,or may indicate infection, other lung disease, or cancer. In an individual with known cancer, such lesions should be aggressively acted upon, but there was no documentation provided that indicated further evaluation of these lesions.<br><br>An x-ray on July 9, 2010 demonstrated mild degenerative spondylosis of the spine. This issue was not added to the diagnosis and problem lists, nor had it been addressed in the clinical record. Degenerative spondylosis is a serious and progressive disorder that must be incorporated into the person's health care plan and routinely assessed for worsening. Severe pain, discomfort, loss of function and other comorbid condition may manifest in the future.<br><br>A follow-up colonoscopy was completed on December 12, 2010, which demonstrated "prominent internal hemorrhoids". Internal hemorrhoids can exacerbate with time and result in pain, discomfort, serious bowel complications and bleeding. This condition is not listing on the diagnosis or problem list and there was no health care plan in place.<br><br>A GI consult completed on December 12, 2010 had not been signed, dated or commented upon and documentation to support that follow-up on recommendation was not in the clinical record.<br><br>The nursing assessment of January 20, 2011, had no indication for the individual's known degenerative spine condition, history of prostate cancer with orchiectomy, nor internal hemorrhoids.<br><br>Individual: #31<br>A urology consult report dated July 9, 2010 was obtained for swelling of the scrotum. An ultrasound of the scrotum was obtained and demonstrated a right hydrocele, complex fluid collection in the right scrotum, and a moderate varicocele and hydrocele of the left testicle. The Facility physician signed and dated the report but did not document the findings or follow-up plan and the PSP did not contain information regarding this important medical issue that requires follow-up. Such conditions can be painful and cause discomfort, which could be manifesting in his serious behavior issues. Such | |

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| | | findings could also result from trauma.<br><br>Specific to the issues of falls, the physical therapy consult notes and assessments, along with orthopedic and physiatry consultations, annual medical evaluation and imaging diagnostics were reviewed on individuals #143, #140, #80, #5 and #27. Following review the Monitoring Team has concluded there was significant lack of documentation on the part of the Facility as to the etiology of the individuals' neuromuscular condition that maybe precipitating the fall. There was also lack of documentation of physical assessment prior to physical therapy recommendations being made. In addition to evaluating for injury, all individuals who fall must be carefully evaluated as to the nature of the fall and determination of whether an underlying medical issue, such as medication, neurological condition, or other physical condition is precipitating the fall. There was no evidence provided to suggest such a review being made on a routine basis.<br><br>Specific to Emergency Drills, Since the last RGSC tour the Facility had begun conducting Mock Medical Emergency Drills as defined in the Medical Emergency Response Policy. Merle Kraft, Vocational Services Manager, was responsible for the Medical Emergency Response system. Interview with Mr. Kraft and review of completed Mock Medical Emergency Drill Sheets, 8/25/10 through 3/2/11, indicated that drills were conducted monthly, per shift, per home, and at Vocational Services. Review of completed Mock Medical Emergency Drill Sheets validated that drills were conducted according to policy. There was evidence that when staff failed to satisfactorily perform they were retrained on the spot and when necessary the drill was repeated. Staff who required retraining in Cardiopulmonary Resuscitation (CPR) were scheduled for such training. There was no verification that staff sent for retraining on CPR received the retraining. The drills reviewed were completed on an outdated drill form, dated 2/07. Mr. Kraft was reminded that the revised form, dated 7/21/10 should be used and the old form purged. He was agreeable and immediately replaced the form with the 7/10 version. Mr. Kraft stated that he does not maintain a formalized schedule for drills and that he knew when drills were due. He agreed that he should develop and implement a formal drill schedule to ensure that drills were conducted timely.<br><br>There was no documented evidence on the completed Mock Medical Emergency Drill forms reviewed that the physicians participated in any of the drills. There was no evidence that the Medical Director and/or CNE actively participated in the Facility's Medical Emergency Response system. The Monitoring Team discussed with Yolanda Gonzalez, Chief Executive Nurse, Dr. David Moron, Clinical Medical Director, and Dr. Maria Dill, Medical Director, the need for more involvement by the nursing and medical staff in the management and oversight of the Facility's Medical Emergency Response. All agreed that more involvement was needed by the nursing and medical staff in the | |

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| | | management and oversight of the Facility's Medical Emergency Response system. Dr. Moron and Dr. Dill offered ideas for improving the system, such as announcing drills and codes over the Public Address system to ensuring that all staff are aware and respond, including physicians, and those physicians in the Out Patient Clinic, and implementing Code Blue and Code Grey Policies that includes a debriefing by the medical and nursing staff as well as other relevant staff. The monitoring team will follow up on improvement to the Medical Emergency Response system at the next tour.<br><br>The Facility failed to conduct a quarterly trend analysis of Mock Medical Emergency Drills. According to the POI the stated date was 9/2010 with a target date for completion 8/2011. The delay of 11 months for the trend analyses to be completed is not acceptable in identifying issues and trends needed to improve the quality of the drills. Review of the Safety/Risk Management/Infection Control Committee Minutes indicated that the status of completing drills was reported but no trends or recommendation for improvement were included. This information was given to the Risk Manager to report by the Vocational Education Manager. The Facility should consider allowing the Vocational Education Manager to attend the Committee meeting to report the results of the drills and provide tracking over time of trends and patterns in areas of weakness and where corrective action is needed.<br><br>On 2/28/11 at 1:00 p.m., the Monitoring Team, accompanied by Yolanda Gonzalez, RN Chief Nurse Executive, Mary Doris Matabalan, RN, Nurse Operation Officer/Hospital Liaison, Marcy Valdez, RN, Nurse Manager, and Lorraine Hinrichs, ICF-MR Program Consultant, observed a Mock Medical Emergency Drill conducted by Mr. Kraft in Vocational Education Building 510, Room 18. Overall the Mock Medical Emergency Drill was a failure. After the drill a debriefing was conducted with Facility management staff. The following deficiencies were identified:<br>• Only one direct care staff immediately began performing CPR, performing both compressions and breaths. Another staff person should have assisted with one performing compressions and the other breaths. This staff was not relieved by other staff for approximately 15 minutes until the nursing staff arrived.<br>• The direct care staff in the room who was on 1:1 duty with an individual continued to assist with shredding paper and did not acknowledge that the drill was being conducted. This staff should have utilized the radio to summon additional staff to the drill location.<br>• The other Vocational Education staff hesitated to respond as if they did not know what to do at certain stages of the drill.<br>• The two nurses were slow to respond to the drill site. It took approximately 15 minutes for the nursing staff to arrive on the scene. Upon arrival to the scene | |

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| | | the nurses failed to immediately take charge of the drill. They failed to check airway, breathing, and chest compression (ABC) until prompted.<br>It is important to point out that in 2010 the American Heath Association updated CPR guidelines. The order of intervention was changed for all age groups, except newborns, from airway, breathing, and chest compression (ABC) to chest compression, airway, and breathing (CAB). An exception to this is for those who are believed to be in respiratory distress. The Facility should ensure that the updated version of American Hearth Association's curricula CPR is used.<br>• The nurses failed to bring a suction machine, AED, and emergency medication box to the scene. The nurses failed to immediately assemble emergency equipment for use. One nurse had difficulty in opening the oxygen tank and did not demonstrate competent skill and knowledge as to how to do so without prompting.<br>• The emergency equipment was comprised of several pieces of equipment that required timely transport to the scene of the drill, e.g., portable oxygen tank, suction machine, ambu bag, AED, portable red emergency bag, and emergency medication box. The Facility should evaluate the use of a cart to rapidly and conveniently transport all emergency equipment to the scene of an emergency or consider storing emergency equipment, except for emergency medication, in a secured area located in Vocational Services Building.<br>• Only one staff conducts, observes, and records the drill. In order to ensure that the staff conducting the drill pays full attention to observations, the Facility should to consider adding another staff to record the observations.<br><br>As a result of the failed Mock Medical Emergency Drill in the Vocational Education Building, Room 18, all staff were retrained with emphasis on the identified deficiencies. The drill was repeated in the same location on 3/2/11 at 9:29 a.m. and was determined successful. The nursing staff responded within five minutes with the full compliment of emergency equipment.<br><br>Review of RGSC Course Due/Delinquent training report indicated that all staff (100%) were current in their Basic CPR training.<br><br>The February Emergency Equipment and AED Checklists were reviewed. The Checklists were not completed until February 16th. It was positive to find that since the last tour the AED Checklist contained a column to check the expiration date of the defibrillator pads and that all emergency equipment items had been consolidated onto one checklist. The Emergency Checklist for oxygen does not include the pounds per square inch of pressure (psi) remaining in the tanks. The Nursing Department needs to add the pounds per | |

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| | | square inch of pressure (psi) remaining in the oxygen tanks to the Emergency Equipment Checklist. The Nursing Department needs to provide nurses training on how to calculate the psi of oxygen tanks and to know at what point they need to order oxygen. The Nursing Department needs to ensure that Emergency Equipment and AEDs are checked daily.<br><br>RGSC had AEDs and Ambu bags located in the following areas:<br>• Administration Building 503<br>• ICF-MR Homes, Buildings 501 and 502<br>• Vocational Services Buildings 510 and 511<br>• Auditorium Building 507<br><br>The Monitoring Team discussed with the Chief Nurse Executive and Vocational Education Manager the possibility of placing signs in buildings next to the AEDs and other emergency medical equipment to readily alert staff as to their location. Both agreed this was a good idea. The Facility should consider posting signs identifying where AEDs are located throughout the Facility.<br><br>It was positive to find that the electronic exam tables ordered at the last tour for 501 and 502 had been procured, were in place, and operational. The battery operated chair scales were checked and found to be out of battery. The nursing staff immediately replaced the battery and added a column on an existing check sheet to daily check battery operated equipment. It was also positive to find since the last tour that the Nursing Department had assigned a Clerk II the task of tracking all orders for medical equipment and supplies along with a procurement card. During the last tour, the Monitoring Team suggested that the Facility replace the non-professional Glucometers with professional grade Glucometers to ensure the accuracy and reliability of blood glucose checks. The Facility had not procured the professional grade Glucometer. The Chief Nurse Executive stated that the Facility was in the process of purchasing professional grade Glucometers. This was validated through review of e-mail documentation from the Fiscal Officer. The Facility was using a 'trial" Glucometer that they planned to purchase. All nurses had been trained to use the Glucometer. The Nursing Department needs to ensure that professional grade Glucometers are purchased. This issue will be followed up at the next tour.<br><br>Appointments continued to be scheduled and entered into the Appointment Database with current schedules printed and posted on the nurses' bulletin board for quick reference. The Nursing Department needs to ensure that nurses performing the nightly record checks for Physician's Orders also cross-checks orders for appointments with the | |

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| | | database to ensure that appointments are entered and scheduled as well as checked for missed appointments and their rescheduling. | |
| 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 Facility had engaged the services of two non-facility, primary care physicians, to review primary care services at the Facility. The intent of this process is to review a random 10% sample of all individuals who reside at the Facility each month, and to identify deficiencies and develop a trends analysis which can be used longitudinally, and used to enhance clinical practice. Only two cases had been completed by the last day of the Monitor's review of the Facility; hence, the sample size was too small and not timely to be evaluated for efficacy.<br><br>This is a robust effort on the part of the Facility and as long as the process is comprehensive, and provides meaningful review, the Facility should be on track for substantial compliance with provision L1 of the Settlement agreement. | Noncompliance |
| 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. | At the time of this review the Facility had not completed developing a comprehensive mechanism to maintain a medical quality improvement process that collects data relating to the quality of medical services, assess related data, and initiate outcome studies and process improvement. Based on these findings, the Monitoring Team has concluded that the Facility remains non-compliant with Provision L3. | Noncompliance |
| 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 | At the time of this review the Facility had implemented policies and procedures that ensure provision of medical care that is consistent with current, generally accepted professional standards of care. To gain compliance the Facility had begun attending weekly medical directors meetings held by the State Office, in which issues addressed and protocols are developed. Until State Office procedures have been completed and adopted, the Facility will follow standards put forth in Conn's Current Therapy 2011 and The Care of the Geriatric Patient, 3rd Edition. The Monitoring Team concurs with utilization of both resources; however, the Monitoring Team highly recommends using clinical judgment and available literature when addressing complex issues in persons with developmental disabilities. Presentation of clinical signs and symptoms, diagnostic strategies, and results, and response to treatment may vary significantly in persons with | Noncompliance |

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| | compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | developmental disabilities. | |

1. An immediate and comprehensive review of primary care services must be performed.

2. The PST must be aware of all clinical issues, develop a plan for each known condition and ensure that the PSP clearly delineates action steps.

3. Health care plans must be complete and meaningful for each known health care issue.

4. The guardian must be well aware of all clinical conditions.

5. Ensure that the Facility is adhering to current standardized recommendations for health care maintenance, especially for colon cancer screening.

6. All consult and diagnostic reports must be reviewed and attended to by the physician. Recommendations and abnormal findings must have an action plan that is well documented.

7. Diagnosis and problem list must be updated and accurate.

8. Nursing assessment must be enhanced and ensure to include all active diagnosis and related health care issues that require monitoring.

9. Health risk screening is completely inaccurate and must be revised. The health risk screening must be revised on each individual.

10. Peer review process must ensure that documentation practice and appropriate follow-up to all identified health care condition, consultations and diagnostics are timely and meet or exceed currently accepted practice standards.

12. When addressing medical issues, be aware that many individual with developmental disabilities present differently with signs and symptoms, require specialized diagnostic procedures, manifest subtle differences in diagnostic results and respond differently to treatment then those of the general population.

13. A formal emergency drill schedule should be developed and maintained to ensure drills are conducted regularly in all areas of the Facility.
14. Nursing and medical staff must participate in emergency drills.
15. The Facility needs to ensure that the updated, 2010, version of American Heart Association's curricula for CPR is used.
16. The Nursing Department needs to add the pounds per square inch of pressure (psi) remaining in the oxygen tanks to the Emergency Equipment Checklist.
17. The Nursing Department needs to provide nurses training on how to calculate the psi of oxygen tanks and to know at what point they need to order oxygen.
18. The Nursing Department needs to ensure that Emergency Equipment and AEDs are checked daily.
19. The Nursing Department needs to ensure that professional grade Glucometers are purchased.
20. The Nursing Department needs to ensure that nurses performing the nightly record checks for Physician's Orders also cross-check orders for

appointments with the database to ensure that appointments are entered and scheduled as well as checked for missed appointments and their rescheduling.

The following are offered as additional suggestions to the facility:

1. The Facility should consider allowing the Vocational Education Manager to attend the Safety/Risk Management/Infection Control Committee meeting to report the results of the drills and provide tracking over time of trends and patterns in areas of weakness and were corrective action is needed.
2. The Facility should evaluate the use of a cart to rapidly and conveniently transport all emergency equipment to the scene of an emergency or consider storing emergency equipment, except for emergency medication, in a secured area located in Vocational Services Building.
3. In order to ensure that the staff conducting the drill pays full attention to observations, the Facility should to consider adding another staff to record the observations.
4. The Facility should consider posting signs identifying where AEDs are located throughout the Facility.

| SECTION M: Nursing Care | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement Plan (POI) updated 2-17-11<br>2. RGSC Standard Operating Procedure (SOP) MR 500 01, Physical Nutritional Management Training, Date Established: December 2003, Revised: January 2010<br>3. RGSC SOP MR 100 18, Medical Emergency Response, Date Established: September 2003, Revised: February 2011<br>5. RGSC SOP MR 400 10, Scheduling Medical Appointments, Date Established: June 2002, Reviewed: February 2010<br>6. RGSC SOP MR 200 49, Use of Restraint, Revised: November 2009, Revised: August 2010<br>4. RGSC SOP MR 700 14, Use of Restraint, Revised February 2011<br>5. RGSC Environment of Care Manual, Standard Operating Procedure EC404-05, Report of Employee Infections, Date Established: July 1992, Revised: September 2010<br>6. RGSC Nursing Manual: SOP NR200-73, Urinary Intermittent Catheterization, Date Established: June 2004, Revised: August 2010<br>7. RGSC SOP EC 407-02, UTI (Urinary Tract Protocol), Date Established: February 9, 2011<br>8. RGSC Nursing Manual: SOP NR200-55, Pre-Treatment and Post-Sedation Monitoring, Date Established: February 2011<br>9. RGSC ICF-MR Services Organizational Chart, 10/27/10<br>10. RGSC ICF-MR Nursing Training Courses, including course title, number of participants trained by course, and date of training, 6/8/10 through 12/22/10, including Percentage of nurses trained per topic, and monthly graphs for percentage of training occurring June 2010 through December 2011<br>11. RGSC Nursing Orientation Manual and Competencies<br>12. RGSC Nursing Staff Analysis July 2010 through December 2010<br>13. RGSC Nursing Services Staffing Plan La Paloma and El Paisano, NR 100-05<br>14. RGSC Safety/Risk Management/Infection Control Committee Minutes, August 13, 2010, September 9, 2010, October 14, 2010, November 10, 2010, and December 14, 2010<br>15. RGSC MR Nurse's Meeting Minutes, August 31, 2010, September 27, 2010, October 13, 2010, November 18, 2010, December 9, 2010, January 28, 2011, and February 18, 2011<br>16. RGSC 24 hour Chart Check Review of Orders, February 2011<br>17. RGSC ICF-MR Monitoring Tool for Scheduled Medical/Dental Appointments, February 2011<br>18. RGSC Physical/Nutritional Management Team Meeting Minutes, 8/24/10, 10/14/10, and 12/16/10<br>19. RGSC Pharmacy and Therapeutic Sub-Committee Meeting Minutes, ICF-MR Area, 6/23/10, 9/15/10, and 3/2/11<br>20. RGSC Medication Management Team Meeting Minutes, 8/25/10, 10/14/10<br>21. RGSC Infection Control Reports for Forth Quarter 2010,First and Second Quarters 2011 and Monthly Infection Control Reports, June, July, August, September, October, November, and December 2010<br>22. RGSC Nursing Department Meeting Minutes with Valley Baptist Hospital, 9/21/10, 10/27/10, and |

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| | 1/31/11<br>23. RGSC Hospital Admissions January 2010 through January 2011<br>24. RGSC Emergency Room Record, January 2010 through December 2010<br>25. RGSC ICF-MR Emergency Room Visits Pie Chart, August 2010 through January 2011<br>26. RGSC Dysphagia Consultation Report – Physician Report and Recommendation for Individual #47, on 7/22/10 and 1/27/11 and Individual #126 on 8/26/10<br>27. RGSC Environment of Care Manual, Surveillance, Prevention, and Control of Infection Manual, Table of Contents<br>28. RGSC Infection Control Training Curricula, including training materials<br>29. RGSC Memorandums from Infection Control Preventionist to Unit Nurse Manager regarding corrective action: 7/22/10 (four memorandums issued), 10/6/10 (two memorandums issued), 12/9/10, and 12/9/10<br>30. RGSC Infection Control Fiscal Year Monitoring Indicators Results:<br>• IC.01.03.01 (5) Prioritize identified risk for acquiring and transmitting infections.<br>• IC.01.04.01 (5) Monitoring and improving compliance with hand hygiene guidelines.<br>• IC.02.01.01 (8) Report surveillance, prevention and control information to appropriate hospital [facility] staff.<br>25. RGSC Infection Control Monthly Surveillance Checklist, June 2010 through November 2010<br>26. RGSC Environment of Care Manual, Surveillance, Prevention, and Control of Infection Manual for Employee Health, Table of Contents<br>27. RGSC Drug Utilization Report – Antibiotics, Date: 1/1/11 through 1/31/11 and 2/1/11 through 2/28/11<br>28. RGSC Active Employee Course Participation Report for Infection Control Training, 3/2/11<br>29. RGSC Preliminary Quarterly TB Report<br>30. RGSC Purified Protein Derivative (PPD) Questionnaires, 2/1/11 thru 2/28/11<br>31. RGSC Infection Control: Trend Analysis Report Summary – Final Baseline Report, Initial Full chart Review (Comprehensive Preventative Health Database)<br>32. RGSC Confidential Infection Control Preventionist/Nurse Educator Individual Client Report for Individuals: #4, #55, #33, #72, #108, #63, #61, #29, #82, #35, and #140<br>33. Influenza Immunization Program FY11 – Second Quarter<br>34. Health-care Associated Infections (HAI) Report First Quarter<br>35. RGSC Trend of Pneumonia Cases for FY 2008, 2009, and 2011<br>36. RGSC Job Descriptions for Employee Health Coordinator Nurse and Infection Control Preventionist/Nurse Educator<br>37. RGSC Course Due/Delinquent Report for Infection Control<br>38. RGSC Nursing Auditing Tools:<br>• Quarterly Medication Administration Observation conducted by Unit Nurse Manager<br>• Quarterly Departmental Indicators conducted by Unit Nurse Manager<br>• Monthly Submissions conducted by Unit Nurse Manager<br>• Medication Administration Record (MAR) Monthly Audit |

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| | • Monitoring Tools for Section M and Q conducted monthly by Quality Enhancement (QE) Nurse and Nurse Operating Officer (NOO)<br>38. RGSC Completed Nursing Audits Reviewed:<br>• Medication Passes Observation<br>• Departmental Performance Indicators<br>• Monthly Submissions<br>• Medication Audits<br>• Monitoring Tools for Sections M<br>39. RGSC Medication Administration Observation Schedule<br>40. RGSC Personal Support Plan (PSP) Schedule<br>41. RGSC Annual and Quarterly Nursing Assessment Tracking Tool<br>42. RGSC Nursing Orientation Manual and Competencies<br>43. RGSC Last Ten Medication Errors<br>44. RGSC Slip Trip and Falls Data Analysis for FY 2011<br>45. Department of Health and Human Services, Center for Medicare and Medicaid Services Survey, 12/9/10 and 1/27/11<br>46. RGSC Health Risk Status List<br>47. Records reviewed for Individuals: #55, #72, #4, #93, #63, #36, #149, #86, #126, #80, #15, #62, #94, #79, #54, #60, #29, #59, #12, #5, #33, #140, #145, #23, #47, #108, #61, #3, #82, #11, #97, #77, #35, #84, #59, and #122<br>**People Interviewed:**<br>1. Yolanda Gonzalez, RN Chief Nurse Executive<br>2. Mary Doris Matabalan, RN, Nurse Operating Officer/Hospital Liaison<br>3. Jessica Juarez, RN, Quality Enhancement Nurse<br>4. Marcy Valdez, RN, Unit Nurse Manager<br>5. Maria Dill, M.D., Medical Director<br>6. Robin Martin, RN, Infection Control Preventionist/Nurse Educator<br>7. HerlindaDeVera, M.D. Staff Physician<br>8. David Moron, M.D., Clinical Director<br>9. Samantha Salinas, Associate Psychologist<br>10. Lorraine Hinrichs, ICF-MR Program Consultant<br>11. Numerous Staff Nurses and Direct Care Professionals<br>**Meetings Attended/Observations:**<br>1. Meeting with Yolanda Gonzalez, RN Chief Nurse Executive, Mary Doris Matabalan, RN, Nurse Operating Officer/Hospital Liaison, and Marcy Valdez, RN, Unit Nurse Manager, 11:00 a.m., 2/28/11<br>2. Observed Mock Medical Drill in Vocational Services Area, at 1:00 p.m., 2/28/11<br>3. Personal Support Plan Quarterly Review Meeting for Individual #140 and #63, 2/28/11<br>4. Building tour of El Paisano, 501 and La Paloma, 502 throughout the day of 3/1/11<br>5. Medication Administration Observations in El Paisano, 501 and La Paloma, 502, at 11:00 a.m. to 12:00 noon and from 3:00 p.m. to 4:00 p.m., including Enteral Nourishment Administration in La Paloma, |

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| | 3/1/11<br>6. Physical and Nutritional Management Team (PNMT) Meeting in 507 Conference Room at 2:00 p.m., 3/1/11<br>7. Meeting with Merle Kraft, Vocational Manager regarding Mock Medical Drills, at 10:30 a.m., 3/2/11<br>8. Pharmacy and Therapeutic Committee Meeting, at 1:30 p.m., 3/2/11<br>9. Meeting with Jessica Juarez, RN, Quality Enhancement Nurse and Marcy Valdez, RN, Unit Nurse Manager., regarding Medication Errors<br>10. Meeting with Robin Martin, RN, Infection Control Preventionist/Nurse Educator, Dr. Maria Dill, MD, Medical Director, and Jessica Juarez, RN, Quality Enhancement Nurse at 1:30 p.m., 3/3/11, regarding Infection Control issues<br>11. Meeting with Yolanda Gonzalez, RN Chief Nurse Executive, Mary Doris Matabalan, RN, Nurse Operating Officer/Hospital Liaison, Marcy Valdez, RN, Unit Nurse Manager, and Jessica Juarez, RN, Quality Enhancement Nurse to review documents requested, at 4:00 p.m., 3/3/11 |
| | **Facility Self-Assessment:**<br>M.1 Provision: The Facility's POI stated they are not in compliance with this provision. The Facility reported the Nursing Department was training direct care professionals on health care plans and had ceased the practice of direct care professionals training other direct care professionals on the healthcare plan. The Facility had begun using the Nursing Monitoring Tools revised by the State Office. The Nursing Monitoring Tools had been used to evaluate one individual's record. The Monitoring Team agrees with the Facility's self assessment for this provision. There was evidence the nursing staff were training the direct care professionals on heath care plans. There was documented evidence that the Nursing Department and Quality Enhancement Nurse had review one individual record using the revised Nursing Monitoring Tools.<br><br>M.2 Provision: The Facility's POI stated they are not in compliance with this provision. The Facility reported that the Nursing Monitoring Tools had been used to evaluate one individual's record. The Personal Support Plan Policy was operationalized. The Monitoring Team agrees with the Facility's self assessment for this provision. There was documented evidence that the Nursing Department and Quality Enhancement Nurse had reviewed one individual record using the revised Nursing Monitoring Tools.<br><br>M.3 Provision: The Facility's POI stated they are not in compliance with this provision. The Facility reported they had begun 'Supporting Visions' training for current employees and administrative staff. Ongoing training continues in new employee orientation and for persons unable to attend since 10/2010. The Personal Support Plan Policy was operationalized, 1/31/11. The Facility received the At-Risk Individual Policy from the State Office on 12/20/10. In 1/2011 the At-Risk Individual Policy was pending committee approval. The Monitoring Team agrees with the Facility's self assessment for this provision.<br><br>M.4 Provision: The Facility's POI stated they are not in compliance with this provision. The Facility reported that the Unit Nurse Manager attended Physical and Nutritional Management Training on 10/2010, at Corpus Christi. The Monitoring Team agrees with the Facility's self assessment for this provision. |

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| | M.5 Provision: The Facility's POI stated they are not in compliance with this provision. The Facility reported they had begun 'Supporting Visions' training for current employees and administrative staff. Ongoing training continues in new employee orientation and for persons unable to attend since 10/2010. The Personal Support Plan Policy was operationalized, 1/31/11. The Monitoring Team concurs with the Facility self assessment for this provision.<br><br>M.6 Provision: The Facility's POI stated they are not in compliance with this provision. The Facility reported on 11/20/10 the Nurse Operating Officer and Unit Nurse Manager prepared a schedule to ensure that all nurses were observed administering medications, at least quarterly. On 12/8/10 the 10 to 6 shift Registered Nurse (RN) was hired and had begun completing chart checks during the night shift and reported variances to the Unit Nurse Manager. On 1/2011 the revised trend analysis for FY 2011 medication errors was implemented. Trend analyses were reviewed by the Pharmacy and Therapeutic Committee quarterly. The Monitoring Team concurs with the Facility's self assessment for this provision. The revised trend analysis was implements and showed improvement from the previous version. There was evidence that medication trend analyses were reported at the quarterly Pharmacy and Therapeutic Committee Meetings. |
| | **Summary of Monitor's Assessment:**<br>M.1 Provision:<br>The Facility's POI stated they were not in compliance with this provision and the Monitoring Team concurs. Some improvements were identified since the last tour. The Nursing Department had hired additional Nurse Case Managers and was in the process of implementing a Nurse Case Management system. A RN had been hired for the 10 to 6 shift to ensure that there was an RN present on all shifts at all times. The Nursing Department had consistently maintained the required nursing ratios for each shift and had continued to minimize the use of agency nurses.<br><br>The Nursing Department in collaboration with the Quality Enhancement Nurse had begun using the revised Nurse Monitoring Tools. The Nursing Department had also developed and implemented other audit tools to help improve the quality of care. The Nursing Department needs to continue to strengthen their ability trend and analysis data derived from the audits and develop plans of corrective action that are tracked through to resolution.<br><br>The Nursing Department had significantly improved communication with the local hospital. The Hospital Liaison Nurse consistently visited and/or communicated by telephone with hospital personnel when individuals were hospitalized. There was documentation in the Integrated Progress Notes regarding the nursing staffs' communication with hospital personnel when individuals were being sent to the emergency room or hospital and prior to discharge.<br><br>The greatest weakness found related to the nursing staffs' management of acute illnesses/injuries. Nurses did not consistently comply with Settlement Agreement and Health Care Guidelines requirement for managing acute illnesses/injuries by completing comprehensive nursing assessments, monitoring each |

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| | shift and/or daily the efficacy of treatments and/or medications and side effects, establish an individualized Acute Care Plan and train the direct care professionals, and follow through to resolution of the identified problems. The nursing staff failed to consistently use the SOAP method of charting.<br><br>M.2 Provision: The Facility stated it was not in compliance with this provision and the Monitoring Team concurs with the Facility's findings. Through the use of the revised Comprehensive Nursing Assessment Form the assessments were more complete and contain more substantive clinical data. However, much improvement is needed to meet compliance with the Settlement Agreement and Health Care Guidelines. The Nurse Case Managers failed to consistently identify all of individuals' health care problems, provide nursing diagnoses, and establish individualized Health Management Plans to address the nursing diagnoses. The nursing summaries consisted primarily of raw clinical data and failed to analyze and summarize each identified nursing problem in terms of individuals' health status toward established goals to measure whether individuals were progressing, maintaining or regressing as compared from quarter to quarter. The Nurse Case Managers need additional training in completing and analyzing nursing assessments.<br><br>M.3 Provision: The Facility stated it was not in compliance with this provision and the Monitoring Team concurs with the Facility's findings. The Nursing Department continued to use the Health Care Protocols for Developmental Disability Nurses. This provision failed consistently to meet the requirements of the Settlement Agreement and Health Care Guidelines for developing individualized Health Management Care Plans and Acute Care Plans. The stock care plans from the Health Care Protocols were used exclusively without much, if any, individualization to meet the individuals' unique health care needs. Often there were no Health Management Plans developed for nursing diagnoses identified in the Comprehensive Nursing Assessments. Most care plans failed to contain documentation validating that the direct care professionals were trained in their responsibilities related to the plans. The nurses failed consistently to document in the Integrated Progress Notes that the care plans were established and that direct care professionals were trained. There was no documentation on the Health Management Plans that they were reviewed and/or revised on a quarterly or annual basis. Typically, the plans would state they were "ongoing." The same was true for Acute Care Plans. Acute Care Plans were not consistently established for acute illnesses/injuries; if established, they were frequently several days after the acute illnesses/injuries were identified. Acute Care Plans were not individualized and were copied directly from the stock care plans. As with the Health Management Plans, most care plans failed to contain documentation validating that the direct care professionals were trained in their responsibilities related to the plans. The nurses failed consistently to document in the Integrated Progress Notes that the care plans were established and that the direct care professionals were trained. It was rare to find that Acute Care Plans were noted to be resolved. The nursing staff needs to be re-trained until they achieve competency in developing Health Management and Acute Care Plans. Acute Care Plans and/or Health Management Plans for individuals prescribed for psychoactive medications were rarely found.<br><br>M.4 Provision: The Facility stated it was not in compliance with this provision and the Monitoring Team concurs with the Facility's findings. Some of the policies and procedures the State Office Nurse Workgroup |

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| | were developing had not been finalized and will need to be incorporated in the Nursing Department's policies and procedures. The Nursing Department and Infection Control Program were revising their Medication Administration/Medication Error and Infection Control Polices and training curricula independent of the State Office Nurse Workgroup. It is important that the Facility's polices are consistent with those developed by the State Office Nurse Workgroup. The Nursing Department had developed and implemented a comprehensive database for tracking training completed by the nursing staff. The ability to track training should facilitate timely completion of required training.<br><br>M.5 Provision: The Facility stated it was not in compliance with this provision and the Monitoring Team concurs with the Facility's findings. However, this provision had made significant progress in meeting compliance with the Settlement Agreement and Health Care Guidelines. It was apparent through review of documents and interviews with the Infection Control Preventionist/Nurse Educator and Medical Director that the Facility had continued to make improvements toward compliance. The most notable improvement was the Trend Analysis Report Summary – Final Baseline Report. The baseline trend analysis was based on review of 100% of individuals' records for status of compliance with immunizations and of preventative health indicators. The Infection Control Program was beginning to issue plans of corrective action for areas of Infection Control were deficiencies were identified. However, there was no database for tracking plans of corrective action through to resolution. Therefore, it was not possible to determine if the plans of corrective action were completed. The Infection Control Policy and training curricula were in the process of being revised. The nursing staff did not consistently follow the Settlement Agreement and Health Care Guidelines for Urinary Tract Infections and Acute Illnesses. The Infection Control Preventionist/Nurse Educator needs to be proactive in monitoring nursing care, developing plans of corrective action for identified deficiencies, and provide nursing staff with education related to infections. The At-Risk Individuals Policy had been operationalized and sent to Quality Management for review but was not finalized at the time of the review.<br><br>M.6 Provision: The Facility stated it was not in compliance with this provision and the Monitoring Team concurs with the Facility's findings. The Nursing Department in collaboration with the Pharmacy Department and with the assistance of the Quality Enhancement Nurse had made significant improvements in reporting and investigating medications errors and in the medication error database to track, trend and analyzed data. The Nursing Department had begun conducting Medication Administration Observation of nurses on a quarterly basis. The Facility continued to lack a space for individuals to receive their medication in privacy. The Pharmacy sends medications that required the nurses to split the tablets for the correct dosage. This was not an acceptable practice due the potential for an inaccurate dose since tablets may not always split equally and the desired therapeutic may not be achieved. The Pharmacy needs to evaluate this practice. The MediMAR electronic system as used at RGSC slowed the process of administering medications, caused duplicate documentation with the potential for documentation errors, and caused situations in which the likelihood of medication errors increased. |

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| M1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status. | <u>Nursing Staffing</u><br>Since the last tour the Nursing Department had made several improvements in nursing staffing and organization. The Chief Nurse Executive reports directly to the Superintendent with the Nurse Operating Officer reporting to the Chief Nurse Executive. The Nurse Operating Officer was responsible for oversight of all nursing staff, who report directly to her as opposed to the Unit Home Managers. There were two vacant Registered Nurse (RN) positions. Review of Nursing Services Staffing Plan, required one RN and one Licensed Vocational Nurse (LVN) on each shift each day in both La Paloma and El Paisano. A RN II was hired on 12/8/10 for the 10 to 6 shift. Review of nursing staffing analyses for the last six months indicated the minimum staffing ratios were consistently met. The use of agency nurses had decreased and they were seldom used.<br><br>The Nursing Department plans to hire another Unit Nurse Manager starting March 16, 2011. The Nursing Department was in the process of implementing a Nurse Case Manager System with a specified caseload. Functional nursing responsibilities were established by level of nurse, as listed below:<br>• RN III<br>o Staffing<br>o Quarterly and Annual Comprehensive Nursing Assessments<br>o MOSES and DISCUS Assessments<br>o Supervision of Charge Nurses<br>o Documentation<br>o Audits<br>• RN II<br>o Referrals<br>o Assessments<br>o Documentation<br>o Help with RN III Caseload<br>• LVN III<br>o Medication Administration<br>o Treatments<br>o Referrals<br>o Documentation (hands-off communication)<br><br><u>Audits, Monitoring, and Quality Assurance</u><br>Beginning on 1/17/11, the Unit Nurse Manager and Nurse Operating Officer began selecting three cases from each home on a monthly basis to audit current Physician's Orders. Review of Physician's Orders for February 2011 indicated 32% compliance with the criteria on the audit tool. The completed audit tools for Scheduled Medical/Dental | Noncompliance |

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| | | Appointments for February 2011 indicated 83% compliance. There were no trend analyses performed on these audits for review nor were there plans of corrective action documented on the forms; therefore, it was not possible to determine what if any efforts were being made to improve compliance with the items listed on the audit tools. To merely perform chart audits and identify deficiencies without a plan of corrective action carried through to resolution is meaningless. The RN II hired for the 10 to 6 shift was to be responsible for monitoring 100% of the new Physician's Orders written each day, reviewing printed Medication Administration Records (MARs), and comparing printed MARs with Physician's Orders and Client Work Station (CWS). Any identified errors for which the RN II cannot correct were referred to the Unit Nurse Manager or Pharmacist. The 24 Hour Chart Check audit tool to be used by the 10 to 6 shift RN II contained the following items: 1. Date/Time of order;2. Was the order inputted correctly into CWS; 3. If order is a treatment not entered into CWS, was the order entered into treatment book correctly;4. Was a 24 hour Chart Check performed. The audit failed to ask if the Physician's Orders were carried out. The Nursing Department needs to add another item on the Chart Check Audit form asking if the Physician's Orders were carried out. The 10 to 6 shift RN II needs to check that Physician's Orders werenot only transcribed but also carried out, e.g., orders for consults, diagnostic procedures, lab work, appointments and other relevant orders. In addition, deficiencies identified through the 24 Hour Chart Check needs to have a plan of corrective action documented and evidence that corrective action was carried through to resolution.<br><br>Since January 2011the Facility began using the Nursing Monitoring Tools modified by the State Office. The State Office modified nursing Monitoring Tools from 21 tools to 12 tools. The revised Nursing Monitoring Tools included:<br>1. Nursing Care: Acute Illness and Injury<br>2. Nursing Care: Annual Nursing Assessment and Quarterly Nursing Assessment combined<br>3. Nursing Care: Documentation<br>4. Nursing Care: Infection Control<br>5. Nursing Care: Management of Chronic Respiratory Distress<br>6. Nursing Care: Medication Administration and Documentation<br>7. Nursing Care: Annual Nursing Care Plans, combined the following Care Plans:<br>a. Psychotropic Medications<br>b. Bowel Management<br>c. Hypertension<br>d. Gastroesophageal Reflux (GERD)<br>e. Aging<br>f. Incontinence and Urinary Tract Infections<br>g. Diabetes | |

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| | | 8. Nursing Care: Pain Management<br>9. Nursing Care: Prevention<br>10. Nursing Care: Seizure Management<br>11. Nursing Care: Skin Integrity Assessment<br>12. Nursing Care: Urgent Care/Emergency Room Visits, and Hospitalizations<br><br>The Facility's plan for selecting the number of records to monitor, frequency, method for record selection for audit, and threshold for percentage of compliance were not made available for review. One individual's record had been monitored using all 12 Nursing Monitoring Tools. The Nursing Monitoring Tools revised by the State Office had associated interpretive guidelines for use with the monitoring tools to ensure that specific criteria, which constitute compliance with each item, were clearly identified so that all staff completing the monitoring tools used the same criteria to measure compliance with each item on the tool. It was not evident to the Monitoring Team that these interpretive guidelines were followed. The monitoring process must also measure the quality of care and supports given. In addition to the interpretive guidelines the Facility needs to establish an inter-rater reliability process to ensure that data are generated accurately and reflect the criteria being monitored. This will ensure that all disciplines were using the same procedure so that data across disciplines were accurate and reliable. Without accuracy and reliability, the analysis and interpretation of the data may be skewed and trends not accurately identified.<br><br>The Nurse Operating Officer, Infection Control Preventionist, and Quality Enhancement Nurse completed the monitoring tools. At the time of the review only one individual's record was monitored with all 12 tools. The Urgent/Emergency Room Visits, and Hospitalizations tool was not included in the tools reviewed; rather, the Dental Monitoring Tool was used. Monitoring of one individual's record did not result in enough data to perform a trend analysis or systemic plan of corrective action. Because of the numerous changes made in the monitoring tools, the current data could not be accurately compared to the data generated from the previous monitoring tools. Many deficiencies were identified in the one record reviewed; however, no plan of corrective action was documented on the specific tool for which the deficiencies were identified. Review of the Nursing Monitoring Tools will be done at the next tour. Example of percentage of total compliance scores derived from the one record monitored with the 12 Nursing Monitoring Tools included:<br>1. Nursing Care: Acute Illness and Injury: 53% compliance<br>2. Nursing Care: Annual Nursing Assessment and Quarterly Nursing Assessment combined: 69% compliance<br>3. Nursing Care: Documentation: 54% compliance<br>4. Nursing Care: Infection Control: 60% compliance | |

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| | | 5. Nursing Care: Management of Chronic Respiratory Distress: 100% compliance<br>6. Nursing Care: Medication Administration and Documentation: 89% compliance<br>7. Nursing Care: Annual Nursing Care Plans, combined the following Care Plans: 30% compliance<br>8. Nursing Care: Pain Management: 75% compliance<br>9. Nursing Care: Prevention: 46% compliance<br>10. Nursing Care: Seizure Management: Not Applicable, individual did not have a seizure diagnosis<br>11. Nursing Care: Skin Integrity Assessment: 71% compliance<br>12. Dental: 71% compliance<br>The Facility needs to ensure that all nursing staff completing the Nursing Monitoring Tools are trained on, and apply, the associated interpretive guidelines such that specific criteria which constitute compliance with each item are clearly identified, and that all staff use the same criteria to measure compliance with each item on the tools. The monitoring process must also measure the quality of care and supports given. The Facility needs to ensure that the Nursing Care: Urgent, Emergency Room Visits, and Hospitalization Tool is used.<br><br><u>Accessibility of Medical Records and Quality of Documentation</u><br>Since the last tour the Facility's record keeping practices improved significantly for records contained in binders. Documents were organized, accessible, and it was easy to locate relevant information. The integrated Progress Notes contained in the CWS continued to make it difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of individuals' clinical status. This posed a barrier when integrating clinical data into a useful manner. While completing record reviews on the Integrated Progress Notes for the last six months related to nursing care, each and every single entry had to be accessed and aggregated together. It was not functionally practical to access chronologically notes from all other disciplines to evaluate nursing's integration of services with other disciplines and gain a true clinical picture of individuals care; for example, physicians' notes were separate and could not be integrated to see a chronological order of notes. For the the Integrated Progress Notes in the CWS system to be useful for integrating services, the system must allow easy access to notes from all disciplines to be reviewed chronologically. Otherwise, there is the potential for vital health related data to be overlooked in making critical clinical decisions.<br><br>Review of individuals' records identified the following trends: The nursing staffs' handwriting legibility had not improved significantly, some signatures, titles, and initials remained difficult, if not impossible, to read. The nursing staff failed to consistently document in the SOAP (Subjective, Objective, Analysis of problems, and Planning) even | |

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| | | though a template was set up in the CWS system. The quality of the nursing documentation was poor. When acute illnesses and injuries were identified, comprehensive nursing assessments were not consistently completed and problems were not documented through to resolution. When an individual complained of pain and/or received pain relief medications, the nursing staff failed to consistently document assessment of pain and effectiveness of the pain relief medication using the FLACC (Face, Legs, Arms, Cry, and Consolability) Pain Scale as required by policy. According to the Health Care Guidelines when individuals' health care issues are identified there must be follow-up documentation reflecting status of the problem, actions taken and response to treatment at least once per day until the problem was resolved. It was rare to find documented communication with other interdisciplinary team members. Numerous late entries were found in the Integrated Progress Notes. It was rare to find documentation following the initiation of a new treatment or medication that included the efficacy of the treatment or medication or instructions to the individual and direct care professionals. The exception to these findings was documentation completed by the Nurse Operating Officer/Hospital Liaison and nursing staff when individuals had emergency room visits and/or Hospitalizations. The Nursing Department needs to continue to retrain nursing staff until competency is achieved in documenting in the SOAP format. The Nursing Department needs to continue to retrain nursing staff until competency is achieved in completing nursing assessments and documentation of identified changes in health status, acute illnesses and/or injuries, and/or when new treatments and/or medications are initiated.<br><br><u>Acute Illnesses Requiring Emergency Room Visits/Hospitalizations</u><br>It was positive to find since the last tour the Chief Nurse Executive and Nurse Operating Officer/Hospital Liaison had established formal communication with the Valley Baptist Hospital. This was evidenced through review of routine meeting minutes with Valley Baptist Hospital, interview with the Chief Nurse Executive, and Nursing Operating Officer. As a result of the enhanced communication with Valley Baptist Hospital personnel when individuals were discharged from the hospital there were nurse-to-nurse conferences prior to individuals' being discharged from the hospital. RGSC nursing staff were given access to Valley Baptist Hospital's lab results via Sunquest software to immediately access critical lab results. Procedures are underway for the RGSC nursing staff to access the hospital's electronic record system to review and print individuals' records during hospitalization. Valley Baptist Hospital has agreed to provide RGSC with a new centrifuge and blood collecting tubes to ensure quality of stability with blood results.<br><br>Review of individuals' records who had recent emergency room visits and/or hospitalizations demonstrated that the Hospital Liaison Nurse, as well as other nursing | |

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| | | staff, communicated routinely with hospital personnel prior to admission, during hospitalization, and prior to discharge. There was evidence that the Hospital Liaison Nurse made frequent visits to individuals hospitalized, documented visit findings in the Integrated Progress Notes contained in CWS, and kept other team members apprised of individuals' health status. The enhanced communication identified in these records between the RGSC nursing staff and hospital nursing staff demonstrated significant improvement in coordinating care for individuals seen in the emergency room and those admitted to the hospital.<br><br><u>Review of Acute Illnesses and/or Injuries</u><br><br>Review of records for individuals: #54, #60, #80, #55, and #11, showed some improvements in the assessment and management of individuals with acute illnesses; however, there remained room for continued improvement, as demonstrated in the examples listed below:<br><br>• Individual #54: On 12/22/10 at 5:27 a.m., the nurse documented in the Integrated Progress Notes that Individual #54's blood pressure was 142/78, was restless, and wanted to stay in bed. The nurse stated she would monitor Individual #54 for any further problems. No other vital signs were documented. At 9:06 a.m. the nurse notified the physician of Individual #54's abnormal lab results for sodium at 122. The physician ordered Individual #54 sent to the emergency room. At 9:35 a.m. the nurse documented that Individual #54 was transported to the emergency room by facility van. The nurse failed to document if medical information was sent to the hospital with Individual #54 or if he was accompanied by staff. There was documentation that Individual #54's family was notified of the transfer. At 11:26 a.m. the nurse called the hospital to check on the individual's status. At that time Individual #54 had been evaluated but not treated. At 4:55 p.m. Individual #54 was admitted to the hospital with diagnosis of Hyponatremia. There was documentation in the Integrated Progress Notes that the Home supervisor was notified of Individual #54's transport to the emergency room and later of the hospital admission. There was documented evidence in the Integrated Progress Notes that the unit nurses and Hospital Liaison Nurse kept in daily contact with the hospital nurses, documented Individual #54's status in the Integrated Progress Notes, and kept the team informed of Individual #54's status. There was documentation in the Integrated Progress Notes that the Hospital Liaison Nurse made routine hospital visits to Individual #54. Prior to Individual #54's discharge from the hospital there was documentation in the Integrated Progress Notes of a nurse-to-nurse consultation prior to Individual #54's discharge. Individual #54 was discharged | |

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| | | home at 7:30 p.m. on 12/27/10 with discharge diagnosis of Hyponatremia. There was documentation in the Integrated Progress Notes that the RN upon return home performed a complete physical assessment. A copy of an Acute Care Plan (ACP) for Hyponatremia was found in the documents reviewed but it failed to contain the signature and title of the nurse who established the plan. There was no documentation in the Integrated Progress Notes that an ACP was established for Hyponatremia or that direct care staff were trained in the plan. Neither was there documentation that the direct care staff were trained in the plan. There were no Physician's Progress Notes regarding the rationale for sending Individual #54 to the hospital, during hospital course, or upon discharge home.<br><br>• Individual #60: On 1/5/11 at 6:00 a.m. the nurse documented in the Integrated Progress Notes that the direct care staff reported Individual #60 was observed to have a swollen left leg during dressing. At 6:00a.m. the nurse documented that Individual #60 had swelling in the left lower extremity with complaints of pain and tenderness. Pulses assessed in the leg were palpable and regular and the leg did not feel warm. The nurse failed to document a full set of vital signs. At 6:15 a.m. the nurse notified the physician of Individual #60's complaint of a swollen left leg with pain and tenderness. The physician gave an order to transfer Individual #60 to the emergency room for evaluation. Individual was transported to the emergency room via Facility van at 6:40 a.m. There was no documentation indicating that Individual #60's transfer medical information was sent to the emergency room. The nurse documented that the emergency room staff was given a report of Individual #60's complaints. The Facility's Administrative Officer on Call (AOC) was also notified of the transfer. There was documented evidence that Individual#60's family was notified of Individual #60's transfer. At 9:50 a.m. the emergency room nurse called the unit nurse and gave a status report for Individual #60 who was negative for deep vein thrombosis, negative chest x-ray with normal lab values. Individual #60 was diagnosed and treated for Cellulitis of the left knee and was given Ancef (cefazolin) 1 gram intravenously. Individual #60 was discharged home on 1/5/11 at 11:00 a.m. The nurse documented at 11:30 a.m. that the physician assessed Individual #60 and wrote orders. Physician's Orders were for: Thrombo Embolic Deterrent (TED) hose to left leg, elevate [left leg], Keflex 500 milligrams [orally] three times a day for 10 days, follow-up with Doppler Studies if swelling continues to progress. At 7:30 p.m. the nurse documented in the Integrated Progress Notes that Individual #60 was assessed and still had swelling in the left leg. Vital signs were taken and were within individual's baseline measurements. On 1/6/11 at 6:56 a.m. the nurse documented in the | |

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| | | Integrated Progress Notes that direct care staff reported that Individual #60 did not sleep the whole night, he only sat up in the bed. There was no documentation that Individual #60 was assessed for pain secondary to Cellulitis. There was no documentation in the Integrated Progress Notes upon Individual #60's discharge from the emergency room on 1/5/11 that an ACP was established for Cellulitis and antibiotic therapy or that the direct care staff were trained in their responsibilities for caring for Individual #60's condition relating to Cellulitis, e.g., to ensure that TED hose were worn, left leg was elevated, how to observe and report worsening signs and symptoms of infection, and how to recognize and report signs and symptoms that would indicate side effects and/or adverse reaction to antibiotic therapy. Neither was an ACP found in the records reviewed. There were no Physician's Progress Notes written by the physician regarding Individual #60's status of Cellulitis.<br><br>• Individual #80: On 1/15/11 at 5:10 p.m. the nurse documented in the Integrated Progress Notes that direct care staff reported that Individual #80 fell while being assisted from the bed to go to the dining room and lost balance, then fell forward hitting the head on the corner of the bed. Individual #60 was assessed by the nurse and was found to have a 2.5-centimeter laceration to the left eyebrow with a moderate amount of bright red bleeding. Vital signs were taken and found to be within normal limits. At 5:15 p.m. the nurse applied pressure to the laceration and notified the physician of the injury. At 5:15 p.m. the physician assessed Individual #80's laceration and ordered Individual #80 sent to the emergency room for suturing and Computed Tomography (CT) scan of the head without contrast. Individual #80's laceration to the left eyebrow was covered by a dressing and the individual was transported to the emergency room at 5:50 p.m. via Facility van accompanied by two staff members. There was no documentation indicating that Individual #80's transfer information was sent to the emergency room. At 5:55 p.m. the nurse called the emergency room staff to inform them that Individual #80 was in route to the emergency room. At 5:55 p.m. the nurse notified the AOC of Individual #80's injury and transfer to the emergency room. At 6:00 p.m. the Unit Nurse Manager was also notified. The nurse documented that Individual #80 returned from the emergency room at 8:35 p.m. Upon return home the nurse assessed the wound and found it to be clean and dry and that it was repaired with four sutures. The CT scan completed at the emergency room was negative. No vital signs were completed. Individual #80 was reported as uncooperative and yelling upon return. Staff believed he was hungry since he had missed dinner. Individual #80 was provided dinner, then "appeared his usual self." The nurse notified the Psychology Manager, AOC and Unit Nurse Manager of Individual #80's return and status. The nurse | |

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| | | documented that the physician did not wish to be notified of Individual #80's return if the CT scan was negative. On 1/16/11 at 7:30 a.m. the nurse documented wound care to the left eyebrow and assessed vital signs which were recorded as within normal range. At 8:15 a.m. the physician was informed on Individual #80's status after the emergency room visit. The physician ordered pain medication and instructions for wound care. There was no documentation in the Integrated Progress Notes upon Individual #80's discharge from the emergency room on 1/15/11 that an ACP was established for wound care to the laceration and suture of the left eyebrow or that the direct care staff were trained in their responsibilities for caring for Individual #80's wound and observing, reporting signs and symptoms of infection. Neither was an ACP found in the records reviewed. There were no Physician's Progress Notes written by the physician regarding Individual #80's laceration and visit to the emergency room.<br><br>• Individual #55: On 8/16/10 at 3:32 p.m. the nurse documented Individual #55 had seizure activity. At 3:33 p.m. the nurse documented the report of seizure activity for Individual #55 was an error and the information was intended for another individual. Individual #55's Annual Comprehensive Nursing Assessment, 1/10/11 documented a seizure on 8/12/10. There was no documentation on the integrated Progress Notes for 8/12/10 indicating that Individual had seizure activity. Review of Individual #55's Annual Medical Assessment, 2/1/11, documented that Individual # 55, who infrequently had seizures, had a seizure in August 2010. This could be erroneous information as there was no other documentation found that indicated that Individual #55actually had a seizure. The nursing staff should clarify whether individual #55 had a seizure in August 2010 and correct the record. It is vital that individuals' clinical data are complete and accurate because clinical data are what clinicians use as basis for making clinical decisions. Making clinical decisions based on erroneous clinical data could be detrimental to individuals' health and well-being.<br><br>On 1/11/11 at 1:29 p.m. the nurse documented in the Integrated Progress Notes that direct care professional reported at 10:00 a.m. that Individual #55 was coughing and very sleepy while at Vocational Services. Individual #55 refused lunch according to direct care professionals. The nurse documented a temperature of 99.0 degrees but was not able to completed further respiratory assessments due to Individual #55's refusal. The nurse notified the physician of Individual #55's status but there was no documentation indicating that the physician saw Individual #55 or prescribed treatment. On 1/13/11 at 5:54 p.m. | |

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| | | the nurse documented that the direct care professionals reported Individual #55 was pacing and coughing. The nurse assessed Individual #55 as having a dry cough, temperature of 99.0 degrees with breath sound clear in the upper fields. The nurse reported she was unable to completely assess breath sounds due to Individual #55's refusal. The physician was notified of Individual #55's status. On 1/13/11 at 5:00 p.m. the physician assessed Individual #55 and prescribed the following: Motrin 600 milligrams, orally every six to eight hours, as need for low grade fever; Zyrtec 10 milligrams, orally every day for seven days for cough, to take temperature every six hours and report fever if over 100 degrees, and would order a chest x-ray. The physician failed to include a diagnosis for Individual's respiratory problem. On 1/14/11 at 8:58 a.m. the nurse documented that the direct care professionals reported that Individual #55 started coughing while at Vocational Services and was sleepy. The nurse reported Individual #55 was having no coughing episode upon assessment. Individual was put in bed as he was already being treated for cough with Zyrtec. The nurse did not document assessment findings. At 1/14/11 at 1:45 p.m. the nurse documented, "*Follow up on temp 97.6 with not distress.*" The nurse did not document a full set of vital signs, including, oxygen saturation (O2Sat) or respiratory assessment. There was no documentation by the nurse that Individual #55 refused to have further assessments. On 1/5/11 at 2:00 a.m. the nurse documented the individual was asleep with temperature taken tymphanically at 97 degrees. No other vital signs were taken or respiratory assessments completed. It was apparent from review of Individual #55's respiratory illness that his temperature was not taken and recorded every six hours as ordered by the physician. Just because the physician order temperatures taken every six hour does not preclude the nurses from using professional judgment and taking a full set of vital signs, including O2Sats and completing a full respiratory assessment. Except for one nurse, the nursing staff failed to document the method temperatures were taken. This was important due to the variability of temperature measurements using different methods to assess temperature. The nursing staff failed to follow generally accepted professional practice for assessing and managing acute illness. The nursing staff should have developed and implemented an ACP plan and monitored Individual #55 every shift until stable and then daily until the respiratory problem was resolved. The direct care professionals should have been trained by the nurse as how to observe and report signs and symptoms of the respiratory problem. The Nursing Department needs to ensure that nursing staff document the method used to assess temperatures.<br><br>Listed below is a detailed example of the Facility's failure to recognize an individual's | |

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| | | signs and symptoms of change in behavior and health, to assess, and take action to identify the underlying problem; and provide treatment. This caused the individual to remain ill and uncomfortable for months:<br>• Individual #11: On 3/1/11 while Monitoring Team was touring La Paloma with the Chief Nurse and Nurse Operating Officer, Individual #11 was observed, off and on from 8:30 a.m. to 5:00 p.m., constantly briskly pacing up and down the hall and frequently hitting his face. This behavior was different from what the Monitoring Team had observed on previous tours. The Chief Nurse Executive and Nurse Operating Officer agreed that Individual #11 was not acting like his usual self. During the day it was observed that Individual #11 had changed clothes at least five times. By noon Individual #11 had change clothes three times. The Monitoring Team asked the Home Supervisor about Individual #11's behavior and frequently changing clothes. He responded that this was Individual #11's usual behavior and that recently the 1:1 staff had been discontinued. When Individual #11 had a 1:1 staff he was able to frequently walk outside and he was missing the ability to be outside. The Home Supervisor did not seem to find it unusual for Individual #11 to have changed clothes several times a day. Monitoring Team continued to be concerned about Individual #11's behavior and prompted the nursing staff to assess Individual #11 to determine if he had an underlying medical problem causing the change in behavior. The Nurse Operating Officer checked with the direct care professionals and found out that the reason Individual #11 had changed clothes several times was due to urinary incontinence.<br><br>Review of Individual #11's Behavior Data Sheet for 3/1/11 at 6:00 a.m. documented that he was slapping his face and trying to hit staff. The behavior lasted two hours. At 1:00 p.m. documentation stated that Individual #11 was slapping face and back for two hours. Monitoring Team discussed Individual #11's behavior and frequently changing clothes with the Associate Psychologist who said Individual #11's usual behavior was to pace. She explained that Seroquel had been increased from 300 milligrams to 400 milligrams on 1/13/11. The Associate Psychologist stated she would follow-up on Individual #11's behavior. No further information was reported to the Monitoring Team on Individual; #11's behavior issues.<br><br>The Monitoring Team discussed Individual #11's behavior with Dr. DeVera. Dr. DeVera said that she had observed Individual #11 with a green nasal discharge and treated empirically for a Sinusitis with purulent Rhinitis with Augmentin, 500 milligrams, orally, three times a day for 10 days. She went on to say that he had recently had a negative urinalysis. On 1/6/11 the physician ordered, "UA | |

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| | | [urinalysis] midstream in the AM [morning]." On 1/7/11 at 5:01 a.m. the nurse documented in the Integrated Progress Notes "*Client is incontinent of urine and urinates on self or in the bed several times a night and throughout the day per staff reports. Clean catch mid stream UA* [urinalysis] *has been ordered but was unable to collect any urine specimen due to incontinence of urine per client. Client unable to comprehend urinating in commode*." According to the Integrated Progress Notes, 1/16/11 at 12:10 p.m., the nurse documented, "*DrDeVera was notified of the U/A results sent yesterday to VBMC* [Valley Baptist Medical Center]. *Results were negative for UTI* [urinary tract infection]. *No orders were given*." This resulted in a 10 day delay in obtaining the urinalysis. There was no nursing or physician documentation explaining the reason for the delay in obtaining urinalysis. This was unacceptable nursing and medical practice. If Individual #11 had been experiencing a urinary tract infection it could have progressed into serious complications, such as urosepsis.<br><br>The Monitoring Team reviewed Individual #11's record with the Chief Nurse Executive. There was a Physician's Order on 1/20/11 at 9:30 a.m. written to "Implement Bladder Scan to spot residual…" The nurse transcribed on 1/20/11 at 1:00 p.m. There was no documented evidence that the Bladder Scan was scheduled or performed. Neither was a Physician's Progress Note explaining the rationale for the Bladder Scan or follow-up to the order. The Chief Nurse Executive reported the failure to obtain the Bladder Scan to the Department of Protective and Family Services as possible neglect. Then she requested that Individual #11 be seen by the on call physician. The on call physician on 3/1/11 assessed Individual #11 at 8:15 p.m. The physician ordered a clean catch urinalysis, if unable to perform a clean catch may use an in and out catheter and Urinary Bladder Ultra Sound. There was much delay in obtaining the bladder ultra sound; it was not performed unit 7:45 p.m. on 3/2/11. The results of the Bladder Ultra Sound revealed urinary retention. The physician ordered a Urology Consult. Individual #11 was seen by the Urologist on 3/3/11 At 10:00 a.m. The Urologist prescribed Uroxatral 10 milligrams orally each night. Individual #11 was to return to the Urologist in one week. The urinalysis performed on 3/2/11 was negative.<br><br>The Monitoring Team requested a copy of Individual #11's ACP related to urinary retention and the initiation of Uroxatral. This documentation was not received by the time tour ended 3/4/11. A copy of the ACP for Urinary Incontinence, dated 3/2/11 was received in the documents shipped after the tour. The ACP for Urinary Incontinence was somewhat individualized but failed to adequately address urinary retention. Although Individual #11 was | |

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| | | incontinent most of the time and the amount of urinary output could not be accurately measured, the plan should have included nursing interventions to monitor the bladder for retention by palpitating the bladder area after urinating, and if the bladder was distended, report the distention to the physician. If the bladder becomes overly distended there is the potential for the bladder to rupture. The ACP nursing intervention included, "*Judicious use of medications to help control urge like oxybutynin.*" Individual #11 was prescribed Uroxatral; therefore, this medication should have been used. There was no instruction on the ACP for the direct care professionals to observe for side effects or adverse reaction to Uroxatral. The ACP stated that Individual #11 would be, "*assessed at least once per shift during the acute phase (including vital signs), then daily to resolution.*" Review of the nursing Integrated Progress Notes from 3/2/11 through 3/4/11, failed to contain documentation that this was done on every shift. Further, there was no documentation on the ACP that direct care professionals were trained on the plan. Neither was there documentation in the Integrated Progress Notes 3/2/11 through 3/4/11 that the ACP had been established and direct care professionals had been trained on the plan. It is imperative that the nursing staff monitor Individual #11's urinary status and therapeutic response to Uroxatral. The Uroxatal has the potential for numerous side effects, such as hypotension that may cause severe dizziness or fainting, especially when first started, and can contribute to falling. The nursing staff needs to be knowledgeable of these side effects and train the direct care professionals on how to observe and report any side effects. The Nursing Department need to ensure when individuals' acute illnesses are diagnosed that ACPs are established and implemented immediately and the direct care professionals are trained in their responsibilities. The initiation of ACPs and direct care staff training needs to be documented on the ACPs and in the Integrated Progress Notes. Nursing staff needs to document in the Integrated Progress Notes that interventions specified in the ACPs are carried out.<br><br>The Monitoring Team reviewed Individual #11's Integrated Progress Notes for nursing and direct care staff from 1/6/11 through 3/1/11. After the note written by the nurse on 1/7/11 describing the numerous episodes of urinary incontinence/frequency there were no further nursing documentation regarding urinary incontinence/frequency. Review of the direct care professionals' documentation found numerous episodes of urinary incontinence/frequency several times a day. Often the notes reported that Individual #11 would say he needed to "*pee*" but when taken to the bathroom would not urinate or when prompted to go to the bathroom he would "refuse" to urinate. None of the direct care professionals' notes documented that they had notified the nurses of the | |

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| | | urinary incontinence/frequency. The direct care professionals did not, nor could they be expected, to understand when they took Individual #11 to the bathroom and he refused to urinate, even with prompting, that he might not have been able to urinate due to an underlying medical problem. There were many episodes of urinary incontinence documented at night, almost daily. Incontinence at night is particularly indicative of urinary retention. Neither could they be expect to understand when he urinated in his clothes shortly after going to the bathroom that it was not a deliberate behavior but associated with the underlying medical problem. The nurses and physicians were remiss in not following up on Individual #11's urinary incontinence although the urinalysis was negative for infection. Many instances, almost daily, of self-abuse were documented in the Integrated Progress Notes. It was plausible that the discomfort Individual #11 was experiencing may have contributed to maladaptive behavior and none of the staff associated the maladaptive behavior with bladder discomfort. It was of concern that had the Monitoring Team had not aggressively insisted that Individual #11's brisk pacing and his frequently changing clothes be evaluated, it was doubtful that his urinary retention would have been identified. It is vital any time individuals demonstrate a change in their usual behavior and/or health status that the professional staff evaluate individuals for the underlying cause. Maladaptive behaviors are often associated with a change in physical condition. Although this deficient practice involved only Individual #11, failure to recognize and assess individuals who experience changes in behavior and/or health status could compromise the health and safety of any of the other individuals living in the facility.<br><br>The Monitoring Team reviewed Individual #11's Personal Support Plan (PSP) and PSP Addendums from 4/27/10 through 1/21/11. Individual #11's PSP, 4/27/10, Nursing Assessment stated there was no medical diagnosis for Individual #11's urinary incontinence. There was no recommendation for medical follow-up to determine the cause of the urinary incontinence. The PSP Addendums were primarily focused on behavioral issues. On 5/5/10 the Personal Support Team (PST) met and discussed allowing Individual #11 wearing Crocs shoes due to *"wetting"*(urinating) his shoes. It was determined that Crocs would not be appropriate due to lack of an arch support or side supports. On 7/6/10 the PST met and discussed a purchase request for shoes because Individual #11 continued to urinate on them and he runs out of shoes even though he had nine pairs. Team agreed to purchase shoes. On 7/12/11 the PST met and discussed the successfulness of Individual #11 toileting schedules as he continued to urinate on his shoes (sic). The Qualified Mental Retardation Professional (QMRP) had tallied up data on number of times he urinated on | |

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| | | himself and in the toilet. It was noted that Individual #11 urinated on himself at least once a day. It was reported that staff were not documenting all toileting successes and attempts. New shoes were requested because he urinated on them and it took a couple of days for the shoes to dry. The Team recommended continuing with the toileting program and schedule. On 1/20/11 the PST met for a Quarterly Review. The PST discussed Individual #11's continued incontinence of urine, "*Bathroom issues discussed. He (sic) had tendency of urinating on his self.Goal in future Possible Bladder Scan, if toileting schedules is not successful.* On 1/21/11, the PST met but did not recommend a Bladder Scan, rather they decided to continue the toileting schedule, prompting Individual #11 to use the toilet every hour on the hour. Never once in all of the PST meetings did the Team discuss the possibility that Individual #11 might have an underlying medical problem causing the incontinence of urine; although the meeting on 1/20/11 casually considered a Bladder Scan but did not state why they considered it. The focus was on the toileting program and schedule. The physician did order a Bladder Scan on 1/20/11 that was never performed. It was only after the Monitoring Team observed Individual #11 briskly pacing the hall, slapping his face throughout the day of 3/1/11, and changing clothes at least five times that it was discovered that the reason he was changing clothes so often was due to incontinence as oppose to a behavioral reason. According to the PST meeting Sign-in Sheets, professional staff, including RNs and physicians, were always present at the meetings where Individual #11's urinary incontinence was discussed yet there was no indication the professional staff considered the possibility of an underlying medical condition that might be causing the urinary incontinence. As a result of the Monitoring Team's persistence in prevailing upon the nursing and medical staff to evaluate Individual #11 to rule out an underlying problem for the urinary incontinence, the Bladder Scan was reordered and performed. The Bladder Scan indicated that Individual #11 had urinary retention. The incontinence was most likely due to the overflow of the bladder. After review of Individual #11's record it was apparent the problem of incontinence had been going on since at least 5/1/10. While a toileting program would not hurt to do, it would not be effective or resolve the urinary retention. In the Integrated Progress Notes there were numerous entries documenting that Individual #11 was taken to the toilet and prompted to urinate and "refused" but would urinate on himself shortly after leaving the toilet. The reason he could not urinate was most likely not due to refusal but because of the involuntary retention of urine. Then, and after the bladder overflowed Individual #11 would have urinary incontinence. It was most regrettable that Individual #11's urinary incontinence was not evaluated for an underlying medical cause for at least 10 months. | |

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| | | The Monitoring Team requested a copy of Individual #11's ACP for Sinusitis on 3/1/11. A copy was not provided to the Monitoring Team, after daily requests, until the approximately 4:00 p.m. on 3/3/11 when the Unit Nurse Manager provided a copy of the ACP for Sinusitis dated 3/1/11. When the Monitoring Team asked the Nurse Operating Officer why there was a delay in providing a copy of the ACP, she explained that the ACP she had reviewed earlier was not adequate and was sent back for revision. Review of the ACP for Sinusitis was not individualized, failed to contain baseline data and goal. It was copied directly from the Health Care Protocol: for Developmental Disability Nurses. There was no documentation on the ACP that direct care professionals were trained in the plan. Review of the nursing Integrated Progress Notes from 3/1/11 at 12:10 p.m. through 3/4/11 at 11:00 a.m. contained documentation for a few entries regarding monitoring Individual #11's acute illness health status for Sinusitis. On 3/1/11 at 2:31 p.m. the nurse documented, "*… was started at 12:50 PM on Augmentin for URI* [Upper Respiratory Infection] *and at 1PM Tylenol 650MG was given for comfort. He was uncooperative for V/S* [vital signs]." The nurse failed to document Individual #11's therapeutic response to Augmentin or Tylenol. There was no documentation that an ACP for Sinusitis had been established or the direct care professionals trained, although the ACP provided by the Unit Nurse Manager was dated 3/1/11. On 3/1/11 there was documentation that the nurse attempted to assess Individual #11 but he was uncooperative. On 3/3/11 at 2:52 p.m. the nurse documented, "*… continues on antibiotics … he was tried for V/S but was uncooperative.* There was no documentation regarding Individual #11's therapeutic response to antibiotics. There was no documentation that the ACP was established and direct care professionals trained in their responsibilities until 3/4/11 at 9:30 p.m. Then, the note stated that the 2 to 10 shift and the 10 to 6 shift direct care professionals were trained. There was no documentation that the 6 to 2 shift were trained. The Integrated Progress notes, as demonstrated above, did not follow the generic the ACP that stated Individual #11 would be, "*assessed at least once per shift during the acute phase (including vital signs), then daily to resolution*." Review of the nursing Integrated Progress Notes from 3/1/11 through 3/4/11, failed to contain documentation that this was done on every shift. The delay of initiating an ACP for four days after Individual #11 was diagnosed with Sinusitis was not acceptable nursing practice.<br><br>Further examples of lack of review and treatment of acute illnesses can be found in the number of, and treatment of, urinary tract infections. As described in Provision M5, the | |

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| | | Facility had identified there was a high frequency of urinary tract infections and had developed a plan of improvement. Two of these cases demonstrate need for improved care in this area. The Monitoring Team reviewed records for Individuals #33 and #108 who recently were diagnosed and treated for Urinary Tract Infections:<br><br>• Individual #33: On 2/15/11 at 7:03 p.m. the nurse documented in the Integrated Progress Notes that direct care professionals reported that Individual #33 told them he saw a little drop of blood when he urinated. The direct care professionals confirmed that they saw blood on Individual #33's underwear. The nurse documented that there was no injury or bleeding observed upon exam of Individual #33 private areas. The nurse notified the physician of Individual #33's report of bleeding on urination. The physician ordered a routine urinalysis in the morning. There was no documentation that the nurse took vital signs or completed any other assessments regarding Individual #33's urinary symptoms. On 2/16/11 at 3:34 p.m. the physician ordered Cipro 500 milligrams, twice a day for 10 days for Urinary Tract Infection and to rule out Proctitis. Follow-up with a urinalysis and culture and sensitivity in two weeks. On 2/16/11 there were no nursing Integrated Progress Notes documenting that a comprehensive assessment was completed regarding Individual #33's urinary system. The Monitoring Team reviewed the nursing Integrated Progress Notes from 2/16/11 through 2/27/11. There was documentation that Individual #33 was assessed at least daily for three days after the initiation of antibiotic therapy for the Urinary Tract Infection. However, the nursing staff did not consistently complete and document comprehensive assessments relating to the Urinary Tract Infection. The methods for which temperatures were taken were not documented. O2 Sats were not consistently included with vital signs. The nurses failed to consistently address the efficacy of the antibiotic therapy and to monitor for side effects. The nursing staff failed to document a resolution note when the antibiotic therapy was completed.<br><br>On 2/16/11 an ACP for Urinary Tract Infection was established. Only the first and third pages of the ACP were made available for review. The plan was not individualized and was copied directly from the stock plan. There were no signatures on the plan indicating that the direct care professionals were trained on the plan. The ACP failed to contain a date indicating that the Urinary Tract Infection was resolved. On 2/16/11 there was no nursing documentation in Integrated Progress Notes that an ACP for Urinary Tract Infection was initiated and direct care professionals trained. | |

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| | | • Individual #108: Individual #108 was diagnosed with a Neurogenic Bladder that required daily intermittent catheterization and history of Urosepsis and Chronic Urinary Tract Infections. On 2/5/11 at 11:00 a.m. the nurse documented in the Integrated Progress Notes that upon catheterizing Individual #108's urine smelled foul, and was yellow and cloudy. Individual #108 was reported in no distress. The nurse failed to take vital signs or complete a comprehensive nursing assessment related to the urinary system. The nurse notified the physician of the foul odor and cloudy urine. The physician ordered a urinalysis. A urine specimen was sent to the lab for a urinalysis. At 3:40 p.m. the report of urinalysis was given to the physician who ordered Levaquin 500 milligrams, orally, daily for seven days. There was no further assessment documentation by the nursing staff regarding the status of Individual #108's Urinary Tract Infection or the initiation of the antibiotic until three days later. On 2/7/11 at 1:08 p.m. the nurse documented that Individual #108 continued on Levaquin as ordered. Vital signs were reported as: Temperature 97.2 (method temperature was taken was not documented), pulse rate 90, respiration rate, 18, and blood pressure 139/86. A comprehensive nursing assessment of Individual #108 urinary system was not completed. The physician discontinued the Levaquin on 2/8/11 and ordered Nitrofurantoin 100 milligrams, orally, twice a day for 10 days for Urinary Tract Infection because of insensitivity to Levaquin. There was no documentation in the nursing Integrated Progress Notes indicating the discontinuation of Levaquin and the initiation of Nitrofurantoin. There was no further nursing documentation regarding Individual #108's Urinary Tract Infection until 2/10/11 at 1:05 p.m. when the nurse documented that Individual #108 continued on Macrodantin (Nitrofurantoin). The nurse assessed Individual #108's temperature but a comprehensive assessment for the Urinary Tract Infection was not completed. Reviewed the nursing Integrated Progress Notes from 2/10/11 through 2/18/11. The nursing staff consistently failed to complete and document comprehensive assessments relating to the Urinary Tract Infection. The methods for which temperatures were taken were not documented. O2Stats were not consistently included with vital signs. The nurses failed to consistently address the efficacy of the antibiotic therapy and to monitor for side effects. The nursing staff failed to document a resolution note when the antibiotic therapy was completed. The nursing staff failed to establish an ACP for Individual #108's Urinary Tract Infection.<br><br>Review of Individuals #33 and #108 revealed nursing care of their Urinary Tract Infections failed to meet compliance with the Settlement Agreement, Health Care Guidelines, and the Facility's protocol for managing Urinary Tract Infections and Acute | |

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| | | Illnesses. The nursing staff consistently failed to complete, at least daily, comprehensive nursing assessments for individuals' Urinary Tract Infection, monitor antibiotic therapy for efficacy and side effects, develop an individualized ACP for Urinary Tract Infections, train the direct care professionals, and follow through to resolution. The Infection Control Preventionist/Nurse Educator needs to take a proactive role in monitoring infections to ensure the nursing staff follows the Settlement Agreement and Health Care Guidelines and to provide corrective action when they are not followed.<br><br>The Nursing Department needs to ensure when individuals' acute illnesses are diagnosed that ACPs are established and implemented immediately and the direct care professionals are trained in their responsibilities. The initiation of ACPs and direct care staff training needs to be documented on the ACPs and in the Integrated Progress Notes. Nursing staff needs to document in the Integrated Progress Notes that interventions specified in the ACPs are carried out. | |
| M2 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status. | Since the last tour the Nursing Department had trained all Nurse Managers and Nurse Case Managers on the revised Comprehensive Nursing Assessment Guidelines and form. However, there was no evidence that formalized competency-based training was provided for completing the Comprehensive Nursing Assessment. The training should include how to clinically analyze data, write the findings of that analysis, and adequately measure the nurses' competency in producing quality nursing assessments. State Chief Nurse Executives were finalizing the draft for Nursing Physical Assessment Training and were waiting final approval from the State Office. When the State Office rolls out the Nursing Physical Assessment Training the Nursing Department needs to ensure that all Nurse Managers and Nurse Case Managers receive competency-based training on Nursing Physical Assessment Training.<br><br>The Nursing Department was consistently using the Comprehensive Nursing Assessment form for completing annual and quarterly nursing assessments. Through the use of this form, assessment of the quality and content of the assessments were beginning to show some improvement but assessments need to continue to improve. While nursing assessments are required quarterly and annually, performing nursing assessments is a dynamic, ongoing, and continuous process of collecting evaluating, and communicating health information regarding each individual's needs. Nursing assessments are the foundation from which actual health care problems, high-risk potential problems and nursing diagnoses are identified, and from such information plans of care are developed and implemented to address, prevent, and/or resolve problems. Therefore, health care plans whether acute or long term must be based on complete and accurate nursing assessments. The assessments summarize pertinent health data from which change and goal achievement can be measured. The Annual and Quarterly Nursing Assessment were | Noncompliance |

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| | | reviewed for the following 12 Individuals: #55, #72, #33, #63, #140, #108, #61, #82, #11, #29, #35, and #4.<br><br>Review found 10 of 12 (83%) individuals' Annual and Quarterly Nursing Assessments were completed according to their Personal Support Plan Schedule. Individual #55's third quarter assessment due in 10/10 was not completed until 11/1/10. Individual #29 was missing the second quarter assessment due in 10/10. The nursing assessment contained in the PSPs failed to adequately and accurately summarize individuals' health status.<br><br>The Braden Scale to rate skin integrity risk assessments were completed for 11 of 12 (92%) individuals' Annual and Quarterly Comprehensive Nursing Assessments. The review included Individual #55 even though it was completed late. The only assessment not reviewed was Individual #29's second quarter assessment, which was missing. None of the individuals assessed with the Braden Scale were scored at risk for developing pressure ulcers. The Comprehensive Nursing Assessment tool failed to include rating score criteria. This should be added to the tool to remind nurses what the assessed score indicates and when to consider individuals at risk for skin integrity problems, e.g., individuals with a total score of 16 or less are considered to be at risk for developing pressure ulcers (15 to 16 = low risk; 13 to 14 = moderate risk; 12 or less = high risk). The State Office should consider adding the Braden Scale rating score criteria for determining the level of risk derived from the assessment.<br><br>The 12 individuals' Annual and Quarterly Nursing Assessments reviewed for the last six months were completed on the revised Comprehensive Nursing Assessment form. Nursing assessments completed on the Comprehensive Nursing Assessment form contained more complete assessment information:<br>• The Comprehensive Nursing Assessment Sections I through IX showed more improvement than Sections X and XI. The summaries in Sections I through IX contained more substantive information than was observed at the last tour. However, issues identified in summary sections were not consistently included in Section X Nursing Summary.<br>• The RN Case Managers completed assessments. The RN Case Managers completing the assessments consistently signed them. The dates of the assessments were not consistently dated along with signatures. The box indicating that the Qualified Mental Retardation Professionals (QMRPs) and Personal Support Team Members were notified of the completed assessments were not consistently marked.<br>• Sections X (Nursing Problems and Diagnoses) contained nursing problems | |

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| | | written in the North America Nursing Diagnosis Association (NANDA) format. They did not consistently contain nursing diagnoses for Health Risk Scores greater than one, or include nursing diagnoses for stable but chronic conditions listed on the Medical Active Problem List for which they were receiving medical interventions that required nursing assessments/monitoring and interventions to ensure that individuals remained stable or for the ability to identify regression in health status.<br>• Section XI (Nursing Summary) primarily consisted of raw clinical data, statements to continue Health Maintenance Plans, and lists of recommendations and goals as opposed to stating whether individuals' health status were progressing, maintaining, or regressing in relation to their established goals. Section XI (Nursing Summary) of the nursing assessment should provide a clinical analysis of the raw data from the previous sections. To determine individual's health status, data should be compared to the previous quarter's assessment regarding the individual's progress related to their health and behavioral goals.<br><br>Examples of problematic findings are listed below:<br><br>• Individual #55 had the following Active Medical Problems: Impulse Control Disorder, Intermittent explosive disorder with self-abusive behavior to right index finger, profound mental retardation with severe speech disorder, seizure disorder, tonic clonic , and history of third degree burn of the right scapula with a BMI of 25.1. At the time of Individual #55's PSP, 1/11/11, health risks were rated as medium risk for polypharmacy due to receiving two medications of the same class with challenging behaviors. Individual #55 had a Behavior Support Plan due to self-injurious behaviors as well as poor oral hygiene. All other risk indicators were rated low. Individual #55's annual Comprehensive Nursing Assessment was completed on 1/10/11. Findings:<br>o Medication Review Section failed to include the response and effectiveness of current medications.<br>o The Seizure Disorder section indicated that Individual #55 had one seizure for the year in August 2010. In the Integrated Progress Notes on 8/16/10 at 3:32 p.m. the nurse documented Individual #55 had seizure activity. At 3:33 p.m. the nurse documented the report of seizure activity for Individual #55 was an error and the information was intended for another individual. There was no documentation on the integrated Progress Notes for 8/12/10 indicating that individual had seizure activity. Review of Individual #55's Annual Medical Assessment, | |

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| | | 2/1/11, documented that Individual # 55, who infrequently had seizures, had a seizure in August 2010. This could be erroneous information as there was no other documentation found that indicated that Individual #55 actually had a seizure. The nursing staff should clarify whether individual had a seizure in August 2010 and correct the record. It is vital that individuals' clinical data are complete and accurate because clinical data are what clinicians use as a basis for making clinical decisions. Making clinical decisions based on erroneous clinical data could be detrimental to individuals' health and well being.<br>o Nursing Problems/Diagnosis included: Impaired verbal communication related to mental retardation, risk for injury to self related to self injurious behaviors; mental condition, and self-care deficits related to profound mental retardation. The care plan boxes were checked indicating there were care plans for each nursing problem/diagnosis. The Monitoring Team requested copies of all care plans for review but these plans were not made available, so the Monitoring Team could not verify they existed. A nursing problem for seizure disorder was not listed although the individual has a medical diagnosis. A copy of a HMP for Seizures, Prolonged, dated 7/1/10, was made available for review. It was generic and was not individualized. There was no documentation indicating it was resolved, or reviewed and revised at the time of this annual nursing assessment. Neither did it contain documentation that the direct care professionals were trained at the time the plan was established. Even though Individual #55 was reported to have infrequent seizures with a Health Risk Score rated low for seizures, this does not negate the need for a HMP for seizure management. Individual #55 continued to receive Dilantin and valproic acid (for use as mood stabilizer) and required routine monitoring of anticonvulsant drug levels, monitoring for therapeutic response (sub-therapeutic levels and toxicity), and management during seizure activity. Direct care professionals need to be trained on their responsibilities related to the plan.<br>o The Nursing Summary provided extensive raw data of individual's health status over the past year but failed to clinically analyze data, write the findings of that analysis, and adequately demonstrate individual's progress or lack of progress relating to each of the established goals for each nursing problem identified.<br>o The check box indicating the assessment was sent to the QMRP and other PST members was not checked.<br>• Individual #72 has the following Active Medical Problems: Organic Brain | |

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| | | Syndrome, Profound Mental Retardation secondary to Encephalitis, Speech Disorder, Seizure Disorder – Grand Mal, Stigmatism and Hyperopia, Zoster, Gynecomastia, Osteoporosis, Vascular Necrosis of Left Hip, Open Reduction Internal Fixation, Coagulation Deficiency, Factor Nine, Adverse Drug Reaction to Niacin, with elevated Liver Function Test, Antibiotic Prophylaxis Secondary to Hip Surgery, Colonoscopy on 10/07, with Polyp Removed at the Transverse Colon. At the time of Individual #72's PSP, 1/11/11, health risks were rated as medium risk for: weight, constipation, osteoporosis, seizures, and polypharmacy. Constipation was not included on the Active Medical Problem List. Individual #72's Annual Comprehensive Nursing Assessment was completed, 1/21/11. Findings:<br>o The Current Medical Diagnosis did not match the physician's active Medical Problem List.<br>o Under current medical diagnosis for the gastrointestinal section constipation was not marked as a problem, nor was there a summary statement regarding constipation status. Individual #72 was rated at medium risk for constipation. Individual #72 was receiving Docusate (laxative) for constipation. Additionally, he was receiving numerous psychoactive and anticonvulsant medications that have the potential to cause constipation.<br>o Under the Breast Exam Section the diagnosis of Gynecomastia was not included, nor was the male annual breast exam marked as having been completed. If Gynecomastia was a true diagnosis, annual male breast exams need to be completed.<br>o The Immunization Section for Hepatitis A, B, and C, and Varicella, and Zoster were not marked. According to the Active Medical Problem list Individual #72 was diagnosed with Zoster 8/2/02.<br>o In the Vital Sign Section indicated that the blood pressure was 148/77, the systolic pressure was elevated 28 millimeter of mercury above the normal limit. There was no discussion documented in the summary regarding the elevated systolic pressure.<br>o In the Eye Exam Section no abnormal findings were marked. Individual #72 was diagnosed with bilateral cataracts on 10/4/10. There was no discussion of cataracts or plan for follow-up eye examinations documented in the summary section.<br>o The Bowel Management Plan was marked as having a plan. It was noted that Individual #72 was receiving Docusate. The effectiveness of the laxative was not documented, nor were bowel elimination patterns documented.<br>o The Nursing Problems/Diagnosis included: Potential for injury during | |

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| | | seizure related to motor activity and changes in level of consciousness. Ineffective health maintenance related to mental retardation. There were no nursing diagnoses for Hypertension, Osteoporosis, and Gynecomastia.<br>o The Nursing Summary stated, *No significant events happened for this quarter except for an episode of rhinorrhea, abrasion and was premedicated for appointments. To continue with monitoring med nursing diagnosis/problems."* The Nursing Summary provided minimal raw data regarding Individual #72's health status over the past year and failed to clinically analyze data, write the findings of that analysis, and adequately demonstrate Individual #72's progress or lack of progress relating to each of the established goals for each nursing problem identified.<br>o Pre-Self-administration of Medications status toward goal and objectives was not documented in the Nursing Summary. The nurse failed to clinically analyze data, write the findings of that analysis, and adequately demonstrate individual's progress or lack of progress relating to each of the established goals for each nursing problem identified.<br>o The check box indicating the assessment was sent to the QMRP and other PST members was not checked.<br>• Individual #35 had the following Active Medical Problems: intermittent Explosive Disorder, Severe Mental Retardation, Speech Impediment, Partial Complex Tonic Clonic seizures, Hypothyroidism, Status Post Gallbladder Surgery, History of Tortuous Large Intestine, with Jejunal Perforation with Laparoscopy, Left Cauliflower Ear, Constipation Secondary to Diverticulitis. Individual #35's Annual Comprehensive Nursing Assessment was completed on 12/30/10. Findings:<br>o The Current Medical Diagnoses did not match the physician's Active Medical Problem List.<br>o The Medication Review Section failed to include the effectiveness of medications.<br>o Current Medical Diagnosis(es) and Conditions Reviewed: Constipation was marked with a note that that Individual #35 takes laxatives daily. The box for Sleep History was marked for interrupted sleep patterns. The summary included past surgical histories and illness that included: Cholecystectomy in 2005, Laparoscopy with Jejunal Perforation, date not noted, Diverticulitis, nasal Fracture with closed reduction in 2008, and Right Elbow Bursitis. There was no documentation regarding bowel elimination patterns or sleep patterns. | |

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| | | o The Functional Status Section marked that Individual #35 ambulated independently. However, throughout the record, including the PNMP it was documented that she required the use of a gait belt at all times and wheelchair at times for transport. The uses of these adaptive equipments were not marked. Only the use of shoes was marked for adaptive equipment. Falls were marked yes. The number of falls per quarter or year was not marked. The summary documented that Individual #35 ambulates with bent forward gait while holding to furniture or walls most of the time with prescribed high top shoes. The summary failed to document the number of falls experienced during the past year.<br>o The Immunization Section for Measles/Mumps/Rubella, Hepatitis A, Varicella, and Zoster were not marked.<br>o The Gastrointestinal Section did not mark any problems in the system. The summary documented that Individual #35 received Lactulose daily. Bowel elimination patterns were not documented.<br>o The Musculoskeletal Section was marked no abnormal findings of the lower extremities and the spine was marked for lordosis. The Nursing Problem list stated, "*Risk for falls or injuries related to racing gait pattern, exaggerated hip flexion and marked lordosis during gait as evidenced by multiple falls and trips.* There was no documentation in summary regarding the musculoskeletal system and problems with ambulation. This was in conflict with the assessment and summary in the Functional Assessment Section.<br>o The Female-Gynecological Section indicated that the last Pap smear was completed on 3/30/01. The Physician's Orders on 1/26/11 indicated that a Gynecological Exam and Pap smear was sent to the lab. There was no documentation in the nursing Integrated Progress Notes for 1/26/11 indicating that this was done. The Dysmenorrhea box was checked as well as the box indicating that Individual #35 received medication for Dysmenorrhea. The summary failed to describe the frequency and intensity of the Dysmenorrhea and the effectiveness of the pain medication.<br>o The Nursing Problems/Diagnosis Section included nursing problems for: Risk for falls or injuries related to awkward pacing gait pattern, exaggerated hip flexion and marked lordosis during gait as evidenced by multiple falls and trips. Ineffective health maintenance related to cognitive limitation as per diagnosis of severe mental retardation. Risk for infection related to poor hygiene practices. Risk for altered bowel eliminations: Constipation related to side effects of medications, | |

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| | | sedentary activity; possible inadequate fiber intake. Risk for Aspiration related to improper meal habits like overstuffing of food and eating at a fast pace, and talkative while eating. Obstetrical [gynecological] pain related to menstrual cramps. Conjunctivitis care plan: Alteration in comfort and risk for spread of infection. The care plan boxes were marked for all the nursing problems. This was a very comprehensive list of nursing problems that were reflective of Individual #35's health problems but failed to include a nursing problem for potential future bowel problems related to history of tortuous large intestine, with Jejunal perforation. This placed Individual #35 at risk for future bowel problems and should be monitored because the development of a tortuous intestine could result in a life threatening event.<br>o The Nursing Summary provided extensive raw data of individual's health status over the past year. Individual #35 had one episode of an Upper Respiratory infection that was resolved after treatment. She had six episodes of Conjunctivitis. Interventions and treatments regarding Conjunctivitis were summarized but failed to state the effectiveness of the interventions and treatment in preventing future infections. Psychotropic medications were tapered and Cogentin was added without any adverse reactions. The summary stated that Individual #35's was noncompliant with medication administration. The nurses go to her room to give her medications almost 95% of the time. Individual #35's Self-Administration of Medication program was to prompt her to come to the medication window. Individual #35 was reported to come to the medication window one to two times a week out of 28 medication times. There was no documentation indicating that the PST were notified of this or were there alternatives discussed to increase Individual #35 compliance with the Self-Administration of Medication Program. The Nursing Summary failed to include issues identified in the assessment. Further, the Nurse Case Manager failed to clinically analyze data, write the findings of that analysis, and adequately demonstrate Individual #35's progress or lack of progress relating to each of the established goals for each nursing problem identified. | |
| 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, | Since the last tour the Nursing Department had provided training to the nursing staff on the Health Care Protocol for Developmental Nursing to assist with care planning. According to the Facility's POI the Nursing Department on 9/20/10 began training the direct care professionals on the HMPs and ACPs as opposed to giving the plans to the Home Leaders/Supervisors to provide the training, as was the case in previous reviews. The Nursing Department purged the older versions of the stock care plans from the | Noncompliance |

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| | 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. | shared folder.<br><br>While there was some improvement in individualizing care plans to meet the individuals' special needs either for HMPs or ACPs it is important to only use the Health Care Protocol as resource guide in the development of care plans. Extraneous information that is not applicable to the individuals' care should be deleted from the stock care plan templates when writing the care plans. For the care plans to be meaningful they must meet the specific needs of the individuals for whom they are written. The care plan should accurately reflect what the nurse is doing for prevention, health maintenance, and health promotion for the individuals. The care plans should contain goals and objectives that are realistic, measurable, and specific to the individual. The care plans should include specific interventions with measurable outcomes that are proactive in nature.<br><br>Several issues were identified during the review of 12 individuals' HMPs and ACPs. A signature and date line had not been added to the HMPs and ACPs template adopted from the Health Care Protocols to validate that the direct care professionals were trained in the plans. The heading of the plans did not specify if the plans were for a HMP or an ACP. When ACPs or HMPs were established, validation that direct care professionals were trained was not consistently documented in the Integrated Progress Notes. HMPs and ACPs were not consistently developed for chronic conditions and acute illnesses and injuries. Care plans were not developed timely when an acute illnesses or injuries were identified.<br><br>The HMPs and ACPs reviewed were only marginally individualized to reflect the unique needs of individuals' chronic conditions and/or acute illnesses or injuries. Baseline data and goals were usually individualized to some degree. Goals were not always realistic, measurable or attainable. The plans continued to contain extraneous information that was not applicable to the individuals' situation or need for care. The Nursing Department needs to provide additional and continuous training on the development, implementation, and documentation of care plans until the nursing staff can competently develop care plans that meet the unique needs of individuals' conditions. Listed below are examples of problematic issues:<br>• The Monitoring Team requested a copy of Individual #11's ACP related to urinary retention and the initiation of Uroxatral but this documentation was not received by the time tour ended 3/4/11. A copy of the ACP for Urinary Incontinence, dated 3/2/11 was received in the documents shipped after the tour. The ACP for Urinary Incontinence was somewhat individualized but failed to adequately address urinary retention. Although Individual #11 was incontinent most of the time and the amount of urinary output could not be accurately measured, the plan should have included nursing an intervention to | |

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| | | monitor the bladder for retention by palpitating the bladder area after urinating; if the bladder was distended, report the distention to the physician. If the bladder becomes overly distended there is the potential for the bladder to rupture. The ACP nursing intervention included, "*Judicious use of medications to help control urge like oxybutynin.*" Individual #11 was prescribed Uroxatral; therefore, this medication should have been used. There was no instruction on the ACP for the direct care professionals to observe for side effects or adverse reaction to Uroxatral. The ACP stated that Individual #11 would be, "*assessed at least once per shift during the acute phase (including vital signs), then daily to resolution*." Review of the nursing Integrated Progress Notes from 3/2/11 through 3/4/11, failed to contain documentation that this was done on every shift. Further, there was no documentation on the ACP that direct care professionals were trained on the plan. Neither was there documentation in the Integrated Progress Notes 3/2/11 through 3/4/11 that the ACP had been established and direct care professionals had been trained on the plan. It is imperative that the nursing staff monitor Individual #11's urinary status and therapeutic response to Uroxatral. The Uroxatral has the potential for numerous side effects, such as hypotension that may cause severe dizziness or fainting, especially when first started, and can contribute to falling. The nursing staff needs to be knowledgeable of these side effects and train the direct care professionals on how to observe and report any side effects. The Nursing Department needs to ensure when individuals' acute illnesses are diagnosed that ACPs are established and implemented immediately and the direct care professionals are trained in their responsibilities. The initiation of ACPs and direct care staff training needs to be documented on the ACPs and in the Integrated Progress Notes. Nursing staff needs to document in the Integrated Progress Notes that interventions specified in the ACPs are carried out.<br><br>• The Monitoring Team requested the nursing staff for a copy of Individual #11's ACP for Sinusitis on 3/1/11. A copy was not provided to the Monitoring Team, after daily requests, until the approximated 4:00 p.m. on 3/3/11 when the Unit Nurse Manager provided a copy of the ACP for Sinusitis dated 3/1/11. When the Monitoring Team asked the Nurse Operating Officer why there was a delay in providing a copy of the ACP, she explained that the ACP she had reviewed earlier was not adequate and was sent back for revision. Review of the ACP for Sinusitis was not individualized and failed to contain baseline data and goal. It was copied directly from the Health Care Protocol: for Developmental Disability Nurses. There was no documentation on the ACP that direct care professionals were trained in the plan. Review of the nursing Integrated Progress Notes from 3/1/11 at 12:10 p.m. through 3/4/11 at 11:00 a.m. contained documentation for | |

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| | | a few entries regarding monitoring Individual #11's acute illness health status for Sinusitis: On 3/1/11 at 2:31 p.m. the nurse documented, "*... was started at 12:50 PM on Augmentin for URI* [Upper Respiratory Infection] *and at 1PM Tylenol 650MG was given for comfort. He was uncooperative for V/S* [vital signs]." The nurse failed to document Individual #11's therapeutic response to Augmentin or Tylenol. There was no documentation that an ACP for Sinusitis had been established or the direct care professionals trained, although the ACP provided by the Unit Nurse Manager was dated 3/1/11. On 3/1/11 there was documentation that the nurse attempted to assess Individual #11 but he was uncooperative. On 3/3/11 at 2:52 p.m. the nurse documented, "*... continues on antibiotics ... he was tried for V/S but was uncooperative.* There was no documentation regarding Individual #11's therapeutic response to antibiotics. There was no documentation that the ACP was established and direct care professionals trained in their responsibilities until 3/4/11at 9:30 p.m. Then, the note stated that the 2 to 10 shift and the 10 to 6 shift direct care professionals were trained. There was no documentation that the 6 to 2 shift were trained. The Integrated Progress notes, as demonstrated above, did not follow the generic ACP that stated Individual #11 would be, "*assessed at least once per shift during the acute phase (including vital signs), then daily to resolution*." Review of the nursing Integrated Progress Notes from 3/1/11 through 3/4/11, failed to contain documentation that this was done on every shift. The delay of initiating an ACP for four days after Individual #11 was diagnosed with Sinusitis was not acceptable nursing practice.<br><br>• Individual #11 had a HMP for Developmental Disability, dated 10/20/10, that was generic in nature. There was no documentation on the HMP validating that the direct care professionals were trained in their area of responsibility. There was no documentation in the Integrated Progress Notes indicating the HMP was established and implemented or that direct care professionals were trained in the plan. There was no documentation that the HMP was reviewed and/or revised at the time of the 1/20/11 Quarterly Comprehensive Nursing Assessment.<br><br>• Individual #11 had a HMP for Risk of Falls/Injury, dated 10/30/10. Only the baseline data was individualized. The remainder of the HMP was copied directly from the stock plans. There was no documentation on the HMP validating that the direct care professionals were trained in their area of responsibility. There was no documentation in the Integrated Progress Notes indicating the HMP was established and implemented or that direct care professionals were trained in | |

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| | | the plan. There was no documentation that the HMP was reviewed and/or revised at the time of the 1/20/11 Quarterly Comprehensive Nursing Assessment.<br><br>• Individual #11 had a HMP for Psychotropic Medication Side Effects. The HMP did not include the name of the nurse who developed the HMP or the baseline/assessment date or implementation date. Only the baseline data was individualized. The remainder of the HMP was copied directly from the stock plan. There was no documentation on the HMP validating that the direct care professionals were trained in their area of responsibility. There was no documentation in the Integrated Progress Notes indicating the HMP was established and implemented or that direct care professionals were trained in the plan.<br><br>• Individual #11 had a HMP for Risk of Aspiration, dated 10/30/10. Only the baseline data was individualized. The remainder of the HMP was copied directly from the stock plan. There was no documentation on the HMP validating that the direct care professionals were trained in their area of responsibility. There was no documentation in the Integrated Progress Notes indicating the HMP was established and implemented or that direct care professionals were trained in the plan.<br><br>• Individual #11 failed to have a HMP for constipation, although his Comprehensive Nursing Assessment on 1/20/11 indicated that he had a Bowel Management Plan. Individual #11 was receiving Milk of Magnesia 30 milliliters orally, daily at bedtime. Individual #11 was receiving several psychotropic medications that had the potential to cause constipation. There were numerous instances of constipation documented in the Integrated Progress Notes.<br><br>• Individual #55 was prescribed on 1/11/11 olanzapine (Zyprexa), 15 milligrams, orally daily, at bedtime as a mood stabilizer. The nursing staff failed to establish an ACP for this psychoactive medication as required by the Settlement Agreement and Health Care Guidelines. There was no documentation in the nursing Integrated Progress Notes regarding the addition of this medication and associated monitoring for effectiveness and/or side effects and/or adverse reactions, or instruction to the direct care professionals how to observe and report side effects and/or adverse reactions.<br><br>• Individual #55 had a medical diagnosis for tonic clonic seizures. A nursing | |

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| | | problem for seizures was not listed on the Annual Comprehensive Nursing Assessment, 1/10/11. A copy of a HMP for Seizures, Prolonged, date 7/1/10, was made available for review. It was generic and was not individualized. There was no documentation indicating it was resolved, or reviewed and revised at the time of the annual nursing assessment. Neither did it contain documentation that the direct care professionals were trained at the time the plan was established. Even though Individual #55 was reported to have infrequent seizures and had a Health Risk Score rated low for seizures, that does not negate the need for a HMP for seizure management. Individual #55 continued to receive Dilantin and Valproic Acid (use as mood stabilizer) and required routine monitoring of anticonvulsant drug levels, monitoring for therapeutic response (sub-therapeutic levels and toxicity), and management during seizure activity. Direct care professions need to be trained on their responsibilities related to the plan. Individual #55 receives numerous psychoactive medications and needs a HMP developed in accordance with the requirements set forth in the Settlement Agreement and Health Care Guidelines.<br><br>• Individual # 72 had a medical and nursing diagnosis for seizures with a HMP for Seizures, Prolong, and dated 7/10/10. Except for the baseline data and goal the plan was generic and copied directly from the stock care plans. The baseline failed to include frequency and duration of seizures. There was no documentation validating that direct care professionals were trained in the plan. Neither was there documentation that the plan was reviewed and/or revised quarterly or at the time of the annual nursing assessment. There were Nursing Care Plans developed from the older version of the stock plans for Aspiration, Ineffective Health Maintenance, and Risk for Falls, dated 10/11/09. These plans were documented as being ongoing but there was no documentation indicating whether these plans were active. There was no documentation that the plan had been reviewed and/or revised quarterly or annually. There was documentation that the direct care professionals had been trained on the plans. Individual #72 also had medical diagnoses of Hypertension, Constipation, Osteoporosis, and Gynecomastia but no HMPs for these diagnoses. Individual #72 had a Health Risk Score of medium for Constipation and Osteoporosis and was receiving medications for these diagnoses. These diagnoses should have HMPs, even if they were considered stable because they were being medically followed and receiving medication. The purpose of having HMPs are to ensure that individuals remain stable and if the health status related to the conditions change negatively, the change is quickly identified, evaluated, and treated. There was no active medical or nursing problem for aspiration and the Health Risk Score was low for Aspiration. Individual #72 receives several psychoactive | |

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| | | medications and needs to have a HMP for Psychoactive Medications according to Settlement Agreement and Health Care Guidelines.<br><br>The Nursing Department needs to ensure that Nurse Case Managers review/revise HMPs at the time of the annual and quarterly nursing assessments and/or when there is a change in individuals' condition related to the plans. The Nursing Department needs to add to the HMPs and ACPs a line for signatures and dates for Home Leaders/Supervisors to sign to validate that the direct care professionals were trained on the plans. Also, when plans are established the heading needs to indicate if the plan was a HMP or ACP.<br><br><u>Psychoactive Medication Health Management Plans and/or Acute Care Plans Reviewed.</u><br>The Monitoring Team requested a list of individuals who had been prescribed psychoactive medications since 8/10, including individuals' names and dates psychoactive medications were prescribed as well as accompanying consents and health care plans. The Monitoring Team reviewed records for Individuals # 82, #80, #77, #84, #59, and #54. There were 10 psychoactive medications prescribed Ten of 10 (100%) failed to have an ACP or HMP established. This was of serious concern and failed to meet compliance with the Settlement Agreement and Health Care Guidelines. Examples of findings:<br><br>• The Monitoring Team requested a copy of Individual #82's ACP and/or HMP for the Clozaril. The Monitoring Team was provided with two generic Nursing Care Plans generated without individualization. A Nursing Care Plan for Disturbed Thought Process was established on 12/7/09. The plan failed to contain the signature of the nurse who developed the plan. There were signatures on the plan validating that a nurse had trained the direct care professionals on the plan, along with the direct care professionals' supervisor signature. The care plan failed to contain specific information regarding the direct care professionals' responsibilities in carrying out the plan. Neither did the plan contain any information regarding psychoactive medication. The plan stated it was "ongoing." There was no documentation indicating that the plan had been reviewed on a quarterly or annual basis or at the time the Clozaril was prescribed on 8/26/10. This plan was inadequate for monitoring psychoactive medications. The other Nursing Care Plan for Violent Behavior was established on 1/6/10. The RN developing the plan signed the plan. There were signatures on the plan validating that a nurse had trained the direct care professionals on the plan, along with the direct care professionals' supervisor signature. The care plan failed to contain specific information regarding the direct care professionals' responsibilities in carrying out the plan. The plan stated it was "ongoing." There was no documentation indicating that the plan had been | |

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| | | reviewed on quarterly or annual bases or at the time of the Clozaril was prescribed on 8/26/10. The only information regarding psychoactive medication was "*Administer medications like antianxiety/antipsychotic agents, sedative, narcotics as prescribed."* The plan contained inappropriate interventions, e.g., "*…place… in seclusion if necessary…"* The use of seclusion is prohibited. This plan was inadequate for monitoring psychoactive medications. Both of the above plans need to be discontinued and new plans established to the meet Individual #82's unique behavioral and mental health needs and be developed in collaboration with other relevant PST members.<br><br>Individual #82's Physician's Orders, 8/26/10 at 3:40 p.m., stated, "*Clozaril 12.5 mg PO BID. Reassess in 1 wk. Justification: mania/psychosis. Decrease (sic) Seroquel 600 mg PO every (sic) am and 200 mg PO every (sic) night. Justification: tapering.* On 9/9/10 at 5:30 p.m. the Physician Order included "(*Clozaril Protocol)".*On 9/13/10 at 5:00 p.m., the Physician's Orders stated, "*Clozaril 12.5 mg PO BID. Reassess every (sic) Wednesday. Justification: mania/psychosis."* On 9/14/10 at 12:00 noon the Physician's Orders stated, *"Hold Clozaril until further ordered."* According to the Physician Progress Note, 12/3/10 the Clozaril was withheld until the required lab work (white blood cells and five part differential) was completed. On 9/17/10 the Physician's Order stated to resume to order for Clozaril as the lab work was normal (white blood cells less that 2.5 and grandulocytes less than 1.5). The Physician Progress Notes stated, *"An attempt should be made to decreasing the Seroquel gradually to zero. If that is successful, we can increase the Clozaril to 100 mg and 50 mg HS …"*<br><br>Reviewed Individual #82's Integrated Progress Notes 8/26/10 through 3/3/11. On 8/26/10 at 10:00 p.m. the nurse documented, "*Medication change. To start on Clozaril 12.5 mg PO Bid, but consent need to be signed before it can be started therefore it was not given tonight. MD made aware. Seroquel decreased to 600 mg in AM and 200 mg at night."* On 9/17/10 at 4:44 p.m. the nurse documented that the results of the complete blood count with absolute differential and comprehensive metabolic panel was called to the physician and the Clozaril was started as ordered. At 7:00 p.m. baseline vital signs were: blood pressure 120/80, temperature 98 degrees, pulse rate 112, and respiration rate 22. O2Sats were not taken. At 8:15 p.m. vital signs were: blood pressure 120/80, pulse rate 90, and respirations rate 20. Temperature and O2Sats were not taken. The nurse did not follow the Clozaril Protocol that states for the initial dose, *"Monitorevery 30 minutes for one hour. If blood pressure fluctuated then continue to monitor every 30 minutes until stable. If blood pressure drops below 90/60 or if the patient experiences any adverse reaction the attending physician must be* | |

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| | | *notified to assess patient… Patient's compliance to weekly/biweekly lab work and to medication administration will be monitored weekly/biweekly by the registered nurse."* The nurse failed to take Individual #82's blood pressure every 30 minutes after the initial dose of Clozaril. There was no documentation that the nursing staff monitored individual weekly/biweekly according to Clozaril Protocol. The Physician's Orders on 9/13/11, 9/9/10, 9/17/10, and 1/14/11 ordered completed blood count with absolute differential weekly on Wednesdays. The nurse documented that venipunctures were performed for complete blood count with absolute differential on 12/15/10, 12/29/10, 1/19/10, 2/9/11 and 2/23/11. Each time the nurses' perform a venipuncture it needs to be documented in the Integrated Progress Notes. None of the lab results for complete blood count with absolute differential and notification to the physician were documented. The Nursing Department needs to provide competency-based training to the nursing staff on the Clozaril Protocol.<br><br>Review of Individual #82's Physician's Orders 9/14/10 through 1/24/11 indicated a progressive tapering down of Seroquel and progressive increase of Clozaril was being carried out. On 1/24/11 the Physician's Orders stated the status of Individual #82's tapering plan was at an increase of Clozaril to 200 milligrams, orally, twice a day and decrease of Seroquel to 100 milligrams, orally, twice a day for 90 days. Individual #82 should have had an ACP related to the titration upward of Clozaril and the tapering down of Seroquel. The Nursing Department needs to ensure that ACPs and HMPs are established for individuals receiving psychoactive medications, according to the Settlement Agreement and Health Care Guidelines. ACPs are critically important to monitor for efficacy, side effects, adverse reactions and other untoward reactions when individuals are newly prescribed psychoactive medications and/or when on a tapering plan, particularly when another psychoactive medication is added and gradually increased. Individuals who are identified as receiving polypharmacy (two or more psychoactive medications of the same class) or who are prescribed long term use of psychoactive medication need to have a HMP.<br><br>• Individual #80 was prescribed Lithium on 9/15/10. The consent for Lithium was signed by Individual #80, the Legally Authorized Representative, nurse providing an explanation, and prescribing physician on 9/15/10. Trileptal was prescribed on 2/16/11. The consent for Trileptal was signed by Individual #80, the Legally Authorized Representative, nurse providing an explanation, and prescribing physician on 12/17/10. There were no ACPs established for Lithium or Trileptal. | |

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| | | • Individual #77 was prescribed Seroquel and Xanax on 11/4/10. The consents for Seroquel and Xanax were signed on 11/4/10 by Individual #77, the Legally Authorized Representative, nurse providing an explanation, and prescribing physician. Mellaril was ordered to re-start on 2/15/15. The consent for Mellaril was signed on 2/18/11 by Individual #77. The Legally Authorized Representative and nurse providing an explanation signed the consent on 2/15/11. The consent for Mellaril failed to include the signature of the prescribing physician. There were no ACPs established for Seroquel or Xanax or Mellaril.<br><br>• Individual #84 was prescribed Xanax on 12/15/10. The consent for Xanax was signed on 12/24/10 by the Individual #84, Legally Authorized Representative, nurse providing an explanation, and prescribing physician. On 2/11/11 Ativan was prescribed. The consent for Ativan was signed on 2/15/11 by the Legally Authorized Representative, nurse providing an explanation, and prescribing physician. There were no ACPs established for Ativan or Xanax.<br><br>• Individual #59 was prescribed Lithobid on 12/29/10. The consent for Lithobid was signed by Individual #59 on 12/31/10. The Legally Authorized Representative, nurse providing an explanation, and prescribing physician signed the consent on 12/29/10. The prescribing physician signed the consent on 1/3/11. There was no ACP for Lithobid.<br><br>• Individual #54 was prescribed Abilify on 2/16/11. Individual #54 had a signature on the consent but no date. The nurse proving an explanation signed the consent on 2/16/11. There were no signatures on the consent for the Legally Authorized Representative and prescribing physician. There was no ACP for Abilify.<br><br>The Nursing Department needs to continue to make improvements to ensure that individuals' health care needs are identified; nursing care plans established for identified health care needs, care plans are individualized to meet individuals' special health care needs that includes preventative and/or proactive interventions, and interventions that would minimized health risks. | |
| M4 | Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting | Since the last tour the Nursing Department had continued to use the Health Care Protocols for Developmental Disability Nurses to assist with developing ACPs and HMPs. The Nurse Case Managers, who developed the ACPs and HMPs failed to consistently, if at all, individualize the care plans. While it was helpful to have the protocol as a resource | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
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| | protocols sufficient to address the health status of the individuals served. | guide, the protocol was not intended to be used verbatim. In review of the care plans described in M.3 it was apparent the ACPs and HMPs were copied directly from the stock protocol without due consideration of the content. Often extraneous information was copied that had no bearing upon the individuals' condition.<br><br>The Chief Nurse Executive stated the Nursing Department was revising the Facility's Medication Administration Policy. When asked if she was participating with the State Nurse Executives Workgroup, which was drafting a Medication Administration and Medication Error/Variance Policy, she stated she was not and had not reviewed the draft polices. It is important that the Facility's Medication Administration and Medication Error/Variance Policies are consistent with the policies being drafted by the State Nurse Executives. Dr. Dill, Medical Director, assured the Monitoring Team that the Facility's policies would be consistent with the policies developed by the State Office. At the next tour the Monitoring Team will compare the Facility policies to the State policies to evaluate for congruency.<br><br>The Nursing Department continued to enter appointments in a centralized Appointment Database as described in M.1. The Nursing Department's SOP, MR 400 10, Scheduling Medical Appointments, Date Established, June 2002, Next Review: Date February 2011 had not been reviewed or revised at the time of the tour. The Nursing Department needs to revise the Scheduling Medical Appointment Policy to include procedures for entering appointments into the Appointment Database and monitoring to ensure that all medical appointments are entered and tracked to ensure appointments are kept and missed appointments are rescheduled and kept.<br><br>Since the last tour the Nursing Department had developed and implemented an excellent database to track all required training. Training records were made available for the Monitoring Team to review. All required trainings on policies, procedures and protocols were tracked by percentages of nurses trained on each topic along with a projected date for completion for nurses who failed to complete specific topics by 100%. Signed Training Rosters were also made available for review of the training completed since the last tour. This was a positive finding and will facilitate tracking to ensure required training is completed.<br><br>Review of the training material failed to demonstrate that the training materials were competency-based. Most of the training was completed by the Nurse Operating Officer and Unit Nurse Manager. Listed below are the percentages of nurses who had received training year to date. For topics where 100% of the nurses had not been trained, the Nursing Department projected all nurses would be trained by the third Quarter FY11. | |

| # | Provision | Assessment of Status | | Compliance |
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| | | **Training Topic** | **% of Nurses Trained** | |
| | | Changes in Restraint Policy | 89% | |
| | | Restraint Policy/Completing Restraint Checklist | 84% | |
| | | Memo: Transfer Implementation | 53% | |
| | | Reporting Unusual Incidents/Injuries to Consumers | 68% | |
| | | Cleaning of Maroon Spoons | 95% | |
| | | Clients Appoints Scheduling and Tracking | 84% | |
| | | Transcriptions Orders | 89% | |
| | | Use of State Vehicles for Personal Errands | 26% | |
| | | Role of Nurse when Attending Meetings | 79% | |
| | | Reporting Unusual Incidents/Serious Injuries | 42% | |
| | | Abuse, Neglect, and Exploitation Tracking Form | 79% | |
| | | Nutritional Orders | 95% | |
| | | SOP-HIM 400-07 Documentation Guidelines | 95% | |
| | | Medication Administration Record Transcription | 95% | |
| | | Pain Medication Policy (FLACC Pain Score and Follow-up) | 89% | |
| | | Charge Nurse Checklist | 95% | |
| | | Documentation of Seizures in CWS | 95% | |
| | | Record Verification Checklist for Hospitalization | 95% | |
| | | Filling out Injury Reports | 95% | |
| | | Steps to follow sending individual to an Acute Care | 95% | |
| | | Facility or Emergency Room | 89% | |
| | | Restraint Policy-Pre-meds | 89% | |
| | | Suicide Risk Assessment | 89% | |
| | | Hypoglycemia (insulin reaction) Protocol | 89% | |
| | | Injuries to Consumers – Timeframes | 84% | |
| | | Dysphagia | 89% | |
| | | QM Department Staff Office Contact Numbers ID | 89% | |
| | | Abuse, Neglect, and Exploitation | 47% | |
| | | Medication Error Policy | 47% | |
| | | MR 400-11 Information to be Sent to the Emergency Room or Hospital Admission | 95% | |
| | | Medication Error Policy | 74% | |
| | | Daily Sign-in Sheet | 74% | |
| | | Injury Report Reminder | 79% | |
| | | Menstrual Record | 95% | |
| | | Medication Error Policy | 47% | |
| | | Daily Bowel Monitoring Form | 89% | |

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| Emergency Equipment Checklist | 79% |
| AED Checklist | 79% |
| Weekly trimming of client's finger nails; per case load | 79% |
| Reminder to use SOAP method of charting Nursing Progress Notes | 74% |
| Nursing Assessment Quarterly/Annual, Nursing Care Plan | 79% |
| Fall Risk and Prevention (Revised Policy 700-09) | 89% |
| New Definition for Falls | 89% |

After review of the percentage of nurses trained in the various topics it was evidenced that there was a sharp correlation between failure of nurses to receive 100% of the required training and the failure to meet compliance with completing the following items, e.g., Restraint Policy/Completing Restraint Checklist, Reporting Unusual Incidents/Serious Injuries, Abuse, Neglect, and Exploitation, Pain Medication Policy, Restraint Policy for Pre-medications, Medication Error Policy, Emergency Equipment Checklist, and AED Checklist, Reminders to use SOAP Method of Charting, Nursing Assessment Quarterly/Annual and Nursing Care Plan, Fall Risk and Prevention Policy, and New Definition for Falls. The Nursing Department needs to ensure that 100% of the nurses are promptly trained in the following topics related to compliance with the Settlement Agreement and Health Care Guidelines: Restraint Policy/Completing Restraint Checklist, Reporting Unusual Incidents/Serious Injuries, Abuse, Neglect, and Exploitation, Pain Medication Policy, Restraint Policy for Pre-medications, Medication Error Policy, Emergency Equipment Checklist, and AED Checklist, Reminders to use SOAP Method of Charting, Nursing Assessment Quarterly/Annual and Nursing Care Plan, Fall Risk and Prevention Policy, and New Definition for Falls. The Nursing Department needs to utilize the Facility's Infection Control /Nurse Educator to assist with providing training to the nursing staff.

It was positive to find that the Chief Nurse Executive had arranged with an external Nursing Consultant, Dr. Rella Adams, to provide the Nurse Managers and Nurse Operating Officer/Hospital Liaison Nurse with Management Training. The training began in February 2011 with ongoing training in March 2011. The Management Training included the following topics:

- Role of the Unit Nurse Manager - Performance Plan
- Challenges in meeting and working with other disciplines
- Staying clinically focused
- Assurances of a productive meeting
- Managing Ethically
- Nurse Managers as an Educator

| # | Provision | Assessment of Status | Compliance |
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| | | • Occupational Health and Safety<br>• Dealing with conflict in the work setting<br>• Prioritizing Tasks<br><br>The Nursing Department participated in other training opportunities, such as: The Unit Nurse Manager attending Physical and Nutritional Management training in Corpus Christi on 10/20/10. In October 2010 the nursing staff began training on Supporting Visions and the new PSP Policy. This training will be included in new employee orientation for those who missed the initial training. The Nurse Operating Officer successfully completed accessHR (Human Resource) Training Program for Managers on 2/8/11 and Managing Employee Performance on 2/9/11, conducted by the Texas Health and Human Services Commission. According to the Facility's POI on 12/21/10 and 12/28/10 the State Office provided trained on the At-Risk Individuals Policy. | |
| M5 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual. | Since the last tour, the State Office had developed a policy for At-Risk Individuals, dated 11/2/10. The policy included Risk Guidelines, which contained criteria to assist the team in determining risk levels for a variety of risk factors. In addition, the assignment and review of risk was to be conducted during the PST meetings, and the Health Status Team would no longer exist. The new policy indicated that nursing in conjunction with the individual's primary care physician were responsible for assessing risk factors for the following categories:<br>• Aspiration<br>• Respiratory Compromise<br>• Cardiac Disease<br>• Constipation/Bowel Obstruction<br>• Diabetes<br>• Gastrointestinal Problems<br>• Osteoporosis<br>• Seizures<br>• Skin Integrity<br>• Infections<br>• Fractures<br>• Fluid Imbalance<br>• Hypothermia<br>• Urinary Tract Infections<br>• Circulatory<br><br>According to the Facility's POI on 12/21/10 and 12/28/10 the State Office provided training on the At-Risk Individuals Policy. In January 2011 At-Risk forms and procedures | Noncompliance |

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| | | were implemented. In February 2011 the Facility operationalized the State Office At-Risk Individuals Policy and submitted it to Quality Enhancement for review. None of the records reviewed contained assessments completed on the new policy.<br><br>Review of Health Risk Assessment Ratings for Individual #11 and #108 did not agree with individuals' health status identified through record review. The following examples represent the disparities identified:<br><br>• Individual #11: On 8/24/10, Individual #11's overall Health Risk Assessment Rating was low. Individual #11 was rated at low risk for aspiration and choking; however, Individual #11's Annual and Quarterly Comprehensive Nursing Assessments' listed high risk for choking as a nursing problem and had an accompanying Health Management Plan for Aspiration. Individual #11 had a Physical and Nutritional Management Plan (PNMP) for a ground texture diet, and special feeding instructions due to risk of choking that included 1:1 supervision because he eats too fast, overstuffs mouth, and fails to chew food before swallowing. Individual #11 was rated low risk for injury. Individual #11's Annual and Quarterly Comprehensive Nursing Assessments' listed high risk for falls and injury and had an accompanying Health Management Plan for Falls and Injury secondary to visual problems contributing to him bumping into things, self-injurious behavior, and aggression toward peers. Individual #11 was rated as low risk for Polypharmacy. Individual #11's Health Risk Assessment Tool for Polypharmacy marked "yes" for both questions: "1. Does this person take two or more medications from the same general class for the same indication?" Individual #11 was documented as taking five medications from the same class for the same indications. "2. Does this person take three or more medications regardless of class for the same indication.?" Individual 11 was documented as taking five medications from different classifications for the same indication.<br><br>• Individual #108: Individual #108's overall Health Risk Assessment Rating was low, dated 3/3/10. Of all individual risk categories, only the risk for Urinary Tract Infections was rated as medium risk. Another Health Risk Assessment was completed on 12/15/10 but only the categories for aspiration, choking and weight were marked and they were marked as low. The overall low Health Risk Assessment Rating did not accurately reflect Individual #108's health status as identified through record review. Individual #108's Active Medical Problem List, 2/17/11, included: Profound Mental Retardation with severe speech disorder, Type II Diabetes, Neurogenic Bladder with intermittent bladder | |

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| | | catheterization, Osteoporosis, History of Chronic Urinary Tract Infections, History of Urosepsis, History of Chronic Constipation, Hyperlipidemia, Uterine Fibroid, Glaucoma, Bilateral Cataracts, History of Pyloric Stenosis and Bowel Obstruction, History of Mallory-Weiss Disease of the Distal Esophagus, and a BMI of 23%. The risk categories for Aspiration, Choking, and Gastrointestinal were rated low but Individual #108 has a PNMP and a HMP for Aspiration and Gastroesophageal Reflux. However, Aspiration was not listed on the Active Medical Problem List. Constipation was listed as low risk, yet the individual had a history of chronic constipation and bowel obstruction and was diagnosed with internal hemorrhoids on 10/19/10 and receives Milk of Magnesia every other night. Once an individual has a bowel obstruction the individual remains at risk for future obstructions. Osteoporosis was rated low, yet the individual was receiving Alendronate and was on fall precautions secondary to the Osteoporosis. Urinary Tract Infection was rated medium but should have been rated high due to a Neurogenic Bladder with intermittent catheterizations, history of Urosepsis, Chronic Urinary Tract Infections.<br><br>Infection Control<br>Infection Control issues are addressed in this provision because clinical data regarding health risk indicators specific to the prevention of infections and communicable diseases should be monitored, collecting, reporting, tracked, trend and analyzed to identify the status of immunizations, preventative health screenings; to identify trends for infections and communicable diseases to prevent and/or control the spread health-care associated infectious process that have the potential to increase individuals' health risks for mobility and mortality.<br><br>The Infection Control Preventionist/Nurse Educator stated the Facility was revising the Infection Control Policy and training Curricula. When asked if he was participating in the State Infection Control Workgroup that was drafting an Infection Control Policy and training curricula, he stated he was not. He stated that he had sent several e-mails to the State Office asking for an update on the final or draft statewide manual but had not received a response. He stated that he was not included on the State Office e-mail distribution list. The State Office should ensure that the Infection Control Preventionist/Nurse Educator is included on the e-mail RG Report distribution list for issues related to risk,infection control and nursing education. It is important that the Facility's Infection Control Policy and training curricula are consistent with the policy and training curricula developed by the State Office. Dr. Dill, Medical Director assured the Monitoring Team that the policy and training curricula would be consistent with those of the State Office. At the next tour the Monitoring Team will compare the Facility | |

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| | | policies to the State policies to evaluate for congruency.<br><br>The Infection Control Preventionist/Nurse Educator reported on improvements made since the last tour. Improvements included the following actions:<br>• Chart review for FY10 for Settlement Agreement, Section I and a trend analysis report created.<br>• Individual trending database created<br>• Section I chart review tool created<br>• Health-care Associated Infections (HAIs) trend analysis report created<br>• Baseline review of 100% of individuals' records<br><br>It was positive to find since the last tour the Infection Control Preventionist/Nurse Educator had completed reviewing all 73 individuals' charts for status of immunizations and preventative clinical indicators. Reviewed the Trend Analysis Report Summary – Final Baseline Report of the Initial Full Chart Review that identified each individual status regarding immunization and preventative health indicators completed in February 2011. The purpose for the trend analysis was to summarize status of goals, clinical indicators, analysis, conclusions, and data over the most recent quarter for the Infection Control/Employee Education Program. The goals stated for the Fiscal Year (FY) 2010/11 were to reduce the risk of infection and reduce health-care associated infections (HAIs) in the population of individuals served. The indicators used included:<br><br>• Determine and assess immunization status for identified individual population by review of six to ten charts monthly, and report to the Professional Improvement Council (PIC) monthly.<br>• Determine tuberculosis status of individual population by review of six to ten charts monthly, and report to PIC quarterly.<br>• Trend and analyze all HAIs of individual population, record and trend monthly, and report to PIC quarterly.<br>• Determine percentage of employees who completed at-risk in-service training, and report to PIC quarterly.<br><br>The Trend Analysis Report indicated that assessments of established risk indicators of communicable diseases and preventative health assessments were completed for the Fourth Quarter FY10, First Quarter FY11, Second Quarter FY11, and Third Quarter FY11. The analysis provided a percentage of compliance with required immunizations and preventive health assessments, as applicable, for each individual as well as for the total population. The Trend Analysis Report for the total population indicated overall percentage of compliance with immunizations and preventative health screenings:: | |

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| Indicators | % of Compliance |
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| Health Status Risk Level | 97% |
| Immunization Status | 100% |
| Measles, Mump, and Rubella | 58% |
| Influenza | 98% |
| Tetanus | 98% |
| Pneumococcal | 97% |
| Varicella | 74% |
| Zoster | 0% |
| Hepatitis B | 36% |
| Tuberculosis | 88% |
| Diabetes | 100% |
| Hypertension | 80% |
| Gastroesophageal Reflux | 88% |
| Cardiac | 89% |
| Infections | 84% |
| Urinary Tract Infections | 0% |
| Infection Control Prevention | 100% |

Through this comprehensive review and analysis the Infection Control Preventionist/Nurse Educator was able to identify areas of deficiencies and develop plans of corrective action to correct the deficiencies identified for each individual. This was evident from the review of plans of corrections, 6/10 through 12/10, sent to the Unit Nurse Manager for correction. The plans of correction included: Identification of individuals' record, findings, plan for correction, responsible person, implementation timeline, and report of completed due (date). However, there was no documentation available for review that validated that the plans of correction were completed. The Infection Control Preventionist needs to develop and implement a tracking database to ensure that plans of corrective action are completed by the due date. While the Infection Control Program did not have a centralized database for tracking immunizations, this database could serve as an immunization database for tracking immunizations.

Review of the Influenza Immunization Program FY11 – Second Quarter indicated that 91% of RGSC employees received immunizations for influenza. There was justification provided for employees who refused to receive influenza vaccines. Employee Tuberculosis Skin Testing and Questionnaires were tracked monthly. Raw monthly data were provided for review but it was not possible to discern qualitatively the percentage of employees who were current in Tuberculosis screenings

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| | | The Infection Control Preventionist/Nurse Educator had completed one Infection Control Monitoring Tool as a baseline. He pointed out that the number 10 question on the Infection Control Monitoring Tools needs to be revised to read, "For individuals born after 1957 without documentation of immunity to MMR (Measles, Mumps, Rubella) should receive or have documentation of MMRs." According to Center for Communicable Disease (CDC), adults born before 1957 are considered immune. The Facility and State Office should revise number 10 on the Infection Control monitoring Tool to read, "For individuals born after 1957 without documentation of immunity to MMR (Measles, Mumps, and Rubella) should receive or have documentation of MMRs."<br><br>The Infection Control Program continued to collect, report, and analyze data regarding infections and communicable diseases on a quarterly basis. For the past two quarters the reportable infections information included:<br><br>• Methicillin-resistant Staphylococcus Aureus – none<br>• Hepatitis A, B, C – none; one individual reported as a Hepatitis Carrier<br>• H1N1 – none<br>• Clostridium Difficile – none<br>• Sexual transmitted Diseases – none<br>• Pneumonia – none<br>• Decubitus Ulcers – none<br>• Urinary tract Infections – five<br>• Bowel Obstructions – none<br>• Individuals with positive skin test for Tuberculosis – eight; no converters<br><br>Dr. Dill reported that in 2008 there were high incidents of Upper Respiratory Infections and Pneumonias due to the failure for the influenza vaccine to cover the contagious influenza. Since 2008 the Infection Control Programs had taken aggressive measures to ensure that individuals and employees were vaccinated against influenza and those individuals who were at risk received pneumococcal vaccine. As a result of these interventions the Facility had reduced the incidents of Upper Respiratory Infections from 29 in FY08 to 10 in FY10 and Pneumonias from 18 in FY08 to one in FY10.<br><br>The Infection Control Preventionist/Nurse Educator indicated that system used to ensure reliability was to review infection data with the Medical Director. The Infection Control Program needs to evaluate the system used to evaluate the reliability of infection data to ensure the system accurately assesses the reliability of the infection data reported. | |

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| | | Interview with the Infection Control Preventionist/Nurse Educator and the Medical Director found that because of the high frequency of Urinary Tract Infections the Infection Control Program plans to make improvements in management of Urinary Tract Infections and reduce level of risk in this area. Plan for improvement included:<br><br>• First, construct a new Urinary Tract Infection Policy/Protocol that is more inclusive and complete over existing policy. Then, train all employees on the protocol and work with physicians.<br>• Second, examine the Urinary Tract Infections that occurred during the past year to determine if the diagnosis was accurate.<br>• Once an accurate picture of the Urinary Tract Infections is identified, look for any patterns that emerge such as several from one or two particular individuals, occurrence with certain staff member assigned, observation of any catheter insertions watching for proper sterile technique, proper hygiene followed, wiping from front to back in the case of females, regularly changing of clothes, particularly clothing close to the urethral area, and proper bathing.<br>• Examine and correct any patterns that emerge that put the individual at risk for developing Urinary Tract Infections.<br>• Continue ongoing monitoring of Urinary Tract Infections within the Facility using the steps outlined above, watching closely for a decrease in occurrence. If decrease does not occur, see what else can be done to ensure proper care, and explore ways to decrease the occurrence.<br>The Monitoring Team will follow-up on this plan of improvement at the next tour.<br><br>The Monitoring Team reviewed records for Individuals #33 and #108 who recently were diagnosed and treated for Urinary Tract Infections. Individual #33 was rated as low risk for Urinary Tract Infections and Individual #108 was rated as medium risk. The risk level was inaccurate as demonstrated by their UTIs and that the treatment did not indicate an appropriate response to a higher risk level. As described in Provision M1, care of their Urinary Tract Infections failed to meet compliance with the Settlement Agreement, Health Care Guidelines, and the Facility's protocol for managing Urinary Tract Infections and Acute Illnesses. The nursing staff consistently failed to complete, at least daily, comprehensive nursing assessments for individuals' Urinary Tract Infection, monitor antibiotic therapy for efficacy and side effects, develop an individualized ACP for Urinary Tract Infections, train the direct care professionals, and follow through to resolution.<br><br>The Monitoring Team reviewed Monthly Surveillance Checklists and Handwashing | |

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| | | Monitoring Sheet, July 2010 through November 2010, completed by the Infection control Nurse indicated that all areas of the Facility were monitored for these two items. When deficiencies were identified there was validation that plans of corrections were sent to the respective staff. There was no documentation validating that the corrective action plans were carried out. The Infection Control Program needs to develop a database for tracking corrective action plans to resolution.<br><br>The Infection Control Program received monthly Drug Utilization Reports for Antibiotics from the Pharmacy. The Infection Control Preventionist/Nurse Educator needs to work collaboratively with the Pharmacist to evaluate the appropriateness and effectiveness of antibiotics prescribed to treat infections.<br><br>Review of the Active Employee Course Participation Report, 3/2/11, indicated that all employees were current in their Infection Control training.<br><br>The Monitoring Team reviewed Safety/Risk Management/Infection Control Committee Minutes, 8/13/10, 9/9/10, 10/14/10, 11/10/10, and 12/14/10. This continued to be a joint committee meeting and it was doubtful that with as many issues were included in this meeting that there was enough time to fully discuss all issues. The only information contained in the minutes regarding Infection Control issues were related to the Quarterly Infection Reports. There was no discussion of findings or problem solving relating to reducing the incidents/rates of infections within the Facility. The Quarterly Reports included the following information:<br><br>• Infection Control Report - Second Quarter FY10<br>o 13 Infections – 18% Rate<br>o 0% Nosocomial Rate<br>o 0% Reportable Diseases<br>o Infections – 1 Upper Respiratory Infection, 2 wound, 1 conjunctivitis, 1 sty, 1 cellulitis, 2 prophylaxis<br>• Infection Report – Forth Quarter FY10<br>o 9 Infections – 12.50% Rate<br>o 1% Nosocomial Rate<br>o 0% Reportable Diseases<br>o Infections – 1 ear, 2 wound, 1 conjunctivitis, 1 rash, 1 colitis, 1 abscess, 1 swollen lymph nodes<br>The third quarter report was not included in the minutes. | |
| M6 | Commencing within six months of | The Chief Nurse Executive stated the Nursing Department was revising the Facility's | Noncompliance |

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>the Effective Date hereof and with full implementation in one year, each Facility shall 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.</td><td>Medication Administration Policy. When asked if she was participating with the State Nurse Executives Workgroup that was drafting a Medication Administration and Medication Error/Variance Policy, she stated she was not and had not reviewed the draft polices. It is important that the Facility's Medication Administration and Medication Error/Variance Policies are consistent with the policies being drafted by the State Nurse Executives. Dr. Dill, Medical Director assured the Monitoring Team that the Facility's policies would be consistent with the policies developed by the State Office. At the next tour the Monitoring Team will compare the Facility policies to the State policies to evaluate for congruency.<br><br>The Monitoring Team reviewed the Medication Administration Record Audits, August 2010 through January 2011, completed by the Quality Enhancement Nurse who used the Facility's audit tool to monthly review six individuals' records. The results of the audits included:<br><br><table><tr><th>Month/Year</th><th>Overall % of Compliance</th></tr><tr><td>August 2010</td><td>66.40%</td></tr><tr><td>September 2010</td><td>75.77%</td></tr><tr><td>October 2010</td><td>78.25%</td></tr><tr><td>November 2010</td><td>88.00%</td></tr><tr><td>December 2010</td><td>79.75%</td></tr><tr><td>January 2011</td><td>84.50%</td></tr></table><br>The completed Medication Administration Audits contained plans of corrective action for each item on the tool that fell below 100% compliance. The plans of corrective action were assigned to the Chief Nurse Executive, Nurse Operating Officer and/or Unit Nurse Manager. The Plans of corrective action included: Dates of Completion, Dates of Follow-up Request and Comments. Of 24 plans of corrective action 9 of 24 (38%) were completed. The Quality Enhancement Nurse needs to ensure that plans of corrective action for deficiencies identified on Medication Administration Records are followed through to resolution.<br><br>It was positive to find that in January 2011 the Nursing Department had developed and implemented a schedule to conduct Medication Administration Observation on a quarterly basis using the revised form developed by the State Office. At the time of the tour Medication Administration Observations had been completed on four nurses. The revised Medication Administration Observation form showed significant improvement from the form previously used. The form includes a section at the bottom of the page for comments and allowed for the calculation of percentage of compliance in administering</td><td></td></tr>
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| | | medication correctly. None of the seven completed Medication Administration Observations met 100% compliance. The seven completed Medication Administration Observations included plans for corrective action for identified areas of deficiencies. It could not be determined from review of the completed Medication Administration Observations whether the observations were completed for the entire medication pass. The Nursing Department needs to ensure that Medication Administration Observations are completed for the entire medication pass. The Nursing Department needs to develop a database to track Medication Administration Observation plans of corrective action to ensure that plans of corrective action are completed.<br><br>When observing medication administration while on site for individuals living in El Paisano and La Paloma, the following significant issues were identified. Issues of concern Included:<br><br>• The MediMAR electronic system was fully implemented. According to the Chief Nurse Executive the system frequently goes down; as a result it was necessary to also maintain a paper Medication Administration Record (MAR) to document medication administration. The duplicate system increased the time to pass medications. Often nurses fail to document on the paper copies, which leads to confusion when monitoring MARs and identifying medication errors. Because of the time it takes to scan medications into the MediMAR, individuals become restless with the wait and may leave before the medications were administered. This also presents another problem because the scanned medications were opened and prepared for administration; this resulted in pre-pouring medications. Therefore, when individuals returned for their medications, medications could not be accurately checked again prior to administration. This violates safe medication administration practices and can lead to medication errors and risk of harm to individuals. The MediMAR electronic system as used at RGSC slowed the process of administering medications, caused duplicate documentation with the potential for documentation errors, and caused situations in which the likelihood of medication errors increased.The Facility needs to re-evaluate the risks and benefits of using the MediMAR system.<br><br>• The nursing staff failed to review each individuals' PNMP prior to administering medications. The MediMAR did not contain PNMP information. The PNMPs were present in both the MAR notebooks as well as in a separate PNMP notebook. This required the nurses to take time to refer to these notebooks, which was not practical due to time constraints; hence the PNMPs were not referred to. This omission had the potential to cause individuals harm if the | |

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| | | nurses failed to follow individuals' PNMP for alteration in textures, consistencies, presentation techniques, positioning, and adaptive equipment. The Facility needs to modify the MediMAR to include PNMP information.<br><br>• Individuals' Self-Administration of Medication Programs and data sheets were kept in a separate notebook. When implementing individuals' programs this required the nursing staff to refer to another notebook. Again, this adds time to the medication pass and could easily be overlooked or omitted due to time constraints.<br><br>• The Pharmacy sent medications in bubble packaging that required the nurses to split the tablet to give the correct dosage. One nurse was observed attempting to split a pill with her fingers while the medication was in the bubble package. The Chief Nurse Executive advised the nurse to use a pill cutter. While that was a better alternative to splitting the pill while in the package, it was not an acceptable practice. Split tablets are often unequal and a substantial amount of the tablet can be lost during splitting and can lead to inaccurate dosing and ineffective medical management. There can be a narrow margin between therapeutic and toxic doses. The practice of nurses splitting tablets should cease because of the risk of harm to individuals due to potential for administering an inaccurate dose of medication. If tablets must be split the Pharmacy needs to purchase and dispense the prescribed dose or split the tablets in the Pharmacy before dispensing to the unit. Although this would take additional time in the Pharmacy, it would reduce the time required to prepare and pass medications at the unit, where the time spent in the medication pass can affect the scheduling of activities for the individuals who live there. It would further ensure accountability by the Pharmacy of the medications they dispense. The Nursing Department needs to collaborate with the Pharmacy to resolve the issue of requiring nurses to split tablets to achieve the correct dosage to administer.<br><br>• The lack of privacy continued to be a problem. Individuals continued to come to the medication rooms' dutch doors to receive medications. Since the last tour the Nursing Department had begun placing large signs outside the medication room when medications were passed. The sign stated "Medication pass in session. Do not disturb." While the signs may help control the traffic in the hall while medicines were passed, they do not afford individuals with privacy. The Chief Nurse Executive stated that a proposal was submitted to the Facility for a walled-off space outside the medication rooms but the proposal had not been acted upon. The Facility needs to provide building space that affords individuals | |

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| | | privacy during medication administration.<br><br>• The nurses failed to consistently tell individuals the name and purpose of the medications they were receiving.<br><br>• Opened liquid medications were not consistently dated and initialed by the nurse who opened the bottle. Outdated medications were found in El Paisano's refrigerator. They were removed and returned to the Pharmacy. The Nursing Department needs to ensure when liquid medication bottles are opened that nurses date and initial the date opened and routinely check medication expiration dates.<br><br>Since the last tour the Quality Enhancement Nurse had made significant improvements the Medication Error tracking database. Medication Error data for ICF-MR were separated from the Mental Health Hospital and Out Patient Clinic. The database now included not only the types and classifications of the medication errors but also contributing factors that lead to causing the medication errors. Although the Medication Error database was recently revised, it appeared to have a great deal of potential in assisting the Facility in identifying medication error trends. The Facility should continue to utilize the Medication Error database to analyze trends and generate plans of corrective action to address problematic trends, which it had not done.<br><br>After review the medication error data over the last six months, the Monitoring Team interviewed the Quality Enhancement Nurse and Unit Nurse Manager regarding concerns identified related to the lengthy delay between the time medication errors were discovered and when they were investigated and corrective action taken as well as the fact that only two medication errors were reported for nursing during the last quarter. The Quality Enhancement Nurse explained that they were concerned about these issues as well and had taken measures to improve their medication administration system and to ensure that all medication errors were reported and investigated timely.<br><br>The Quality Enhancement Nurse explained that the Medication Administration/Medication Error Committee had been disbanded and replaced with a Medication Error Workgroup on 10/5/10 to streamline the process to effectively report medication errors and to decide a timeframe for entering medication errors and investigations into CWS. The Workgroup members included the Chief Nurse Executive, Nurse Operating Officer, Quality Enhancement Nurse, Unit Nurse Manager, Pharmacist, and Medical Staff Coordinator. Planned corrective action included: | |

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| | | • Medication errors will be entered by the party who discovered the error.<br>• Investigations will be conducted by the party discovering the error.<br>• Nursing and pharmacy agreed to input medication errors into CWS within seven days of the date discovered/witnessed.<br>• Investigations of medication error events will be completed within seven days of entry into CWS.<br>• Reporting date of completed medication errors/investigations will be on the 25th of every month.<br>• The Pharmacist and Chief Nurse Executive will assure that each department's policies/procedures regarding medication errors are similar and concurrent with the above process regarding medication investigations.<br><br>The Workgroup met again in October 2010 to review the corrective action plan. The Quality Enhancement Nurse had developed a spreadsheet to track medication errors in CWS and whether investigations were completed. The Pharmacist began inputting discovered medication errors into CWS for September and October and individual departments began investigating reported errors. Copies of the spreadsheet with errors in CWS pending investigations were given to the Unit Nurse Manager, Chief Nurse Executive, and Pharmacist via e-mail on 10/14/10. The Workgroup met again on 10/28/10 to discuss how the process was working and they agreed the process was working well. The Pharmacist request that the Pharmacy Technician be trained on inputting data into CWS for medication errors and investigations. The Quality Enhancement Nurse provided training to a Pharmacy Technician 10/28/10.<br><br>The Workgroup met again in November 2010. Medication errors remained uninvestigated. Copies of the spreadsheet of medication errors in CWS was e-mailed to each discipline head responsible for completing investigations. There were several errors inputted into CWS that lacked information for investigation and the discipline heads responsible for investigation were asked to meet with each other regarding unclear medication errors prior to completing the investigation.<br><br>In December 2010, an e-mail was sent to the Unit Nurse Manager regarding one medication error in CWS that was pending investigation. The Unit Nurse Manager completed the investigation.<br><br>In January 2011, the Quality Enhancement Nurse was able to verify medication errors/investigation data with the Information Technology's data. It was noted that several medication errors had two investigations. The Workgroup was notified and agreed on which investigation to delete and they were deleted. After all corrections, the | |

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| | | data matched with information Technology's data in regard to having equivalent Medication Error database number of medication errors and investigations. The date changed to have all errors completed for the month from the 25th of the month to the 5th of the next month so that all data for the previous month can be inputted into CWS for tracking and trending.<br><br>In February 2011, the policies from the Pharmacy Department and Nursing Department were submitted to Quality Management to review the timeline for the correct action plan submitted in October. After Quality Management reviewed the timeline for corrective action they determined it to be too long. The Workgroup met again to discuss this and agreed the medication errors would be investigated immediately and have seven business days to input all documentation into CWS. | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. The Nursing Department needs to add another item on the Chart Check Audit form asking if the Physician's Orders were carried out. The 10 to 6 shift RN II needs to check that Physician's Orders werenot only transcribed but also carried out, e.g., orders for consults, diagnostic procedures, lab work, appointments and other relevant orders. In addition, deficiencies identified through the 24 Hour Chart Check needs to have a plan of corrective action documented and evidence that corrective action was carried through to resolution.
2. The Facility needs to establish an inter-rater reliability process for use of nursing audit tools to ensure that data are generated accurately and reflect the criteria being monitored.
3. The Facility needs to ensure that all nursing staff completing the Nursing Monitoring Tools are trained on, and apply, the associated interpretive guidelines such that specific criteria that constitute compliance with each item are clearly identified, and that all staff use the same criteria to measure compliance with each item on the tools. The monitoring process must also measure the quality of care and supports given.
4. The Facility needs to ensure that the Nursing Care: Urgent, Emergency Room Visits, and Hospitalization Tool is used.
5. The Nursing Department needs to continue to retrain nursing staff until competency is achieved in documenting in the SOAP format.
6. The Nursing Department needs to continue to retrain nursing staff until competency is achieved in completing nursing assessments and documentation of identified changes in health status, acute illnesses and/or injuries, and/or when new treatments and/or medications are initiated.
7. The Nursing Department needs to ensure that nursing staff document the method used to assess temperatures.
8. The Nursing Department needs to ensure that Nurse Case Managers review/revise HMPs at the time of the annual and quarterly nursing assessments and/or when there is a change in individuals' condition related to the plans.
9. The Nursing Department needs to add to the HMPs and ACPs a line for signatures and dates for Home Leaders/Supervisors to sign to validate that the direct care professionals were trained on the plans. Also, when plans are established the heading needs to indicate if the plan was a HMP or ACP.
10. The Nursing Department needs to ensure when acute illnesses are diagnosed that ACPs are established and implemented immediately and the direct care professionals are trained in their responsibilities.

11. When the State Office rolls out the Nursing Physical Assessment Training, the Nursing Department needs to ensure that all Nurse Managers and Nurse Case Managers receive competency-based training on Nursing Physical Assessment Training.
12. The ACP and HMP plans continued to contain extraneous information that was not applicable to the individuals' situation or need for care. The Nursing Department needs to provide additional and continuous training on the development, implementation, and documentation of care plans until the nursing staff can competently develop care plans that meet the unique needs of individuals' conditions.
13. The Nursing Department needs to provide competency-based training to the nursing staff on the Clozaril Protocol.
14. The Nursing Department needs to ensure that ACPs and HMPs are established for individuals receiving psychoactive medications, according to the Settlement Agreement and Health Care Guidelines. ACPs are critically important when individuals are newly prescribed psychoactive medications and/or when on a tapering plan. Individuals who are identified as receiving polypharmacy (two or more psychoactive medication of the same class) or who are prescribed long term use of psychoactive medication need to have a HMP.
15. The Nursing Department needs to continue to make improvements to ensure that individuals' health care needs are identified; nursing care plans are established for identified health care needs, and care plans are individualized to meet individuals' special health care needs that include preventative and/or proactive interventions that would minimize health risks.
16. The Nursing Department needs to revise the Scheduling Medical Appointment Policy to include procedures for entering appointments into the Appointment Database and monitoring to ensure that all medical appointments are entered and tracked to ensure appointments are kept and missed appointments are rescheduled and kept.
17. The State Office should ensure that the Infection Control Preventionist/Nurse Educator is included on the e-mail RG Report distribution list for issues related to Infection Control and Nursing Education.
18. The Nursing Department needs to ensure that 100% of the nurses are promptly trained in the following topics related to compliance with the Settlement Agreement and Health Care Guidelines: Restraint Policy/Completing Restraint Checklist, Reporting Unusual Incidents/Serious Injuries, Abuse, Neglect, and Exploitation, Pain Medication Policy, Restraint Policy for Pre-medications, Medication Error Policy, Emergency Equipment Checklist, and AED Checklist, Reminders to use SOAP Method of Charting, Nursing Assessment Quarterly/Annual and Nursing Care Plan, Fall Risk and Prevention Policy, and New Definition for Falls.
19. The Infection Control Preventionist needs to develop and implement a tracking database to ensure that plans of corrective action are completed by the due date and for tracking corrective action plans to resolution.
20. The Infection Control Program needs to evaluate the system used for checking the reliability of infection data to ensure the system accurately assesses the infection data reported.
21. The Infection Control Preventionist/Nurse Educator needs to take a proactive role in monitoring infections to ensure the nursing staff follows the Settlement Agreement and Health Care Guidelines and to provide corrective action when they are not followed.
22. The Infection Control Preventionist/Nurse Educator needs to work collaboratively with the Pharmacist to evaluate the appropriateness and effectiveness of antibiotics prescribed to treat infections.
23. The Quality Enhancement Nurse needs to ensure that plans of corrective action for deficiencies identified on Medication Administration Records are followed through to resolution.
24. The Nursing Department needs to ensure that Medication Administration Observations are completed for the entire medication pass.
25. The Nursing Department needs to develop a database to track Medication Administration Observation plans of corrective action to ensure that plans of corrective action are completed.
26. The Facility needs to modify the MediMAR to include PNMP information.
27. The Nursing Department needs to collaborate with the Pharmacy to resolve the issue of requiring nurses to split tablets to achieve the correct

dosage to administer.

28. The Facility needs to provide building space that affords individuals privacy during medication administration.
29. The Nursing Department needs to ensure when liquid medication bottles are opened that nurses date and initial the date opened and routinely check medication expiration dates.

The following are offered as additional suggestions to the Facility:

1. The State Office should consider adding the Braden Scale rating score criteria for determining the level of risk derived from the assessment.
2. The Facility and State Office should revise number 10 on the Infection Control monitoring Tool to read, "For individuals born after 1957 without documentation of immunity to MMR (Measles, Mumps, and Rubella) should receive or have documentation of MMRs.
3. The Nursing Department needs to utilize the Facility's Infection Control Preventionist/Nurse to assist with providing training to the nursing staff.
4. The Facility needs to re-evaluate the risks and benefits of using of the MediMAR system.

| SECTION N: Pharmacy Services and Safe Medication Practices | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. Single Patient Intervention reports for individuals #82 and 83.<br>3. Quarterly and Annual Drug Reviews, and medication lists for Individuals: #27, #139, #140, #15, #35, 35, #3, #12, and #82.<br>4. MOSES and DISCUS assessments for Individuals: #27, #139, #140, #15, #35, 35, #3, #12, and #82.<br>5. Standard Operating Procedure PH100-010-01-02, dated December 1, 1995<br>6. ADR report form<br>7. Medical Staff Summary: DUE Results for December 2010-February 2011<br>8. List of Individual who have received STAT medications From July 1, 2010 through February 28, 2011.<br>**People Interviewed:**<br>1. Dr. David Moron., MD, Clinical Director<br>2. Anne Ikponmwonba, R.Ph. Director of Pharmacy<br>**Meeting Attended/Observations:**<br>1. P&T Meeting, March 2, 2011 |
| | **Self Assessment:**<br>RGSC reported being in not in compliance with four provisions of the Section and in compliance with four provisions.<br><br>For Provision N1, the Facility stated it is not in compliance. The Facility reported that it will establish a new process for monitoring by external pharmacists of 20 random orders monthly to assess for completion. An audit tool will be developed.<br><br>For Provision N2, the Facility stated it is not in compliance. The Facility reported it will establish a process in which external pharmacists will review 10 Quarterly Drug Regimen Reviews (DRRs) for compliance. An audit tool will be developed.<br><br>For Provision N3, the Facility stated it is not in compliance. The Facility reported that the pharmacist reviews the restraint checklists. The Facility will establish a process in which external pharmacists will review all chemical restraint checklists each month to ensure pharmacist review of clinical justification is completed. An audit tool will be developed.<br><br>For Provision N4, the Facility stated it is not in compliance. The Facility reported that a written description of the process by which the pharmacist call the ordering physician with any recommendations will be added to the Pharmacy Procedure. The physician will then dictate into the record a clinical justification if the recommendation is not being followed. The Monitoring Team has a significant concern that this will |

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| | not result in compliance with this provision. Merely entering into the record a reason for not following a recommendation does not substantiate that serious and critical consideration was given to the recommendation.<br><br>For Provision N5, the Facility stated it is in compliance. The Facility reported it will develop a process in which external pharmacists will review all chemical restraint checklists each month to ensure pharmacist review of clinical justification is completed. The Monitoring Team does not concur that the Facility is in compliance. Although DISCUS and MOSES assessments were noted to be timely in the clinical record, there were instances in which findings of possible side effects did not lead to further evaluation, increased monitoring, or changes in treatment. Also, physicians did not always document review of the DISCUS and MOSES assessments. Monitoring is not complete until the results are reviewed and implications for treatment are considered.<br><br>For Provision N6, the Facility stated it is in compliance. The Facility reported no Adverse Drug Reactions (ADRs) during the last six months. However, the Monitoring Team determined that the lack of follow up to side effects noted in MOSES and DISCUS assessments and to findings of lab results made the lack of identification of ADRs questionable. Furthermore, policy does not comment on the need for close monitoring following an ADR, necessary physicians involvement, such as physical assessment in the event of an ADR, nor does the policy delineate the role of the PST and notification of the LAR in the event of an ADR.<br><br>For Provision N7, the Facility stated it is in compliance. The Facility reported the DUE review process is conducted by contract pharmacist. The Monitoring Team does not find that to meet the requirements of the provision. The Facility's current practice is limited reviewing individual records prior to their annual PSP meeting. A Facility DUE program must utilize a systems approach and include concerns raised by other clinical disciplines.<br><br>For Provision N8, the Facility stated it is in compliance. The Facility reported the Medication Error workgroup started meeting monthly to discuss and follow-up on remedial actions and ensure investigations were being completed in a timely manner. The ICF-MR program had two medication variances and the Pharmacy Department had one, during the first quarter for FY 2011. The QE Nurse will audit all Medication Errors to ensure investigation was completed within 7 business days. |
| | **Summary of Monitor Assessment:**<br>The Monitoring Team is not satisfied with the current direction of pharmacy services and has determined that it is not making sufficient progress toward compliance with the settlement agreement. Pharmacy services must immediately review requirements of the Settlement Agreements, consult with pharmacy services who are making advances towards compliance with the Settlement Agreement, and review the current literatures on practice standards for pharmacy services. |

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| | Most important, pharmacy services must immediately enhance its own documentation practices and ensure appropriate filing of clinical documents.<br><br>The quality of annual and quarterly pharmacy reviews must be immediately enhanced.<br><br>Medication variances and drug utilization reviews must be immediate enhanced per the Monitoring Teams recommendations.<br><br>The polypharmacy committee must be improved and include active participation by pharmacy, nursing and physician services in reviewing and addressing issues.<br><br>Given its review, the Monitoring Team has determined that the Facility is not only not in compliance with Provisions N1 through N8, the Facility has not made progress towards compliance. |

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| N1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature. | The Monitoring Team has been informed by the Director of Pharmacy Services that the Facility's pharmacists understand their responsibility of identifying all new prescriptions and the need to assess the prescription for completeness, including assessing for the need to ensure that appropriate labs are being monitored, potential adverse reactions, drug and food interactions, allergies, appropriate dosage.<br><br>The MonitoringTeam requested a sample of Single Patient Intervention Reports and was provided a total of four reports on two individuals, #82, and #33. Of the four reports, the MonitoringTeam determined that the content of the report was fragmented, did not provide meaningful insight into the clinical issues and was, in part, illegible. It should be noted that instead of documenting the recommendations and assessments, the pharmacist had written by hand various statements, which were noted not to be signed, dated, or timed. The MonitoringTeam finds this practice to be of concern.<br><br>There was no organized mechanism to file drug interventions and there were no data collected to perform longitudinal analysis of errors.<br><br>The Facility has determined that it is not in compliance with Provision N1 and the Monitoring Team concurs with their assessment. | Noncompliance |
| N2 | Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist | The Monitoring Team reviewed the Quarterly Drug Regimen Reviews of Individuals #66, #94, #31, #55, #27, #19, #31, #93, #54, #133, #143, #55, #36, #88, # 69, #140, #80, #5 and #27, and specific laboratory results to assess drug levels and toxic effects | Noncompliance |

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| | shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values. | were identified. The Facility raised concerns that this issue is not appropriately monitored and considers itself out of compliance with Provision N2 because of its lack of self-monitoring to ensure the appropriateness their process. The Monitoring Team agrees that such a process was not in place and needs to be developed. Given the Facility's concerns of this important function, and verification that no self-monitoring process is available, the Monitoring Team concurs with the Facilities self assessment. | |
| 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 use of Stat Medications, anticholinergics, benzodiazapines and polypharmacy are reviewed at this time through the polypharmacy committee and presented to the P&T committee. Per discussion with Dr. Moron, and following the Monitoring Teams review of the Facility's process, it has been determined that a meaningful review is not completed when assessing the utilization of these particular medications. The Facility must ensure that all relevant professionals are not only present at the time of the Facility's review of these issues, but fully participate in the review process. Importantly, relevant utilization data must be collected and analyzed longitudinally, which was not being done at the time of the Monitoring Teams review.<br><br>Following review of Individuals #139, #150, #5, #66, #94, #31, #55, #27, #19, #31, #93, #54, #133, #143, #55, #36, #88, # 69, #140, #80, #5 and #27. For metabolic syndrome, the Monitoring Team has determined that the Pharmacy Services did not have a currently acceptable standard of care process in place to regularly monitor individuals who are on medications known to manifest in metabolic syndrome.<br><br>Specific data for the use of benzodiazepines andanticholinergicswere not presented to the Monitoring Team. The Monitoring Team is aware of the Facility's Polypharmacy Review Committee.Dr. Moron informed the Monitoring Teamthat the Polypharmacy Review Committee will be enhanced by ensuring that the clinical director is closely involved in the process and that enhanced documentation strategies will be developed.<br><br>The Monitoring Team concurs with the Facility's self assessment of not being in compliance with Provision N3. | Noncompliance |
| 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 | The Monitoring Team concurs with the Facility's self assessment of not being compliant with Provision N4, of the Settlement Agreement. The Quarterly Reviews of individuals #66, #94, #31, #55, #27, #19, #31, #93, #54, #133, #143, #55, #36, #88, # 69, #140, #80, #5 and #27 were reviewed by the Monitoring Team to determine compliance or non-compliance with Provision N4. The clinical pharmacist must identify all significant risks, including adverse drug reactions, drug interaction, | Noncompliance |

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| | and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed. | allergies, lack of response, inappropriate dosage, inappropriate use and justification of use, abnormal labs, and toxicity and discuss and document the issue with the treating physician. A formal process for documenting this effort must be developed and implemented. | |
| N5 | Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia. | The Monitoring Team disagrees with the Facilities self assessment and determines that the Facility is not in compliance with Provision N5. As per Provision J12, the DISCUS and MOSES assessments were reviewed for individuals #27, #139, #140, #15, #35, 35, #3, #12, and #82.<br><br>Although DISCUS and MOSES assessments were noted to be timely in the clinical record, the Monitoring Team did not observe any instance of all clinical records reviewed for Provision J and L, having additional or more enhanced monitoring for potential side effects, especially when new medications were added, dose change or when and individual was noted to have functional changes. Furthermore, as the following examples indicate, there were instances in which findings of possible side effects did not lead to further evaluation, increased monitoring, or changes in treatment. Also, physicians did not always document review of the DISCUS and MOSES assessments. Monitoring is not complete until the results are reviewed and implications for treatment are considered.<br><br>The DISCUS for individual 15, indicated a score of 3 on 11/7/10 and a conclusion of "probable TD" was assessed by the physician and instruction to "continue to monitor" was noted. The dose of Thorazine was increased from 75 mg/day to 250 mg/day was noted. On re-screening with the DISCUS on January 7, 2011 the DISCUS score decreased to 1 and the conclusion of "no TD" was assessed. A comment was made noting that "no TD at this time but since he is on polypharmacy" and "on and off symptoms, will be monitored closely. Takes Cogentin already". Given the individual's symptoms that most likely are masked by the increased dose of Thorazine, and probable diagnosis of TD,the PSP must reflect this issue, which it did not. Importantly, enhanced monitoring must be completed by the Facility. No enhanced Monitoring was noted. There was no health care plan for the diagnosis or suspected diagnosis of TD in the record.<br><br>The DISCUS assessment dated June 3, 2010, was noted to have a total score of 1, and the Physician assessed a conclusion of no TD. A comment by the nurse indicated that she was unable to complete the assessment because, "client did not stay longer for psychotropic med review". There was no further effort to assess this individual sooner then the subsequent scheduled review. | Noncompliance |

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| | | Individual #5 is noted to have positive findings on the DISCUS assessments dated 12/28/10 and 2/16/11 and the Individual has been on long-term Haldol. The Physician's conclusion was that there was no TD, without providing a clinically rational explanation of the assessments interpretation.<br><br>Individual #3, who has been on long-term neuroleptics, has a DISCUS score of 4, with noted lip smacking and lateral tongue movements. No TD was assessed per the DISCUSassessment and there is no clinical rationale for the individual's abnormal movements located in the clinical record.<br><br>Upon review of Discus and MOSES assessments and nursing health care plans, and medical evaluations for Individuals #27, #139, #140, #15, #35, 35, #3, #12, and #82, there were numerous omissions on the part of the physician in completing the physician's reviews and comments.<br>#27: MOSES 8/28/10<br>#130: MOSES 2/10/11 and DISCUS 2/27/10<br>#15: MOSES 8/26/10<br>#5: MOSES 2/16/11, 12/28/10<br>#3: MOSES 8/28/10, 5/25/10 AND DISCUS 11/10/10<br>#82: MOSES 8/26/10, 1/31/11<br>#12: MOSES 11/17/10, 2/28/10 AND DISCUS 7/16/10<br>#180: MOSES 8/23/10 | |
| 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. | The Facility reports no adverse drug reactions to report; hence, the MonitoringTeam was unable to review their process. The Facility provided the Monitoring Team with a copy of the "ADR FORM" for review. The Adverse Drug Reaction Report and Evaluation Form, Standard Operating Procedure PH100-020-01-02, dated December 1, 1995 were reviewed. Current policy does not comment on the need for close monitoring following an ADR, necessary physicians involvement, such as physical assessment in the event of an ADR, nor does the policy delineate the role of the PST and notification of the LAR in the event of an ADR.<br>Given the lack of comprehensive monitoring for adverse drug reactions, noted in N5 and J12, the Monitoring Team has concerns over the Facilities ability to closely monitor, report and follow-up on ADRs.<br>The Monitoring Team disagrees with the Facility's assessment and has determined that the Facility remains non-compliant with Provision N6. | Noncompliance |
| N7 | Commencing within six months of | The Facility's Drug Utilization Evaluation did not meet current professional standards | Noncompliance |

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| | the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | of care and must be enhanced. The Facility's current practice was limited to reviewing individuals' records prior to their annual PSP meeting. A Facility DUE program must utilize a systems approach and include concerns raised by other clinical disciplines, including nursing and physician services, as well as routine selection of drug per random selection. Data must be collected and assessed by longitudinal trends analysis. In-services and/or continuing medical education must be developed to address DUE findings, for all relevant staff, including nursing and physician services. Relevant staff must be assessed for competency and regular re-evaluations performed to assess efficacy. | |
| N8 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances. | The Monitoring Team reviewed the Facility's mechanism to perform monitoring of medication variances and determined that the Facility did not perform comprehensive medication variance evaluations. A medication variance program must be multidisciplinary and include members form pharmacy, nursing, and physician services. Five major issues should be addressed was developing a drug utilization program: Storage (temperature, humidity, security); Prescribing (appropriateness and completeness of the order); Dispensing of the Medication; Administration errors.<br><br>The Monitoring Team was informed that only two medication variances were reported by nursing staff during the preceding six month period, which is significantly lower then one would expect; hence, the Monitoring Team has concerns of underreporting of medication variances.<br><br>Data for all medication variances must be carefully reviewed and longitudinally assessed by trends analysis. Information gained by the trends analysis and reviews must be used to better educate staff and develop specific safety protocols to mitigate future variances. | Noncompliance |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. Patient Intervention Reports must be comprehensive and address all issues related to Provision N1, be legible and filed in a secure location for immediate retrieval. The pharmacist must ensure that appropriate drug monitoring has been ordered, when necessary. When an issue has been identified on the part of the pharmacist, the physician's response must be documented. Unresolved issues must be clearly documented and be addressed by the clinical director.

2. Develop and implement a monitoring process to ensure that quarterly reviews appropriately assess drug and laboratory reviews.

3. Refer to guidelines of the American Diabetes Association, or other professional resources to develop a acceptable mechanism to regularly assess individuals for Metabolic Syndrome. Abdominal girth, blood pressure, Triglycerides, and blood glucose monitoring are some of the important issues that must be regularly assessed for all persons being prescribed medications that are known to manifest metabolic syndrome. A formal process for metabolic syndrome should be developed by pharmacy services.

4. Continue collaborative efforts with Dr. Moron to enhance the polypharmacy review process. Ensure that data are collected and longitudinal analysis is completed for the use of Benzodiazepines, anticholinergics, and polypharmacy.

5. Quarterly reviews must be enhanced as outlined above, under Provision N4.

6. It is essential that effective immediately the Facility review its practice for medication monitoring of adverse effects and develop and initiate a process that will ensure all persons who are prescribed medications are monitored for adverse effects. This process must include robust involvement of the PST, and involvement of nursing, physician, pharmacy, and direct care staff. Individuals must be assessed regularly when there is a noted change in functional ability, sudden illness, change in medications and dose changes.

7. When enhancing side effect monitoring efforts, the Facility should also include monitoring practices for ADRs.

8. Develop and implement policy and procedure that ensure appropriate clinical assessment by nursing and physician staff following any noted drug side effect or adverse reaction. Ensure that direct care staff are aware how to monitor for side effects and adverse drug reactions.

9. Develop and implement a comprehensive medication variance process that is multidisciplinary and addresses storage, prescribing, dispensing, and administration issues. Trends analysis must be developed and information gained from the trends analysis and reports must be used to enhance practice standards at the Facility.

10. A drug utilization review process must be enhanced per provision N7.

| SECTION O: Minimum Common Elements of Physical and Nutritional Management | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated2-17-11<br>2. Policies, procedures, and/or other documents related to Physical and Nutritional Management,(Policy #013 dated 1/31/2010 and #012 dated 1/31/2010)<br>3. DADS At Risk Policy 6.2 updated 2/18/11<br>4. RGSC SOP MR 400-02 At Risk Individuals last revised 2/11<br>5. Record reviews of Individuals #27, #33, #35, #47, #48, #75, #77, #88, #94, #96, #126, #140<br>6. Review of PNMPs for Individuals #8, #13, #15, #31, #36, #48, #51, #54, #66, #72, #85, #88, #93, #94, #96, #108, #121, #126, #139, #140, #143, #149<br>7. Review of Speech language evaluations and OT/PT evaluations of Individuals #2, #8, #27, #31, #35, #39, #55, #59, #62, #63, #67, #75, #77, #84, #85, #87,#98, #108, #149<br>8. Observations of individuals #11, #13#26, #29, #48, #80, #91, #93, #94, #97, #140, #149<br>9. A list of all therapy and/or clinical staff (OT, PT, SLP, RD,), and Physical and Nutritional Management (PNM) team members, including credentials<br>10. Curriculum vitae (CVs) for PNMT members<br>11. A list of continuing education sessions or activities participated in by PNMT members since 1/2011<br>12. Minutes, including documentation of attendance, for the following meetings<br>i. PNMT meetings (10/10 to 2/11)<br>ii. HST meetings (10/10 to 12/10)<br>13. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order.<br>14. Tools used to assess PNM status and needs.<br>15. A list of PNM assessments and updates completed in the last two (2) quarters.<br>16. PSPs for the individuals on the list above for whom PNM assessments and updates have been completed in the last quarter<br>17. Completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs<br>18. Tools used to monitor implementation of PNM procedures and plans<br>19. A list of individuals for whom PNM monitoring tools were completed in the last quarter<br>20. 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<br>21. Nutritional management plan template and any instructions for use of template.<br>22. Dining Plan template<br>23. Lists of individuals:<br>a. On modified diets/thickened liquids;<br>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 8/2010, 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

24. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year
25. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials
26. Tools and checklists used to provide competency-based training addressing:
    a. Foundational skills in PNM; and
    b. Individual PNM and Dining Plans
27. For the prior 12 months, a list of competency-based training sessions addressing foundational skills in PNM

Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM

**People Interviewed:**

1. Betty Lopez PNMP tech
2. Jane Plumlee, PT and Acting Habilitation Director
3. Four DCPS

**Meeting Attended/Observations:**

1. La Paloma lunch and dinner 3/2/11
2. El Paisano lunch and dinner 3/3/11
3. Las Paloma and El Paisano transition times 3/2/11 and 3/3/11
4. PNM meeting (3-1-11)
5. PSP meeting for Individual #113

**Facility Self-Assessment:**

For Provision O.1, the Facility stated it is not in compliance with this provision. RGSC stated that the OT/PT/SLP is now attending the annuals when the individual has a PNMP.

For Provision O.2, the Facility stated it is not in compliance with this provision. RGSC is in the process of

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| | adding oral care and medication administration to the PNMP and are being trained on the process.<br><br>For Provision O.3, the Facility stated it is not in compliance with this provision. RGSC stated that Mealtime cards were being updated to include pictures of individuals, adaptive equipment, and pictures of positioning.<br><br>For Provision O.4, the Facility stated it is not in compliance with this provision. RGSC stated that it is ensuring staff engages in safe intake strategies by monitoring two individuals per month.<br><br>For Provision O.5, the Facility stated it is not in compliance with this provision. RGSC stated that staff was trained annually on PNMP concepts and individual specific training was provided as indicated.<br><br>For Provision O6, the Facility stated it is not in compliance with this provision. RGSC stated that staff was trained annually on PNMP concepts and individual specific training was provided as indicated.<br><br>For Provision O.7, the Facility stated it is not in compliance with this provision. RGSC stated six of seven Actions Steps are not in compliance. RGSC stated that staff is being trained on PNMP concepts.<br><br>For Provision O.8, the Facility stated it is not in compliance with this provision. RGSC stated that at the time of annual staffing, a medical assessment is completed and a follow up MBSS with a request for recommendations on administration of pleasure foods.<br><br>The self-assessment of noncompliance in all sections was consistent with the monitoring team's assessment of noncompliance with this provision. |
| | **Summary of Monitor's Assessment:**<br>RGSC had shown improvements regarding multiple aspects of physical and nutritional supports. The full time Speech Language Pathologist (SLP) had been focusing on swallowing disorder identification through the administration of tableside swallow evaluations and the use of the mobile modified Barium Swallow Study Suite. As a result of the assessments, people were provided with more appropriate textures than in previous visits. Another example of improvement is that an individual who was previously NPO was now receiving small pleasure feedings. While it is a positive event that the individual was receiving pleasure foods, RGSC should also identify therapy methods that would help strengthen the swallow in an effort to facilitate increased oral intake in the future and avoid repeat aspiration.<br><br>**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. While there is a team called the PNMT, the team failed to meet on a monthly basis as per state policy 013 and did not meet when there was a change in status. Failure to meet to discuss the root cause of problems and develop plans to address the identified issue resulted in their reoccurrence. |

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| | **Provision O.2:** This provision was determined to be not in compliance. A new risk process that is intended to more accurately identify individuals at risk had been developed but had not been implemented as of this review. Additionally, supports regarding the areas of oral care and medication administration were missing from the assessment process and were not comprehensively included in the PNMP.<br><br>**Provision O.3:** This provision was determined to be not in compliance. PNMPs were not comprehensive due to the plans lacking information regarding oral care and medication administration strategies. While the plans did contain positioning for these activities, strategies intended to mitigate risk were lacking in detail thus resulting in an increased risk of variance when implementing the activity among multiple staff.<br><br>**Provision O.4:** This provision was determined to be not in compliance. Staff was observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline. Per interview, staff was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being.<br><br>**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.<br><br>**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. The primary focus of monitoring remained mealtime. Failure to provide monitoring in all aspects of PNM results in the individual being exposed to unnecessary risk.<br><br>**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.<br><br>**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. An assessment (MBSS) was conducted but potential pathways to increased intake were still not comprehensively addressed. While it is a positive event that the individual was receiving pleasure foods, RGSC should also identify therapy methods that would help strengthen the swallow in an effort to facilitate increased oral intake in the future and avoid repeat aspiration. |

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| O1 | Commencing within six months of the Effective Date hereof and with | RGSC had developed a 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 | Noncompliance |

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| | 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 medical doctor, nurse practitioner, or physician's assistant. All | and consisted of the Occupational Therapist (OT), Registered Nurse (RN), Physical Therapist (PT), Registered Dietitian (RD), and Speech Language Pathologist (SLP). The creation of this group is an improvement since the last visit when RGSC had multiple teams addressing components of the PNM. The previous role of the HST had been taken over by the PST and will occur during the scheduled PSP quarterlies.<br><br>Per review of the minutes, the team met during the months of November 2010, December 2010, January 2011, and February 2011. During the months of November 2010 and December 2010 there was limited to no discussion of individuals who experienced multiple falls. For example:<br>• Individual #77 had four falls occurring during the month of November and three falls during the month of December with no discussion by the PNMT or assessment by PT.<br>• Individual #94 had four falls occurring during the month of November and three falls during January with no discussion by the PNMT or assessment by PT.<br>• Individual #35 had two falls occurring during the month of November and eight falls during December with no discussion by the PNMT or assessment by PT.<br>• Individual #63 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT.<br><br>Failure to respond and implement changes to ones' plan resulted in the continuation of falls into the months of December and January and thus increased the potential of injury.<br><br>The same can be said for individuals who are listed as having BMIs in excess of 35, and diet downgrades. For example:<br>• Individual #33 has a BMI of 41.41 but there was no evidence of discussion at the level of the PNMT.<br>• Individuals #15, #48 #31, and #149 had diet downgrades but there was no evidence of discussion by the PNMT.<br><br>Issues related to falls are discussed during morning meeting but upon review of the meeting minutes; this serves as more of a notification rather than an active discussion of how to address these issues or the root cause of the issue. For example:<br>• Individual #35 had a fall on 1/26/11. The morning meeting minutes simply stated, "encourage to slow pace."<br><br>PNM Team attendance records and meeting minutes from 11/15/10, 12/16/10, and 1/31/11 documented an 88% attendance level by PNM Team standing members. Examples of individuals missing from the meetings included occasionally the Food | |

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| | members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. | Services Manager and routinely the physician.<br><br>Based on review of PNM trainings provided by RGSC, PNM Team members did complete training and professional development related to physical and nutritional supports since the previous visit. Trainings focused on core PNM values as well as the PNMP.<br><br>Based on a review of the Fall record, documentation supported that the PNMT did not meet regularly to address change in status, assessment, clinical data and monitoring results.<br>• Individual examples: Please see further above in Provision O.1 for examples of where the PNM Team did not meet regularly to address change in status, assessment, clinical data and monitoring results.<br><br>Per RGSC, therapists are now participating in PSPs when the individual has an identified need (i.e. PNMP). | |
| O2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems. | A process was not in place that identifies individuals with PNM concerns. DADS developed a new risk screening process but this process was not implemented at the time of the review.<br><br>Nine of 12 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:<br>• Individual #48 was on a modified diet, had problems chewing, required cues to avoid overstuffing and was identified on 12-4-10 via a swallow study to be "High Risk" of aspiration but was listed as a "low risk" of aspiration.<br>• Individual#85 was on a modified diet, has poor oral hygiene, requires cues to prevent from eating fast, and must swallow twice to ensure clearance was listed as a "low risk" of choking or aspiration.<br>• Individual #126 had pneumonia within the past 12 months and received enteral nutrition but was listed as a "low risk" of choking or aspiration.<br>• Individual #77 had ten falls occurring from November 2010 to January 2011 but was listed as being at low risk of injury.<br>• Individual #94 had eight falls occurring from November 2010 to January 2011 but was listed as being at low risk of injury<br>• Individuals#27 and #88 had a BMI greater than 35 but were listed as being "low risk" for weight.<br><br>Based on the monitoring team conducting a trial of the new risk screening process, | Noncompliance |

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| | | • Individuals #48 and #85 would be listed as "medium risk of choking."<br>• Individual #126 would be listed as "high risk of aspiration."<br>• Individuals #77 and #94 would be at a "high risk of falls."<br><br>This discrepancy in risk identification demonstrated how inadequately people were being identified as having PNM risks. Failure to accurately identify the level of risk results in lack of awareness regarding the severity by staff and in lack of adequate supports being planned as part of the PSP.<br><br>Based on a review of 19 individuals' OT/PT and SLP assessments, zero of 19 Individuals are 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.<br><br>The swallowing components of the OT/PT as well as Speech assessment are vague and did not provide consistent measurable data. For example:<br>• Individual #149's assessment (10/10) states the individual had weakness to the oral cavity 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).<br>• Individual # 63's assessment (12/10) stated what strategies needed to be implemented at mealtime but did not mention what issues the strategies addressed.<br>An example of an improved swallowing component was noted in Individual # 85's Speech Evaluation (10/10)<br><br>While the function of adaptive equipment was included in the assessments, zero of 19 assessments reviewed contained the link between a piece fo equipment and the decline in function in which it was intended to address. For example:<br>• Most recent OT/PT assessments for individuals #27, #33, #35, #47, #48, #75, #77, #88, #94, #96, #126, #140 state the standard function of a device but does not clearly draw a connection between the equipment and the issue it is intended to resolve. For example:<br>o Individuals #48's OT/PT assessment (9-10) stated that a build up handle spoon is to assist with grasp but does not mention the person has difficulty grasping objects.<br>o Individual #67's SLP evaluation (9/10) stated to alternate liquids and solids but there was no evidence in the assessment as to why this was needed. | |

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| | | Review of 19 documents (19 SLP and OT/PT evaluations) involving individuals revealed:<br>• In zero of the 19 documents reviewed (0%), there was 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:<br>  • Oral care in a comprehensive manner<br>  • Medication administration in a comprehensive manner<br>  • Mealtime strategies in a method that is clear as to why the strategies are relevant.<br>  • Adaptive equipment rationale<br><br>Per interview with Habilitation Services, observations or reviews were at times delayed due to lack of notification of a consult. | |
| 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 did not contain all the needed components and were not comprehensive as they lacked detail regarding oral care and medication administration.<br><br>Based on a review of 22 individuals' PNMPs, individuals were not provided with a comprehensive PNMP. A breakdown of the PNMP revealed:<br>• In 22 of 22 PNMPs reviewed (100 %) positioning instructions for wheelchair and alternate positions instructions were included as indicated.<br>• In 22 of 22 PNMPs reviewed (100%) transfer instructions were included as indicated.<br>• In three of 22 PNMPs (13 %) the mealtime/dining plan included oral intake strategies for mealtime and snacks. As mentioned below, the PNMPs did have strategies listed but were not comprehensive in that they did not provide enough information to ensure consistency across staff and shifts. Additionally, there was not a clear link between the strategies listed and the decrease in function in which it was intended to address.<br>• In 22 of 22 PNMPs reviewed (100 %) the mealtime/dining plan included food/fluid textures.<br>• In zero of 22 PNMPs reviewed (0 %) the mealtime/dining plan included behavioral concerns related to intake.<br>• In 22 of 22 PNMPs reviewed (100%) positioning of the individual during medication administration was included as indicated. | Noncompliance |

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| | | • In 22 of 22 PNMPs reviewed (100%) positioning of the individual during oral hygiene was included.<br>• In 18 of 22 PNMPs reviewed (81%) strategies for oral hygiene were included.<br>• In 22 of 22 PNMPs reviewed (100%) individual adaptive equipment was included as indicated.<br>• In 22 of 22 PNMPs reviewed (100%) bathing/showering positioning and instructions were included as indicated.<br>• In 22 of 22 PNMPs reviewed (100%) communication was listed but zero of 22 PNMPs contained strategies that staff could utilize to improve communication during activities..<br><br>Although the PNMPs reviewed contained some the needed components, the PNMP components were not comprehensive as the following examples indicate: For example:<br>• Individual #48, and #85's PNMP stated the position during oral care but did not provide information regarding thickness of liquids or strategies to implement to increase safety.<br>• Individual #96's PNMP stated the position of the individual during oral care and medication administration but did not provide information regarding positioning of staff. Staff positioning during these activities was important due to the negative impact it has on positioning of the individuals. A staff member standing over someone encourages hyperextension of the neck thus increasing risk of aspiration.<br>• Individuals #48, #85, #96, #72, #93's PNMPs stated to provide cues to slow down and to alternate liquids and solids but did not provide information on what type of cues should be utilized.<br><br>Overall, there was not a clear link between recommended strategies or use of adaptive equipment and the decline in function in which it was intended to address.<br><br>PNMPs were not formally developed with input from the PST, home staff, medical and nursing staff.In zero of 12 records reviewed (0%), PNMPs were clearly developed with input from the PST with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per interview with Habilitation Services, PNMPs are developed by Habilitation Services. However, there was evidence in the PSP attended by the monitoring team of discussion of the PNMP.<br><br>Per interview with nine DCPS, zero of nine DCPs stated they had input into the development of the PNMPs. DCPs stated that the plans are often passed down with no opportunity for discussion with team members regarding the development. | |

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| | | Per PNMT and HST minutes (10/10 to 1/11), zero of four individuals who experienced multiple falls (0%) had their PNMPs reviewed and updated as indicated by this change in the individual's status,.<br><br>Additional examples of lack of review when the need is indicated by a change in the individual's status are found in Provision O1. | |
| O4 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties. | Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan.<br><br>Four mealtime observations demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plans that were most likely to prevent swallowing difficulties and/or increased risk of aspiration. In zero of eight individual observations, staff was following mealtime plans accurately. Nevertheless, there were some examples of accurate implementation:<br>• In four of four observations staff were following transfer instructions.<br>• In two of two observations, nursing staff were following mealtime instructions for medication administration.<br><br>Examples in which staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan include:<br>• Individual #29 was not provided cues to slow down or cues to prevent overfilling of the oral cavity. Additionally, staff did not check for pocketing post-meal.<br>• Individual #94 was not provided cues to eat slowly, take small bites or alternate liquids and solids.<br>• Individual #26 was not provided with cues to alternate liquids and solids.<br>• Individual #11 was leaning forward over his plate and was not cued to reposition.<br>• Individual #97 was overstuffing and was not cued to decrease size of bite or rate of intake as well alternate bites and sips.<br>• Individuals #48, #91, #93 #140 and #149 were not provided with alternating bites and sips and were observed taking large unsafe bites and eating at an unsafe rate.<br><br>In addition, Individuals #13 and #80 were observed coughing during the meal with no staff intervention. When staff was asked about the coughing, they stated that they sometimes do this. | Noncompliance |

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| | | Staff did not understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. Per staff, they are often trained on what to do but not the reason why it must be done.<br><br>Based on interviews with four DCPS on El Paisano and five DCPs on La Paloma:<br>• In nine of nine (100%) interviews with staff, they were able to identify the location of PNMP and/or mealtime plan.<br>• In four of nine (44%) interviews with staff, staff could describe individual-specific PNMP strategies.<br>• In five of nine (55%) interviews with staff, staff could describe the schedule for implementation of PNMP strategies.<br>• In five of nine (55%) interviews with staff, staff stated they had received individual-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.<br><br>Review of the Facility's training curricula revealed that it did not include adequate PNM training in a timely manner in the following areas:<br>• Body mechanics<br>• Handling techniques<br>• Optimal alignment and support in seating systems and alternate positions<br>• Mechanical lift transfers<br>• Manual transfers approved by facility policy<br>• Mealtime positioning<br>• Food and fluid consistency<br>• Safe presentation techniques for food and fluid<br>• PNMPs.<br><br>Per interview with the habilitation director, PNMP was not part of the new employee orientation (NEO) schedule.Therefore Habilitation Services had to track down staff, which often resulted in staff being on the homes without dysphagia- and other pnm-related trainings. This method also resulted in habilitation services being unable to easily pull a training log to determine if all staff had received appropriate pnm training. | Noncompliance |

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| 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 still did not exist at RGSC that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.<br><br>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:<br>• Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk,<br>• Identification of monitors and their roles and responsibilities,<br>• Re-validation of monitors 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<br>• Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician.<br><br>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.<br><br>Per review of the PNMT minutes (October 2010 to January 2011)the PNM team met monthly to discuss health issues related to PNM but response to indicators identified by monitoring was not a focus of conversation nor was the development of the PNM system.<br><br>There was no mechanism to track data for system analysis in order to focus training and coaching. The PNMT did not utilize PNMP or mealtime monitoring information in their reviews consistently. The PNMT did not specifically review aggregated findings across the two homes for trend analysis to drive system change and training in most areas.<br><br>Monitoring did not cover staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities, including medication administration, oral care, and ambulation).<br><br>Based on a review of all four monitoring forms submitted to the monitoring team, four of four focused on mealtime. No observations or monitoring forms were completed that focused on:<br>• Oral care | Noncompliance |

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| | | • Medication Administration<br>• Bathing<br>• Transfers<br>• In bed positioning (as applicable)<br><br>Per review of the Comprehensive Monitoring Training Roster (11-3-10),all members of the PNM team were trained to conduct monitoring; 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. Per Habilitation Director and the POI, two individuals are monitored monthly, but there was no clear direction on what individuals will be monitored and during what activity. This lack of clarity resulted in individuals not receiving monitoring during activities in which the risk of physical and nutritional decline is increased.<br><br>Additionally, the frequency (2 x month) of monitoring by PNM professionals was not sufficient to ensure consistent implementation of PNM strategies. See provision O.3 for examples. | |
| 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.<br><br>While the PNM status is scheduled to be regularly reviewed during the PSP meetings, there was 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 for examples of lack of review when there was a change in status..<br><br>Per review of the PNMT minutes, there was no indication that data is gathered from monitoring reports and reviewed by the PNMT to help identify trends and methods to mitigate risk on a systems basis. Failure to utilize this information increases the likelihood of systemic issues going undetected. | Noncompliance |
| 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 | There were two individuals listed as receiving enteral nutrition and hydration. Both of these were placed in 2010.<br><br>While the assessment identified the need for continued NPO (nothing by mouth) status there was no evidence of identification, discussion or development of a plan that may lead the individual back to full PO (oral) status other than the administration of a Video | Noncompliance |

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| | 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. | fluoroscopy (VFS) (swallow study). The VFS identifies what the person can tolerate at that moment but does not provide details regarding how to improve the swallow function to mitigate the risk of a declined swallow.<br><br>Two of two individuals (100%) who received enteral nutrition and/or therapeutic/pleasure feedings were provided with a PNMP. This PNMP, however, was missing the same information as listed in Provision O.3.<br><br>PSPs for the individuals who received enteral nutrition did not clearly document the rationale for the continued need for enteral nutrition.<br><br>Examples of individual PSPs that did not document the rationale for the continued need for enteral nutrition was:<br>• It was mentioned in the PSP that Individual #47 and #126 tolerated tube feedings and required it as a means of nutrition but did not identify possible pathways to PO intake.<br><br>A policy did 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. | |

**Recommendations:** The following recommendations are offered for consideration by the State and the Facility:

1. 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. Strategies regarding methods to improve safety should be included as well as positioning not only for the individual but also for staff providing assistance.
3. A formal process should be developed that ensures individuals who are at an increased risk receive more intensive monitoring during the activities in which their risk is increased. Include a mechanism to document recommendations for follow-up and a means to document closure on issues identified. This often works well when this is included on the form used to monitor.
4. The monitoring policy for mealtime and PNMP monitoring should describe a monitoring system that includes criteria for, and identification of,who will complete the monitoring, competency-based training for monitors, descriptions of each indicator with monitoring strategy, definitionof staff retraining thresholds, a validation/inter-rater reliability process, the use of monitoring reports to assist in the identification ofproblematic issues and/or trends, the formulation of corrective strategies to address areas of deficiency, and integration of the monitoringsystem into facility Risk Management and Quality Assurance systems.
5. All staff should be trained in all areas of PNM prior to working at the homes.
6. 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.
7. 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).

8. 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.
9. 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.
10. Conduct trend analysis of all monitoring data. Review findings and make system adjustments. Consider review of trends as a role for the PSTand PNMT.
11. The PNMT should establish thresholds to trigger further evaluation based on degree of, and/or frequency of, certain types of incidents, and/orkey health care indicators. Individual-specific outcomes and criteria should be clearly recorded, utilized for monitoring, and analyzed todetermine efficacy of the supports provided, at both the individual-specific and systemic level. This information should be integrated into theFacility's Quality Assurance/Enhancement, Incident Management and Risk Management systems.
12. PNM training should become part of new employee training to ensure all staff have been trained prior to assisting individuals and to allow habilitation services the ability to track all that have received training.

The following are offered as additional suggestions to the facility:

1. In an effort to increase staff awareness regarding an individual's risk, it would be beneficial to note the level of risk on the individuals PNMP.
2. The Habilitation Services Department would benefit from having a commercial level color printer to allow for mass production of PNMPs.
3. The consult process should be clearly defined to avoid response delays. It may be beneficial to have the consult scanned and emailed along with a phone to notify Habilitation Services of a pending consult.
4. Habilitation Services and Residential Services should review current dining arrangements and groupings to determine if dining groups are appropriate and promote facilitation of skills. For example, RGSC may not want to have all individuals who are more complex as it relates to swallowing all in one group. This type of grouping often puts a strain on staff-client ratios.

| SECTION P: Physical and Occupational Therapy | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated2-17-11<br>2. Wheelchair Maintenance "Draft" Policy (ICF-MR 500-08)<br>3. Record reviews of Individuals Record reviews of Individuals #19, #27, #33, #35, #47, #48, #75, #77, #88, #94, #96, #126, #140<br>4. Review of PNMPs for Individuals #8, #13, #15, #31, #36, #48, #51, #54, #66, #72, #85, #88, #93, #94, #96, #108, #121, #126, #139, #140, #143, #149<br>5. OT/PT Consult Logs and reports for the months of October 2010-Mid February 2011<br>6. OT/PT evaluations of Individuals #2, #8, #27, #31, #35, #39, #55, #59, #62, #63, #67, #75, #77, #84, #85, #87,#98, #108, #149<br>7. 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)<br>8. Current Lists of people:<br>9. Who use wheelchair as primary mobility;<br>10. With transport wheelchairs;<br>11. With other ambulation assistive devices, including the name of the device;<br>12. With orthotics and/or braces;<br>13. 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<br>14. 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.<br>15. Habilitation Therapy Adaptive Equipment Spreadsheet<br>16. OT/PT assessments template<br>17. Five (5) most current OT/PT assessments conducted by each therapist and corresponding PSPs<br>18. 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<br>19. List of individuals receiving direct OT and/or PT services and focus of intervention<br>**People Interviewed:**<br>1. Betty Lopez PNMP tech<br>2. Jane Plumlee PT and Acting Habilitation Director<br>3. Four DCPS on El Paisano and five DCPs on La Paloma<br>**Meetings Attended/Observations:**<br>1. La Paloma lunch and dinner 3/2/11<br>2. El Paisano lunch and dinner 3/3/11<br>3. Las Paloma and El Paisano transition times 3/2/11 and 3/3/11<br>4. PNM Meeting (3-1-11) |

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| | 5. PSP meeting for Individual #113 |
| | **Facility Self-Assessment:**<br><br>For Provision P.1, the Facility stated it is in compliance with this provision. RGSC stated that all individuals receive an evaluation within 30 days of admission with results presented to the PSP for review.<br><br>For Provision P.2, the Facility stated it is in compliance with this provision. RGSC stated that all evaluations are addressed at the PSP and implemented within 30 days.<br><br>For Provision P.3, the Facility stated it is not in compliance with this provision. RGSC stated that staff was trained on PNMPs as changes occurred. A PNMP check sheet is to be implemented by June 2011.<br><br>For Provision P.4, the Facility stated it is not in compliance with this provision. RGSC stated that staff was trained on PNMPs as changes occurred. A PNMP check sheet is to be implemented by June 2011.<br><br>The monitoring team is not in agreement with RGSC's self assessment as it pertains to Provisions P.1 and P.2. Although individuals were receiving assessments within 30 days of admission, individuals did not receive consistent assessments in response to changes in status or a comprehensive approach to address identified issues. |
| | **Summary of Monitor's Assessment:**<br>RGSC has made some noticeable improvements with regards to Occupational and Physical Therapies. It should be noted that RGSC has improved their use of outside consultations (i.e., neurology and physiatry) in an effort to improve the identification of problems. Additionally, a rehab data sheet was in development that should assist the therapists in tracking consults and ensuring completion.<br><br>A major obstacle facing RGSC is lack of therapists to address the needs of the individuals. Individuals were not provided with direct services at a frequency to prevent decline or sustain progress. Per interview with OT/PT, individuals used to participate in restorative programs designed to maintain level of functioning but many of these programs have dissipated over the last few years.<br><br>**Provision P.1:** This provision was determined to be not in compliance. Assessments were completed in accordance to the schedule set forth by RGSC; however, assessments were not being consistently completed in response to a change in status. Medical issues and health risk indicators were not included in the assessment process with appropriate analysis to establish rationale for recommendations /therapeutic interventions.<br><br>**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. On multiple occurrences, there was lack of follow up by OT/PT in response to consults occurring within (from the PST) and outside the facility. Individuals experiencing a decline in status were often provided with |

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| | wheelchairs and lift vests and did not receive direct or indirect OT/PT intervention as a comprehensive approach.<br><br>**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.<br><br>**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 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. | OT services were provided by one contract occupational therapist (12 hours per week) as the previous OT and Director of Habilitation Services resigned in January 2011. There were no OT assistants. One full time therapist provided PT services: Jane Plumlee, PT. There was one PT vacancy. There were no PT assistants.<br><br>Based on the current caseload and the issues that the individuals living at RGSC are experiencing (i.e., falls and decreased ambulation), a single full time PT and an OT providing 12 hours of services per week was not enough to provided the needed services. Examples of services not being addressed will be included in this provision and provisions P.2, P.3 and P.4.<br><br>Based on a review of CVs for each clinician (2) and interviews with therapy staff, the department did document appropriate qualifications for licensed OTs, PTs, and assistants. Per online review, all therapists are adequately licensed in the state of Texas.<br><br>Evidence of participation in continuing education for therapy clinicians was submitted as follows:<br>• Habilitation Therapies Conference 9/2010<br>o Sarah Smalley OTR , 12 CEUs<br><br>The Facility should continue to support therapists' attendance at a variety of annual continuing education courses, to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at RGSC.<br><br>Although individuals had an OT/PT Evaluation or Update, there had not been updates when there was a change in status, such as a fall, diet downgrade, or BMI in the obesity range. The following individual concerns were identified:<br>• Individual #77 had four falls occurring during the month of November with no | Noncompliance |

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| | | discussion by the PNMT or assessment by PT.<br>• Individual #94 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT.<br>• Individual #35 had two falls occurring during the month of November with no discussion by the PNMT or assessment by PT.<br>• Individual #63 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT.<br>• Individual #33 has a BMI of 41.41 but there was no evidence of discussion at the level of the PNMT or assessment from PT.<br>• Individuals #48 and #15 had diet downgrades but there was no evidence of discussion by the PNMT.<br><br>There was a morning meeting at which incidents were reported; however,based on review of minutes, the meeting served as a notification event and did not support the concept of active discussion or root cause analysis.<br><br>Specific to the issues of falls, the physical therapy consults, notes and assessments, along with orthopedic and physiatry consultations, annual medical evaluation and imaging diagnostics were reviewed on individuals #143, #140, #80, #5 and #27. Following review the Monitor Team has concluded that physical therapy consultations and reviews are inadequate and do not provide meaningful information, and lack appropriate recommendations for care. Physical therapy did not provide standard of care assessments for persons with complex neuromotor conditions and did not appropriately monitor for functional ability or functional decline and provide recommendations without an understanding of the etiology of the conditions they provide treatment for. This practice may result in significant harm to persons served.<br><br>Additionally, there was a lack of follow up by OT and PT in response to consults or in response to their own recommendations. For example:<br>• Individual #19 had a skin tear and a consult was made to OT. Per review of the record, there was no evidence that this consult was addressed to by OT.<br>• Individual #35 had a PT consult completed on 1/21/11. The PT stated that multiple types of adaptive equipment would be trialed to improve safety. There was no evidence in the record that this was completed.<br>• Individual #77 had a Physiatrist consult completed on 2/7/11. Recommendation was for aggressive PT. There was no evidence that this was initiated.<br>• Individual #19 was reviewed by PT on 2/9/11. The recommendation was for a neurology consult to determine if a cervical brace would be beneficial. Per | |

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| | | neurology consult on 2/21/11, this issue was not addressed. There was no evidence of follow up by the PT.<br><br>Additionally, plans are not consistently developed to address issues:<br>For example:<br>• Individual #80 and #10 used a gait belt to assist with stability but there was no plan in place to minimize regression or increase stability<br><br>All people identified with therapy needs did not receive a comprehensive OT and PT assessment within 30 days of identification.Per review of OT/PT consult logs for the months of October 2010 to February 2011, eight of 11 issues occurring that required additional assessment by OT or PT were addressed within the 30-day period. The other three referrals for individuals were either beyond the 30 day window or were unable to be determined if the criteria was met due to lack of dates listed on the reports.<br>Examples include:<br>• Individual #29 had a PT consult requested on 10/27/10 for frequent falls but the consult was not initiated until 12/23/10. During this delayed response, Individual #29 had two more falls.<br>• Individual #139 was referred to PT on 11/18/10 but was not seen by the PT until 12/23/10.<br>• Individual #19 had a skin tear and a consult was made to OT. Per review of the record, there was no evidence that this consult was addressed to by OT.<br>• Individual #35 had a PT consult completed on 1/21/11. The PT stated that multiple types of adaptive equipment would be trialed to improve safety. There was no evidence in the record that this was completed.<br>• Individual #77 had a Physiatrist consult completed on 2/7/11. Recommendation was for aggressive PT. There was no evidence that this was initiated.<br><br>Based on review of 13 OT/PT assessments, 100% included signatures and date of both OT and PT and included evidence of active collaboration between OT and PT. There was a communication section with a brief review of communication status and supports, but otherwise little to no evidence of collaboration with any other PST members.<br><br>Based on review of 13 OT/PT assessments, zero of 13 were comprehensive with content from each discipline as indicated. For example:<br>• Oral Motor section of the report was primarily a summary and does not provide objective measurable data. | |

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| | | • Oral Care and Medication Administration was not adequately addressed in the assessment as there were limited specific strategies other than positioning that may be utilized to decrease risk of choking and/or aspiration.<br>• Most recent OT/PT assessments for individuals #19, #27, #33, #35, #47, #48, #75, #77, #88, #94, #96, #126, #140 stated the standard function of a device but did not clearly draw a connection between the equipment and the issue it is intended to resolve. For example:<br>o Individual #48's OT/PT assessment (9-10) stated that a built up handle spoon is to assist with grasp but does not mention the person has difficulty grasping objects.<br>o Individual #19's gait assessment simply stated that they required two staff via gait belt to ambulate. This statement was a recommendation and did not investigate or identify the root cause of the decreased ambulation.<br><br>Medical issues and health risk indicators were not included in the assessment process with appropriate analysis to establish rationale for recommendations /therapeutic interventions. While there was generally a review of health and medical status included in various sections of the OT/PT assessment reports, merely identifying the issues was not sufficient toensure that they were addressed appropriately by therapy services. Recommendationswere in general terms and not individualized, such as "NMC will monitor on a prn basis,""continue PNMP,""and continue adaptive equipment." A rationale for selection of a specific strategy was not consistently noted. | |
| 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 | Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for 12 individuals receiving OT/PT services, plans were developed within 30 days of the date of the assessment/update as indicated by the assessment.<br><br>Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. For example:<br>• Individual #19 had a skin tear and a consult was made to OT. Per review of the record, there was no evidence that this consult was addressed by OT.<br>• Individual #35 had a PT consult completed on 1/21/11. The PT stated that multiple types of adaptive equipment would be trialed to improve safety. There was no evidence in the record that this was completed.<br>• Individual #77 had a Physiatrist consult completed on 2/7/11. Recommendation was for aggressive PT. There was no evidence that this was initiated.<br>• Individual #80 had multiple falls and received a PT consult for unsteady gate. | Noncompliance |

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| | outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression. | Recommendation was for utilization of gait belt and wheelchair as a way to improve safety. There was no evidence of investigating methods of treatment to improve gait and stability.<br><br>Based on reviews of PNMPs and other positioning plans for 12 individuals, equipment was specified for 12 of 12 plans reviewed.<br><br>Individuals not receiving direct services were not consistently reviewed by OT/PT should there be a change in status. Please refer to Provision O.1 for additional information.<br><br>On at least a monthly basis or more often as needed, four of four individuals (Individuals #51, #77, #140, and #150) (100%) who received direct services from OT/PT had their OT/PT status documented in the CWS progress notes; however, there was no indication of a discharge note or summary demonstrating overall improvement or lack of improvement from provided services.<br><br>An issue that remained a 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. An interdisciplinary process improvement project was being conducted through the Facility's quality improvement program., As part of this effort to decrease the frequency of falls, RGSC had leveled floors that were uneven, improved lighting and was in process of purchasing handrails for use on the homes. Nevertheless, there remained a need for more comprehensive physical and occupational therapy review and action.<br><br>A thorough assessment of gait and balance should be included as part of the assessment as well as identification of treatment methods. 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, were not being taken. For example:<br>• Individual #77 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT<br>• Individual #94 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT<br>• Individual #35 had two falls occurring during the month of November with no discussion by the PNMT or assessment by PT | |

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| | | • Individual #63 had four falls occurring during the month of November with no discussion by the PNMT or assessment by PT<br>• Individual #80 had multiple falls and received a PT consult for unsteady gate. Recommendation was for utilization of gait belt and wheelchair as a way to improve safety. There was no evidence of investigating methods of treatment to improve gait and stability.<br><br>If "falls" are determined to be chronic in nature, then a clear path of restoration or use of assistive devices should be identified and implemented.<br><br>Despite the issue noted above, it should be noted that RGSC has improved their use of outside consultations (i.e., neurology and physiatry) in an effort to identify problems but as listed previously, follow up to recommendations and identification outside of specialists remained limited. | |
| 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, PNMPs or other intervention plans were implemented as written for zero of seven individuals reviewed in the sample. For example:<br>• Individual #29 was not provided cues to slow down or cues to prevent overfilling of the oral cavity. Additionally, staff did not check for pocketing post meal.<br>• Individual #94 was not provided cues to eat slowly, take small bites or alternate liquids and solids.<br>• Individual #26 was not provided with cues to alternate liquids and solids.<br>• Individual #11 was leaning forward over his plate and was not cued to reposition.<br>• Individual #97 was overstuffing and was not cued to decrease size of bite or rate of intake as well alternate bites and sips.<br><br>DCPs 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.<br><br>Based on interviews with four DCPS on El Paisano and five DCPs on La Paloma:<br>• In nine of nine (100%) interviews with staff, they were able to identify the location of the OT/PT plans.<br>• In four of nine (44%) interviews with staff, staff could describe individual-specific strategies outlined in the plan. | Noncompliance |

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| | | • In five of nine (55%) interviews with staff, staff could describe the schedule for implementation of the OT/PT plans.<br>• In five of nine (55%) interviews with staff, staff stated they had received individual-specific training for OT/PT intervention/support plans.<br><br>Examples of direct care professionals who were not able to describe the rationale for OT/PT interventions and recommendations:<br>• DCP on La Paloma was not able to describe rationale for maintaining appropriate elevation.<br>• DCP on La Paloma was not able to describe why individuals used modified dining equipment.<br>• DCP on El Paisano stated that the PNMP was to utilized only during meals | |
| 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 POI, all staff was monitored for their continued competence in implementing the OT/PT programs. This was inconsistent due to lack of a formalized process.<br>A policy did not exist that clearly defines the details of the monitoring system including frequency, implementation and acquisition of data.<br><br>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. Per interview with Habilitation Services Director and PNMP Tech, staff was often placed on the homes prior to receiving training.<br><br>Per POI, there was no formal process to ensure a data collection method is validated by the program's author(s).<br><br>The current system of PNMP monitoring was conducted by the PNMP tech and therapy clinicians. The PNM tech and rest of the PNM team were directed to monitor a total of two individuals each month. Monitoring was generally limited to availability and condition of adaptive equipment rather than function and fit. Function and fit were were reviewed by the therapists at a minimum during annual updates but there was not a process in place to monitor throughout the year<br><br>Per Habilitation Director, wheelchair function and availability was not an area addressed by Habilitation Services with the exception of custom wheelchairs. This resulted in Individuals #140, and #51 not having appropriate wheelchairs available at the time of need. | Noncompliance |

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| | | A draft policy focusing on wheelchair maintenance was developed that should help identify the need for wheelchair repair and availability.<br><br>Approximately four monitoring sheets were submitted as completed from 11/1/10 through 12/7/10. Only 25% of the monitoring sheets documented any concerns with regard to implementation of the PNMPs. In one case, the Registered Dietitian (RD) documented the need for staff retraining, but there was no signature confirmation that this retraining occurred. Additionally, there was no mechanism on the form to track back to resolution of problems identified or remedial actions required.<br><br>As stated above, monitoring typically focused on availability and condition of equipment, rather than efficacy of the interventions. Currently there was no system to ensure that those at greatest risk were monitored consistently and at an appropriate frequency as indicated by their level of risk. | |

**Recommendations:** The following recommendations are offered for consideration by the State and the Facility:

1. The current assessment format was modified to contain oral care and medication administration but information and assessment in these areas remain lacking in detail. These areas should include assessment in these areas and not just state the position. Additionally, the areas of activity tolerance, and balance should be addressed consistently in a comprehensive manner. 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 and the method for determining these strategies.
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. The frequency of PNMP monitoring needs to be driven by risk level; those at highest risk must be monitored with sufficient frequency to ensure adequacy and efficacy of the supports provided as well as the accuracy of staff implementation of these supports.
5. OT/PT should be in charge of ensuring wheelchairs and wheelchair parts are onsite and available at the time of individual need. A system should be implemented that routinely reviews the presence and working condition of the devices.
6. Restorative and maintenance programs should be developed by OT/PT to prevent decline in ambulation and overall functioning.
7. Additional therapists (full time OT and full time Physical Therapy Assistant (PTA) should be hired to assist habilitation services in developing and implementing restorative programs.
8. Wheelchair fit and availability may be monitored on a daily basis by home staff but OT/PT staff should also play a role in monitoring the equipment and the individuals using the equipment to ensure the equipment remains appropriate.

The following are offered as additional suggestions to the facility:

1. RGSC would benefit from increased availability of exercise and equipment to assist and compliment formal methods of therapy. A gym consisting of standers, parallel bars, and mats would be a great asset to the clinicians and individuals at RGSC. Additionally, the PT is a certified Aquatic

Therapist, so reopening the pool would be a great asset to the overall level of care.

2. The installation of rails would assist in decreasing the amount of falls by providing another layer of support for the person. Physical Therapy should be consulted prior to purchasing rails to ensure rails are functional for individuals with visual impairments.

| SECTION Q: Dental Services | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. Standard Operating Procedure ICF-MR 400-9, dated December 2008.<br>3. Standard Operating Procedure ICF-MR 400, dated December 1, 2010.<br>4. Standard Operating Procedure ICF-MR 200-55, dated February, 2011.<br>5. Current dental appointment tracking sheet<br>6. List of names of persons who are delayed with dental treatment<br>7. Nursing assessment of pre and post sedation for Individuals #91, #94, #15, and #3<br>8. PSP and PSP addendums and Health Care Plans for Individuals #19, #31, #93, #54, #133, 143#55, #36, #88, # 69, #140, #80, #5 and #27.<br>**People Interviewed:**<br>1. Yolanda Gonzalez, RN, Chief Nurse Executive (CNE)<br>**2.** Mary Doris Matabalan, RN, Nurse Operation Officer/Hospital Liaison<br>**Meeting Attended/Observations:**<br>None |
| | **Facility Self-Assessment:**<br>The Facility has determined itself to be noncompliant with Provisions Q1 and Q2 and offers the following comments:<br>7/2010- a dental appointment database was established which will assist in assuring all individuals are seen by dentist for routine dental treatment.<br>11/2010- contract obtained with community dentist who will see individuals without pre-sedation. Continue with existing contracted dentist in the community for those individuals who are able to comply with dental appointments.<br>1/2011- all department heads were provided access to view all appointments per database.<br>1/2011- Initiated a new PSP process that will address pre-sedation.<br>1/31/2011- facility policy for Dental Services completed to meet DADS policy expectations and approved by PSO committee<br>1/2010- contracted dentist began seeing individuals without pre-sedation.<br>7/2010- a dental appointment database was established which will assist in assuring all individuals are seen by dentist for routine dental treatment.<br>11/2010- contract obtained with community dentist who will see individuals without pre-sedation. Continue with existing contracted dentist in the community for those individuals who are able to comply with dental appointments. |

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| | 1/2010- contracted dentist begin seeing individuals without pre-sedation.<br>1/2011- all department heads were provided access to view all appointments per database established 7/2010 for review during PST meetings as needed. .<br>Dental Hygienist contracted in December 2009. Hygienist provides Oral Care procedure training/evaluation to nursing staff and direct care staff.<br>1/2011- PST initiated a desensitization process as formulated by the Psychology Department. This process includes having the individuals sit in a dental chair in a mobile dental unit – named "HOWie" – Health on Wheels.<br>The Monitoring Team concurs with the Facility's self assessment but contends that further enhancements must continue in order to be on the track for substantial compliance. Substantial compliance will require that all Individuals served by the center must be up to date with their oral and dental health care needs and that services provided meet current standard of care practice. |
| | **Summary of Monitor's Assessment:**<br>To assess compliance with dental services, the Monitor interviewed Yolanda Gonzales, RN and Mary Doris Matabalan, RN, on March 3, 2011, both of whom are responsible for dental services at the Facility. Because of the limited size of the Facility, dental services are provided off grounds at a private dental clinic. During the interview, staff reported that they had made little progress in addressing this Section; however, they had completed important initial steps that will subsequently ensure compliance in the near future.<br><br>The Facility had developed a new, computerized dental appointment log that is comprehensive in nature. The Nursing Department is responsible for maintaining the schedule. During nursing quarterly reviews, nurses will ensure that the schedule is accurate. This process will be fully implemented in the near future.<br><br>The Facility did have efficient and functional emergency dental services available to persons served; however, there was no formal policy or procedure in place that outlines the process.<br><br>Psychology Services had developed a new and robust desensitization program; however, full implementation was pending and the Monitoring Team could not assess efficacy.<br><br>Policies and procedures for pre and postanesthesia monitoring had not been developed or updated and nursing monitoring remains non-standardized at the Facility.<br><br>The Facility remained significantly backlogged on dental cases. Because the database was not fully implement for tracking cases, an actual accounting of those deficient with dental services could not be provided.<br><br>Policies and procedures for dental services had been updated in December, 2010, and are being reviewed by the Facility for possible further enhancements. The Monitoring Team had an opportunity to do a cursory review of the updated policy and advised the Facility that some additional issues need to be enhanced, especially in the area of pre-treatment sedation, monitoring of those who undergo sedation and |

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| | anesthesia, and to more clearly delineate their emergency dental treatment component to reflect their actual practice.<br><br>The Facility was in process of enhancing oral hygiene efforts at the living area and in the process of developing policies and procedures for providing hygiene to individuals at the living area. The use of suction toothbrushes is being explored and expanded.<br><br>The PST and the PSP did not adequately reflect the individuals' oral and dental needs.<br><br>Following review of the Facility and discussion with staff, the Monitoring Team concurs with the Facilities self-assessment of not being in compliance with provisions Q1 or Q2. |

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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. | The Nurse Operations Officer and CNE explained the Dental Emergency Services plan, which as delineated is robust and adequate to meet the needs of individuals who reside at the Facility. As stated, in the event of a dental emergency that occurs after hours, the on-call physician will evaluate the issue and if necessary refer the person to either the local contract dentist or to the emergency room, if the dentist is unavailable. The emergency room will triage the case, provide necessary treatment and when stable, and depending on the type of dental emergency, have the individual follow-up with the Facility's contract dentist or immediately refer the individual to the hospital's emergency on-call oral surgeon.<br><br>A local contract dentist had provided routine dental services. The Facility was in the process of enhancing the availability of dental services by exploring additional contract relationships to expand services. Individuals who require anesthesia are provided treatment at the local hospital. The Monitoring Team was informed that Dental records are maintained off site at maintained by the contract Dentist, so were not available for review. A consult report was located in the clinical record; however, it was not comprehensive in nature, as to advise the PST of the comprehensive oral and dental needs of the Individual served. The Facility is working on means to enhance the Facility's dental record system. The Facility recognized that there existed a significant backlog of individuals who require dental services but was confident that the additional contract dentist will bring the caseload up to date within the subsequent six month period.<br><br>To assist in better identifying individuals and their dental needs, the Facility had developed a new dental log, which will be maintained by nursing services. To ensure that required dental services are not overlooked, nursing will review the log data and compare to dental records that will be provided by the dentist. The dental log will be | Noncompliance |

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| | | maintained on a shared server so all relevant staff can review.<br><br>The Facility had yet to implement dental services per the guidelines promulgated by the American Dental Association for persons with developmental disabilities but will address this issue in the near future.<br><br>The Facility had intensified its approach to providing oral hygiene at the living area and was in the process of evaluating people for suction tooth brushing. The contract oral hygienist will be evaluating individuals to assess efficacy of oral hygiene efforts by direct care staff. At the time of this review the Facility's oral hygiene program was not fully implemented and assessment of efficacy was not possible.<br><br>Following review of dental services, the Monitoring Team concurs with the Facility's self assessment and has determined that the Facility remains non-compliant with provision Q1 | |
| Q2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints. | The Facility continues to enhance a new dental log that will enable better tracking and monitoring of dental health care practice at the Facility. This process continues to undergo enhancement but should be fully operational within two to three months from the time of the review.<br><br>The Facility had developed a robust, updated policy and procedure for dental services, "Standard Operating Procedure NR200-55; Dental Services", which was established on December 1, 2010. This policy outlines the provision of dental services to ensure that comprehensive and timely dental assessments and treatment is provided to Individuals served by the Facility, to Facilitate emergency dental services and to ensure that the PST and PSP process addresses dental services per the Settlement Agreement. A new policy, "Standard Operating Procedure NR200-55; Pre-Treatment and Post-Sedation Monitoring" which was established in February, 2011, delineates the necessary steps to ensure for nurses to monitor the safety of persons prior to and following non-intravenous sedation. The policy for sedation does not include provisions for the necessary role and participation of the primary care physician, nor direct care staff. Per discussion with the Nurse Operations Officer and CNE, the Facility had yet to implement the practices set forth by the policies but will be moving forward as staff are better trained, the dental log is enhanced, and the additional contract dentist is officially retained.<br><br>Per review of the clinical records and PSPs, there is no documentation that comments on health care risks associated with dental treatment, or failure to provide dental treatments, such as a history of valve disease, diabetes, severe periodontal treatment. The Facility must better ensure that primary care services become more involved in | Noncompliance |

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| | | monitoring oral and dental health care issues and liaison between the contract dentist and PST.<br><br>Sedation has been used infrequently at the Facility for dental procedures; however, the exact number of uses was not available for review by the Monitoring Team. The prior lack of a standardized approach to the safe use of sedation for dental services, lack of a meaningful desensitization program, limited behavior intervention to attempt in place of the need for sedation had result in individuals not receiving necessary dental services. As previously stated, the Facility was reviewing all dental practices and individuals served to better assess the exact status of dental services at the Facility.<br><br>Following review of Individuals #19, #31, #93, #54, #133, #143, #55, #36, #88, # 69, #140, #80, #5 and #27, the Monitor noted a significant lack of involvement by the PST, nursing services, physician services and the PSP with regards to dental issues. The Facility recognizes that much effort must be directed to ensure better involvement with the team process, specific to dental services. | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. Continue to enhance the dental log and ensure that all individuals are identified as to their need for dental services and timing of dental services.

2. Ensure that an updated policy and procedure is developed for the Facility's Emergency Dental Practice, that clearly delineates the Facility's practice.

3. Important clinical areas that require enhancement include:

    a. Review standard of care practices for the use of sedation and monitoring of individuals with complex health care issues, such as cardiac conditions, and behavioral and physical anomalies secondary to developmental disabilities.

    b. Ensure that appropriate documentation practices are developed and implemented.

    c. Enable enhanced clinical monitoring of individuals who receive pre-treatment sedation and anesthesia .

    d. Ensure that professional staff involvement, including nurses, physicians, dentist, and direct care staff are all actively involved in the sedation process.

4. The PST and the PSP, must identify all oral and dental needs for the person served, understand the risks and benefits of treatment and no treatment for dental issues, understand the behavioral and clinical risks associated with an Individual's oral health issues, make informed and meaningful decisions regarding the need for sedation and the type of sedations, and understand the person's daily oral hygiene needs and results of daily oral hygiene practices at the Facility.

5. Ensure that the Facility's newly developed desensitization process is fully implemented within six months.

6. Ensure that all dental treatments are well documented in the clinical record and that the PST can fully understand the status of the Individuals comprehensive oral/dental needs are.

7. Continue to implement enhanced oral hygiene practices at the living area. The use of oral suction tooth brushing is essential for individuals with aspiration risk factors. Surveillance of oral hygiene outcomes should be assessed regularly to ensure efficacy.

8. Obtain and adopt the "Dental Care Guidelines" that are promulgated by the American Dental Association for persons with developmental disabilities.

| SECTION R: Communication | |
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| 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:<br>**Review of Following Documents**:<br>1. RGSC Plan of Improvement (POI) updated2-17-11<br>2. Record reviews for Individuals #19, #27, #35, #47, #55, #59, #62, #75, #77, #85, #88, #96, #126, #143<br>3. Review of Speech language evaluations of Individuals #2, #8, #27, #31, #35, #39, #55, #59, #62, #63, #67, #75, #77, #84, #85, #87,#98, #108, #149<br>4. Consult Logs and reports for the months of September 2010 to February 2011<br>5. 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)<br>6. A list of people with Alternative and Augmentative Communication (AAC) devices<br>7. AAC evaluation and Speech Language assessment template.<br>8. Five most current AAC and SLP assessments conducted by each therapist, and corresponding PSPs<br>9. List of individuals receiving direct speech services, and focus of intervention<br>**People Interviewed**:<br>1. Belinda Lopez MA CCC-SLP<br>2. La Paloma (two) and El Paisano (two) DCPs<br>**Meetings Attended/Observations**:<br>1. PNM meeting (3-1-11)<br>2. PSP meeting for Individual #113<br>3. La Paloma lunch and dinner 3/2/11<br>4. El Paisano lunch and dinner 3/3/11<br>5. Las Paloma and El Paisano transition times 3/2/11 and 3/3/11 |
| | **Facility Self-Assessment:**<br><br>For Provision R.1, the Facility stated it isin compliance with this provision as they have a full time SLP.<br><br>For Provision R.2, the Facility stated it is not in compliance with this provision. RGSC stated that communication assessments will begin June 2011.<br><br>For Provision R.3, the Facility stated it is not in compliance with this provision. RGSC stated that communication assessments will begin June 2011 but is currently focusing on dysphagia assessments<br><br>For Provision R.4, the Facility stated it is not in compliance with this provision. RGSC stated that all individuals will be assessed by June 2012 and that a PSP policy is pending Professional Staff Organization (PSO) approval. |

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| | The monitoring team is in agreement with the findings of RGSC with the exception of provision R.1. Due to the lack of a Speech Therapist over an extended period of time, a single therapist was not sufficient to meet the needs of the individuals. |
| | **Summary of Monitor's Assessment:**<br>There has been very little progress in this area since the baseline visit. Assessments lack the comprehensiveness needed to identify strengths, needs and to develop appropriate plans of action to improve communication. Individuals who are nonverbal or have severe expressive and receptive language disorders were not provided with services to enhance or develop communication.<br><br>Improvements noted were that individuals were now receiving audiology evaluations on an annual basis if a hearing deficit was noted and a minimum of every 3 years for all other individuals. Implementation of audiology evaluations and screenings will assist the SLP in having a better understanding of what the individual is able to hear thus improving the ability to treat any speech impairments.<br><br>Another improvement noted was increased participation by the SLP during PSPs.<br><br>**Provision R.1:** This provision was determined to be not in compliance. Even though a full time SLP had been hired, the workload for the speech language pathologist was excessive thus not allowing the therapist to be an active member of individuals' Personal Support Team, nor to provide adequate functional communication supports to the individuals.<br><br>**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 either through the use of AAC or other methods of communication.<br><br>**Provision R.3:** This provision was determined to be not in compliance. The presence of AAC devices was essentially nonexistent. DCPs interviewed were not knowledgeable of communication strategies to utilize with individuals residing at their homes.<br><br>**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 nor was there monitoring of whether or not the device was effective and or meaningful to the individual. |

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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 | RGSC has hired Belinda Lopez, a full time Speech language Pathologist (SLP). Per interview with the SLP, the focus of the Speech department has been to focus on swallowing issues first and communication second. Due to the lack of a Speech Therapy presence over the years, the current number of SLPs was not sufficient to meet the needs | Noncompliance |

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| | adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. | of the individuals as identified below in provisions R.1, R.2, R.3, and R.4.<br><br>One out of 14 records reviewed (7 %) indicated individuals with identified language difficulties were receiving active Speech Treatment or participating in a Speech program of any kind.Examples of Individuals with identified Speech or language difficulties not receiving services:<br>• Individuals #27, #35, #47, #96, #126 and #143 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<br><br>Based on a review of the CV for the therapy clinician (1) and interviews with therapy staff, the Department did document appropriate qualifications for licensed SLP.<br><br>Based on a review of 14 records involving individuals who were identified with severe expressive or receptive language deficits, 14 individuals did not receive comprehensive supports designed to improve or augment existing language. For example:<br>• See above for examples of individuals in need of services not receiving services.<br>• Individual #75 had a communication goal; however, documentation regarding progress was only completed once weekly. This level of frequency may not sufficient to develop an accurate picture of how well the person is performing or to document that the program is implemented frequently enough to provide meaningful training or as planned.<br>• Individual #88's PST stated that a communication book would be beneficial, but there was no evidence that this was implemented by the SLP. | |
| 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. | Zero of 14 records reviewed indicated individuals identified with severe expressive/receptive language had AAC investigated and assessed. For example:<br>• Individuals #27, #35, #47, #96, #126 and #143 are all diagnosed with a severe speech disorder but AAC was not assessed or investigated.<br><br>Out of the 14 records reviewed, the Communication Assessment did not address all necessary components. For example,<br>• In zero of 14 records reviewed, the assessment addressed verbal and Nonverbal Skills.<br>• In zero of 14 records reviewed, the assessment addressed expansion of current abilities.<br>• In one of 14 records reviewed, the assessment addressed development of new | Noncompliance |

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| | | skills.<br><br>Due to there being only one communication program, the monitoring team was unable to assess overall whether the goals were functional and meaningful.<br><br>Programs, goals and objectives related to the acquisition or improvement of speech or language are not written by the SLP.<br><br>In zero of 14 records reviewed (0%), individuals had goals/objectives/outcomes written by the SLP. The one individual receiving SpeechTreatment was not followed on a monthly basis.<br><br>There were no active communication programs; therefore there was no opportunity for integration into the PBSP.<br><br>Examples of individuals with identified communication difficulties whose plans were not integrated in the PBSP:<br>• Record Review of Individuals #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 target behaviors and lack of communication.<br><br>A policy did not exist that outlined the assessment schedule and staff responsibilities. The Communication Services policy, dated 10/7/09, Section II on Assessments stated: "comprehensive communication assessment will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need." | |
| R3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of | Rationales and descriptions of interventions regarding use and benefit from AAC were not clearly integrated into the PSP.<br><br>One of the 14 records reviewed (7%) 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:<br>• Individuals #27, #35, #47, #96, #126 and #143 did not have communication present in the PSP.<br>• Individual #75 had a communication goal to utilize his communication folder during interactions but use of the communication folder was not integrated into other training programs. | Noncompliance |

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| | settings. | The PSP did not contain information regarding how the person communicates and strategies staff may utilize to enhance communication.<br>• Zero of the 14 records reviewed (0%) clearly identified how the individual communicates with others and interacts with his surroundings.<br>• The examples above demonstrate that PSPs do not contain information on communication nor include strategies to enhance communication, as information about communication is absent.<br><br>Per observation of the PSP for Individual #113, the nonverbal status of the individual was thoroughly discussed; however, existing methods of communication that the individual utilized were not discussed (i.e., gestural communication, facial expressions).<br><br>Communication interventions and information on supporting communication were not integrated into the daily schedule.<br>• Zero of the 14 records reviewed contained communication interventions and methods to improve communication, whether related to formal goals and interventions or involving informal ways to communicate with an individual and support that individual's communication methods and communication dictionary, that wereintegrated into the daily schedule; therefore, opportunities to promote generalization were minimal to none. For example:<br>o Individual #75, the one individual who had a formal goal, had a communication goal to utilize his communication folder during interactions but use of the communication folder was not integrated into other training programs.<br><br>Per interview with four DCPS (two on El Paisano and two on La Paloma), staff were not trained in the use of the AAC or knowledgeable of the communication strategies of individuals on their homes as evidenced by:<br>• In zero of four interviews, the importance of AAC and how the assigned programs lent themselves to the development of language was expressed.<br>• In one of four interviews, DCPs were able to locate adaptive equipment.<br>• In one of four interviews, staff could describe individual-specific communication strategies such as the individuals' communication dictionaries for the people they worked with regularly.All staff who work with an individual should be aware of that person's communicative style, communication methods and dictionary (if applicable) and methods identified in the PSP (as well as general strategies adapted for that individual to improve communication).<br>• In zero of four interviews, staff could describe the schedule for implementation of communication strategies. | |

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| | | • In zero of four interviews, staff stated they had received individual-specific training for communication strategies.<br><br>General AAC devices were not available in common areas.<br>• Zero of the two homes had general AAC devices present in the Common areas.<br><br>Due to the lack of AAC presence, the monitoring team was unable to assess whether AAC was portable and functional in a variety of settings or if the devices were meaningful to the person. | |
| R4 | Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually. | RGSC did not have a formal or informal monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device. Because of this, a proper assessment cannot be made at this time. | Noncompliance |

**Recommendations:** The following recommendations are offered for consideration by the State and the Facility:

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 understand between staff and the person. Even an individual who has some verbalizations may benefit from AAC. 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' speech 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. Examples of locations would be vocational rehabilitation, dining rooms and common areas within the homes.
5. 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 should be monthly if receiving direct services and quarterly for all others.
6. A monitoring system should be developed that ensures availability of equipment as well as the equipment's use.
7. RGSC would benefit from an additional therapist to assist with providing assessments and to possibly focus on the implementation of communication related initiatives.
8. Audiology evaluations should be scheduled in advance of the PSP to allow the SLP time to review the findings then apply those findings to the communication assessment.
9. In consultation with the SLP, an AAC library should be developed consisting of various devices to allow for trials to be conducted when assessing communication and the appropriateness of augmentative communication. This library should include but not be limited to tactile switches, single and multi button speech generating devices, and activity schedulers.

The following are offered as additional suggestions to the facility:

1. The Habilitation Services Department would benefit from having a commercial level color printer to allow for mass production of communication boards and pictures for AAC equipment.

| SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs | |
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| 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:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #2, #11, #12, #27, #35, #36, #55, #58, #61, #62, #77, #82, #84, #94, #98, #101, #122, #139, and #149.<br>**People Interviewed:**<br>3. Megan Gianotti, M.Ed. – Behavioral Services Director<br>4. Samantha Salinas, MSW – Associate Psychologist<br>5. Cheryl Fielding, Ph.D. – BCBA consultant<br>6. Janie Villa, QMRP Coordinator<br>7. Rebecca Olivarez, QMRP<br>**8.** Direct Care Professionals: Approximately 12 staff members in residences, classrooms and vocational settings.<br>**Meeting Attended/Observations:**<br>9. Observed lunch at La Paloma (3/7/2011)<br>10. Observed dinner at El Paisano (3/7/2011)<br>11. Observed active treatment, staff performance and environmental characteristics in La Paloma, El Paisano, classrooms and vocational settings. |
| | **Facility Self-Assessment:**<br>The Facility reported that it is not yet in compliance with any provision of this Section. The Monitoring Team was in agreement with the facility self-assessment.<br><br>RGSC stated that, "the PST develops and implements individualized program to promote the growth, development, and independence of all individuals." Based upon observations and record reviews, the Monitoring Team could not confirm that the facility was developing effective programs. The facility also indicated that, "The PST currently develops programming based on identified needs." It was not indicated in the records that the assessments necessary for identifying personal needs were routinely conducted. Therefore, the Monitoring Team could not confirm the assessment by RGSC.<br><br>During the site visit, observations reflected that neither formal nor informal training was routinely |

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| | provided to individuals living at the facility. Facility staff were not observed to implement programs or to address undesired behavior with basic skills in applied behavior analysis. During interviews, staff were often unable to describe the training programs that had been developed or to demonstrate how programs were to be implemented and documented. |
| | **Summary of Monitor's Assessment:**<br>**For Provision S.1**: This provision was determined to be not in compliance. Observations and recorded reviews reflected substantial limitations in formal assessment and skill acquisition plans.<br><br>**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.<br><br>**For Provision S.3:** This provision was determined to be not in compliance. Based upon information obtained from observations, staff interviews and record reviews, it was apparent that RGSC routinely failed to provide formal and informal training to the individuals living at the facility, either on campus or in the community. |

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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. | 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 19 individuals were reviewed to establish the accuracy of the statements about assessment and skill acquisition programs made by the Facility. This review revealed that 19 of 19 individuals lacked assessments that could be shown to be accurate or that had identified real and meaningful needs. The PALS had been completed, and the annual PSP planning process using the new process had begun, but neither provided an assessment that would meet the requirements of this provision.<br><br>Substantial weaknesses in psychological assessments that could, done correctly, help PSTs plan training, education, and skill acquisition programs, are documented in Provision K.<br><br>In addition to valid assessment procedures, the successful introduction and strengthening of skills requires that the training program include 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. Nineteen records were reviewed to assess the status of the skill acquisition programs. The findings of that review are presented below. | Noncompliance |

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| | | • Zero of 19 records contained training plans that reflected development based upon a task analysis.<br>• Zero of 19 records contained training plans that included behavioral objective(s).<br>• Zero of 19 records contained training plans that included operational definitions of target behavior(s).<br>• Zero of 19 records contained training plans that included a description of teaching conditions.<br>• Zero of 19 records contained training plans that included a schedule of implementation comprised of sufficient trials for learning to occur.<br>• Zero of 19 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.<br>• Zero of 19 records contained training plans that included specific instructions.<br>• Zero of 19 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 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.<br>• Zero of 19 records contained training plans that included specific consequences for correct responses.<br>• Zero of 19 records contained training plans that included specific consequences for incorrect responses.<br>• Zero of 19 records contained training plans that included a plan for maintenance and generalization (i.e. assessment and measurement methodology)<br><br>Due to the limitations noted in the assessments of skills, the identification of needs and the components of skill acquisition programs, at the time of the site visit it was unlikely that the majority of skill acquisition programs were effectively enhancing the skills and independence of the people living at Rio Grande State Supported Living Center. | |
| S2 | Within two years of the Effective | The Facility indicated that at the time of the site visit there were no data to support | Noncompliance |

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| | 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. | 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. The PALS had been completed, and the annual PSP planning process using the new process had begun, but neither provided an assessment that would meet the requirements of this provision.<br><br>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. | |
| S3 | Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall: | The Facility did not provide regular and routine programs of training, education, and skill acquisition to address each individual's needs. There was a lack of planned and structured activities that involved identification of skills to be trained and specific actions staff were to take to provide the training. | Noncompliance |
| | (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 | During the current site visit, observations were conducted in La Paloma and El Paisano residences, as well as in classrooms, vocational settings, and outside areas of RGSC. In all settings where observations were conducted, the most striking factor was the lack of formal or informal teaching. Even when individuals were observed engaging in structured activities, there was no indication that the activities included procedures designed to teach new skills or strengthen existing abilities.<br>• Individual #94 was observed during lunch. The individual displayed screams and attempted to strike peers and staff. Staff responded by standing back and allowing the individual to escape the meal. No effort was made to preempt undesired behavior, redirect the undesired behavior, or encourage appropriate | Noncompliance |

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| | | attempts to escape.<br>• Individual #31 was observed seated on the ground in the yard between the two residences. One staff member was present. This staff member encouraged the individual to rise from the ground, but did not reinforce approximations of the desired behavior and struggled to entice the individual to stand. Interviews with staff reflected that the individual on a daily basis displayed this behavior.<br>• Eight individuals were observed in the main living area of La Paloma residence. Over the course of 30 minutes, staff in the immediate vicinity of the eight individuals offered no interaction or teaching to any individual. No teaching or recreational materials were present in the room. Of the eight individuals present, one was asleep, five were engaged in stereotypic behavior, and two were seated quietly.<br>• In classroom 15, the primary trainer attempted without success to engage the six individuals present in a ring toss game. When asked about formal training, the primary trainer indicated that training activities involved viewing television programs, as well as engaging in structured programs. The trainer was unable, however, to explain how training trials were used or the manner in which data were collected. No structured activities were observed in the classroom.<br>• In classroom 16, several individuals were observed folding towels while several other individuals were seated without activities or interaction. Based upon events in the classroom, it was apparent that those individuals who had mastered the towel folding were provided with towels while those who lacked the skills to fold were provided with no training to acquire the skills.<br><br>During interviews with facility staff it was apparent that QMRPs and Psychology Department staff were familiar with the lack of active treatment and formal program implementation. Specific concerns voiced during interviews included the following.<br>• The lack of active treatment in most settings at the facility<br>• A lack of staff knowledge regarding general teaching and specific program components<br>• The lack of formal measures of staff competence<br>• The lack of task analyses upon which training programs were to be developed<br>• The lack of adequate skills assessment<br>• The lack of administrative and supervisory support for program implementation<br><br>Based upon information obtained from observations, staff interviews and record reviews, it was apparent that RGSC routinely failed to provide formal and informal training to the individuals living at the facility. The factors that contributed to the lack of programming pervaded all levels of staff and administration. As a result, the individuals | |

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| | | living at the facility were routinely denied the opportunity to develop the skills and abilities that would facilitate transition to living in the community and contribute to an improved quality of life. | |
| | (b) Include to the degree practicable training opportunities in community settings. | Based upon documentation submitted by RGSC, there was no indication that formal or informal training was provided in the community. Furthermore, it was not evident that people living at the facility had been provided with assessments necessary for the development of skill acquisition programming within the community.<br><br>From August 2010 through January 2011, RGSC conducted several community outings per month: August – 84, September – 52, October – 105, November – 106, December – 52 and January – 62. Due to limitations in recording information about outings, it was not possible to calculate a summary of participants. There were no indications that formal training activities were provided during community outings. | Noncompliance |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. The Facility must address the lack of formal and informal training with the utmost diligence. The lack of meaningful teaching denied the individuals living at the facility the opportunity to increase personal abilities and independence. Without adequate training, these individuals were substantial hindered in transitioning toward community integration. The facility must act to ensure that all staff are aware of the essential nature of skill acquisition programs and recognize that the implementation of training programs is of the highest priority.
2. The Facility must act to ensure that all necessary assessments are completed within the relevant time frames and using the appropriate tools and instruments.
3. The Facility must develop and implement a process by which the quality of training programs, as well as the implementation of those training programs, is documented and monitored so as to ensure that the individuals living at the facility receive and benefit from skill acquisition training.
4. The Facility should identify community training and learning opportunities that could be planned to meet the goals identified in PSPs.

| SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. DADS Policy 018.1 Most Integrated Setting Practices 3/31/10<br>3. RGSC SOP 300 20 Most Integrated Setting January 2010<br>4. RGSC SOP 600 01 Personal Support Plan Process October 2010<br>5. PSP Addendums for Individual #140 dated 11/15/10 and1-3-11<br>6. PSP for Individuals #35, #55, and #87<br>7. List of individuals who had have been referred for community placement by his or her PST since the last compliance visit.<br>8. List of individuals who had requested community placement since the last compliance visit but had not been referred<br>9. List of individuals who had not been referred solely due to LAR preference since the last compliance visit<br>10. List of individuals who had been transferred to community settings since the last compliance visit<br>11. List of alleged offenders committed to the Facility following court-ordered evaluations<br>12. Documents related to the movement of Individual #10 to a more integrated environment, including:<br>a. Last PSP for Individual #10<br>b. Community Living Discharge Plan<br>c. Training/ Course Sign–In Sheet for training provided to HCS staff 11/16/10<br>d. Post-Move Monitoring (PMM) Checklists for visits 11/24/10, 12/28/10, and 2/15/11<br>e. Tropical Texas Behavioral Health Mental Retardation Authority (MRA)—various documentation of assessments and service logs<br>13. Notes prepared by RGSC of a meeting held 2/9/11 re outplacement/discharge for Individuals #13, #80, and #121<br>**People Interviewed:**<br>1. Alma Ortiz, Admissions/PlacementCoordinator (APC)<br>2. Karina Serrato, QMRP<br>**Meetings Attended/Observations:**<br>1. Post Move Monitoring Visit for Individual #10, special visit following 90 day visit<br>2. PSP annual planning meeting for Individual #113 3/3/11 |
| | **Facility Self-Assessment:**<br>RGSC reported that it was not in compliance with one provision, did not comment on one provision, and that the other two provisions were not applicable. |

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| | For Provision T1, the Facility stated that it was not in compliance with the provision as a whole or with any component of the provision. The Monitoring Team concurs with this assessment. The Facility reported it had taken a number of actions to achieve compliance. A revision of the policy on admissions, transfers and discharges had been drafted and was to be reviewed to include the CLDP, CLOIP, and PMM processes. The PST had begun to identify the major obstacles to the individual's movement to the most integrated setting and the supports needed to overcome these obstacles. A provider fair had been scheduled. One individual had been discharged, and a Discharge Plan had been completed prior to the move. The State Office had revised the CLDP to define essential and nonessential supports identified by the PST. The Facility had not yet put in place a quality assurance process to ensure development and implementation of discharge plans.<br><br>The Facility did not comment on Provision T2. The Monitoring Team finds the Facility in substantial compliance with the requirements of this provision.<br><br>For Provisions T3 and T4, the Facility stated these provisions were Not Applicable, as the population did not include individuals meeting the criteria of those provisions. |
| | **Summary of Monitor's Assessment:**<br>RGSC had made little progress in moving people into more integrated settings but had made significant progress in planning and monitoring when such moves occur.<br><br>The Facility is not in compliance with Provision T1. The lack of outcome is indicated by the move of only one person and by having only one additional person referred at the time of the compliance visit. This outcome may have resulted from the Facility's approach of waiting for an individual or LAR to express interest in moving. PSPs stated RGSC was the most integrated setting when an individual did not express an interest in moving, even when few barriers to movement were stated. PSTs did not identify that information from PFAs that would indicate a preference for smaller and quieter environments should lead to consideration of appropriateness of a move to such an environment. Obstacles to movement were not identified and addressed. There was no standardized approach to assessment in order for professional members of the PST to make determinations that community placement is appropriate. If the new PSP process does not lead to either determinations that community placement is appropriate for a greater number of individuals or more complete documentation of real obstacles to such movement, RGSC will need to develop and implement training or other means to improve assessment of individuals for placement.<br><br>The Facility was in substantial compliance with Provision T2. The Monitoring Team made this determination although the sample included only one individual who had moved and there is not a quality assurance mechanism in place to ensure continuing compliance. The Post-Move Monitor carried out the required activities comprehensively and verified supports were in place in both home and work settings. |

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| **T1** | **Planning for Movement, Transition, and Discharge** | This provision is not in compliance. | Noncompliance |
| T1a | Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. | One person of 71 in residence (1%), Individual #10, had moved from RGSC to a more integrated setting since the last compliance visit.<br><br>The Facility had recently implemented the new statewide PSP process. The PSP annual planning meeting for Individual #113 began with a discussion of the potential for referral to move to a more integrated environment; this remained the focus of the meeting. A representative of the MRA was present at the meeting. Supports needed included tours of group homes (that the MRA took responsibility to set up) and discussion of supports the individual would need both for visits and for successful living. Also, at the last compliance visit, a PSP annual planning meeting led by the same QMRP for Individual #140 had followed the same process and resulted in referral for a move to a more integrated setting. The Facility had followed up on that, and the individual had gone for several visits, including a 10-day visit; at the end of the 10-day visit, the individual indicated a choice to remain living at RGSC. These two PSP meetings did include determination by the professionals that community living was appropriate.<br><br>The Facility took some positive steps toward encouraging people to learn about community living and make educated choices. As noted for Individual #140, the Facility gave individuals opportunities to experience living in specific homes by offering visits of up to 10 days routinely to individuals who agree to consider moving to a more integrated environment. Individual #140 completed a 10-day visit to a group home after having participated in two three-day visits. The PSP Addendum of 11/15/10 stated the individual "liked her 2nd 3-day visit." Per the PSP Addendum of 1-3-11, at the end of the visit, the individual stated she did not want to live at the group home. The LAR and QMRP agreed that the individual could continue living at RGSC. Although this was an appropriate recognition of the individual's choice, the decision documented in the PSP Addendum stated, "No further living options for [Individual #140]." The Facility should continue to provide opportunities for the individual to learn about and consider other options for a more integrated living environment. Furthermore, given that the individual had liked the shorter visits, there should be some exploration of the reason for the individual's change of choice; if no reason could be determined, the Facility should make a decision as to whether an additional visit might be appropriate, to determine whether this would be a consistent choice.<br><br>The Facility provided opportunities for other individuals to tour community living settings. For example, Individual #58 was "referred for placement" and visited group homes. However, these visits were for people who had not objected to movement to a | Noncompliance |

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| | | more integrated environment. The Monitoring Team did not have information to determine whether the Facility or MRA routinely provided opportunities for visits to who had not yet expressed interest in moving to a more integrated setting.<br><br>There were other indications that the Facility may not routinely take active steps to encourage individuals to experience and consider community placement. Instead, the Facility, in many cases, documented waiting for the individual to express the interest in moving before providing opportunities to learn about and experience options for movement to a more integrated environment. This approach is not in compliance with the requirements of this provision, which requires that professionals make a determination that community placement is appropriate, and that the Facility take action to encourage and assist individuals to move to more integrated settings unless they or their LARs oppose the moves.<br>• In response to a request that the Facility describe how it assesses an individual for placement, the Facility responded, "If the individual expresses an informed interest the facility provides tours, Group home visits and assists the individual to make the selection of his/her Choice. If the individual is non-verbal, the facility still provides tours if there is interest expressed and the team feels the individual will do well living in the community a formal recommendation is then made, and the individual is assisted for a smooth transition."<br>• The PSP for Individual #35 stated under "Obstacles identified by the PST" that the individual "did not show interest in any living options" but did not address this through documented plans to provide opportunities to learn about or experience more integrated settings or to initiate referral for movement. The PSP did not document any other obstacles. The remainder of the documentation of obstacles listed the need for annual medical evaluation and follow up by various clinicians who should be readily available in community settings.<br>• The PFA for Individual #55 documented a preference to have personal space and avoid noisy or crowded places. The PSP did not address this preference in relation to the possibility of movement from the large home on campus where the individual lives to a smaller community setting where there would be fewer people in the same area and less noise.<br>• The PSP for Individual #87 did not identify obstacles to the individual's movement to more integrated living. The PSP, under "Obstacles identified by the PST," stated the individual "was not able to give a definite answer to wanting to live at a group home." The section of the PSP titled "Preferences of [Individual #87] and/or LAR for a specific living option" documented that the individual "stated he would like to live in a group home but later changed his mined [sic] and stated that he wants to live at RGSC." Although there were no obstacles to | |

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| | | movement and the individual did not object to movement, the PSP stated, "The PST determined that the most integrated setting at the current time is: Rio Grande State Center [.]" The PSP included a statement that some tours should be arranged; the attached MRA Service Coordinator Community Living Options Information Process (CLOIP) Worksheet stated, "will schedule tours of providers for the individual to see and visit."<br><br>Thus, PSPs did not include determinations by professionals that community placement is appropriate, and the Facility response indicated that this would occur when an individual expresses interest.<br><br>Notes prepared by RGSC of a meeting held 2/9/11 regarding a request from Advocacy Inc. to have these Individuals #13, #80, and #121 "placed in a Community Setting (Home)" included documentation that the position of the professionals from RGSC was that all three individuals should move together, but one individual was "not ready or stable enough for outplacement." According to the Guardianship Level of Need document described in Section V of this report, advocacy is provided by Advocacy (presumably Advocacy, Inc., now named Disability Rights Texas). Although advocacy does not carry the legal standing of Legally Authorized Representative (LAR), the Facility documented this in the same way it documented family advocacy. The Facility needs to clarify whether Advocacy, Inc. has the authority to participate as a member of the PST and seek movement to a more integrated setting. In any case, the PST was documented in these notes as having determined appropriateness of movement. The Monitoring Team did not review the PSP to identify what actions the Facility had taken identify the supports the third individual would need in order to move to a more integrated setting. | |
| T1b | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that: | RGSC SOP MR 300 20 Most Integrated Setting, dated January, 2010 implements DADS Policy 108.1 and governs the procedures the Facility is to follow regarding transition and discharge.. 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 beinitiated 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. | Noncompliance |
| | 1. The IDT will identify in each individual's ISP the | During the PSP annual planning meeting for Individual #113, there was extensive discussion of the supports that would be needed for the individual to move to community | Noncompliance |

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| | protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles. | living, including environment, medical, nutritional management, and transportation needs, as well as preferences for leisure and private bedroom. The QMRP repeated each of these and stated they would be included in the PSP. Goals to be established in the PSP, however, focused on self-care, a specific work activity, and—as the only goal directly related to a support discussed for community living (making music and TV available)—turning radio and TV on and off using a switch. The Monitoring Team did not have the opportunity to see a completed PSP following this meeting, so there was no chance to determine how the final PSP addressed the supports needed for community living.<br><br>For three of three (100%) PSPs reviewed by the Monitoring Team, the PST either determined the most integrated setting was RGSC or did not document determination of the most integrated appropriate environment. In two of three (67%) PSPs, no significant obstacles were identified; in the other PSP, obstacles were not documented at all.<br>• The PSP for Individual #35 stated "The PST determined the most integrated setting at the current time is: Rio Grande State Center [.]" Obstacles listed included that the individual "did not show interest in any living options…" The only other obstacles were the need to be followed up by clinicians who should be available in a community, and therefore should not constitute obstacles. The PSP did not list any strategy to overcome the obstacle of lack of interest (which, as noted in the finding for Provision T1.a, is not a requirement for referral to a more integrated environment), nor was there any plan listed to determine the availability of the required clinicians in various possible community settings.<br>• The PSP for Individual #87 documented that the individual "stated he would like to live in a group home but later changed his mined [sic] and stated that he wants to live at RGSC." Although there were no obstacles to movement and the individual did not object to movement, the PSP stated, "The PST determined that the most integrated setting at the current time is: Rio Grande State Center." As no obstacles were identified, the PSP did not address strategies to overcome obstacles.<br>• The PSP for Individual #55 did not include documentation of any discussion of movement to a more integrated environment or any discussion of obstacles to such a move. | |
| | 2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them | RGSC SOP 300 01 requires the Facility to hold an annual community provider fair or other educational activity. The SOP also requires the Facility to host a Community Living Options inservice to include participation of "MRAs, families, LARs, residents, RGSC staff, and visitors" and to document attendance.<br><br>In response to a request fora list of all trainings/educational opportunities provided to | Noncompliance |

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| | to make informed choices. | individuals, families and LARs to enable them to make informed choices, including but not limited to any self-advocacy activities that address community living options and transition and discharge processes, provider fairs, community living option in-services, and/or on-site reviews of community homes and resources," the Facility replied, "The APC does not have the information available." No information was provided documenting that either of these activities was provided.<br><br>Per interview with the APC and communication with the Facility following the visit, the Facility reported that a Provider Fair was held 2/22/11. Although many individuals who receive services at RGSC participated, no families attended.<br><br>The Monitoring Team did not receive information on the number of visits made by individuals to explore more integrated settings before expressing an interest in moving. There were at least a few such visits. Individual #58, per report of the Facility, participated in a tour on February 18, 2011. For Individual #113, one plan developed at the PSP annual planning meeting was for the MRA to arrange tours. The Facility should provide opportunities for people to visit community living settings as a way to experience them and be able to make informed choices. The Facility should also track tours provided to determine the number of tours provided and the number of people who go on tours, and to ensure recommendations for individuals going on tours are implemented.<br><br>As noted in Provision T1a, the Facility gave individuals opportunities to experience living in specific homes by offering visits of up to 10 days routinely to individuals who agree to consider moving to a more integrated environment. This is a positive process that allows an individual to experience living in a home where the person could move and provide an informed choice of residence. If a person chooses not to move to that setting, the Facility should continue to provide opportunities for the individual to learn about and consider other options for a more integrated living environment. Furthermore, given that the individual would have chosen to participate in a long visit after having shorter visits, there should be some exploration of the reason for the individual's change of choice; if no reason could be determined, the Facility should make a decision as to whether an additional visit might be appropriate, to determine whether this would be a consistent choice. | |
| | 3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement | In response to a request for a list of all individuals who have been assessed for placement and the date of assessment and resulting recommendations, the Facility provided a table listing all individuals at the Facility and a "date of staffing." For 72 people listed in the table, the following were the comments in the column headed "Recommendations": | Noncompliance |

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| | 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. | • For two individuals (3%), there was a statement that the individual had moved.<br>• For one individual (1%), there was a statement that the person had moved to an SSLC.<br>• For one individual (1%), there was documentation that the individual had gone on visits to a group home and had chosen to remain living at RGSC.<br>• For 53 individuals (74%), the column stated "None."<br>• For six individuals (8%), there was a recommendation for the individual to visit group homes.<br>• For eight individuals (11%), the column stated "Not a citizen."<br>• For one individual (1%) who was noted as "30 day," there was nothing documented under Recommendations.<br><br>No indication was provided of use of any standard procedure or tool to assess whether community living was appropriate for each individual. Observation of the PSP annual planning meeting for Individual #113 indicated that, for this individual, the assessment was done through discussion at the PSP meeting.<br><br>This observation was supported by the identical statement found in PSPs for Individuals #35 and #55, " The PST determined that the most integrated setting at the current time is: Rio Grande State Center." One of these individuals had documented, under Recommendations, "None" and the other had documented "Not a citizen."<br><br>The high percentage of individuals for whom there was no recommendation (which apparently meant that the PST determined that the most integrated setting at the current time is RGSC), indicates a lack of thorough assessment, especially when few or no obstacles to movement are listed in the PSPs. If the new PSP process does not lead to either determinations that community placement is appropriate for a greater number of individuals or more complete documentation of real obstacles to such movement, RGSC will need to develop and implement training or other means to improve assessment of individuals for placement.<br><br>A number of improvements should be made to the process of PST assessment before the facility begins to consider that individuals have been truly assessed for placement.<br><br>These improvements should begin with:<br>• A clarification and additional training for PSTs on their responsibility, as qualified professionals, to assess each individual for the most integrated setting appropriate to their needs as called for by the ADA and the Olmstead decision<br>• A focus on the ability of the PSTs to engage in critical thinking, interdisciplinary | |

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| | | assessment and actual person-centered planning. This will require considerable staff training and mentoring.<br><br>The number of people for whom "Not a citizen" was listed is also a concern. This statement does not describe a reason why community living is not appropriate; instead, it most likely describes a problem with either policy or funding that does not permit a move. That is a separate issue and should not be part of the determination of appropriateness of community living. The State needs to know how many people have been determined appropriate for community living but do not move because of policy or funding. Therefore, RGSC needs to document which individuals are not referred for movement solely because of citizenship. | |
| T1c | When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall: | For Individual #10, a CLDP had been developed prior to the individual's move.<br><br>The Admissions/Placement Coordinator (APC) reported that development of the CLDP began at the time of referral to a specific agency. At the time of referral, she reviews assessments from clinicians by reviewing the chart (the Active and Master records) and identifies support needs from that information. She stated that she did not use the PSP in preparing the CLDP but instead reviewed assessments. Regardless of how well the APC was able to translate from the PSP to the CLDP (and, as noted below, the CLDP and the PSP identified many of the same supports needed), the development of the CLDP needs to be done by the people who have been planning services through the PSP process, including direct care staff. Furthermore, development of the CLDP should begin at the time of a decision to refer for alternate community placement rather than waiting until referral to a specific agency and should continue past the transition date and include the following:<br>• The CLDP should be completed using the person directed planning philosophy.<br>• PSTs should meet at various stages of the community transition process. Deliberations from these meetings should be captured in the CLDP.<br><br>The Essential Supports listed in the CLDP included some of the services and learning goals in the individual's PSP. The PSP listed adaptive equipment under the General Discussion Record but did not describe any action plan for use of the equipment; nevertheless, the CLDP did include each item of this equipment listed in the PSP. The PSP included a PBSP that was listed in the CLDP as an Essential Support. The PSP did not have an action plan for modified diet and food texture but did list that in the Assessments/Service the Person Uses/Needs section; this was in the CLDP as an Essential Support. Thus, the PSP and CLDP addressed many of the same needs. However, there was no direct correspondence between the supports and services | Noncompliance |

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| | | documented in the PSP as being provided and the supports in the CLDP. Instead, the PMM had to review all parts of the PSP carefully to select the needed supports. As the new PSP system is implemented and matures, the Monitoring Team will assess to determine whether PSPs more accurately and comprehensively list the supports planned and provided; if so, the development of CLDPs should be more likely to cover all needs.<br><br>A concern of the Monitoring Team with the comprehensiveness of supports identified in the CLDP resulted from review of the CLDP itself. The CLDP stated that a glucometer and colostomy/urostomy equipment would be provided on the day of transition. Neither of these was mentioned under Essential Supports. If these are needed, a plan for use and for training of staff should have been included as an Essential Support. | |
| | 1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff. | This was done to some degree but was not yet in compliance. The CLDP listed items (including medications, personal property, and adaptive equipment) that were to be provided on the day of transition. The CLDP identified training to be provided by RGSC to the staff of the home on the PBSP, the use of the gait belt, and thickened liquid but not on food texture or wrist splint. The Facility did not assign specific Facility staff responsibility for the essential and non-essential supports other than the PBSP training; all responsibilities were listed as "Texas HCS." | Noncompliance |
| | 2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed. | Even for the actions that were assigned to the Facility—provision of medications and adaptive equipment and medical orders—there was no documentation in the CLDP of the specific Facility staff assigned responsibility. The Facility did not assign Facility staff responsibility for essential and non-essential supports. However, for the training the Facility offered to the provider on use of gait belt and PBSP, specific Facility staff were identified, and an inservice training date was established in the CLDP. | Noncompliance |
| | 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. | None of the documentation verified that the CLDP for Individual #10 was reviewed with the individual and LAR prior to the move, except for a meeting with the PST, individual, and family to finalize discharge. However, at the special PMM visit, the individual's family was present and stated they attended each PMM visit. The family was aware of each of the supports in the CLDP. Furthermore, there was documentation in the CLDP that the individual and family selected the new home following visits to that home and another. Although this component is found in substantial compliance, the Facility should develop a way to document each time the CLDP and the supports and services included in it are reviewed with the individual and LAR. | Substantial Compliance |
| T1d | Each Facility shall ensure that each | A current assessment of needs and supports was documented in the CLDP for Individual | Noncompliance |

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| | 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. | #10, which summarized the assessments. Some of the assessments included had been done more than 45 days prior to the individual's leaving, and the CLDP did not include any updates or statements that these assessments were still accurate. For example, the Psychological Assessment was dated July 16, 2010; in light of continuation of the PBSP as an essential support, and update to the assessment should have been provided. The Medical Assessment was dated 7-30-10; given the supports in the CLDP, this should have been updated. One report related to CLDP supports that was done within 45 days was the OT-PT report, dated 10/5/10. | |
| T1e | Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility. | The Facility did verify that essential supports were in place. The Facility provided sign-in sheets documenting training of staff of the new home prior to the move as required in the CLDP. The Continuity of Care Pre-Move Site Review Instrument was completed; this was dated 9/24/11, nearly two months prior to the move but after the pre-placement visit. The form stated, "RGSC has not yet facilitated to [the provider agency] a copy of the consumer's draft Community Living Discharge Plan. [The provider agency] is aware of client's needs and able to meet them due to pre-placement trial." The CLDP stated that the date of the pre-placement visit was 11/16/2010 and said "See Section IX' but Section IX was not provided to the Monitoring Team. The PMM Checklist for the seven-day visit dated 11/24/10 listed each essential support and marked each was in place. These were confirmed at the 45 day and 90 day visits. The Monitoring Team could not confirm the process used by the Post-Move Monitor at those visits but did observe an additional review done during the compliance visit. The Post-Move Monitor interviewed both management and direct care staff as well as speaking with the individual's family, checked the presence and condition of adaptive equipment listed as essential supports, checked at the home for the Thick-It, asked for copies of psychiatry notes that were in the chart and about neurologist notes (report not sent by neurologist yet), and observed the individual. Nonessential supports involving visits to specialists for medical evaluation had not yet been provided, and the PMM checklist noted the need for follow up. At the 45-day visit, those appointments had not yet occurred, so follow up was continued to the 90-day check, at which time the Post-Move Monitor verified the appointments had been made. | Substantial Compliance |
| 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 | The Facility did not have quality assurance policies, procedures and/or processes to ensure that community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible. | Noncompliance |

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| | provisions of this Section T. | | |
| T1g | Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature. | In response to a request by the Monitoring Team for a report summarizing the obstacles for movement to more integrated appropriate settings, the Facility provided a table for two individuals who had been referred (Individual #58, and Individual #140, who had stated a preference to remain living at RGSC) that listed only three headings that might be obstacles—Client Preference, Correspondent/LAR Preference, and Program Competency. A number or a Y, N, or X was noted for each person under each of these categories. However, even for these two individuals, no description or more comprehensive listing of obstacles was provided.<br><br>No report of obstacles was provided for the rest of the individuals at the Facility. Given the lack of obstacles identified in the PSPs reviewed and noted for Provision T1b1, there was a lack of both identification of obstacles and of a process to aggregate and report that information. | Noncompliance |
| 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 | In response to a request from the Monitoring Team for the most recent Community Placement Report, the Facility provided a listing dated 9/1/10-2/10/11 of individuals who:<br>• Were currently referred (Individual #58),<br>• Had rescinded referral (Individual #140),<br>• Had been placed in community (Individual #10),<br>• Prefer community but not referred—LAR Choice (none),<br>• Prefer community but not referred—Other reasons (none), and<br>• LAR prefers community but not referred (none). | Substantial Compliance |

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| | community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I. | | |
| **T2** | **Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs** | The Monitoring Team finds the Facility to be in Substantial Compliance with this provision. | |
| 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 | The PMM was the responsibility of the APC. The APC provided the Monitoring Team with copies of the Post-Move Monitoring Checklist for Individual #10's 7-day, 45-day, and 90-day visits. The visits were done within the required timelines.<br><br>The PMM Checklist is a standard form that matches the form in Appendix C of the SA. The Facility had not yet begun to use the new format that State Office was finalizing. The checklist lists the essential and non-essential supports identified on the CLDP and provides a place to check whether these are in place. It asked whether the support plan has been updated and whether there have been changes in medication. It asks whether the provider has documentation to confirm staff have been trained on various categories of needs, whether personal belongings are available to the individual, whether the individual's records indicate injury or behavioral incidents, whether the individual is | Substantial Compliance |

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| | discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency. | satisfied, and whether specialty provider appointments were kept consistent with the CLDP or individual support plan. It provides a place for action plans and narrative about the visit. The PMM Checklist can comply with the requirement for an assessment tool. Efforts clearly were being made to add to the Checklist narrative information regarding the interviews conducted, the documents reviewed, and the observations made.At RGSC, the Post-Move Monitor provided this narrative information to describe the individual's adjustment and any issues with provision of supports. This should be improved further when the new CLDP format is implemented, and teams are better defining the evidence expected to confirm the existence of an essential or non-essential support.<br><br>The Post-Move Monitor addressed each of the items on the Checklist at each visit and during the observed additional visit. The Post-Move Monitor interviewed both management and direct care staff as well as speaking with the individual's family, checked the presence and condition of adaptive equipment listed as essential supports, checked at the home for the Thick-It, asked for copies of psychiatry notes that were in the chart and about neurologist notes (report not sent by neurologist yet), and observed the individual. Nonessential supports involving visits to specialists for medical evaluation had not yet been provided, and the PMM checklist noted the need for follow up. At the 45 day visit, those appointments had not yet occurred, so follow up was continued to the 90 day check, at which time the Post-Move Monitor verified the appointments had been made.<br><br>On each Checklist, the Post-Move Monitor provided either a description of an action plan (for example, on the 7-day visit Checklist, the action was that the individual had a doctor appoint scheduled about two weeks later, and the Post-Move Monitor wrote a response that she would check at the 45-day visit, when the narrative noted that had been completed) or a narrative of the individual's status, or both. | |
| 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 | The Monitoring Team accompanied the Post-Move Monitor on a special PMM visit for Individual #10. Because no individual had moved during the prior 90 days, the Facility arranged with the new home provider, with approval of the individual's family, to have this special visit. Upon arrival, the Monitoring Team asked the individual for permission to observe, and the individual agreed. When the individual's family arrived shortly after, they also gave permission for the Monitoring Team to observe. The Monitoring Team also had the opportunity to observe the responses of the agency management and of the MRA representatives who were at the interview portion of the visit.<br><br>As indicated in Provision T2a, the Monitoring Team observed the Post-Move Monitor checking all supports as well as asking other questions to determine the individual's | Not Rated |

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| | accuracy of the Facility's monitoring and shall occur before the 90th day following the move date. | status. Nevertheless, because the Monitoring Team had no opportunity to observe an actual post-move monitoring visit, this provision element cannot be rated. The Monitoring Team urges the Facility to continue the post-move monitoring process as observed at this visit. | |
| **T3** | **Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations. | | Not Rated |
| **T4** | **Alternate Discharges -** | | Not Rated |
| | 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:<br>(a) individuals who move out of state;<br>(b) individuals discharged at the expiration of an emergency admission;<br>(c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held | The Facility reported that no individuals have been discharged since the last compliance visit pursuant to an alternative discharge as defined in the Settlement Agreement. Therefore, this provision was not rated.<br><br>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. | |

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| | during the required 20-day timeframe;<br>(d) individuals receiving respite services at the Facility for a maximum period of 60 days;<br>(e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;<br>(f) individuals discharged pursuant to a court order vacating the commitment order. | | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. The expectation that professionals must make determinations and document when movement to community living is appropriate for an individual must be clearly stated in policy and procedure, and PST members must act on that expectation when making decisions regarding services for each individual. A statement of the determination of appropriateness should be included in each PSP.
2. The Facility should develop a standard procedure or tool to assess whether community living was appropriate for each individual as a means to provide information to improve the decision-making of the PST.
3. If the new PSP process does not lead to either determinations that community placement is appropriate for a greater number of individuals or more complete documentation of real obstacles to such movement, RGSC will need to develop and implement training or other means to improve assessment of individuals for placement.
4. The Facility should develop a comprehensive strategic plan for education of individuals, LARs and families and facility staff on community living options. The strategic plan should include assigned responsibilities, timelines and outcome measures. PSTs should receive additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.
5. If an individual states a choice to return to living at RGSC after a community home visit overnight or longer, the Facility should explore further the reason for this decision, and then determine actions such as providing an additional visit or visits to other homes.
6. RGSC needs to assess appropriateness of community living for individuals without reference to citizenship and provide the State with information on the number of people who do not move solely because of citizenship.
7. The CLDP should identify which Facility staff are responsible for carrying out transition activities and ensuring that essential and nonessential supports are provided.
8. The Facility must develop quality assurance procedures to ensure CLDPs are developed and that Facility staff implement the portions of the CLDP that the Facility is responsible for.
9. The Facility should provide opportunities for people visit community living settings as a way to experience them and be able to make informed choices. The Facility should also track tours provided to determine the number of tours provided and the number of people who go on tours, and to ensure recommendations for individuals going on tours are implemented.
10. The Facility needs to clarify whether Advocacy, Inc. has the authority to participate as a member of the PST and seek movement to a more

integrated setting.

The following are offered as additional suggestions to the facility:

1. The Facility should develop a way to document each time the CLDP and the supports and services included in it are reviewed with the individual and LAR.
2. Establish a quality assurance process to ensure the Post-Move Monitoring process continues to be implemented consistently and thoroughly, and to track failures of community providers to implement all essential supports and those non-essential supports that remain in the individual's support plan.
3. As it is possible that an alternative discharge of an individual who meets a criterion of Provision T4 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.

| SECTION U: Consent | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. RGSC SOP MR 200 04 Process for Reviewing the Need for Guardianship February 2010<br>3. Texas Administrative Code Title 40, Part 1, Chapter 4, Rights and Protection of Individuals Receiving Mental Retardation Services<br>4. Texas Probate Code Chapter XIII, Guardianship<br>5. Letter to Guardians and Families introducing Human Rights Officer Liza Pena February 7, 2011<br>6. Guardianship List criteria definitions (undated)<br>7. Training Course Sign-In Sheet for course titled Need for Guardianship Record January 21, 2011<br>8. Need for Guardianship Record 01/21/2011<br>9. Rights Assessment for Individual #87<br>10. Minutes of the Human Rights Committee 3/3/11<br>**People Interviewed:**<br>1. Liza Pena, Human Rights Officer<br>**Meetings Attended/Observations:**<br>1. RGSC Advocates (Self Advocacy council) meeting of 3/1/11<br>2. Human Rights Committee meeting of 3/3/11 |
| | **Facility Self-Assessment:**<br>The RGSC POI reported not being in compliance with either provision of this Section. Steps had been taken to make progress.<br><br>A new Human Rights Officer began at the Facility in December, 2010.<br><br>Criteria for ranking the "Need for Guardianship" were updated and all individuals in the ICF-MR Program were reviewed for level of priority. Four individuals were rated as having the highest level of guardianship need.<br><br>At a meeting in January, 2011, DADS instructed Human Rights Officers to focus their efforts on the people rated as highest priority for guardianship.<br><br>A letter was sent in February, 2011, to current guardians, family members and loved ones. The letter asked any other family members to contact the new HRO if they were interested in any information on how to become a guardian.<br><br>The Monitoring Team concurs that the Facility is not in compliance with the requirements of either provision of this section and recognizes the steps that have been taken. |

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| | **Summary of Monitor's Assessment:**<br>RGSC was not in compliance with either provision of this Section. The Facility had hired a new Human Rights Officer. The Facility was taking actions to rank need for guardianship and to identify ways to recruit guardians. No guardians had been obtained since the last compliance visit.<br><br>RGSC had revised criteria used for rating need and priority for guardianship. The Facility had reviewed all individuals served and developed rankings of need for guardianship based on the criteria that had been revised. Based on these criteria, only four people were ranked as having a high need for guardianship. DADS had drafted a policy on guardianship but had not completed or implemented it. When that is done, the Facility will need to review and revise its policy and may need to reevaluate need for guardianship. At that time, the Facility should also train both the rating panel and PSTs on making decisions on the need for guardianship.<br><br>Although a panel of four staff (Human Rights Officer, two QMRPs, and a Unit Manager) did the annual review of need for guardianship and established the rankings, the PSTs had a responsibility under RGSC policy to participate in identifying need for guardianship. PSTs had received no training about guardianship and consent. Although both QMRPs served on the panel that established the rankings of need, the PSTs as a whole need to provide the information necessary for such decisions.<br><br>The Facility used no specific assessments or processes to aid in classifying an individual as low or high functioning, which are terms used on the criteria for rating need for guardianship. Furthermore, the Facility did not use any standardized assessment instrument or process to assist the PST to make the determination of whether an individual could advocate for him or herself.<br><br>A letter to families and guardians introducing the new Human Rights Officer included a request for people interested in obtaining guardianship to contact her. No other structured recruitment process had been implemented. The Human Rights Officer had begun looking at ways to reduce the cost of gaining guardianship. |

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| U1 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a | The Facility revised the criteria used for rating need and priority for guardianship. Four Facility staff—the Human Rights Officer, two QMRPs, and a home supervisorreviewed all individuals on 1/21/11 based on these criteria. There are four levels of need—high, medium, low, and N/A (N/A means individual has a guardian). The revision of criteria included eliminating a category of "critical." The criteria do not mention the frequency of need for consent or the level of restrictiveness of programming. DADS SO was in process of developing a policy that would provider greater guidance to the facilities but had not completed or implemented the policy. State Office held a meeting January 27-28, 2011, with facility Human Rights Officers; discussion was held on this policy at that | Noncompliance |

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| | 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. | meeting. Human Rights Officers provided (and continue to provide) feedback and recommendations for the development of this policy. Once the State policy is implemented, the Facility should review and revise, as necessary, its policy, including criteria and procedures for ranking level of need for guardianship. At that time, there may be a need to reevaluate need for guardianship.<br><br>Information on training for ranking need for guardianship was minimal. No curriculum was provided other than the criteria for level of need. Per interview, training consisted primarily of presenting the criteria to trainees and then jointly ranking 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.<br><br>The Human Rights Officer reported that the revised ranking resulted in fewer people being rated as in High need for guardianship; four people have been ranked at the High level of need. Eight people have been ranked at the Medium level, and 36 people have been ranked at a Low level of need, with the remaining 22 ranked as N/A. The ranking sheet provided the individual's name, ranked level of need, a brief description of the reason for the ranking, and a brief status giving the reason why there was no guardian and whether the family is active. Although this form provided useful information about the reason for ranking, and there was general consistency across the reasons given for rankings, there were a few cases in which similar statements were found justifying different levels of need.<br>• The criterion for Low level of need included, for individuals who cannot advocate for themselves, "Individual has family to advocate for them." Individuals #13, #80, and #121 did not have family to advocate for them. Instead, advocacy is provided by Disability Rights Texas (identified on the ranking sheet as "Advocacy").<br>• Individual #118 was listed at a Medium level of need; the Need for Guardianship description stated the individual's family advocates for the individual. The individual has a medical condition that "has not progressed very much in recent years." All other individuals whose families are not guardians but do advocate for them were ranked at a Low level of need.<br><br>A greater issue is that the criterion for High level of need stated that the "Individual is low functioning and is unable to advocate for themselves." The criterion for Low level of need stated that the "Individual is high functioning and is able to advocate for himself/herself." The Facility used no specific assessments or processes to aid in classifying an individual as low or high functioning. The criterion for the High level of | |

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| | | need included "Individual is non-verbal and is unable to communicate his/her wants or needs." The Human Rights Officer stated that other criteria for "low functioning" included that the person could not make gestures to communicate or needed tubes or wheelchairs, whereas other criteria for 'high functioning" included the ability to walk, communicate by gestures, and understand through pictures or reading. The Facility had not determined whether independent raters would agree on level of functioning for individuals. Descriptions of the need for guardianship, with few exceptions, did not mention level of functioning but instead addressed whether the individual could advocate for him or herself. Again, the Facility did not use any standardized assessment instrument or process to assist the PST to make the determination of whether an individual could advocate for him or herself.<br><br>Determination of the need for guardianship was done as part of the Rights Assessment within the PSP planning process. Facility SOP 200 04 requires that the QMRP and PST assess the need for guardianship at the 30-day program planning conference and review at least annually. Per report of the Human Rights Officer, PSTs had received no training about guardianship and consent. Although both QMRPs served on the panel that established the rankings of need, the PSTs as a whole need to provide the information necessary for such decisions. The Facility should provide training not only to the panel but also to PST members who provide the information.<br><br>The PST should ensure that decisions on need for guardianship and on "level of functioning" match the information and assessments in the Active Record. For Individual #87, the description of reason for level of need indicated that the individual's mother came to visit recently, whereas the Active Record stated that the individual's mother was deceased. When the Monitoring Team pointed this out, the Human Rights Officer checked and learned that the information in the Active Record had been reported to the Facility inaccurately; when accurate information had been provided, the Active Record had not been corrected. Although the information in the ranking of level of need was correct, it had been made without reference to the Active Record. This demonstrates that the information brought by the QMRP and used in making decisions on rankings has the potential to be inaccurate.<br><br>RGSC had a Human Rights Committee that reviewed rights restrictions. At the meeting observed, the Monitoring Team noted active discussion, including review of history of interventions, current programs and treatments, and information on rights assessments. | |
| U2 | Commencing within six months of the Effective Date hereof and with | DADS SO was in process of developing a policy that would provider greater guidance on guardianship recruitment procedures including prioritizing efforts to recruit guardians | Noncompliance |

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| | 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. | to the facilities but had not completed or implemented the policy.<br><br>Per interview with the Human Rights Officer, DADS held a training session for Human Rights Officers from the SSLCs and RGSC. The Human Rights Officer found the information provided to be helpful; the session also provided the opportunity for the Human Rights Officers from the various facilities to discuss issues. Furthermore, according to the RGSC POI, the SO informed Rights Officers they should focus on those individuals with the highest level of guardianship need.After the session, the Human Rights Officer had contacted other facilities to discuss relevant issues and found this helpful. This could provide opportunity to discuss initiatives to recruit guardians.<br><br>Information in the Need for Guardianship Record identified four individuals for whom guardianship had expired and there was no power of attorney. The Human Rights Officer reported that she was aware as of February 25, 2011, of six expired guardianships and had followed up; one had been renewed, two were waiting for response from the court, and she was working with the remaining three families to prompt action. Aside from renewals, no new guardians had been obtained since the last compliance visit.<br><br>The Facility sent a letter to guardians and families introducing the Human Rights Officer. The letter included a request for people interested in obtaining guardianship to contact her.<br><br>No other structured recruitment activities had been implemented. The Human Rights Officer estimated that she spent 5-6 hours per week attempting to recruit guardians or following up on guardianships about to expire. Because a major barrier to obtaining guardianship is the cost, including legal representation, she was planning to seek ways to get low-cost legal representation. The Monitoring Team encouraged her to move forward on this.<br><br>Because there was not yet a State policy guiding guardianship, it is understandable and appropriate that the Facility take a cautious approach to recruiting guardians while at the same time seeking ways to have effective recruitment.<br><br>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. One way to provide opportunity to learn decision-making skills is through | |

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| | | participation in a self-advocacy council. The Advocates meeting provides a venue to do this. The Monitoring Team attended a meeting of the Advocates. Only two individuals participated. The Human Rights Officer reported it is difficult to get individuals to participate. One obstacle is that many individuals do not want to leave work or activities to attend. The Monitoring Team encouraged the Facility to reschedule the meeting and explore ways to encourage participation. | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. DADS should complete development and implementation of policy on guardianship and consent. Following development of a policy or policies, the Facility should revise its local policy to operationalize DADS policy.
2. Training the panel on ranking levels of guardianship need should include presenting the criteria for levels; ranking of individuals independently by trainees could serve to verify competence.
3. The Facility should provide training about guardianship and consent not only to the panel that ranks level of need but also to PST members who provide the information.

The following are offered as additional suggestions to the facility:

1. Continue to explore ways to reduce the financial obstacle to obtaining guardians.
2. The Facility should consider rescheduling the Advocacy meeting and should explore ways to encourage participation.

| SECTION V: Recordkeeping and General Plan Implementation | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Plan of Improvement (POI) updated 2-17-11<br>2. RGSC SOP HIM 400-07 Documentation Guidelines revised 1/26/11<br>3. RGSC SOP ICF-MR 400=14 Medical Care established December 9, 2010<br>4. RGSC SOP HIM 400-20 Monthly Review and Reporting Percentage of Delinquent Medical Records (ICF-MR Services) revised 1/18/11<br>5. DADS Policy 020 Recordkeeping Practices revised 3/5/10<br>6. PSP for Individual #87 dated 12/28/10<br>7. RGSC Active Record Order & Guidelines for individuals with two charts revised 1/27/11 and for three charts revised 11/09/10 (first two charts) and 1/27/11 (third chart)<br>8. Individual Notebook & Guidelines revised 1/26/11<br>9. Table of Contents-Master Records revised 1/21/11<br>10. Master Record Purging Schedule dated 03/15/11<br>11. Active Record Audit form undated<br>12. Active Record Audit form revised 3/1/11<br>13. Active Record Audits for Individuals #2, #21, #31, #59, #63, #74, #76, #87, #122, #139<br>14. Action/Corrective Action Reporting Document from Record Audits October, November, December 2010<br>15. Active, Individual, and Master Records for Individuals #87 and #140<br>16. Progress notes on Clinical Work Station (CWS)<br>**People Interviewed:**<br>17. Letty Gonzalez, RHIT, Health Information Management Director, and Melissa Canales, RHIT, Unified Records Coordinator<br>18. David Moron, M.D., Clinical Medical Director and HerlindaDeVera, M.D.<br>19. Various nurses including CNE, QA Nurse, and staff nurses<br>**Meetings Attended/Observations:**<br>20. PSP Quarterly Review for Individual #140<br>21. PSP Annual Planning Meeting for Individual #113 |
| | **Facility Self-Assessment:**<br>RGSC reported it is not yet in compliance with any provision of this section. The Monitoring Team concurs.<br><br>For Provision V1, the Facility reported the new unified record format has been implemented and staff trained. The Documentation Guidelines have been updated. A new psychiatric evaluation has been implemented.<br><br>For Provision V2, the Facility reported Health Information Management (HIM) Policies and the Diagnosis |

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| | Input procedure have been updated. This provision requires that policies be developed and implemented as necessary to implement Part II of the SA. The Facility had developed or revised, and implemented, other relevant policies.<br><br>For Provision V3, the Facility reported HIM is completing a record audit of each individual who is due for an annual staffing each month. A Corrective Action Plan (CAP) is initiated and staff are required to complete corrections for each deficiency noted.<br><br>For Provision V4, the Facility reported that staff utilize records for all staffings and the completion of quarterly monitoring tools. Although the Monitoring Team found that the records had improved significantly and were better organized, problems with legibility and late entries made them more difficult to use to make decisions. Records were brought to annual and quarterly PSP planning, but there was little discussion of information from the records. The Facility did not have a process for monitoring use of the record for decision-making. |
| | **Summary of Monitor's Assessment:**<br>RGSC had made significant steps toward compliance with the requirements of this Section. The new unified record system was fully in place. At the same time, there remain difficulties in using a record that includes both the hard copy record and electronic record.<br><br>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.<br><br>RGSC had developed a process to audit at least five records per month. The sample consisted of all the individuals whose PSP annual meetings occurred during the prior month. Audits of active records used the Active Record Audit form that listed each of the items from the Active Records Order. Findings from the audits resulted in requirements for corrective actions; disciplines were notified of the corrective actions they needed to take. A process for tracking and confirming completion was in place. For many corrections required, there was no documentation of completion.<br><br>The Facility had revised numerous policies. Many of those revisions had occurred in the month prior to the compliance visit.<br><br>The Facility did not have a process in place to monitor and evaluate use of information from the record in making decisions on care, medical treatment, and training. PSPs were accessible, and records were well organized. There was a separate electronic system, the Clinical Work Station that contained progress notes, medical progress notes, and other information. Not all information could be accessed chronologically, which made this system more difficult to use when tracking the actions and results related to a health care condition. |

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| V1 | Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D. | The unified record at RGSC consisted of an active record, individual notebook (the Me Book), Master Record, Overflow (which remained in the Master Record until the retention period is completed), and the Clinical Work Station (CWS). The CWS, an electronic system, included progress notes, medical progress notes, nutritional reports (not including PNM), and psychiatric evaluations. HIM had just begun to update diagnosis screens in CWS.<br><br>Since the last tour the Facility's record keeping practices improved significantly for records contained in binders. Documents were organized, accessible, and it was easy to locate relevant information.<br><br>The Monitoring Team reviewed two complete records, Individuals #87 and #140. Each contained the active record, the master record, an individual notebook, and information in CWS. The active records for both had the table of contents, but each was missing several required items and had several outdated items remaining in the record. One of the two (50%) had gaps at the bottoms of physician orders pages. One of the two (50%) had at least one document undated. One of the two (50%) had a correction; this was done correctly, with a line-through initialed by the person who made the correction.<br><br>Both of these sample records were legible. Other information indicated problems with legibility. The nursing staffs' handwriting legibility had not improved significantly, and some signatures, titles, and initials remained difficult, if not impossible, to read.<br><br>Documentation in the CWS was, of course, legible and readable. However, the presence of two separate systems was problematic. To review progress notes, staff must open the CWS; if there is a need to cross-reference information from the active record with information in progress notes, the active record must be taken to the computer area. The integrated Progress Notes contained in the CWS continued to make it difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of individuals' clinical status. This posed a barrier when integrating clinical data into a useful manner. | Noncompliance |
| 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 | The Facility had updated numerous policies. Many of these had been revised only within the prior month.<br><br>RGSC SOP HIM 400-07, revised 1/26/11, included minor revisions. One revision allowed the use of blue ink, whereas Appendix A of the SA recommends black ink. Other additions included instructions on how to enter late entries and correct errors. | Noncompliance |

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| | appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement. | RGSC SOP HIM 400-20, revised 1/18/11, was revised to state that records for audit will be selected from the annual staffing list for the month reviewed.<br><br>Other policies relevant to implementation of the SA were also revised since the last compliance visit.<br><br>RGSC SOP ICFMR 700-14, The Use of Restraint, revised 2/11, guides facility practices with respect to restraint use. The policy is comprehensive and directed to the practices necessary to achieve compliance with the Settlement Agreement and include the necessary components called for in this provision of the SA.<br><br>RGSC had not established and implemented the Standard Operating Procedure NR200-55, Pre-Treatment and Post-Sedation Monitoring Policy until February 2011. This Policy was not congruent with the DADS Pre-Treatment and Post-Sedation Policy and needs to be revised accordingly.<br><br>The Facility's policies and procedures included a commitment that abuse and neglect of individuals will not be tolerated and required that staff report abuse and/or neglect of individuals. According to the RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11), staff were required to report abuse, neglect, and exploitation to the Department of Family Protective Services (DFPS) within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement.<br><br>RGSC SOP ICFMR 200-07 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/11) and RGSC SOP ICFMR 200-03 titled Incident Management (revision date 1/11) govern all aspects of abuse/neglect/exploitation reporting and follow-up. In reviewing these policies the Monitoring Team did not find explicit language that directed staff to take the necessary action to stop the abuse, neglect, or exploitation. Nor was language found that required the removal of alleged perpetrators from contact with individuals (it should be noted that from its review of UIRs it was clearly the practice at RGSC to remove alleged perpetrators from contact with individuals). The policies did contain language addressing other safety concerns, including initiating first aid and notifying a nurse. The policy addressing these issues needs to contain additional requirements and be organized more efficiently so that all the steps expected to be taken to protect individuals are in one section.<br><br>The Facility had implemented a standard operating procedure for psychiatric services (Standard Operating Procedure ICF-MR 400-13), on December 13, 2010. The Monitoring | |

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| | | Team reviewed the new procedure and determined its clinical efficacy. To assess implementation of the procedure, the Monitor reviewed three psychiatric evaluations (Individuals #66, #3, #54). The Monitor determined that the psychiatric evaluations reflected the Facility's procedure and were well within expected standard of care practice.<br><br>RGSC SOP ICF-MR 400=14 Medical Care was established December 9, 2010 to guide medical services. The policy does not reference the need for integrated planning or interdisciplinary involvement. It does not mention the PSP process or involvement of the clinician with the PST.<br><br>Some of the policies and procedures the State Office Nurse Workgroup were developing had not been finalized and will need to be incorporated in the Nursing Department's policies and procedures.<br><br>DADS was in process of developing other statewide policies relevant to the SA. For example, a policy that would provide greater guidance to the facilities about guardianship had been drafted but not yet completed or implemented. Therefore, the Facility had not revised its guardianship policy, as there was a need to wait for the DADS policy in order to ensure consistency. DADS and the Facility should continue the process of developing policies to cover all issues required in the SA. | |
| V3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence. | RGSC had established a process to audit. The Health Information Management Director and Unified Records Coordinator stated that audits are performed on the records for each individual for whom a PSP annual planning meeting is held during the prior month; if fewer than five PSP annual planning meetings are held during a month, records from the current month are to be added so that five records will be audited. Seven audits were completed in January, 2011. At least five audits were completed in December, 2010.<br><br>Audits of active records used the Active Record Audit form that listed each of the items from the Active Records Order and provides cells in which to mark Yes, No, or NA for "Present" and for "In order" as well as a place for comments. The Facility provided Active Record Audit forms for the last 10 audits completed. Nearly all items marked present had a comment with the date of the item in the record that showed the item in the record was outdated; a few noted that a date or time was missing.<br><br>The Facility had a corrective action plan process in which an Action/Corrective Action Reporting Document was prepared and sent to each department responsible for addressing corrective actions. The document listed all the corrective actions required from all the audits for the month. When an action was confirmed as completed, the date | Noncompliance |

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| | | cleared was noted on the form; the Monitoring Team was told that the correction was checked by observation by HIM staff before noting the item as cleared. If not completed by due date, a date of follow up request was added to the form. Of 38 actions required from the December 2010 audits, 11 (29%) were documented as cleared.<br><br>The Monitoring Team reviewed two active records using the Active Record Audit form. For one of those records, the Facility had completed an audit in January. The Unified Records Coordinator and two audit staff completed audits. For the audits of the records for Individual #87, the Monitoring Team determined interrater agreement in which agreement was reviewed for any item in which at least one rater (the Facility or the Monitoring Team) rated the item as Yes or No for Present but did not count agreements where both identified the item as N/A. Using this conservative approach, there were 35 items on which there was agreement and 17 on which there was disagreement (67% agreement). Given the difference in time, the disagreements were examined to determine how many could have been the result of clearing of a corrective action. There were five items for which the Facility rating was Absent and the Monitoring Team rating was Present. For each of those, the Facility had requested corrective action on an Action/Corrective Action Reporting Document. Although only one of these was noted as cleared, these additional five items had been corrected. Had these been counted by the Monitoring Team as Absent (which would have been likely if the interrater checks had been done at the same time), there would have been agreement on 40 of 52 items (77% agreement). As the Monitoring Team had no training or specific definitions for items, this seems to be an acceptable agreement level. One concern was that three disagreements occurred on items in which the Monitoring Team marked Absent while the Facility marked N/A; in these cases, review of the records indicated the item should be present. These included two PNM-related items identified as needed because the individual's health risk assessment indicated that he ate fast and stuffed food. The third was the lack of a vocational assessment, which should be present because the PSP stated the individual attends work. This excellent audit process should be refined to ensure that items asterisked as not always required are checked for each individual to determine whether they should be present.<br><br>The Monitoring Team was told that data from the audits are provided to the Program Improvement Committee (SA-PIC) for trending. The process, which began in October 2010, had not yet identified trends leading to systemic action. At the same time, a concern of the Monitoring Team was the lack of documentation of completion of corrective actions. When corrective action can be routinely documented and trends have been identified and addressed, the Facility should be able to demonstrate compliance with this | |

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| V4 | Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions. | 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 separate from PBSP goals, which limit the holistic understanding of how these relate to each other.<br><br>There was indication that staff used the information in records as they were considering supports and services. During the PSP Quarterly Review for Individual #140, the active record was present. The record was reviewed to check on whether a specific diagnosis had been made. Furthermore, at least two participants reviewed copies of other documents that would be in the active record during the meeting, although they did not discuss the data or other information they were looking at. For the whole PST to participate in integrated decision-making, it would be useful for data and other information to be provided.<br><br>However, there were also indications that such information was not used. Inaccuracies in the record were not always corrected, and the information used in meetings was not based on what was in the record. For example, information in the active record for Individual #87 stated that the individual's mother was deceased. Rankings of need for guardianship mentioned that the individual's mother had visited recently. The Human Rights Officer checked after the Monitoring Team pointed this out. The active record had not been updated when the Facility received information that the individual's mother, who had been noted in the record as deceased, was alive and had visited. The decision on ranking need for guardianship was made without reference to the active record.<br><br>Since the last tour the Facility's record keeping practices improved significantly for records contained in binders. Documents were organized, accessible, and it was easy to locate relevant information. The integrated Progress Notes contained in the CWS continued to make it difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of individuals' clinical status. This posed a barrier when integrating clinical data into a useful manner. While completing record reviews on the Integrated Progress Notes for the last six months related to nursing care, each and every single entry had to be accessed and aggregated together. It was not functionally practical to access chronologically the physicians' medical notes with other discipline notes to evaluate integration of services and gain a true clinical picture of individuals care; physicians' notes were separate and could not be integrated to see a chronological order of notes. For the Integrated Progress Notes in the CWS system to be useful for integrating services, the system must allow easy access to notes from all disciplines to be reviewed chronologically. Otherwise, there is the potential for vital health related data to | Noncompliance |

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| | | be overlooked in making critical clinical decisions.<br><br>The nursing staffs' handwriting legibility had not improved significantly, some signatures, titles, and initials remained difficult, if not impossible, to read. The nursing staff failed to consistently document in the SOAP (Subjective, Objective, Analysis of problems, and Planning) even though a template was set up in the CWS system. Furthermore, numerous late entries were found in the Integrated Progress Notes. This reduced the value and usability of the documentation in making decisions.<br><br>Readability of the PBSPs was evaluated. A Flesch-Kincaid Grade Level was obtained for the direct service staff instructions in the nine most recently written PBSPs. Microsoft Word 2010 was used to obtain readability statistics. The measures revealed that direct service staff instructions consistently fell within the 9th to 10th grade reading level. Interviews with direct service staff, as well as residence administrators, indicated that staff infrequently experienced problems understanding PBSPs.<br><br>The Unified Records Coordinator reported she had begun to review two individuals per month to look for underreporting of injuries. She reads through all progress notes in the CWS for reports of injuries or referral to nursing and checks to see if there was a client injury report. She had found all injuries reported in progress notes were also reported on injury reports. There were, however, some injury reports for which no progress note was written. This process demonstrates a way in which the records were useful in providing information for quality improvement.<br><br>The Facility did not have a process in place to monitor and evaluate the use of information from the records in making care, medical treatment, and training decisions. The Facility will need to develop such a process.<br><br>DADS had drafted an interview format to evaluate use of records in decision making. The Monitoring Team used the format to interview physicians and nurses. Eight of eight individuals stated they used the records regularly. Some items they review included medical orders, seizure records, progress notes, changes in medications, consults and labs, history of prior treatment, and diagnoses. One of eight (13%) individuals stated that she looks at reports such as injuries and restraints. One of eight (13%) individuals reported looking at PST information. The form appears to have potential to gather narrative information and look for common themes; it might also have value for coaching staff in how to use the records for decision making. | |

**Recommendations:**The following recommendations are offered for consideration by the State and the Facility:

1. The Facility did not have a process in place to monitor and evaluate the use of information from the records in making care, medical treatment, and training decisions. The Facility will need to develop such a process.
2. The process should be refined to ensure that items asterisked as not always required are checked for each individual to determine whether they should be present.
3. CWS should be revised so that all progress notes can be viewed chronologically so that health conditions and actions can be viewed in an integrated way and actions and progress followed until resolved

List of Acronyms Used in This Report
Rio Grande State Center
February 28-March 4, 2011 Compliance Visit

| Acronym | Meaning |
|---|---|
| AAC | Alternative and Augmentative Communication |
| ACP | Acute Care Plan |
| AED | Anti-Epileptic Drug/Automated External Defibrillator |
| ADL | Activity of Daily Living |
| ADR | Adverse Drug Reaction |
| AIMS | Abnormal Involuntary Movement Scale |
| ANA | American Nurses Association |
| A/N/E | Abuse/Neglect/Exploitation |
| AOC | Administrative Officer on Call |
| AP | Alleged Perpetrator |
| APC | Admissions/Placement Coordinator |
| APRN | Advanced Practice Registered Nurse |
| APS | Adult Protective Services |
| BCBA | Board Certified Behavior Analyst |
| BP | Blood Pressure |
| BSP | Behavior Support Plan |
| BSRC | Behavior Support Review Committee |
| CAP | Corrective Action Plan |
| CBC | Criminal Background Check |
| CDC | Centers for Disease Control and Prevention |
| C-Diff | Clostridium Difficile |
| CLDP | Community Living Discharge Plan |
| CLO | Community Living Options |
| CLODR | Community Living Options Discussion Record |
| CLOIP | Community Living Options Information Process |
| CMS | Centers for Medicare and Medicaid Services |
| CEU | Continuing Education Unit |
| CNE | Chief Nurse Executive |
| COP | ICF/MR Condition of Participation |
| CP | Cerebral Palsy |
| CPR | Cardiopulmonary Resuscitation |
| CRIPA | Civil Rights of Institutionalized Persons Act |
| CSO | Campus Supervision Overnight |
| CT | Computed Tomography |
| CTD | Competency Training and Development |

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| CV | Curriculum vitae (resume) |
| CWS | Client Work Station |
| DADS | Texas Department of Aging and Disability Services |
| DCP | Direct Care Professional |
| DD | Developmentally Delayed |
| DFPS | Department of Family and Protective Services |
| DISCUS | Dyskinesia Identification System: Condensed User Scale |
| DOJ | U.S. Department of Justice |
| DMID | Diagnostic Manual-Intellectual Disability |
| DRO | Differential Reinforcement of Other Behavior |
| DSM/DSM IV TR | Diagnostic and Statistical Manual of the American Psychiatric Association |
| DUE | Drug Utilization Evaluation |
| EKG | Electrocardiogram |
| ER | Emergency Room |
| FA | Functional Analysis or Functional Assessment |
| FLACC | Face, Leg, Arm, Cry, Consolability Pain Scale |
| FSPI | Facility Support Performance Indicator |
| FTE | Full Time Equivalent |
| FY | Fiscal Year |
| GERD | Gastroesophageal reflux disease |
| HAI | Health-care Associated Infections |
| HCG | Health Care Guidelines |
| HCP | Health Care Plan |
| HIPAA | Health Information Portability and Accountability Act |
| HIV | Human Immunodeficiency Virus |
| HMP | Health Maintenance Plan |
| HOB | Head of Bed |
| HR | Human Resource |
| HRC | Human rights committee |
| HO | Human Rights Officer |
| HST | Health Support Team |
| IBW | Ideal Body Weight |
| ICF/MR | Intermediate Care Facility for the Mentally Retarded |
| IDT | Interdisciplinary Team |
| IMC | Incident Management Committee |
| IMRT | Incident Management Review Team |
| ISP | Individual Support Plan |
| i.v. | Intravenous |
| LAR | Legally Authorized Representative |
| LVN | Licensed Vocational Nurse |
| MAR | Medication Administration Record |

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| MBSS | Modified Barium Swallow Study |
| MD/M.D. | Medical Doctor |
| MediMAR | Electron Medication Administration Record |
| MOSES | Monitoring of Side Effects Scale |
| MRA | Mental Retardation Authority |
| MRSA | Methicillin-resistant Staphyloccus Aureus |
| NA | Not Applicable |
| NANDA | North America Nursing Diagnosis Association |
| NCP | Nursing Care Plan |
| NMT | Nutritional Management Team |
| NOO | Nurse Operations Officer |
| NP | Nurse Practitioner |
| NPO | Nothing by mouth |
| OIG | Office of the Inspector General |
| OJT | On the Job Training |
| OT | Occupational Therapy |
| OTR | Occupational Therapist, Registered |
| O2Sat | Oxygen saturation |
| PALS | Positive Adaptive Living Survey |
| PAO | Physical Aggression toward Others |
| P&P | Policies and Procedures |
| P&TC | Pharmacy and Therapeutics Committee |
| PBSP | Positive Behavior Support Plan |
| PBST | Personal Behavior Support Team |
| PCD | Planned Completion Date |
| PCP | Primary Care Physician |
| PDB | Physically Disruptive Behavior |
| PDP | Personal Development Plan |
| PFA | Personal Focus Assessment |
| PIC | Performance Improvement Council |
| PMAB | Physical Management of Aggressive Behavior |
| PMR | Psychiatric Medication Review |
| PMT | Psychotropic Medication |
| PNA | Psychiatric Nurse Assistant (Direct Care Professional) |
| PNM | Physical and Nutritional Management |
| PNMC | Physical and Nutritional Management Coordinator |
| PNMP | Physical and Nutritional Management Plan |
| PNMT | Physical and Nutritional Management Team |
| POC | Plan of Correction |
| POI | Plan of Improvement |
| PPD | Purified Protein Derivative |

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| PRN | Pro Re Nata (as needed) |
| PSA | Prostate Specific Antigen |
| PSO | Professional Staff Organization |
| PSP | Personal Support Plan |
| PSPA | Personal Support Plan Addendum |
| PST | Personal Support Team |
| PT | Physical Therapy |
| PTR | Psychiatric Treatment Review |
| QA | Quality Assurance |
| QDRR | Quarterly Drug Regimen Review |
| QE | Quality Enhancement |
| QI | Quality Improvement |
| QMRP | Qualified Mental Retardation Professional |
| RD | Registered Dietician |
| RN | Registered Nurse |
| r/o | Rule out |
| SA | Settlement Agreement |
| SAC | Settlement Agreement Coordinator |
| SAM | Self-Administration of Medication |
| SA-PIC | Settlement Agreement-Process Improvement Council |
| SIB | Self-injurious Behavior |
| SLP | Speech and Language Pathologist |
| SOAP | Subjective, Objective, Assessment/Analysis, and Plan charting method |
| SSLC | State Supported Living Center |
| SPCI | Safety Plan for Crisis Intervention |
| SPO | Specific Program Objective |
| SPOI | Supplementary Plan of Improvement |
| SQRA | Standard of Quality for Risk Assessment |
| STAT | Immediate |
| STD | Sexually Transmitted Disease |
| TB | Tuberculosis |
| UA | Urinalysis |
| UIR | Unusual Incident Review or Unusual Incident Report |
| VBMC | Valley Baptist Medical Center |
| VCF | Virtual Client Folder |
| VDB | Verbally Disruptive Behavior |
| VFS | Videofluoroscopy |
| VNS | Vagal Nerve Stimulator |
| VRE | Vancomycin-resistant enterococcus |
| V/S | Vital Signs |